WEST VIRGINIA I/DD WAIVER CARECONNECTION© WEB USER MANUAL

VERSION 2.1

REVISION SHEET

Release No.	Date	Revision Description
Version 1.0	3/20/2008	Initial Release of Web User Manual
Version 1.1	4/09/2008	• Updated page numbers • Added Appendix A: Transferring Services
Version 2.0	08/02/2013	• Updated to include new user roles- IPN, PCA Admin, PCA, F/EA Admin • Updated to include new functionality- Initial Application Submission/tracking, Wait List, Service Delivery Model, Attach Documents, Discharge-service provision update. • Updated to include I/DD language (replacing MR/DD language)
Version 2.1	6/9/2016	• Rebranded document to reflect KEPRO as the UMC. • Updated Appendix F - Demo can only be created or edited by UMC users. Providers should contact KEPRO staff for necessary updates.

KEPRO
I/DD WAIVER CARECONNECTION© WEB USER MANUAL

Contents

1. General Information

Kepro - West Virginia (KEPRO) is the Utilization Management Contractor (UMC) contracted by the West Virginia Department of Health and Human Resources (DHHR) Bureau for Medical Services (BMS) Intellectual/Developmental Disabilities (I/DD) Waiver program. KEPRO performs administrative functions to enhance communication, effectiveness and a continuum of care for members served.

The effectiveness of the I/DD Waiver program is enhanced by:

- Providing standardized assessments used to determine Individualized Waiver Budgets and program eligibility,
- Promoting a person-centered philosophy with members, providers and all stakeholders,
- Prior authorizing services specific to member needs,
- Providing education and technical assistance to improve the quality of care and increase successful outcomes,
- Providing training and education for members and families to promote empowerment, knowledge and understanding of the program,
- Investigating complaints,
- Conducting provider reviews to ensure services are provided in accordance to the needs of the program member,
- Building and maintaining the I/DD Waiver CareConnection© system which serves as a comprehensive electronic database for managing program application and enrollment.

1.1. System Overview

The I/DD Waiver CareConnection© system allows multiple user types to interface with member records as their user role permits; provides a framework and a process for the prior authorization request of waiver services; provides authorization for services that are based on the member's assessed needs; determines the fair and equitable distribution of available funds through assessment of the program member's needs, functionality and supports; assists with management of assessment completion through tracking of appointment contacts and outcomes; provides a framework for oversight of the eligibility process; tracks slot allocation distribution through waitlist management; and provides a central location for document storage by allowing multiple users to attach documents onto a single member's record.

It is recommended that users reviewing this manual do so in its entirety to gain a comprehensive and global perspective of I/DD Waiver CareConnection© operations. Minimally, readers should review both "All Users" section as well as the section specific to their user role, as general functions spanning multiple user roles are not repeated in each user section.

1.2. Technical Requirements

1.2.1. Internet Access

Users must have a computer with Internet access. The program is optimized when using Internet Explorer (IE) 8.0 and higher. In order to print any forms, the user must also be connected to a printer.

1.2.2. Security and HIPAA Compliant

This application follows Health Care Financing Administration (HCFA) security regulations and complies with Health Insurance Portability and Accountability Act (HIPAA) regulations. Consequently, there are multiple levels of security. For more information on the security of this online application, please contact Kepro, Inc. at 866-385-8920.

1.2.3. Privacy Policy

The system Privacy Policy can be retrieved and reviewed from the bottom of each page in CareConnection© by clicking on the Privacy Policy hyperlink.

Figure 1- KEPRO Privacy Policy

1.2.4. Trouble-Shooting

If users experience difficulty logging on or using the program, the following are recommended.

- Check to confirm that the browser's security settings are set to 128-bit encryption. This can be done in the Microsoft Internet Explorer session by clicking "Help" and then clicking "About Internet Explorer." The resulting display will specify the "Version" of Internet Explorer running, along with the encryption specification in terms of "Cipher Strength."
- Upgrade the browser to Internet Explorer 8.0 or higher.
  - ✓ Windows XP or higher is required
  - ✓ To download a free upgrade of IE visit http://www.microsoft.com/windows/ie/downloads/ie6/default.asp
- Reset the Internet security to Medium.
  - ✓ Right Click on the IE icon
  - ✓ Choose "Properties"
  - ✓ Select the "Securities" tab
  - ✓ Click "Default" level.

1.2.5. All Users-User Access Levels

The web system recognizes different users and/or user groups and places restrictions on system accessibility for each user/user group based on the functions the user/user group performs.

2. ALL USERS

2.1. Log In

Users can access the I/DD Waiver Program CareConnection© web site at https://WVLTC.kepro.com and logon with an assigned **User Name** and **Password**.

The *Log In* screen welcome note will be a means by which KEPRO can communicate changes about the web system, upcoming trainings, and general information.

After the user logs in, he/she is directed to the appropriate web page inherent to the role associated with the user name (e.g. Administrator, Service Coordinator, BMS User, IPN User, etc.).

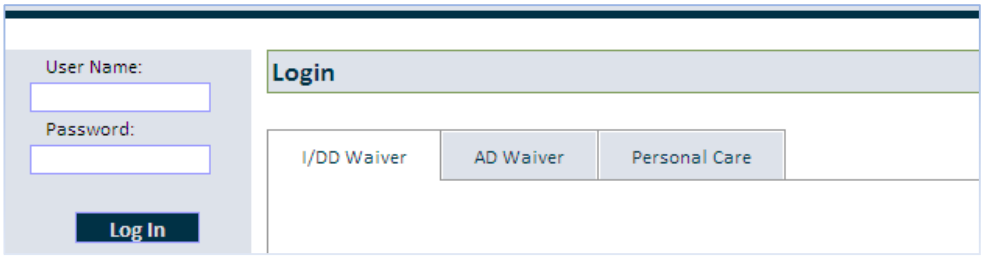


Figure 2-Login

2.2. System Layout

2.2.1. I/DD Waiver Menu

Upon logging into the system, the users will notice a menu on the left side of the screen. This menu contains overall system functions the user can access. I/DD Waiver Menu functions vary per user role. Upon log in, the system always defaults to **Notifications**.

2.2.2. Consumer Navigation Menu

After retrieving a member record, and entering that record, the **Consumer Navigation Menu** will display at the bottom of the screen. This menu allows the user to view or take action specific to that applicant or member. Buttons available in the **Consumer Navigation Menu** are dependent on the user's role as well as the member's eligibility status.

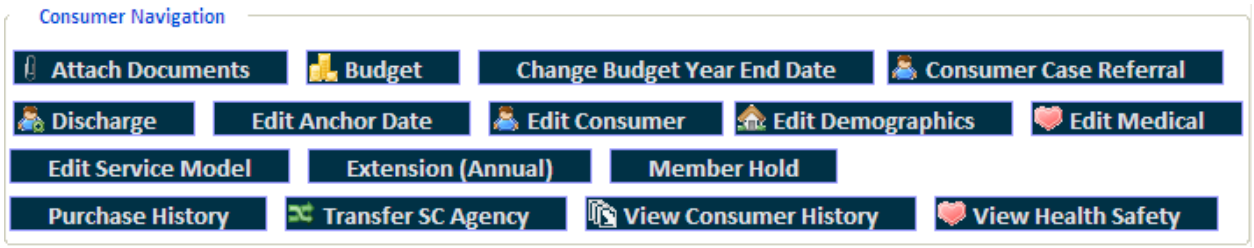


Figure 3-Consumer Navigation Menu

2.3. Notifications

Most user roles receive notifications specific to their function in Care Connection©. The default page following **Log In** is **Notifications**. These notifications are generated by the system when the user performs some operation in the application or to notify the user of items requiring their attention. There are two broad categories of notifications in the system.

Actionable notifications are those that require the user to take an action before they are dismissed. An example of an actionable notification would be to a Provider Administrator letting them know a service has been requested of them which requires them to either accept or reject the service referral. This notification will not disappear until the user clicks on the link and either accepts or rejects the service referral.

Non-actionable notifications are those that essentially notify the user of some action, information or update. For Non-actionable notifications the user has the ability to either "Dismiss All" Dismiss All messages tied to the notification or Dismiss an individual message.

Figure 4-Notifications

2.4. Search

All user roles can click on the **Search** link in the left-hand menu which yields the searches available for that user role. A web user can access a *Search* screen by clicking on the **Search** menu item, then the specific, desired search link. This screen will enable searching of the I/DD Waiver application via a variety of search methods, either by entering data into an individual search field, or combining data fields. For example, certain user roles can search consumers served by their agency. Other user roles can search for all members served through the I/DD Waiver program. Users should filter their search results by entering the characteristics of the search they desire.

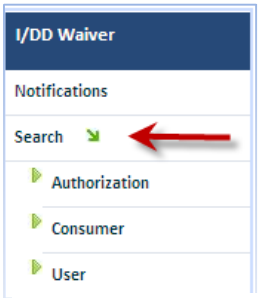


Figure 5-Search

Entering a search with no predetermined criteria will result in all members, providers, users, and/or authorizations for which the user logged in has a relationship.

Depending upon user-role functionality, the following searches can be performed:

- Search Appointment-KEPRO Only
- Search Authorization
- Search Consumer
- Search Notification-KEPRO Only
- Search Provider
- Search Purchase Request-KEPRO Only
- Search Service-KEPRO Only
- Search Service Note-KEPRO Only
- Search User.

2.4.1. Search Appointment

Search Appointment is a function reserved only for KEPRO, PCA Admin and IPN users relative to scheduling and searching for member Annual Functional Assessments conducted by KEPRO Service Support Facilitators and Independent Psychological Evaluations completed by Independent Psychologists (IPN Users).

2.4.2. Search Authorization

Provider Administrators conducting a search for members for which they do not provide Service Coordination must do so via the **Search Authorization** feature. If an agency does not provide Service Coordination for a specific member, that member will not be visible via **Search Consumer**. Entering search criteria under **Search Authorization** will result in the icons to **View Consumer** , **View Purchase** , or **Modify Purchase** .

When the **View Consumer** icon is selected, the Provider Administrator has access to the member's **Consumer Snapshot** (overview of demographics) and the **Consumer Navigation Menu** which provides the ability to view member items specific to the user's role.

2.4.3. Search Consumer Consumer

The user may **Search Consumer** by entering any combination of the following search criteria, after selecting **Search Consumer** from the left-hand menu.

- First Name
- Last Name
- Guardian First Name
- Guardian Last Name
- Medicaid #
- KEPRO ID
- County
- Decision Date
- SC Last Name
- Eligibility Status

Once the desired combination of search criteria are entered into the appropriate field(s), the user selects **Search** by using the button at the bottom of the screen or by hitting the **Enter** key. The user will then be directed to a list of consumers on the program who meet the search criteria.

2.4.4. Search Notification

Search Notification is applicable to only KEPRO users. This feature allows the user to search notifications for a specific member or circumstance so that timely action can be taken in authorizing member services.

2.4.5. Search Provider Provider

Administrative Users may search provider by selecting **Search** from the left-hand menu and then selecting **Provider**. Once in the *Search Provider* screen, the user can view a list of all providers actively enrolled in the I/DD Waiver program with which the user is affiliated, or can sort by entering search criteria: Counties Serviced, Services Offered, City, or State. After entering search criteria, the user

should select **Search** to yield results meeting the criteria entered. To view specific information about the chosen provider, the user should select the **Edit** hyperlink to the left of the desired provider. Selecting **Edit** will take the user to the *View Provider Locations* screen.

View Providers - To view a list of providers without the search feature, select **View Providers** from the left-hand menu.

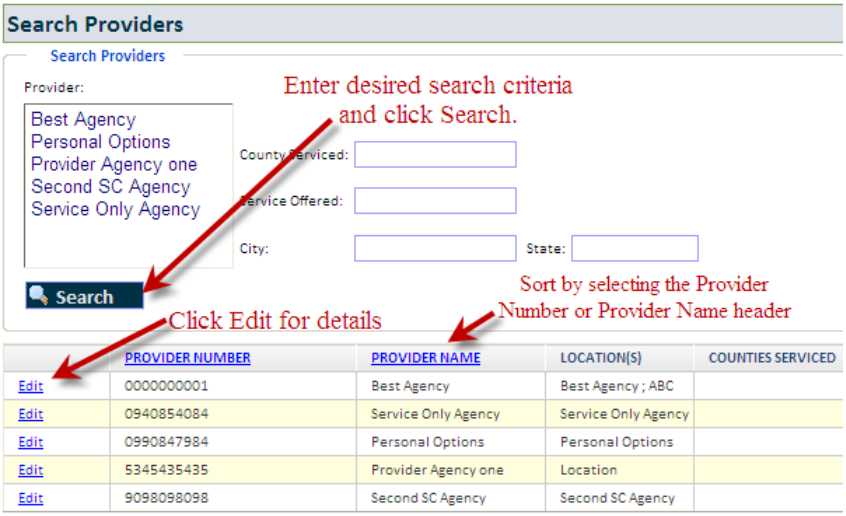


Figure 6-Search Providers and Results Grid

To View the provider's demographic and leadership information select **Edit** from the *View Provider Locations* screen. To view the list of approved services and counties the provider is authorized to operate within select **View** from this screen.

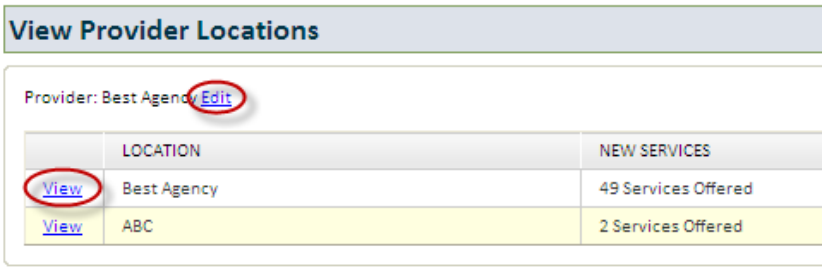


Figure 7-View Provider Details

2.4.6. Search Service

Search Service is available only to KEPRO users. This feature allows KEPRO to search for services as provided per the authorization information, consumer information, and provider of service or service request status.

2.4.7. Search Service Note

Search Service Note is available to only KEPRO users. This feature allows KEPRO to search for specific internal notes which were previously entered to document information pertaining to a member's record.

2.4.8. Search User

User

Administrative users can search users by selecting **Search** from the left-hand menu and then selecting **User**. Once in the *Search User* screen, the user can view a list of all affiliated users who have a user id for I/DD Waiver CareConnection©. The user can limit their search by entering search criteria: First Name, Last Name, Show Users [Active Only], [Inactive Only] or [Show All Users], username or Provider with which the user is affiliated. Clicking **Search** will result in a table of users meeting the search criteria.

View Users - To view a list of users without the search feature, select View Users from the left-hand menu.

2.4.9. Search Results Column Sort

Throughout CareConnection© the user will have the ability to perform multiple types of searches depending on the intended action. Results of the search will display in the Search Results Grid. Columns containing hyperlinked headers are generally sortable.

Sort

	ELIGIBILITY STATUS	APS ID	PROVIDER ID	SERVICE COORDINATOR	CONSUMER NAME	MEDICAID NUMBER
Detail	Active	58		Coordinator , Service	Name, Member1	
Detail	Applicant-Eligible	63		Coordinator , Service	Name, Member2	
Detail	Applicant-Eligible	68		Coordinator , Service	Name, Member3	
Detail	Applicant-Eligible	73		Coordinator , Service	Name, Member4	

Figure 8-Search Results Column Sort

2.5. Change Password

After successfully logging in, the user may choose to change their password via the **Change Password** link in the I/DD Waiver Menu. Clicking this link will direct the user to the *Change Password* screen allowing them to choose a new password. Note that existing password must be entered in the data entry field **Password**, and then the new password can be entered and confirmed.

To complete the action of changing the password, click **Change Password.**

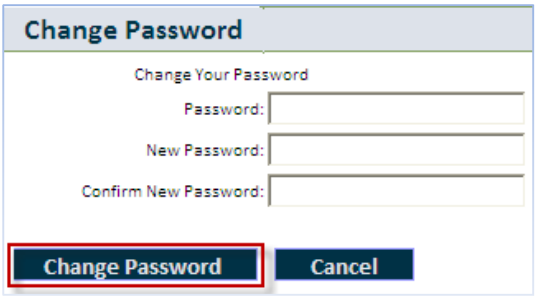


Figure 9-Change Password

2.6. Print

All users have the capability to print from CareConnection© by clicking the link on the menu at the top of the page.

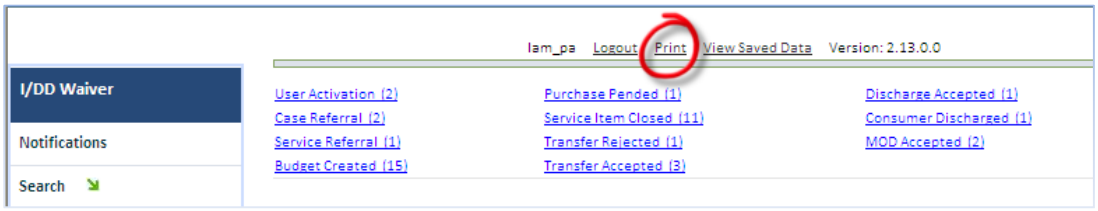


Figure 10-Print

By selecting the **Print** link above, the user will be taken to their system's print options. An example is displayed; however, options and screens will vary depending on the user's specific system.

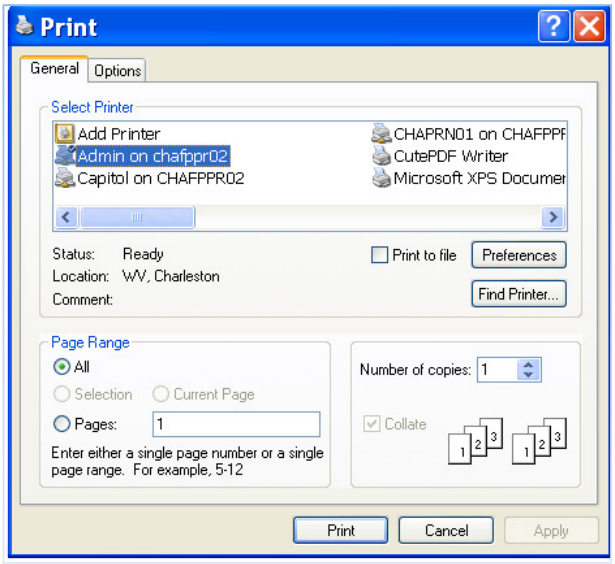


Figure 11-Print Detail

2.7. View Saved Data

Some features, such as **Edit Consumer** and **Edit Medical** offer the user the option to save data to return at a later time. In order to view the data that has been saved, the user selects **View Saved Data** from the top of the screen. This results in a list from which the user can choose to open and then edit, or delete data previously saved.

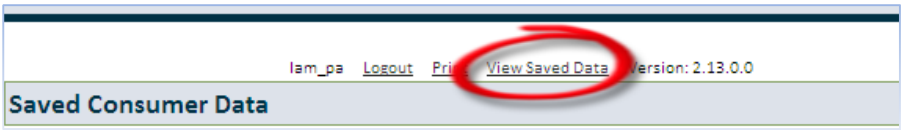


Figure 12-View Saved Data

2.8. View Consumer Snapshot

All users can also **View Consumer Snapshot** for the consumers assigned to them. New features include the consumer's eligibility status and anchor date.

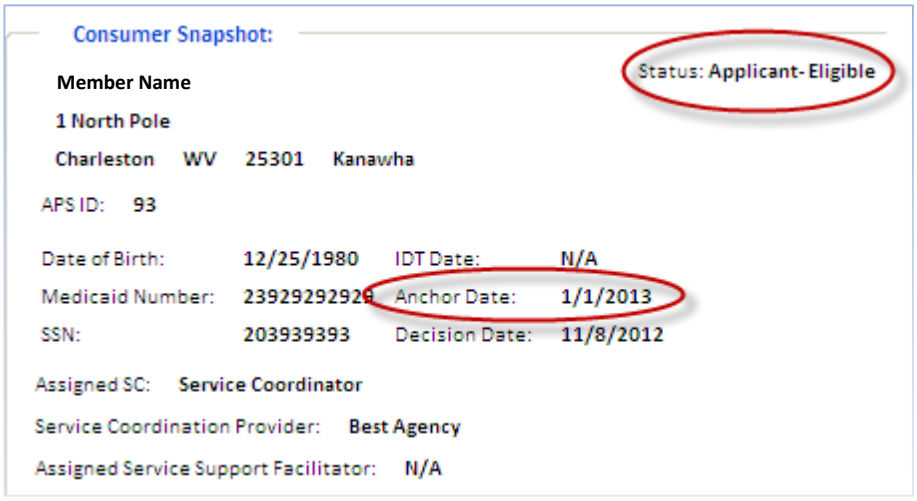


Figure 13-Consumer Snapshot

2.9. Access Denied

When a user receives the *Access Denied* screen it means their user role does not have the privileges to access the information contained on the screen they were trying to enter.

2.10. Attach Documents

Attach Documents is a feature in CareConnection© that allows users to upload and/or view pertinent clinical information about the members/applicants in which they are affiliated. This feature should be used if and when KEPRO staff request additional information pertinent to an authorization request, for viewing/attaching member program plans, Independent Psychological Evaluations, and other member-specific clinical records.

Although some processes throughout the flow of data in CareConnection© prompt users to attach at different stages, users can always go to **Attach Documents** through the **Consumer Navigation Menu** at the bottom of a member's record.

Attach Document/View Attached Document

Once in the *Attach Documents* screen, the user should select "Browse." This will enact the user's computer's upload feature which will allow the user to find the file on their computer.

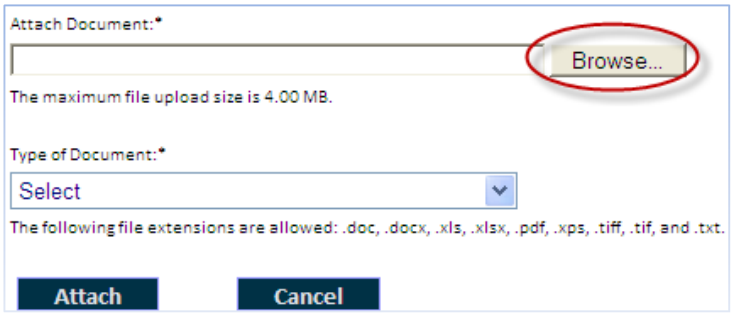


Figure 14-Browse to Attach Document

The user should find the appropriate file on their computer by navigating the "Look in:" drop-down. The file path selected will automatically display in the *Attach Document* screen.

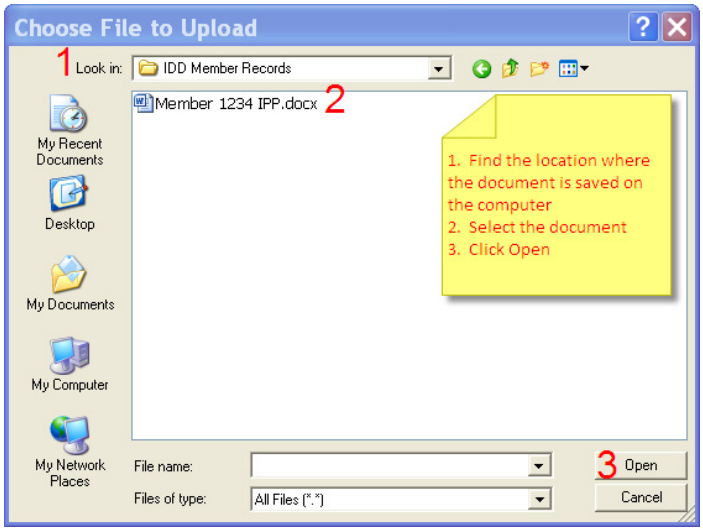


Figure 15-Choose File to Upload

The user should then select the type of document they are attaching from the drop-down. For security purposes, items available in the drop-down vary by user role. Once the file path, and type of document are displayed, the user should select **Attach** to attach the document to the member's record.

The user will receive a confirmation message that the file was uploaded successfully. The user and any others affiliated with the member's case will now be able to access documents attached (specific to user role) via the Attached Documents grid. The grid will display the date the document was attached (Create Date), the first and last name of the user who attached (Create By) and the Type of Document attached. The user can retrieve and view the document already attached by selecting the hyperlink under "Type of Document."

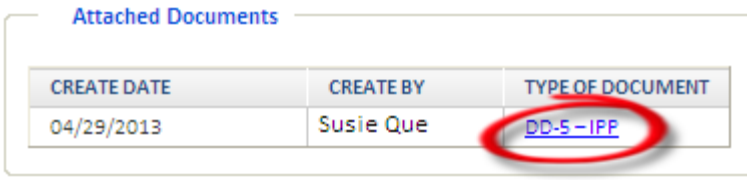


Figure 16-Attached Documents

2.10.1. The system will accommodate the following file extensions: .doc, .docx, .xls, .xlsx, .pdf, .xps, .tiff, .tif and .txt.

2.10.2. Maximum file upload size is 4.00 MB

2.11. Logout

The **Log Out** link can be accessed by the user via any screen.

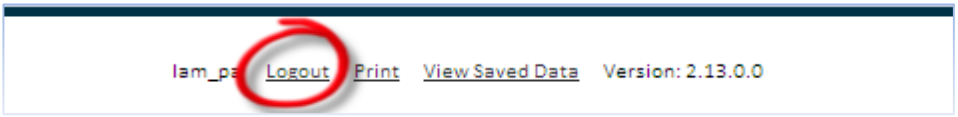


Figure 17-Logout

3. BMS USER

The Bureau for Medical Services User has read-only access to all member, provider and user records in CareConnection©. The BMS User receives no notifications, and is not expected to take action in the system. The BMS User can: Search and View Consumers, Providers, and Users, view and Search Waitlist and Change password.

3.1. Search 

The user may Search Consumer, Search Provider, and Search User by selecting the appropriate Search link from the left-hand menu option.

3.2. View Providers

The user may view a comprehensive list of registered providers (*Provider List* screen) by selecting **View Providers**. Once on this screen, the user may select **Edit** to view details about the chosen provider.

3.3. Expiration Report

Expiration Report will allow the user to view a summary of items related to KEPRO response times in acting on purchase requests. Additionally, the user may elect to view a list of first and second notices that went to providers as a result of non-response to service referrals.

3.4. View Users

View Users allows the user to view a comprehensive list of users affiliated with the I/DD Waiver CareConnection© system.

3.5. View Waitlist

The user can select **View Waitlist** from the left-hand menu. The user is then directed to the *View Waitlist* screen, which displays the Waitlist Summary and gives the user the ability to search for applicants who have been determined medically eligible but are not yet enrolled in the I/DD Waiver program.

The Waitlist Summary allows the BMS User to view point-in-time Waitlist statistics, including:

- Total Slots Available,
- Number of Individuals Currently on Waitlist,
- Number of Individuals Active,
- Number of Unduplicated Slots Occupied During Current Fiscal Year,
- Slots Available for Immediate Release,
- Slots Available Next Fiscal Year.

In addition, the user can search for a particular member on the Waitlist by entering any combination of search criteria in the data fields, and selecting the **Search Waitlist** button or by pressing the **Enter** key. This action will display individuals on the Waitlist who meet the search criteria, as well as their slot number, KEPRO ID, MECA Date of Decision, Hearing Date of Decision, First Name, Last Name, DOB, SSN, County, SSF, and Date of Activation. Note that fields that do not apply to the individual are left blank.

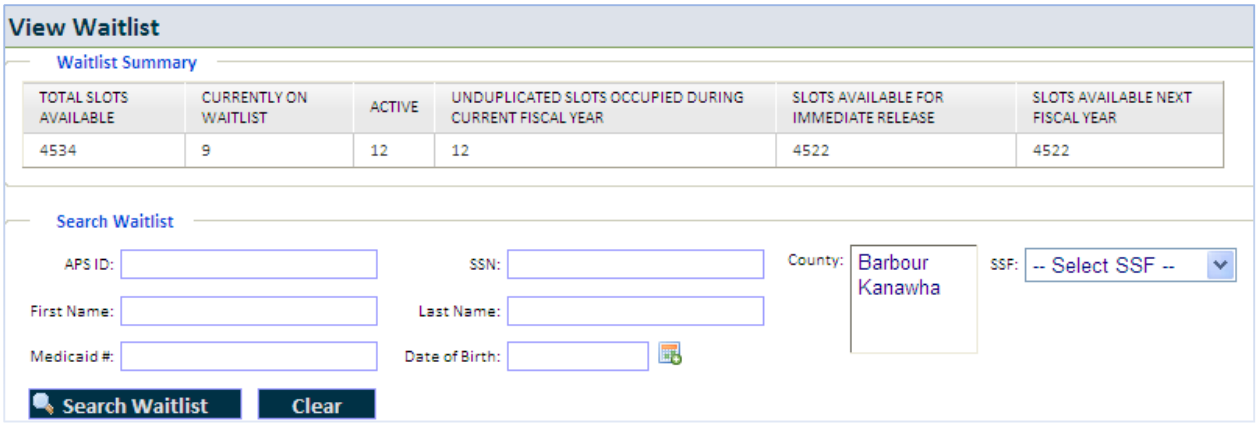
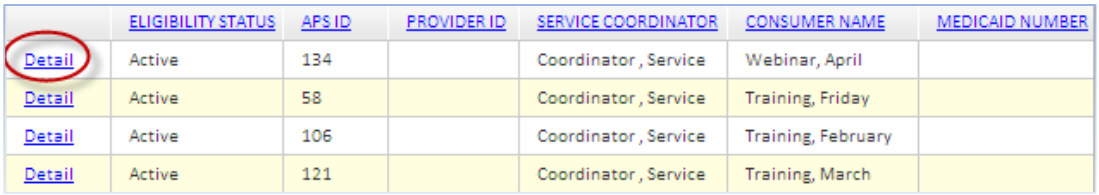


Figure 18-View Waitlist

3.6. Consumer Detail Consumer Detail

When the BMS user selects the **Detail** link to the left of the consumer's eligibility status on the *Search Consumers* screen, he or she is directed to the *Consumer Detail* screen. Additionally, while already in a member record, the BMS User can select **Consumer Detail** from the **Consumer Navigation Menu**.



	ELIGIBILITY STATUS	APS ID	PROVIDER ID	SERVICE COORDINATOR	CONSUMER NAME	MEDICAID NUMBER
Detail	Active	134		Coordinator , Service	Webinar, April	
Detail	Active	58		Coordinator , Service	Training, Friday	
Detail	Active	106		Coordinator , Service	Training, February	
Detail	Active	121		Coordinator , Service	Training, March	

Figure 19-Search Consumers and Results Grid

The *Consumer Detail* screen displays the Consumer Snapshot and allows the user to select to view the applicant's/member's eligibility **Status and Recent Purchases**. The **Consumer Navigation** Menu at the bottom of the page allows the user to **View Documents**, **View Budget**, **View Consumer**, **View Demographics**, **View Health Safety**, **View Service Model**, and **View Member Hold**.

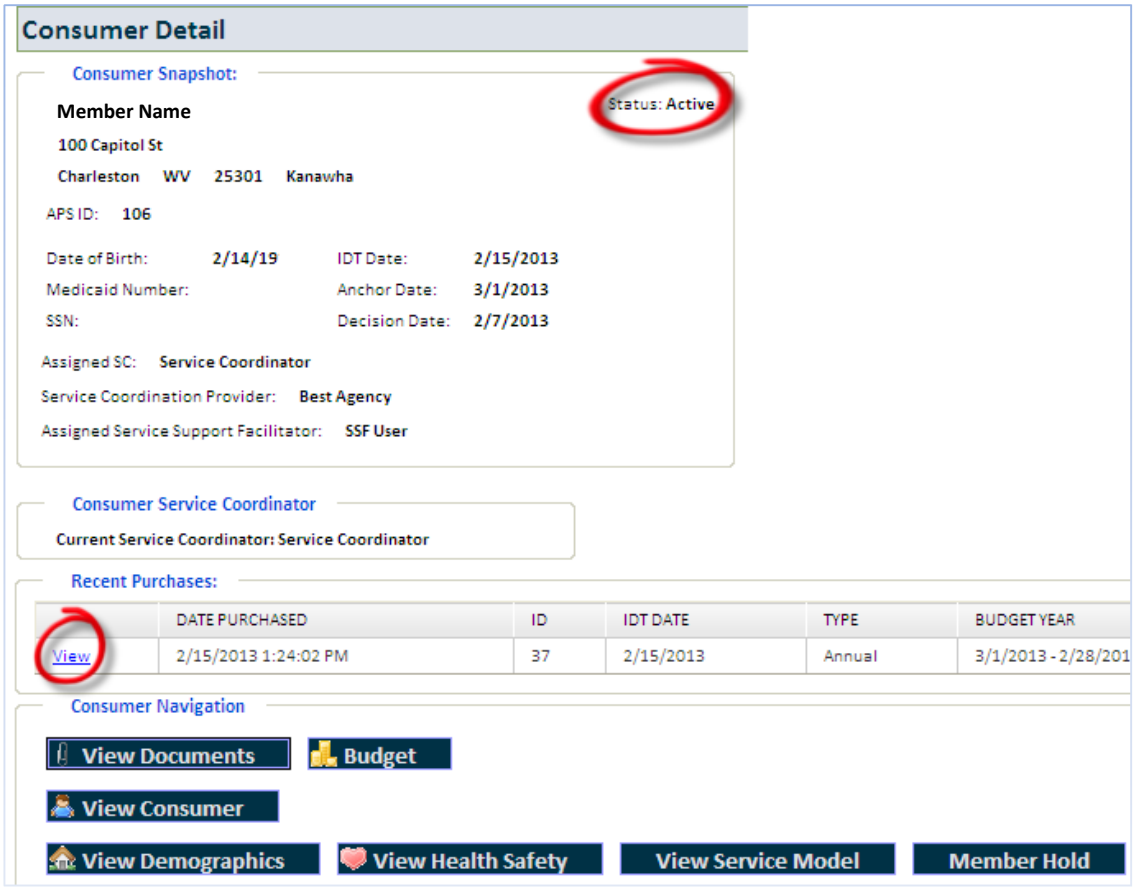


Figure 20-Consumer Detail Screen

3.7. View Purchase Request Details

To view a list of I/DD Waiver services requested and the status of the prior authorization request, the user should select the **View** link to the left of *the* **Date Purchased** box in the **Recent Purchases** section of the **Consumer Detail** page. When this link is selected, the user is directed to the *View Purchase Request Details* screen.

The user has the ability to tailor the details in the table by sorting by certain category headers. The user can also "check" or "uncheck" the boxes per categories shown to increase of decrease the amount of information that is shown.

Figure 21-View Purchase Request Details

3.8. View Demographics, Health Safety, Service Model and Member Hold

When the user selects one of these buttons from the **Consumer Navigation Menu**, he or she is directed to the appropriate screen:

- View Demographics allows viewing of the member's demographics information entered by the Service Coordination Provider;
- View Health Safety allows viewing of the medical and psychological information entered by the Service Coordination Provider – any items with a red exclamation point are those which are considered to be critical health and safety issues, and should be addressed in the member's Individualized Program Plan.
- View Service Model allows viewing of the member's history of choices related to the Service Delivery Model;
- Member Hold allows viewing of the member's Hold History- Holds are implemented when the member is temporarily not accessing I/DD Waiver services.

3.9. View Documents View Documents

To view any documents attached into CareConnection© by any user, the BMS user should select **View Documents** from the **Consumer Navigation Menu** at the bottom of the *Consumer Detail* or other screen from which the menu is available. The user will be able to choose the document they wish to view by reviewing the Create Date (date document was attached), Create By (first and last name of user who attached the document) or type of document and then selecting the hyperlink under **Type of Document**.

Attached Documents

CREATE DATE	CREATE BY	TYPE OF DOCUMENT
02/12/2013	Service Coordinator	DD-1 – Application
02/12/2013	Service Coordinator	IPE
02/15/2013	Service Coordinator	Legal Forms
02/15/2013	Service Coordinator	DD-5 – IPP

Figure 22-View Documents

3.10. View Budget Budget

By selecting the **Budget** button from the **Consumer Navigation Menu**, the user is directed to the **Assign** *Budget* screen. In addition to the **Consumer Snapshot** and the **Consumer Navigation Menu**, the user can also view the **Budget History** table. This table contains a history of Individualized Waiver Budgets, cost of authorized services and member assessment information per member's service year. The user may also view the list of services requested/authorized per year by selecting the year's **View** link in the Budget History table and view Assessment results by selecting the link in the Assessment box.

Click on any assessment to view results

Budget History

ACTION	START DATE	END DATE	AMOUNT	PURCHASED	DATE ENTERED	VIEW PURCHASE HISTORY	ASSESSMENT
	10/1/2007	10/30/2008	$46,127.33	$45,821.49	12/1/2007	View	ECA SIS ICAP ECA Detail SIS Detail
	10/1/2008	10/30/2009	$28,653.32	$46,754.70	8/14/2008	View	ECA SIS ICAP ECA Detail SIS Detail
	10/1/2009	10/30/2010	$31,360.86	$45,161.30	8/6/2009	View	ECA SIS ICAP ECA Detail SIS Detail

Figure 23-Budget History Results

4. INDEPENDENT PSYCHOLOGICAL NETWORK (IPN) USER

The IPN User is the psychologist responsible/selected to provide an initial psychological evaluation and any 2nd psychological [medical] evaluations which are used to determine program eligibility. The user schedules evaluation appointments and attaches completed evaluations into the system so that eligibility can be determined by the Medical Eligibility Contract Agent. IPN Users will have access to Applicants/Consumers assigned to them for Independent Psychological Evaluation (IPE) completion.

4.1. Notifications

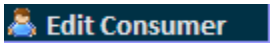
The IPN User will receive notifications relevant to assessments the IP has been chosen to perform. The **IPE Requested** notification is actionable, and will not dismiss until the IPE or Second IPE documentation type has been attached via **Attach Documents** in the system. See **Appendix C** for a list of common notifications associated with the IPN User.

4.2. Search 

The IPN User can Search Appointment, Search Authorization, and Search Consumer.

4.3. Authorizations for Independent Psychological Evaluations

Authorizations for payment of Independent Psychological Evaluations will only be generated by CareConnection© and forwarded to the state's claims payer if the IPN User has provided KEPRO with the Provider Medicaid ID Number and when the applicant or member has a valid Medicaid ID Number. If an Authorization is not generated because both of the conditions above are not met, the IPN should contact the MECA for payment. Available authorizations are retrievable via the **Search Authorization** feature

4.4. Edit Consumer 

When the IPN User is ready to contact the applicant/member to schedule the IPE, they can access the applicable contact information via **Edit Consumer** which is accessed through the member's **Consumer Navigation Menu**. Upon clicking **Edit Consumer**, the IPN User will find a read-only version of the member's/applicant's demographic information and any notes KEPRO has entered into the applicant's record.

4.5. Attach Documents 

The user is able to view attached documents associated with a specific member by clicking on the **blue paperclip** located at the top of the screen when in the member's record. Once on the *Attach Documents Details* screen, the user can either attach a new document or view documents already attached. The user may also get the *Attach Documents* screen by selecting **Attach Documents** from a member's **Consumer Navigation Menu**.

4.6. Create Appointment

Creating an appointment can be done in two ways. First, an appointment can be created through the **IPE Requested** notification. An appointment may also be created through the **Create Appointment** feature accessible through the I/DD Waiver Menu options.

4.6.1. Accessing *Create Appointment* through the 'IPE Requested' Notification

When KEPRO receives the IPN Response Form identifying who the applicant/member has chosen to complete their IPE, KEPRO will send a referral via Care Connection® to the IPN User notifying them

to complete the IPE. To create an appointment through the **IPE Requested** notification, click on the **IPE Requested** notification from the *Notification* screen.

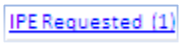


Figure 24-IPE Requested Notification

Next, choose the applicable individual's name and click on the **yellow folder** icon. This will take the user to the *Create Appointment* screen where they can enter their appointment information.

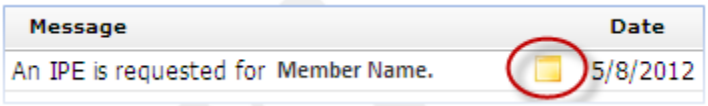
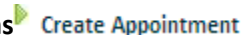


Figure 25-IPE Requested Message

4.6.2. Accessing *Create Appointment* through Menu Options



The IPN User can access the *Create Appointment* screen by clicking on **Scheduler** from the I/DD Waiver Menu options and clicking the **Create Appointment** link. This allows the user to search for the specific individual in which they wish to create an appointment. Once the IPN User searches for and finds the applicant/member for which they wish to schedule an appointment, the user can select the hyperlinked **KEPRO ID** for that person. This action takes the user to the *Create Appointment* screen.

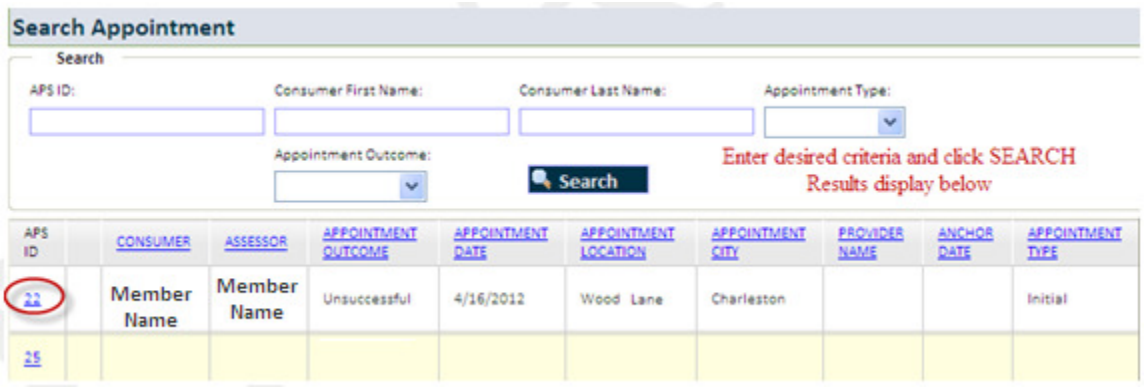


Figure 26-Search Appointment

4.7. Add Contacts

Prior to creating an appointment, the IPN User must document the attempted and/or successful contacts made in effort to reach the applicant/member to schedule an appointment. Ultimately, the IPN User must have a successful contact (meaning an appointment was scheduled) prior to entering the date/time and location of the scheduled appointment. **Add Contacts** allows the user to track the number of

attempts made to schedule an appointment for IPE Completion with the applicant/member. Contact attempts can be viewed in the *Contact Logs* table*.*

4.7.1. Add Contact Date: Enter the date the contact was made or attempted.

4.7.2. Contact: Select the person or entity for which a contact was attempted or successful.

4.7.3. Contact Type: Select the type of contact attempted. User will select either Email, Letter, Other, or Phone Call. If "Other" is selected, the user is prompted to provide additional information about the type of contact.

4.7.4. Contact Outcome: Identify whether or not the contact resulted in an appointment being scheduled.

4.7.4.1. If an appointment was scheduled, the user should select **IPE/KEPRO Assessment Scheduled.**

4.7.4.2. If an appointment was not scheduled, the user should select **IPE/KEPRO Assessment Not Scheduled.**

4.7.5. Follow-up Date: This field allows the user to schedule a date as a reminder/notification to attempt future contact. The system will send a notification [Scheduling Follow-up Contact Reminder] to the user per the date entered reminding them to attempt another contact. When Contact Outcome is "Assessment Not Scheduled" the system requires the user to enter a **Follow-up Date.**

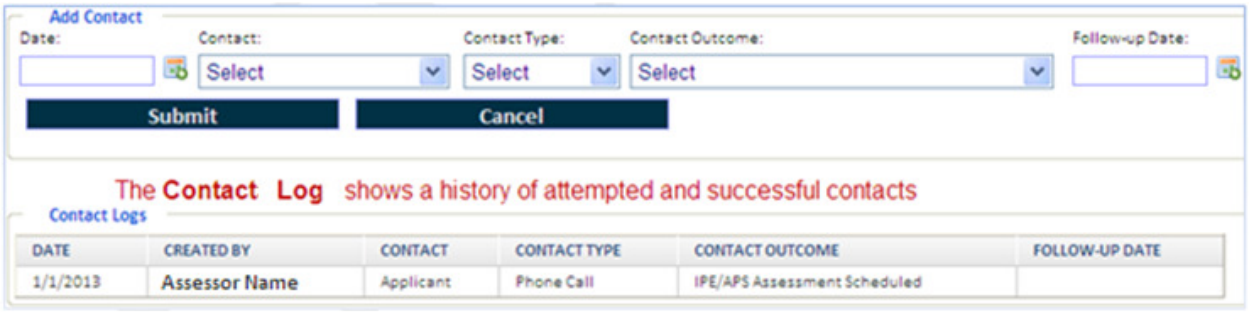


Figure 27-Add Contact and Contacts Log

4.8. Create Appointment

After a successful contact is created, and the Independent Psychological Evaluation has been scheduled, the IPN can document the appointment in the *Create Appointment* screen.

4.8.1. Assessor: Pre-populates with the user logged into the system.

4.8.2. Start Date: Enter the date the appointment is scheduled to occur. If the user attempts to enter an appointment start date that is prior to the date contact was made to schedule the appointment, user will receive a prompt that this cannot occur.

4.8.3. Start Time: Enter the time the appointment is scheduled to begin.

4.8.4. End Date: Enter the date the appointment is scheduled to end (typically the same as Start Date).

4.8.5. End Time: Enter the time through which the appointment is scheduled to occur.

4.8.6. Appointment Type: Select appointment type. For IPs, the appointment types are limited to either Initial or 2nd Medical evaluation.

4.8.7. Address, City, State, Zip: If the appointment is to occur in the applicant's/member's home, the address fields will pre-populate with the member's address. Otherwise, the user should document the address of the location the appointment will occur.

4.8.8. Driving Directions: Contains a hyperlink to Mapquest that will allow the user to retrieve driving directions.

4.8.9. Notes: User should enter any additional information relative to the appointment.

If the user attempts to enter an appointment into a time slot already containing an appointment for that date they will be prompted to choose another date or time for the appointment they are attempting to enter.

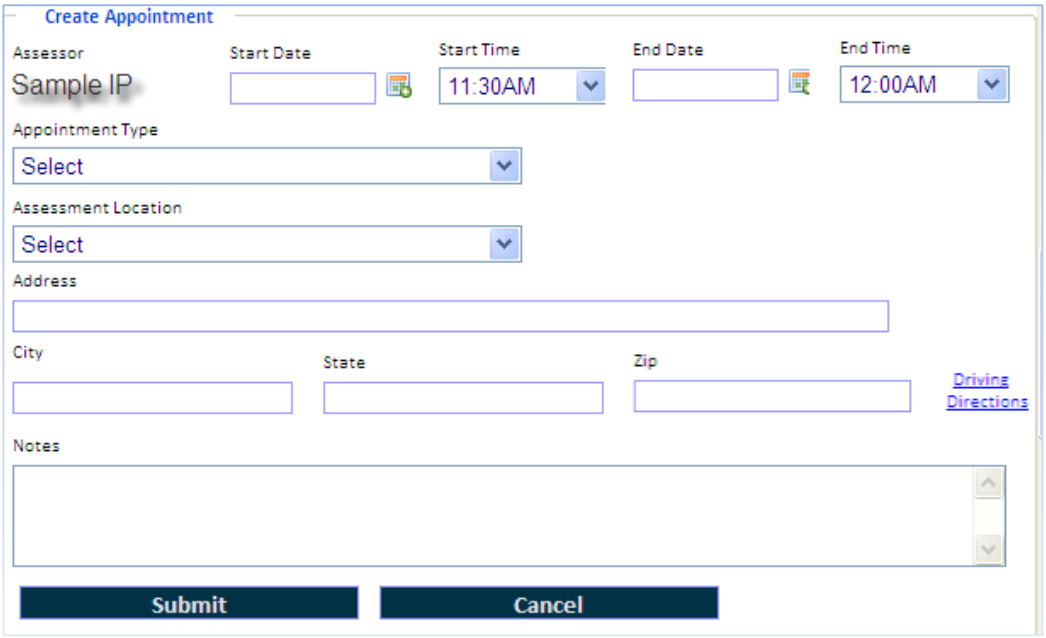


Figure 28- Create Appointment

4.9. Appointment History Grid, Calendar, Edit Appointment, and Appointment Outcome

Once the appointment has been successfully created, the appointment will be written to the **Appointments History** grid and will appear on the user's calendar. The calendar can be referenced to

determine availability for scheduling new appointments and functions similarly to standard calendar programs. The user can view by Day, Week, Month, and can scroll up and down for exposure to earlier/later times during the day.

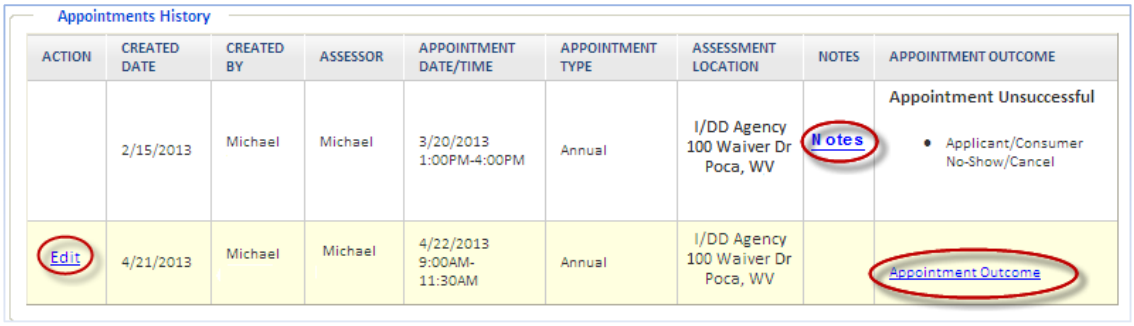


Figure 29-Appointments History Grid

4.9.1. Edit Appointment

From the *Appointments History* grid the user can edit an existing appointment whose appointment date has not yet occurred. This is done by clicking on the **Edit** hyperlink. If this hyperlink is not available, the appointment date is in the past, requiring the user to enter an appointment outcome.

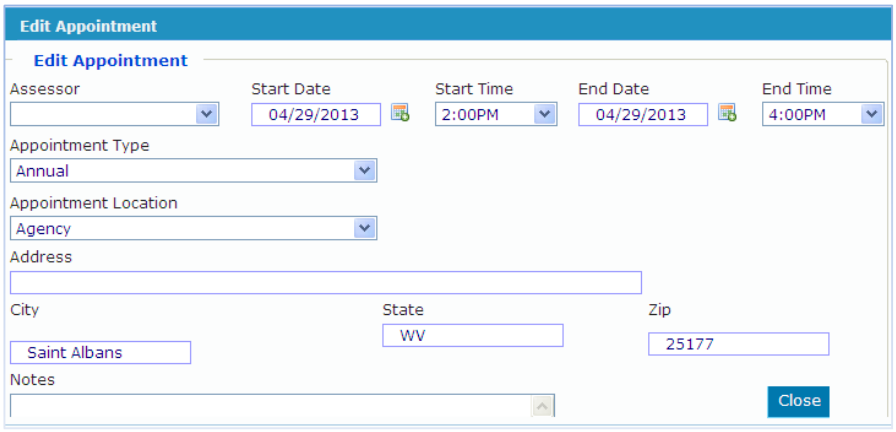


Figure 30-Edit Appointment

4.9.2. Appointment Outcome

Upon completion of the appointment, the IPN User will identify the outcome of the appointment as **Successful** or **Unsuccessful** from the *Appointment Outcome* hyperlink located in the *Appointments History* grid. An appointment outcome cannot be entered prior to the date of the appointment. If the user attempts to do this, they will receive an error message. If the appointment is unsuccessful the user is prompted to identify *why* the outcome was unsuccessful. If the appointment is successful, the IP will be prompted to attach the IPE.

4.9.2.1. Unsuccessful Appointment Outcome

When a scheduled appointment did not occur, the user is expected to identify the reason. This data is necessary for tracking the Centers for Medicare and Medicaid Services (CMS) Discovery

and Remediation Report. Tracking this data verifies whether members receive their assessments in a timely manner, as is required by CMS.

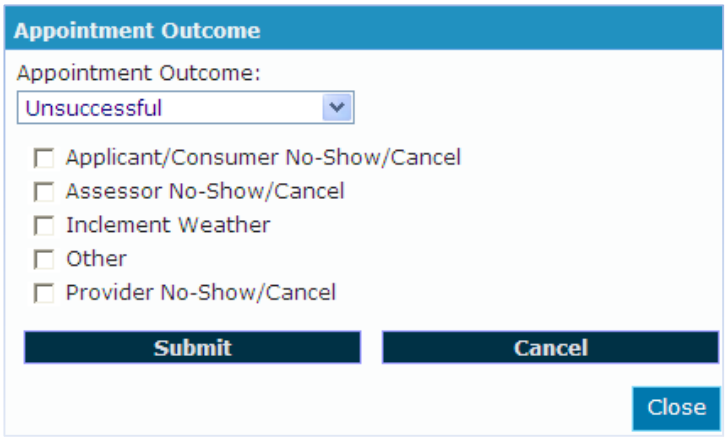


Figure 31-IPN Unsuccessful Appointment

4.9.2.2. Successful Appointment Outcome

When the scheduled appointment successfully occurs, the user should select **Successful** from the drop-down, and then click **Submit**. The green banner success message will prompt the user to attach the member's or applicant's Independent Psychological Evaluation to CareConnection© for review by the Medical Eligibility Contract Agent.

Clicking the "Please Attach IPE for this consumer" hyperlink will take the user to the *Attach Documents* screen where they should attach the IPE to the system for review by the MECA.

The attachment type for a Second Medical Evaluation completed as a result of a denial or program termination should be **Second IPE**.

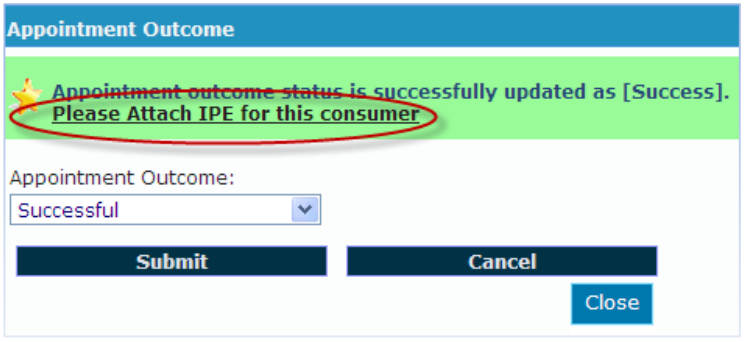


Figure 32-Appointment Outcome Successful

4.10. IPE Denied for Invoice or Additional Documentation is Requested by MECA

The user will receive a system notification [IPE Denied for Invoice/Other Reason] if the previously-submitted IPE has been denied for invoice and/or if the MECA requires additional information about the applicant/member in order to make a medical eligibility determination.

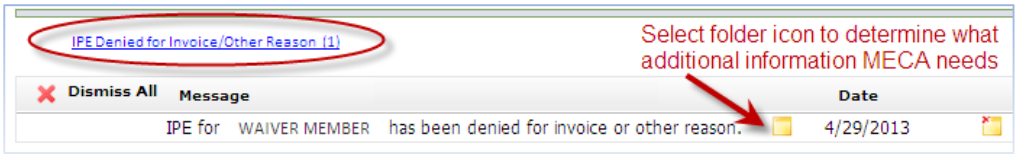


Figure 33-IPE Denied for Invoice

Clicking on the **yellow folder icon** from the notification will take the user to the *Edit Consumer* screen where they will be able to view an explanation of the administrative denial and determine what additional documentation has been requested by MECA.

5. PCA ADMINISTRATOR (PCA ADMIN) USER

The state's Medical Eligibility Contract Agent (MECA) is Psychological Consultation & Assessment. PC&A has two distinct user roles associated with tasks performed to track and move medical eligibility determinations through the CareConnection© system. The PCA Admin User has oversight of the medical eligibility process related to the IPN Users and the PCA User (MECA Reviewer).

5.1. Notifications

The PCA Admin User will receive notifications relevant to medical eligibility assessments completed and submitted by the IPN User. See **Appendix F** for a list of common notifications associated with the PCA Admin User.

5.2. Search Appointment and Consumer

The PCA Admin User can search appointment and consumer by clicking **Search Appointments** from the I/DD Waiver Menu. The user should filter search results applicable to those characteristics desired in the search results.

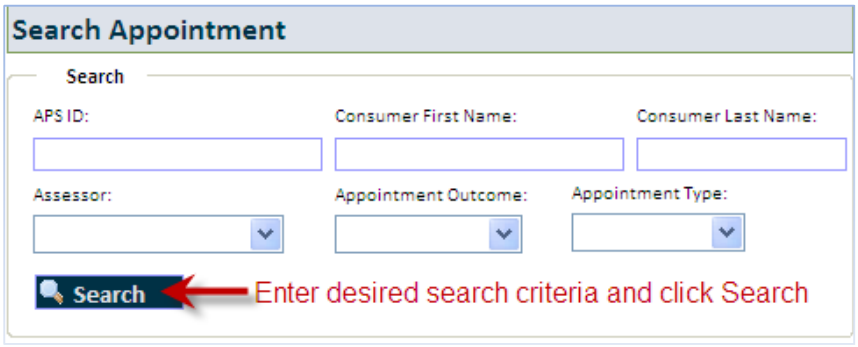


Figure 34-PCA Admin Search Appointment

5.3. Create User

The PCA Admin User has the ability to create IPN, PCA and other PCA Administrator Users via Create User in the I/DD Waiver Menu. The user should enter all required fields and click Create User. This will send notification to KEPRO that a request for a new user has been submitted.

- PCA Admin Users DO NOT have the ability to activate or deactivate other users. In order to have an account activated, KEPRO will require submission of a Web User Request Form which is signed by the new user as well as an owner or administrator of the company.
- For security purposes, companies must contact KEPRO when a user no longer requires access to the CareConnection© system. Only KEPRO can deactivate an account.
- When creating an account, users should select the applicable user role for the user they are creating. This web user manual should serve with description of user roles from which to choose.

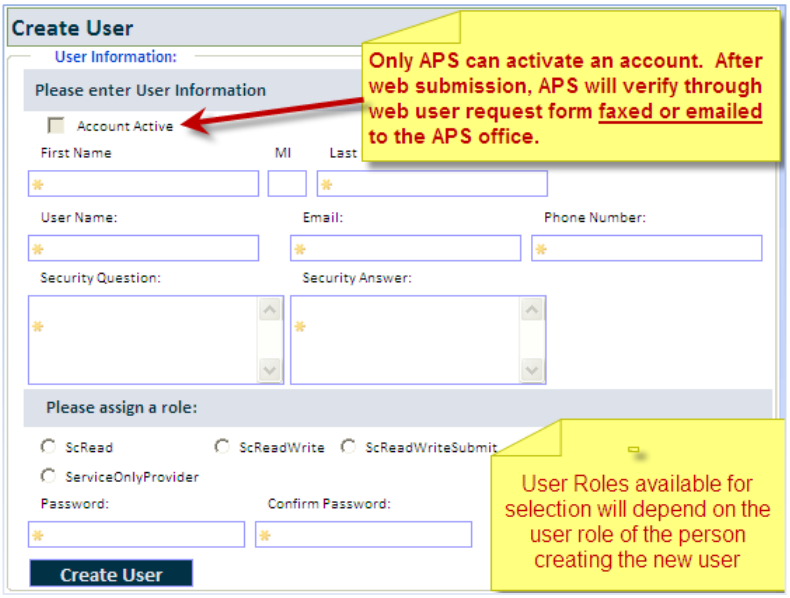


Figure 35-PCA Admin Create User

5.4. Scheduler Scheduler

Because the PCA Admin User has oversight responsibilities for the IPN Users, the PCA Admin User has access to the Scheduler functions. The PCA Admin can Create Appointments, Reassign Appointments, and View Appointments already scheduled.

5.4.1. Create Appointment Create Appointment

The PCA Admin has the ability to create an appointment on behalf of an IPN User. When necessary, the PCA Admin can perform all functions described above (IPN User) to create contact, create appointment, identify appointment outcome and attach the IPE document as necessary to move an applicant or program member through the eligibility process.

Create Appointment can be accessed through the IPE Requested notification or through the Create Appointment link in the Scheduler.

5.4.2. Reassign Appointments Reassign Appointments

In the event that the originally-assigned IPN User cannot complete the IPE for an individual assigned, the appointment will require reassignment to another IP. To complete the reassignment, the PCA Admin User will click on **Scheduler** in the Menu Options and click the **Reassign Appointment** link. Reassignment can only be made if an appointment has already been created. This feature allows the PCA Admin User to select multiple appointments for reassignment. Instructions are as follows.

1) Identify the **Reassign Appointment Reason** by clicking the appropriate box.
2) Filter search results by selecting **Current Assessor** assigned to the member for whom the appointment will be reassigned or by indicating a **Start or End date** the appointment is to occur. When a specific assessor is selected from the drop-down menu, the system will show all appointments assigned to that assessor within the date range entered.
3) Either ☑ Select All or select an individual or multiple appointments to be reassigned.
4) Identify the **New Assessor** to whom the appointment will be reassigned.

5) If the user wants to reassign appointments from one assessor to another on a specific date, or within a date range they will chose the Assessor from the drop-down, enter the desired date range and click **Refresh Current Assessor Assessment Search Results.** This will bring up the assessor's appointments within the specified date(s).
6) Click **Reassign Appointments** to finalize the reassignment. If the appointment is successfully reassigned, both the previous and new assessors will receive a system notication and the new appointment will show under the new assessor's appointment results.

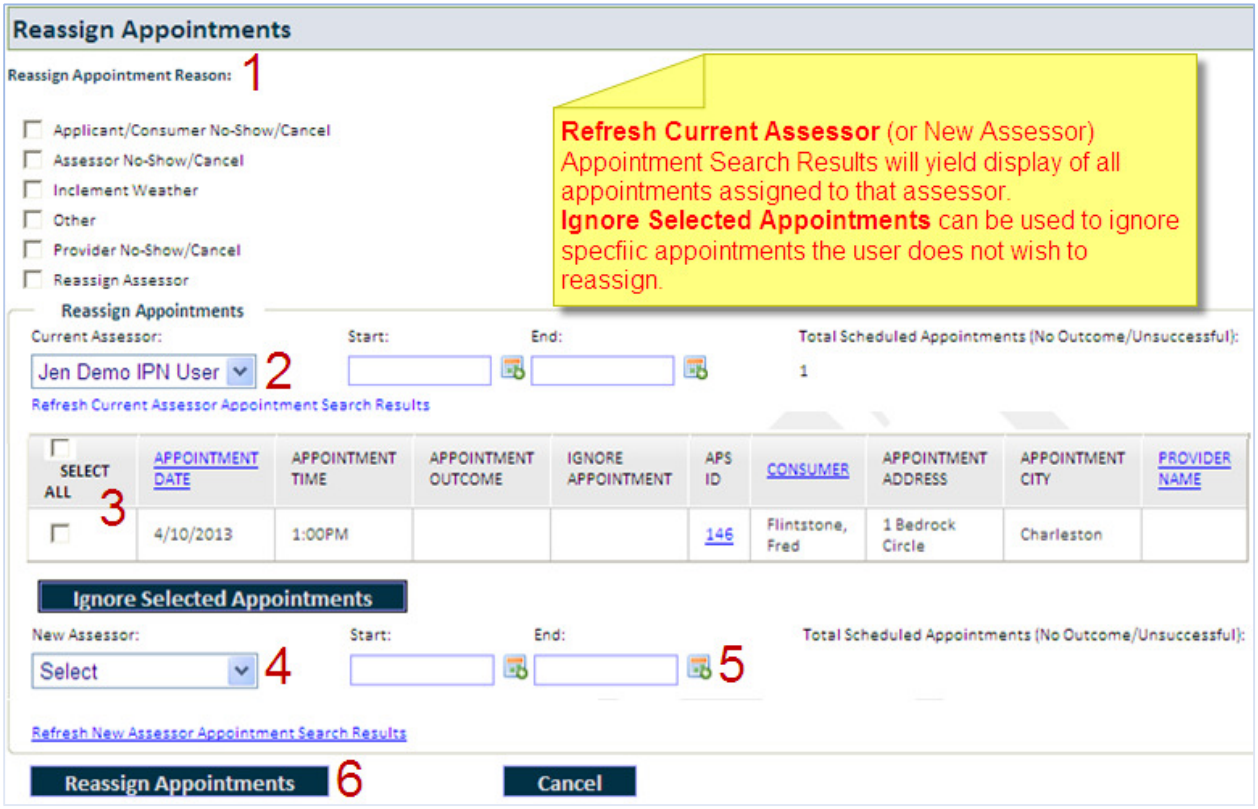


Figure 36-Reassign Appointments

5.4.3. View Appointment

The PCA Admin User has the ability to view the dates and times of scheduled appointments for an individual assessor. To view appointments, the user will click on **Scheduler** on the I/DD Waiver Menu and then **View Appointments**.

The *View Appointment* screen displays the option to filter results by Assessor, Start Date and/or End Date. Once desired criteria are entered, the user should click **Submit**.

5.5. Edit Consumer

Through the **Edit Consumer** button in the **Consumer Navigation Menu** the user can access the demographic information for the Applicant/Program Member. The Edit Consumer button will contain a running summary of the eligibility process. This screen will include an Applicant Information (demographic) section, Legal Representative Details, IPN Details, MECA Administrative Review and MECA

Eligibility Review. Through notifications to appropriate users, the system will guide the eligibility process; all parts are ultimately tracked on the *Edit Consumer* screen.

5.6. Attach Documents

The PCA Admin has the ability to view and attach documents stored in CareConnection©. For this user, this feature will primarily be used to attach the completed IPE, Second IPE or additional documentation related to IPE completion used to assist the Medical Eligibility Contract Agent (MECA) in determining medical eligibility. The PCA Admin or the PCA User will also attach eligibility letters after the Medical Eligibility review has been completed. See **All Users** section of this guide for specific instructions for attaching and viewing attached documents.

5.7. Administrative Review

Once the IPE has been uploaded, the PCA Admin User will receive notification to perform an administrative review of the documents to verify all necessary components are included for the MECA Reviewer to make an eligibility determination. To complete the administrative review, the user will click on the **IPE Completed** notification from the *Notifications* screen. The user will then choose the individual's file from which to perform an Administrative Review by clicking the yellow folder icon.

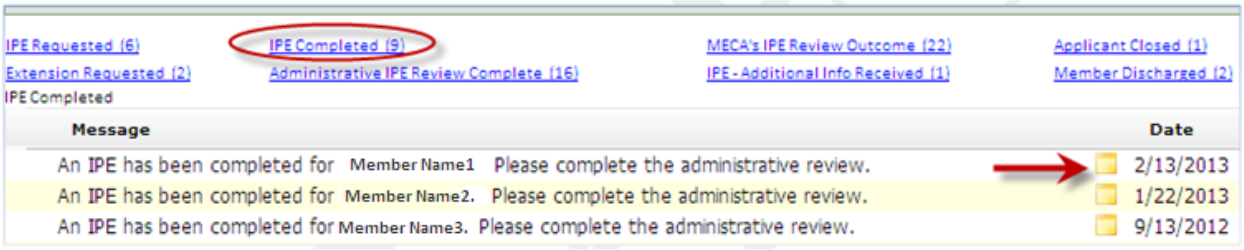


Figure 37-IPE Completed

If the IPN User has multiple IPE or Second IPE Attachment types for the same individual, this will trigger the individual to show up several times in the **IPE Completed** or **Second Medical Evaluation Complete** notifications.

Once the MECA Administrative Review Outcome has been identified for the individual, notifications related to that individual will no longer display.

The user will be taken to the *Edit Consumer* screen where they can scroll down to enter the **MECA Administrative Review Outcome**. To access the IPE document from this screen, the user can click on the **blue paperclip** icon at the top of the screen which will direct the user to the *Attach Documents* screen where they can retrieve the IPE for Review.

After a thorough review to make sure the IPN User has attached a complete IPE, the PCA Admin User should enter the MECA Administrative Review Outcome and the MECA Administrative Review Date.

Figure 38-MECA Administrative Review

Approved for Invoice: If the IPE is a complete document from which the PCA User will be able to make an eligibiltiy determination, the PCA Admin User should select **Approved for Invoice**. If the provider's Medicaid number and the applicant's/member's Medicaid number are in the CareConnection© system, an authorization will be sent to Molina.

Denied for Invoice: If the document is incomplete, the user should select **Denied for Invoice** or **Other**. The PCA Admin User should include a description of the Administrative Review denial in the explanation box which will be communicated via notification to the IPN User who completed the IPE. The IPN User will receive a notification to attach the corrected IPE or additional documentation under IPE – Additional Doc Requested attachment type.

When the IPN User has attached additional documentation, the PCA Admin User will receive an **IPE-Additional Info Received** notification that will prompt them to review the documentation and complete another administrative review based on the newly submitted documentation.

Selecting the **yellow folder** icon next to the individual whose documentation the user wants to review will take the user to the *Attach Documents* screen where they may review the documentation.

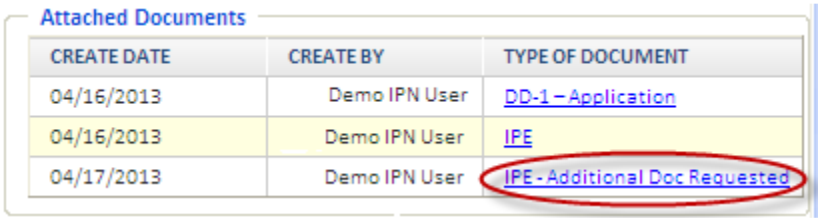
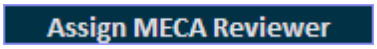


Figure 39-IPE Additional Doc Requested

After documentation review is complete, the user will click on the **Edit Consumer** button to change the MECA Administrative Review Outcome from Denied or Other to **Approved for Invoice**. The previously entered MECA Administrative Review Outcome data will remain in the data fields. The PCA Admin User can overwrite the data by choosing a new **MECA Administrative Review Outcome** and **MECA Administrative Review Date** and clicking **Submit.** The user will then receive a successful message asking for a MECA Reviewer to be assigned.

5.8. Assign MECA Reviewer 

Notifications will vary relative to assigning a MECA Review based on whether the review is for an applicant, a member or if the review is of a Second Medical Evaluation (based on a previous denial or termination notice).

While on the *Assign MECA Reviewer* Screen, the PCA Admin User should select the appropriate MECA Reviewer from the drop-down and enter any pertinent comments they wish to share with the MECA Reviewer who will be evaluating information submitted to determine medical eligibility for the program.

Figure 40-Assign MECA Reviewer

5.8.1. Applicant-Initial IPE

A MECA Reviewer can be assigned from the **Administrative IPE Review Complete** notification or from the **Assign MECA Reviewer** button located under **Consumer Navigation Menu**.

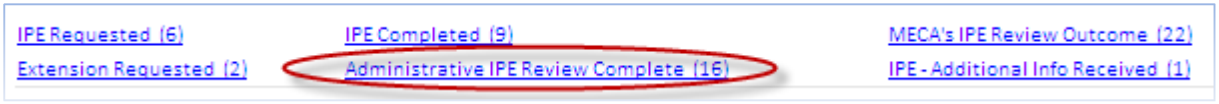


Figure 41-Administrative IPE Review Complete

Either of these actions will take the user to the *Assign MECA Reviewer* screen where they will make the assignment, which will then be written to the MECA Reviewer History table. Having the knowledge of the first reviewer will be useful when assigning a MECA Reviewer for a Second Medical Exam.

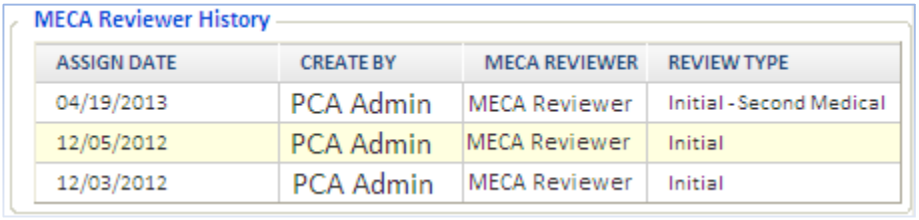


Figure 42-MECA Reviewer History

5.8.2. Member-Annual Functional Assessment

The MECA Review can be assigned from the **Annual Assessment Uploaded** notification. The user will then click on the **yellow folder** icon located next to the name of the Program Member's file they are opening which will take the user to the *Assign MECA Reviewer* screen. For system and process flow

integrity, the PCA Admin should always assign a MECA Reviewer for each Redetermination Review Outcome.

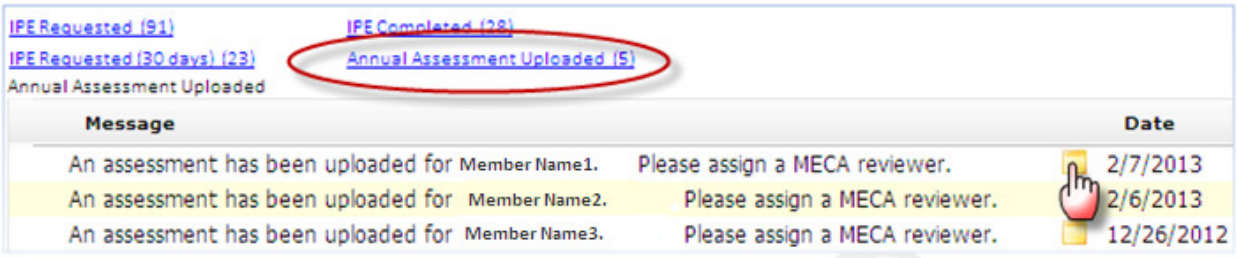


Figure 43-Annual Assessment Uploaded

5.8.3. Second Medical Evaluation (Either Applicant or Member)

The MECA Reviewer can be assigned from the **Second Medical Admin Review Complete** notification. The user will click on the **yellow folder** icon located next to the name of the Program Member's file they are opening which will take the user to the *Assign MECA Reviewer* screen

5.9. View Waitlist

The PCA Admin User can view and search for eligible applicants on the I/DD Waiver Waitlist by clicking **View Waitlist** from the I/DD Waiver Menu. The *View Waitlist* screen displays a summary of Waitlist numbers and allows the user to search for persons on the Waitlist.

6. PCA USER

The PCA User is synonymous with the Medical Eligibility Contract Agent (MECA) Reviewer. The primary functionality of this role is to review documentation associated with medical eligibility and make eligibility determinations within Care Connection®.

6.1. Notifications

PCA Users receive notifications related to their primary function of making medical eligibility determinations based on initial assessments completed by an Independent Psychologist, annual assessments completed by the Kepro, or Second Medical Evaluation assessments completed by an Independent Psychologist. See **Appendix G** for a list of common notifications associated with the PCA User.

6.2. Edit Consumer

Although the *Edit Consumer* screen contains the applicant's/member's demographic and legal representative information, the primary function of this screen for the PCA User is to document/track medical eligibility determinations.

6.3. MECA Eligibility Review – Initial Assessments

When the PCA User has been assigned by the PCA Admin to review an IPE for medical eligibility determination, the user will receive the **Assessment Review Requested** notification. The user will choose the individual's name whose file they wish to open and click on the **yellow folder** icon.

This notification cannot be dismissed until a determination has been made and documented within the system.

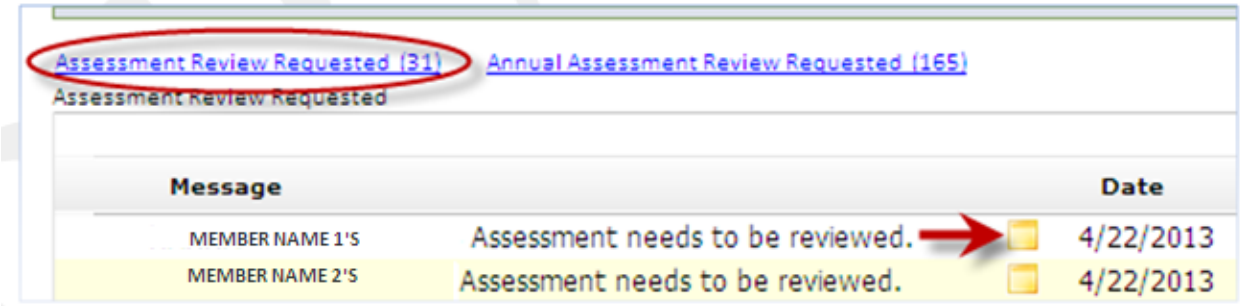


Figure 44 - PCA Assessment Review Requested

Clicking the yellow folder icon will take the user to the *Edit Consumer* screen. Clicking on the paperclip icon at the top of the screen will take the user to the *Attach Documents* screen where the Independent Psychological Evaluation submitted by the IPN User can be viewed. Once a clinical decision is made, the PCA User should scroll down to the portion of the screen labeled "MECA Eligibility Review" where he/she can make a medical eligibility determination.

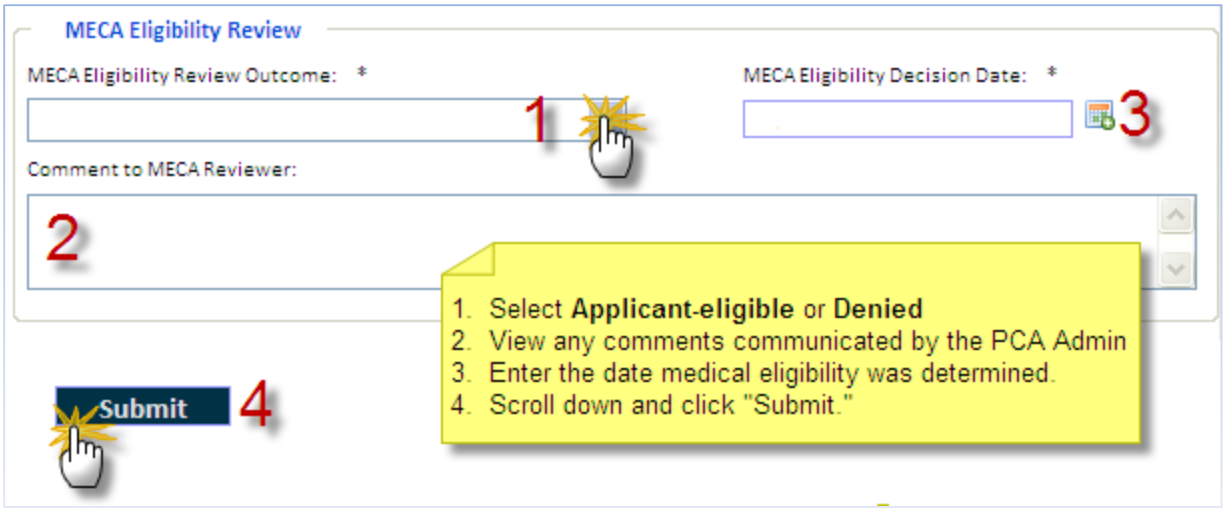


Figure 45 - MECA Eligibility Review

6.4. Medical Eligibility Review – Annual Assessments

The user can access the Annual Functional Assessment data through **the Annual Assessment Review Requested** notification or through the **Budget** button in the **Consumer Navigation Menu**. When the Annual Functional Assessment has been uploaded into CareConnection©, the PCA Admin will assign a MECA Reviewer (PCA User) to make an eligibility determination. An **Annual Assessment Review Requested** notification will be sent to the PCA User assigned as the MECA Reviewer. The user will choose the individual's name whose file they wish to open and click on the **yellow folder** icon.

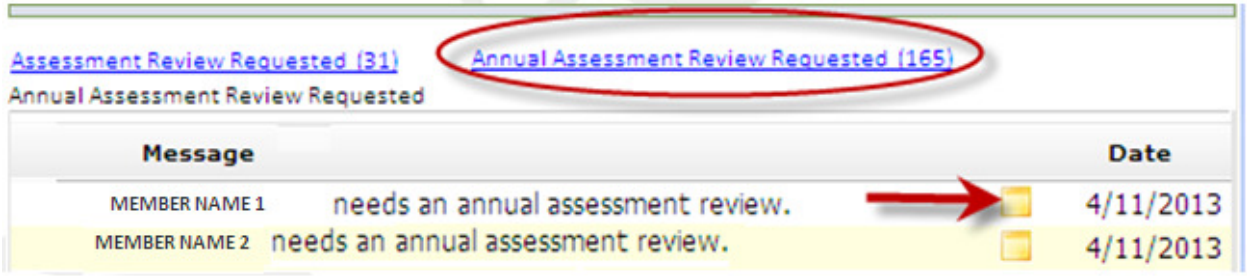


Figure 46 - PCA User Annual Assessment Review

This action will take the user to the member's *Budget* screen where the user can view the Annual Functional Assessment documentation. In the *Budget History* grid, the user will select the ABAS II, ICAP or ECA in the *Assessment* column to review the results of the Assessment.

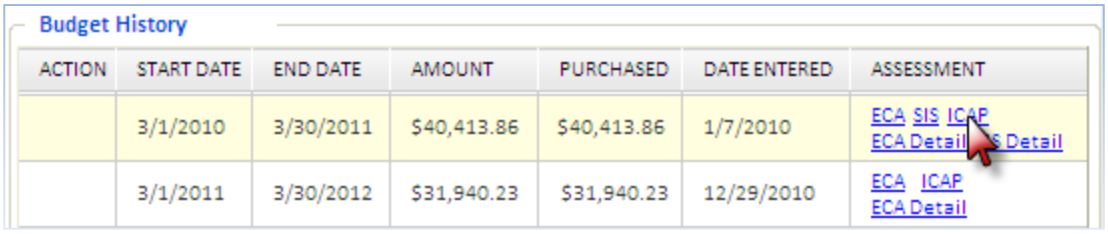


Figure 47 - PCA User Retrieve Annual Assessments

To make the eligibility determination following review of the Annual Functional Assessment the user will click on the **Redetermination** button Redetermination located in the **Consumer Navigation Menu.**

Selecting **Redetermination** will take the user to the *Consumer Redetermination* screen, where he/she can enter the redetermination outcome and click **Submit**. The outcome of the determination will then be written to the *Redetermination* history grid which identifies the user making the eligibility determination. Having the knowledge of who made the determination will be useful when assigning a MECA Reviewer for a Second Medical Exam, if necessary.

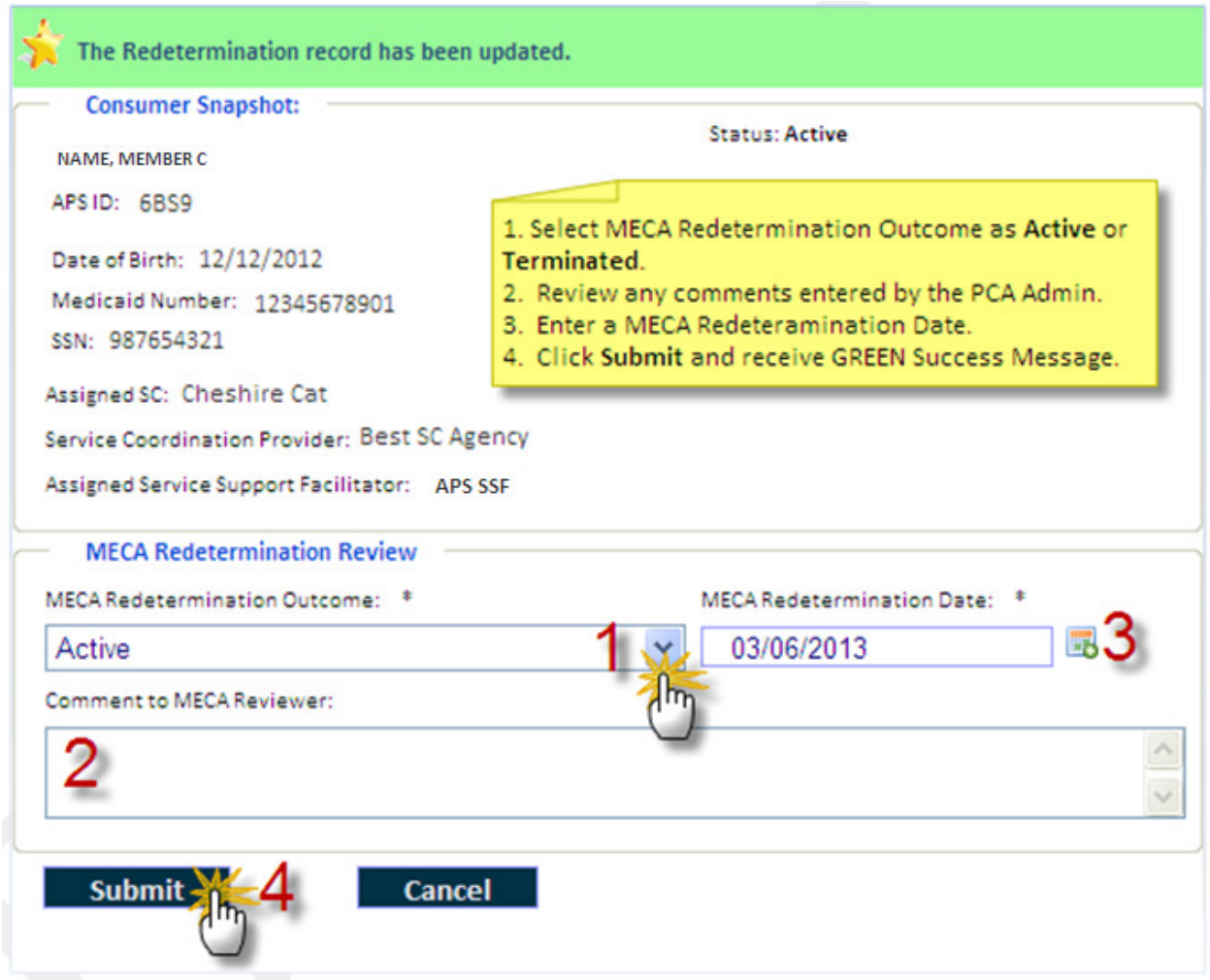


Figure 48 - MECA Redetermination Outcome

6.5. Attach Documents

The PCA Admin or the PCA User will attach eligibility letters following the Medical Eligibility review.

6.6. View Waitlist

The PCA User can view and search for eligible applicants on the I/DD Waiver Waitlist by clicking **View Waitlist** from the I/DD Waiver Menu. The *View Waitlist* screen displays a summary of Waitlist numbers and allows the user to search for persons on the Waitlist.

7. Provider and Fiscal Employment Agency Users

Provider Administrators are created similarly in the CareConnection© system. The variance lies in the relationship the agency/user logged in has to the members assigned to them for Service Coordination (SC), Personal Options or other services. When an agency serves a member for a service other than Service Coordination, they are considered a Non-SC agency for that member (even if they serve other members for Service Coordination). When an agency does not provide SC, they cannot take actions such as purchasing services or editing a member's demographic and medical information, etc. When an agency serves a member for services other than Service Coordination, the user must search for members through Authorizations.

7.1. All Provider Administrators

The system contains functions that are comparable across Provider Administrator Users including: Provider Super Administrator [Multiple Provider], Provide Super Administrator Read Only [Multiple Provider], Provider Administrator Service Coordination Agency, Provider Administrator Non-SC Agency, and Provider Administrator Fiscal Employment Agency. Functions available in the I/DD Waiver Menu relative to each Administrator role are outlined below.

Functions in the I/DD Waiver Menu per Administrator User Role	Provider Super Admin-Multiple Provider	Provider Super Admin-Read Only-Multiple Provider	Provider Admin SC	Provider Admin Non-SC	Provider Admin F/EA
View Providers	✓	✓	✓	✓	
Reassign SC	✓	✓	✓	✓	
Download	✓	✓	✓	✓	✓
SC Assignment Report	✓	✓	✓	✓	
Create User	✓	✓	✓	✓	✓
View Users	✓	✓	✓	✓	✓

Figure 49-PA I/DD Waiver Menu Function Availability

7.1.1. View Providers (*UPDATE PROVIDER INFORMATION)

The **View Providers** option is available in the I/DD Waiver Menu. This feature allows the agency's PA to edit the provider's information. Any time the provider has a change in demographic information, leadership or locations, the PA should update the information. KEPRO and BMS utilize the provider contact information in CareConnection© to communicate important I/DD Waiver Program updates.

To update provider information, the PA should select **View Providers** from the I/DD Waiver Menu. This takes the user to the *View Provider* screen. The PA should select Edit beside the provider/location they wish to update or edit.

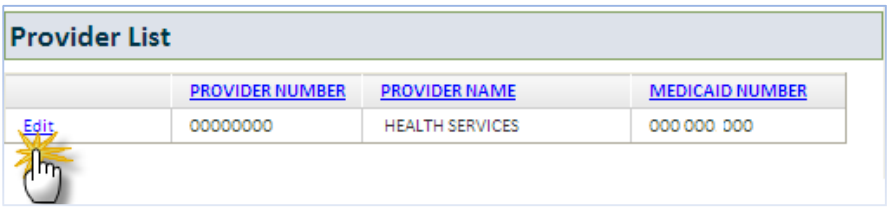


Figure 50-PA Update Provider

This action takes the PA to the *View Provider Locations* screen. On this screen the PA should select **Edit** to edit/update the provider's leadership, location or demographic information.

The PA should select **View** in order to view the locations and services in which the provider agency can receive a service referral.

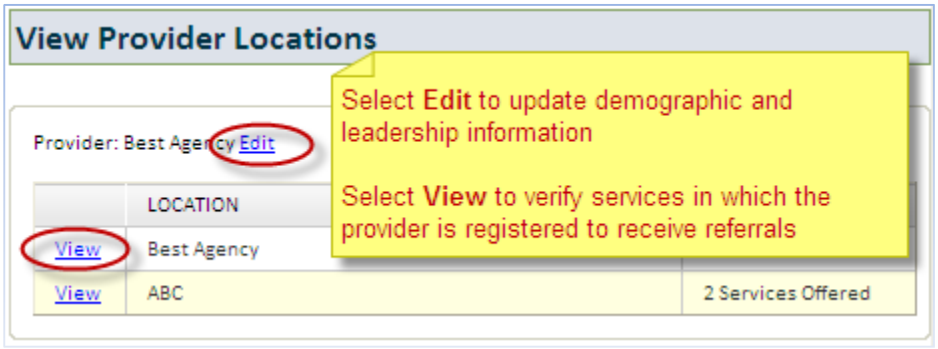


Figure 51-Edit/View Provider

7.1.2. Reassign SC

The PA is responsible to maintain Service Coordinator (SC) caseloads and assign/reassign member cases to the appropriate SC. When the PA wishes to reassign one or multiple members from a SC's caseload to another, he/she can do so by pulling up a specific member's record, or can select **Re-Assign SC** from the I/DD Waiver Menu.

This action will take the user to the *Reassign Service Coordinator* screen. From this screen, the user should take the following steps.

1. Select the current SC from which they wish to reassign case(s). Selecting the current SC will populate all members assigned to that SC.
2. Select one or more members to transfer.
3. Select the new SC to which the case(s) will be transferred.
4. Click **Submit**.

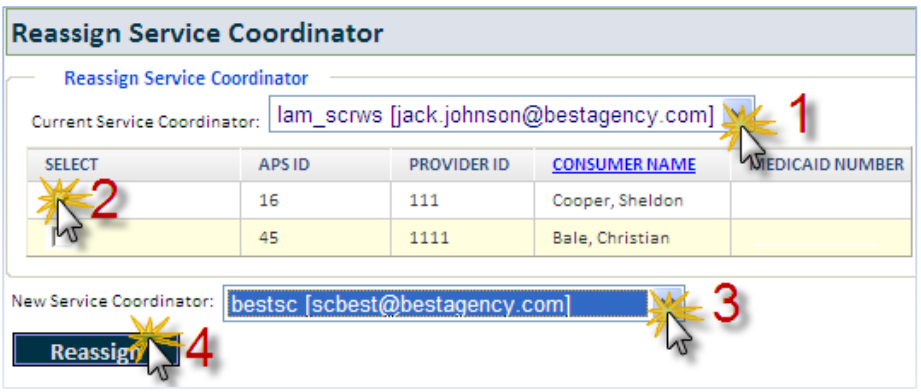


Figure 52-Reassign SC

7.1.3. Download

The Download feature (available in the I/DD Waiver Menu) allows a PA to access pipe-delimited files (Electronic Data Interchange-EDI) containing information about the members served, authorized services, budgets, modifications, etc. PAs can download one or multiple records at one time. PAs

should Archive Selected Files Archive Selected Files by selecting the icon at the bottom of the *Download* screen to avoid system delay.

PRST=Purchase Status- Used by KEPRO to notify SC Providers of the current status of the Purchase Plan -- specifically, SC Providers will need to know details about who has accepted/rejected/not responded.
SERV=Service-KEPRO Notifies all Service Providers listed in the Purchase Plan that a consumer has requested to purchase a service for them.
AUTH=Authorization-Conveys the authorization status and number for specific requested services.
MDFY=Modification-Conveys the authorization status for specific requested service modifications.

7.1.4. SC Assignment Report

The SC Assignment Report allows the PA to see "at a glance" the number of active members assigned to each Service Coordinator registered at the agency. The current I/DD Waiver Policy Manual limits SC caseloads to no more than twenty members. This feature is meant to assist with managing that requirement.

7.1.5. Create User

The PA has the ability to create new users within the CareConnection© system. The PA should enter all required fields and click **Create User**. This will send notification to KEPRO that a request for a new user has been submitted.

- PAs DO NOT have the ability to activate or deactivate other users. In order to have an account activated, KEPRO will require submission of a Web User Request Form which is signed by the new user as well as a PA at the agency.
- For security purposes, agencies must contact KEPRO when a user no longer requires access to the CareConnection© system. Only KEPRO can deactivate an account.
- When creating an account, PAs should select the applicable user role for the user they are creating. This web user manual should serve with description of user roles from which to choose.

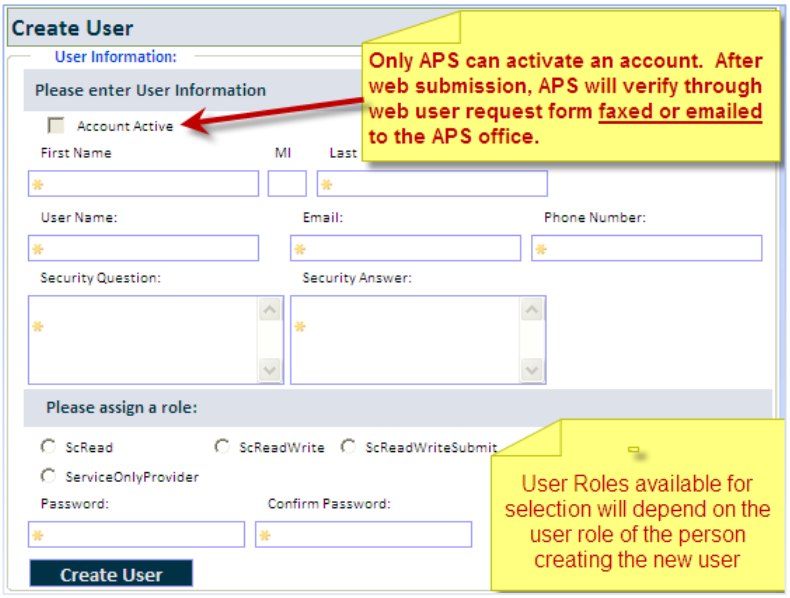


Figure 53-Create User

7.1.6. View Users

View Users is available in the I/DD Waiver Menu. This feature allows the PA to view all, only active or only inactive users affiliated with the provider agency. PAs should reference this screen to ascertain the status of users affiliated with the agency. For any users no longer requiring system access, the PA should contact KEPRO and request deactivation.

7.2. Provider Super Administrator [Multiple Provider]

This user is affiliated with multiple approved provider locations registered in CareConnection© (e.g. same provider with multiple locations). They have the ability to perform administrative functions and search for/view details about all members affiliated with all the associated providers. The Provider Super Administrator can perform all functions of a Provider Administrator for each agency in which they are affiliated. See Provider Administrator Service Coordination Agency, Provide Administrator Non-Service Coordination Agency for details of functions this user can perform.

7.3. Provider Super Administrator Read Only [Multiple Provider]

This user is affiliated with multiple approved provider locations registered in CareConnection© (e.g. same provider with multiple locations). The user has access to the same information as a Provider Super Administrator. However, this role has Read Only privileges which are limited in that the user cannot take any functional actions. This user role is generally used for staff in a Utilization Management role affiliated with multiple provider locations.

7.4. Provider Administrator -Service Coordination Agency (PA)

The PA for an agency that serves the member with Service Coordination can take all actions of a Service Coordinator (example- update demographic, medical, make purchases, etc.). This user is responsible for accepting/rejecting I/DD Waiver service referrals, can create new users and can change Service Coordinator caseloads. The user can view all information for members assigned to the provider with which the user is affiliated. All functions that can be taken by a Service Coordination will be detailed in that section. It is recommended that providers maintain a minimum of two registered Provider Administrator users at all times.

7.4.1. Notifications

The PA for a Service Coordination agency will receive multiple notifications. Some require action on the part of the PA; others are simply a notice of an action already taken. Primary notifications associated with action required by the user are detailed in this section.

7.4.2. Search

PA Users may search Authorizations, Consumers or Users.

7.4.3. Approve SC-RW Submissions

The PA of a Service Coordination agency will receive notification to approve actions taken by Service Coordinators for whom they have allowed Read/Write privileges. This allows a level of oversight by the agency administrator. The PA has an opportunity to review and approve information submitted by a Service Coordinator prior to it being transmitted to KEPRO. Examples of notifications prompting administrative approval are **Purchase Admin Review**, **MOD Admin Review**, **Approve Consumer**, **Approve Demo**, **Approve Medical**, and **Approve Service Delivery Model Change**.

The PA should select the notification which will reveal the members/cases requiring approval. The PA should then select the yellow folder icon to open the member's record.

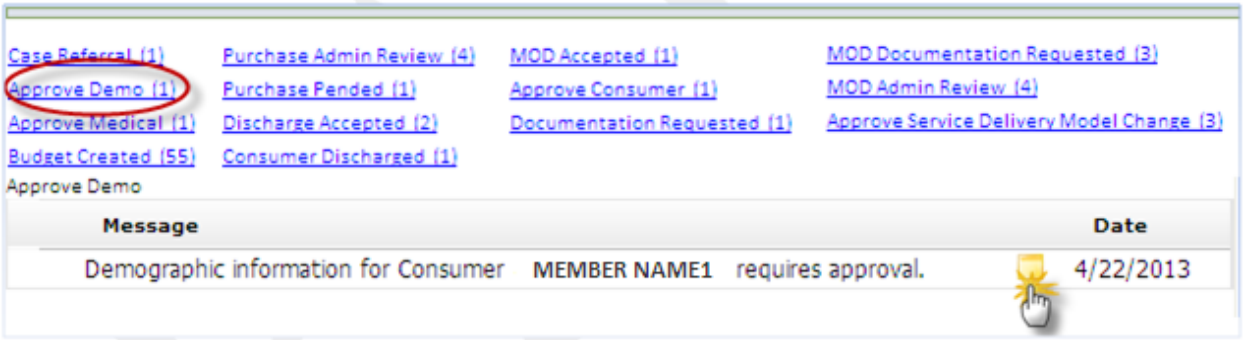


Figure 54-PA Approvals

Once in the record, the system will display the screen applicable to the approval being requested. In this example, the demographic information entered by the Service Coordinator-Read/Write is displayed for the PA to review. After review, the PA should take action to **Reject Demographic Information**, **Approve Demographic information** or **Edit Demographic Information**.

Reject Demographic Information- Sends the form back to the Service Coordinator for revision. A pop-up will display asking the PA if he/she is "sure he/she wants to reject?"

Approve Demographic Information - Approves the form as submitted by the Service Coordinator and transmits to KEPRO.

Edit Demographic Information- Opens editing capability so the PA can edit and submit information directly to KEPRO without sending back to the Service Coordinator.

7.4.4. Consumer Referral

The user will receive the **Consumer Referral** notification when a newly enrolled consumer has chosen the user's agency to provide Service Coordination. The user should click on the notification and then on the yellow folder icon associated with the new member. The user will view the member's **Consumer Details** and can act to either **Reject Consumer** or **Accept Consumer**.

Figure 55-PA Approve Consumer Referral

7.4.5. Approve Transfer

The PA will receive notification to **Approve Transfer** when another agency has initiated a transfer of Service Coordination to the agency affiliated with the PA. The PA should select the notification and the yellow folder icon associated with the member requesting transfer. Upon opening, the PA will see the Consumer Snapshot and Transfer summary.

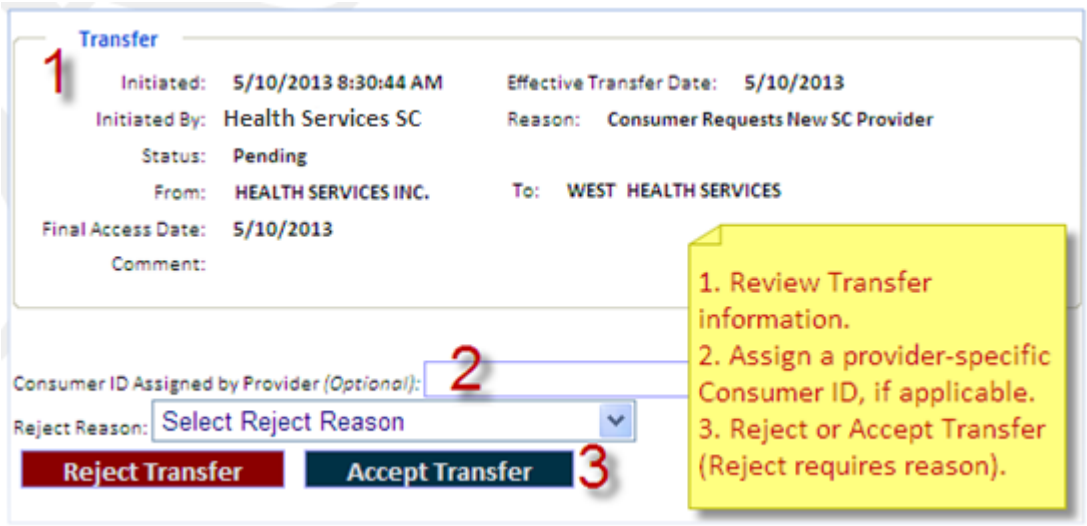


Figure 56-Approve Transfer

Upon accepting a transfer, the case is automatically assigned to the PA who accepted the transfer**.** If the PA wants another staff to serve as Service Coordinator, he/she should search for the consumer, pull up the case, and transfer to a new Service Coordinator (within the same agency). To do so, the PA would click to open the **Change Service Coordinator To** drop-down. A list of SCs affiliated with the agency will display. The PA should select the appropriate SC and then click **Assign**.

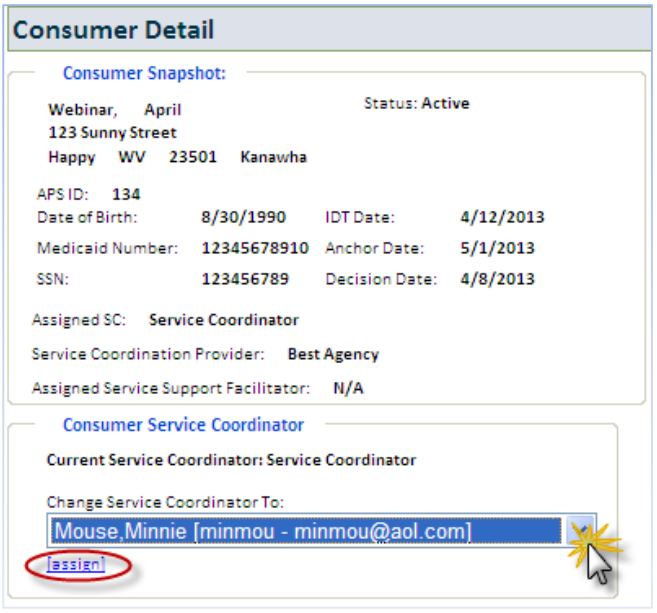


Figure 57-Change Assigned SC

7.4.6. Approve Service Delivery Model Change

Provider Administrators whose agency provides Service Coordination will receive notifications related to the member's chosen Service Delivery Model of Traditional and Personal Options or Traditional and Agency with Choice as indicated on the Freedom of Choice form (I/DD-02). To act on these referrals, the user should select the notification and then click the yellow folder icon beside the member name they wish to select.

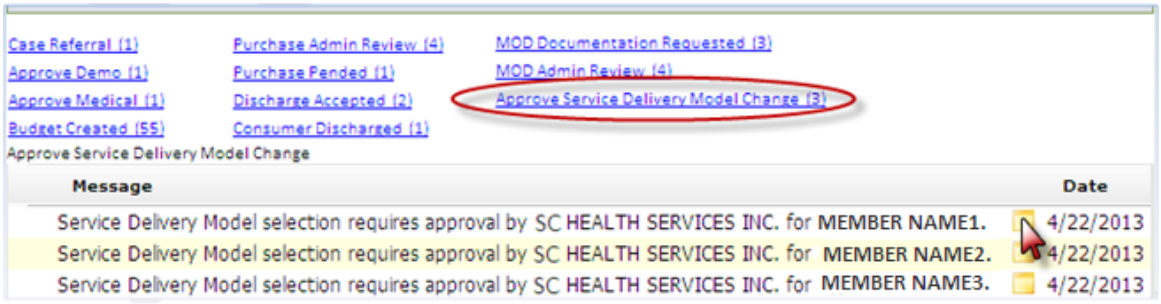


Figure 58-Approve Service Delivery Model Change

This action takes the user to the *Approve Service Delivery Model* screen where he/she can act upon the referral. The user should select the radio button beside either **Accept** or **Reject** and then click **Submit.** Rejecting the referral will prompt the user to enter a reason for rejection. Member selections will save to the **Service Delivery Model History** grid available on the *Service Delivery Model Selection* screen.

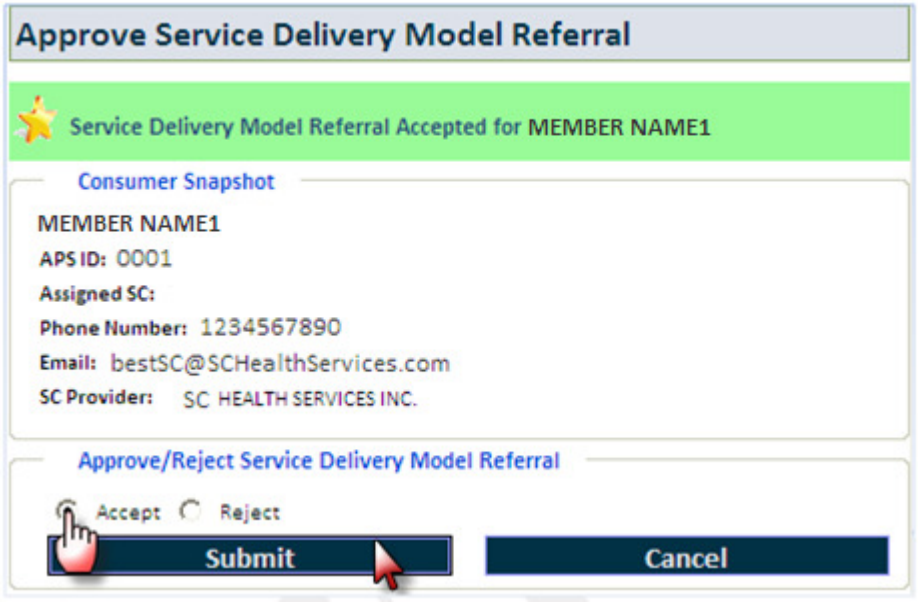


Figure 59-Approve Service Delivery Model Referral

7.4.7. Accept/Reject Service Referral

The PA is responsible to accept or reject service referrals and will receive the **Service Referral** notification. This function allows the PA to review services requested by the consumer from the PA's agency and to make a determination as to whether the agency will accept the referral and provide the service(s).

When the PA opens the Service Referral notification he/she will be taken to the *Authorize Purchase* screen. The screen displays a consumer snapshot with the basic demographic information. Below that, the PA will see the **Items Requiring Action**. The PA should review all service requests for accuracy prior to accepting a referral. The PA can take action individually on each service requested, or can Accept All or Reject all. A Rejected service referral requires the PA to enter a rejection reason.

The PA will receive additional notification if he/she does not act upon a Service Referral within five days. After five days, the request for the provider to serve the member for the particular service will be withdrawn.

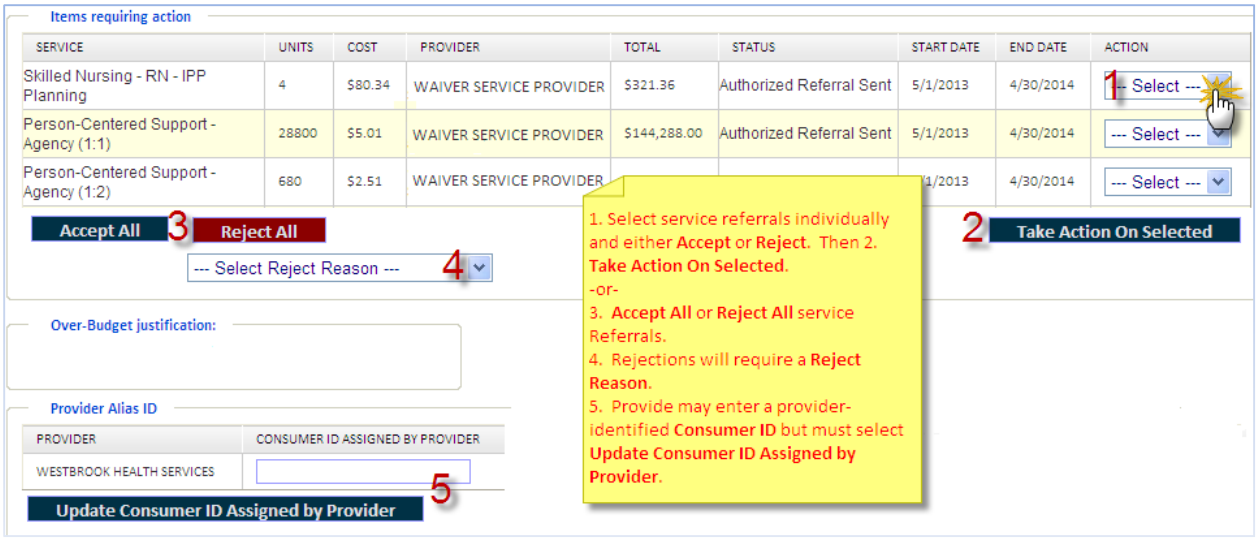


Figure 60-PA Service Referral Requested

7.4.8. Consumer Navigation

The PA whose agency provides Service Coordination can take action in place of any SC affiliated with their agency. All member-related actions/functions will be defined in the Service Coordinator section of this manual.

7.5. Provider Administrator –Non-Service Coordination Agency (PA)

This user has limited action privileges, as they are not responsible for creating/editing member demographic/medical information or making purchases. This user will accept/reject I/DD service referrals. After accepting a service referral, the agency will receive authorization, and the user can access the member's full record.

7.5.1. Notifications

The PA for an agency that does not provide Service Coordination will generally receive notifications relative to service referrals and users activated.

7.5.1.1. Service Referral

The PA is responsible to accept or reject service referrals and will receive the **Service Referral** Notification. This function allows the PA to review services requested by the consumer from the PA's agency and to make a determination as to whether the agency will accept the referral and provide the service(s).

When the PA opens the Service Referral notification he/she will be taken to the *Authorize Purchase* screen. The screen displays a consumer snapshot with the basic demographic information. Below that, the PA will see the **Items Requiring Action**. The PA should review all service requests for accuracy prior to accepting a referral. The PA can take action individually on each service requested, or can Accept All or Reject All. A rejected service referral requires the PA to enter a rejection reason.

The PA will receive additional notification if he/she does not act upon a Service Referral within five days. After five days, the request for the provider to serve the member for the particular service will be withdrawn.

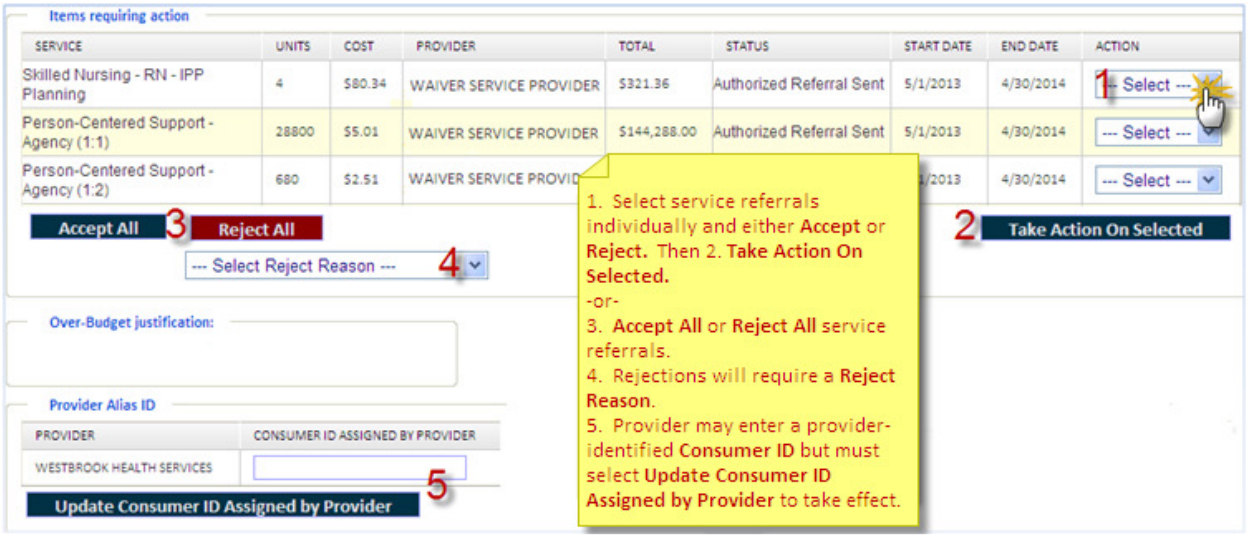


Figure 61-PA Service Referral Requested

7.5.2. Search

The user may search by Authorization, Consumer or User.

7.5.2.1. Search Authorization

Provider Administrators conducting a search for members for which they do not provide Service Coordination must do so via the **Search Authorization** feature. If an agency does not provide Service Coordination for a specific member, that member will not be visible via **Search Consumer**.

Entering search criteria under Search Authorization will result in the icons to **View Consumer** , **View Purchase** , or **Modify Purchase** .

When the **View Consumer** icon is selected, the Provider Administrator has access to the member's Consumer Snapshot (overview of demographics) and the **Consumer Navigation Menu** which provides the ability to view items specific to the user's role.

7.5.3. Modify Purchase

The Provider Administrator user associated with an agency that does not provide Service Coordination but does have an authorization for another service may make a modification request for any service they provide. Although this feature is available, it should be noted that all services must be documented by the Service Coordinator on the member's Individual Program Plan (IPP). Services/Authorizations/Modifications made in CareConnection© must match those documented and approved by the member's interdisciplinary team on the IPP.

To make a modification, the Non-SC Provider Administrator will perform a **Search** of **Authorization** through the I/DD Waiver Menu. User will enter desired criteria (authorization information, service code and/or consumer information) and click **Search**. The user will click on the Modify Purchase Icon.

Views (Mouseover for def.)	Consumer Name	Start Date	End Date	Purchase Request Id	Authorization Number	Service	Units
	MEMBER NAME1	5/1/2013	4/30/2014	58511	1234567890	T2021HN - Therapeutic Consultant	420
	MEMBER NAME2	5/1/2013	4/30/2014	58511	2345678901	T2024TD - Skilled Nursing - RN - IPP Planning	2
	MEMBER NAME3	5/1/2013	4/30/2014	58511	3456789012	T2024HI - Therapeutic Consultant - IPP Planning	2

Figure 62-Modify Purchase

The user is taken to the **Create Modification** page. The user should **Select a Modification Type** which includes the following options: Consumer Medicaid Number, Provider Medicaid Number, Service Units and Service End Date. Once type is selected, the user will select **Reason** for modification, view the existing value, and input a new or requested value. The user will then click **Request Modification**. Upon submission, KEPRO will review the request. The provider will be notified of the outcome via notification.

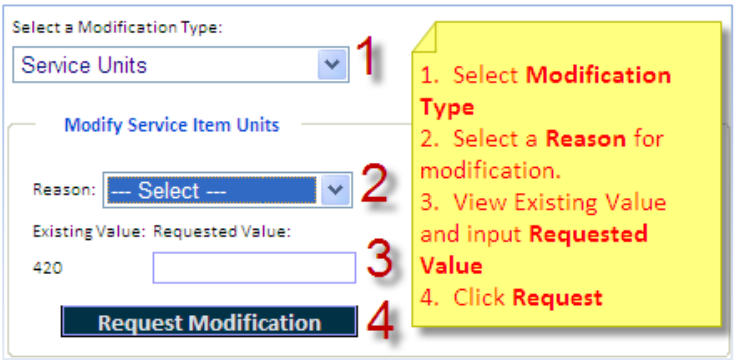


Figure 63-Create Modification

7.5.4. Consumer Navigation

The PA not affiliated with providing Service Coordination can access a member's **Consumer Navigation Menu** by retrieving the member information through **Search Authorization**. It is in **Consumer Navigation** that the PA user can view and *Attach Documents*, view the *Budget* and assessment history, view the *Consumer Details*, *Demographics* and the member's *Health and Safety* screens.

7.6. Provider Administrator –Fiscal/Employer Agent (PA-F/EA)

The PA-F/EA User is affiliated with services offered through the state's Personal Options program. User can accept/reject a member's **Traditional and Personal Options** service delivery model selections. The PA-F/EA role functions similarly to the Provider Administrator at a Service Only agency in that user cannot directly purchase services.

7.6.1. Notifications

The Provider Administrator with the Fiscal/Employer Agent will receive notifications pertinent to service delivery model referrals, service referrals and user activations. Functions of Service Delivery Model specific to the PA-F/EA User are described below.

7.6.1.1. Service Delivery Model

Each year, either KEPRO or the Service Coordination agency is responsible to update a member's choice of Service Delivery Model within the CareConnection© system. There will be times when the system conveys that a member originally had Personal Options, and that they are continuing to choose Personal Options. At other times, the notification will convey a member is newly choosing the Personal Options Service Delivery Model. Either way, the PA-F/EA User should click on the yellow folder icon to go to the *Approve Service Delivery Model* screen.

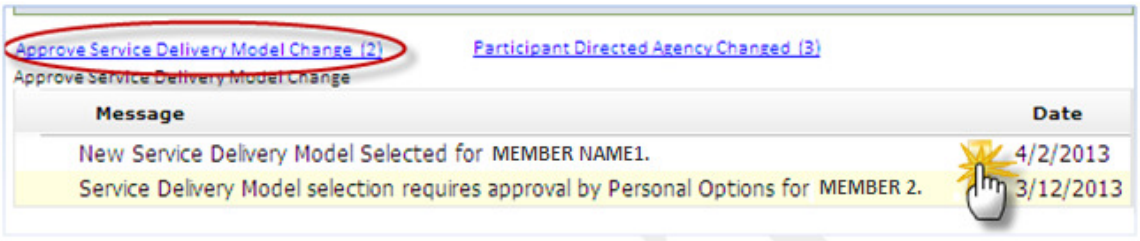


Figure 64-Service Delivery Model Notification

While on the *Approve Service Delivery Model Referral* screen, the user can view an abbreviated **Consumer Snapshot** with general contact information for the member. The user should either **Accept** or **Reject** the referral and click **Submit**.

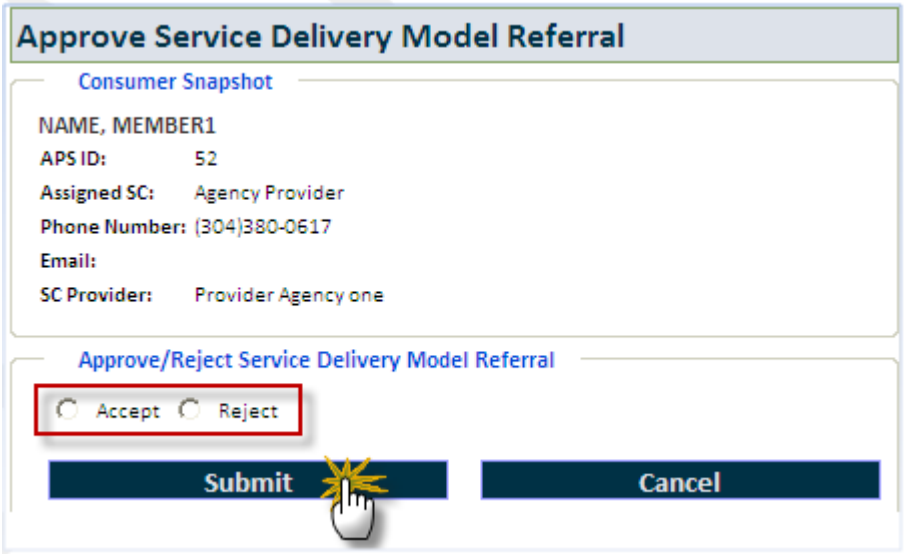


Figure 65-Approve Service Delivery Model

7.6.2. Search

The PA-F/EA User has the ability to search **Authorization**, **Consumer** and **User** by accessing the **Search** feature in the I/DD Waiver Menu.

7.6.2.1. Search Consumer

Searching by Consumer will yield results where a member has chosen Traditional and Personal Options as their Service Delivery Model.

7.6.2.2. Search Authorization

Search by Authorization will yield results where a member has chosen a Personal Options service, the Service Coordinator has requested, and KEPRO has authorized the service.

7.6.3. Consumer Navigation

The PA-F/EA can access a member's Consumer Navigation by retrieving the member information through **Search Authorization or Search Consumer**. It is in **Consumer Navigation Menu** that the PA-F/EA user can view and **Attach Documents**, **View Consumer**, **View Demographics** and **View Health Safety** as previously entered by the Service Coordinator.

7.7. Fiscal Employment Agent User (F/EA)

The F/EA User receives no notifications. This role functions as "read-only" specific to viewing members who have selected Traditional and Personal Options as their service delivery model. This user can search **Authorization** and **Consumer** by accessing in the I/DD Waiver Menu. A member is not available in the **Search Consumer** or **Search Authorization** until Personal Options services have been requested by the Service Coordinator and authorized by Kepro.

7.8. Service Coordinator Read/Write/Submit (SC-RWS)

The Service Coordination Agency is responsible to create/edit member demographic information, medical information, input member service delivery model selections, and request interdisciplinary-team-approved services for authorization. KEPRO has created three Service Coordinator user roles to allow the provider agency greater control over how they set up their individual Service Coordinator staff.

The SC-RWS User can search/view/edit all information relative to members assigned to his/her caseload. When this user selects "submit" on any page in CareConnection©, the system sends information directly to KEPRO for review and/or determination. This is the least restrictive Service Coordinator user role, and is generally used for Service Coordinators with experience in I/DD Waiver and with the use of CareConnection©.

7.8.1. Notifications

The SC-RWS User receives notifications relative to members who have been assigned to their caseload. These notifications will include information related to member eligibility, services requested/authorized and when documentation is requested by KEPRO.

7.8.1.1. Documentation Requested

There are times when the Service Coordinator submits a request for authorization or modification, and KEPRO requires additional documentation in order to process the request and make an authorization determination. When this occurs, the SC will receive notification (Documentation Requested or MOD Documentation Requested). The notification will display the service, member name, provider name and a brief comment from the KEPRO staff. The SC must contact KEPRO outside the system to arrange for submission of additional information. The SC may use the *Attach Documents* feature to store requested documentation; however, SC must still notify KEPRO via email or telephone that the documentation was attached.

7.8.2. Search Consumer

The SC User may search for consumers on his/her caseload, as assigned by a Provider Administrator. A blind search in which the SC enters no search criteria will yield the SC's entire caseload. To enter the member's record, the SC should select **Detail** from the Search results grid.

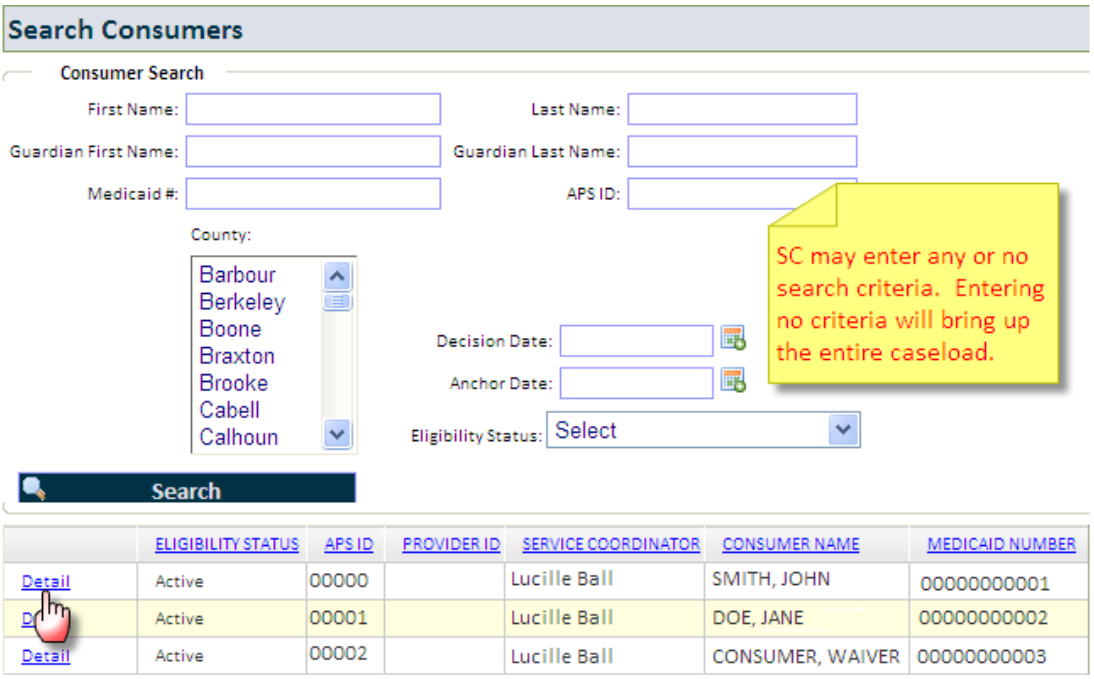
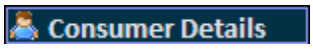
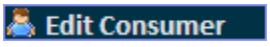


Figure 66-SC Search Consumers

7.8.3. Consumer Details 

The *Consumer Detail* screen is the default when pulling up a member from the **Search Consumer** function. This screen contains the **Consumer Snapshot**, the currently assigned **Service Coordinator**, a history of purchases (**Recent Purchases**) and the **Consumer Navigation Menu**.

7.8.4. Edit Consumer 

The **Edit Consumer** button is available in the **Consumer Navigation Menu**. This screen contains the member's location and legal representative information. If the member experiences a change in contact information (address, phone number, etc.) or legal representative information, the SC Agency is responsible to update it here. Information submitted on the *Edit Consumer* screen will display in the Consumer Snapshot throughout the rest of the application.

7.8.5. Create/Edit Demographics 

The **Demographics** button is available in the **Consumer Navigation Menu**. For new members, the button label will display "Create Demographics." When the button displays "Approve Demographics" the system is awaiting a Provider Administrator's approval before submitting to KEPRO (applicable only to SC-RW Users). The *Consumer Demographic Information* screen is used to capture information pertaining to the member's marital status, day setting/environment, residential setting/environment and respondents chosen to participate in the member's annual functional assessment.

See Appendix F for instructions to enter information into the member's *Demographic* screen.

For newly enrolled members, KEPRO cannot enter a budget amount until both *Demographic* and *Medical* screens are entered and submitted by the Service Coordination Agency.

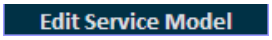
7.8.6. Create/Edit Medical 

The Medical button is available in the **Consumer Navigation Menu**. For new members, the button label will display "Create Medical." When the button displays "Approve Medical" the system is awaiting a Provider Administrator's approval before submitting to KEPRO (applicable to SC-RW Users). The *Consumer Medical Information* screen is used to capture information pertaining to the member's most recent medical evaluation and psychological evaluations.

See Appendix G for instructions to enter information into the member's *Medical* screen.

7.8.7. View Health Safety 

The **View Health Safety** button can be accessed from the member's **Consumer Navigation Menu**. This screen depicts all items entered on the Create/Edit Medical button that have been identified by the Bureau for Medical Services as significant health and/or safety issues. It is expected that every item identified be addressed by the member's interdisciplinary team and that all issues and resolutions be documented on the member's Individualized Program Plan.

7.8.8. Edit Service Model 

Options for a model of service delivery were added with the October 2011 updates to the I/DD Waiver Policy Manual. Each member will receive their choice of service delivery model at least annually.

To update service delivery model, the user should select **Edit Service Model** from the **Consumer Navigation Menu**. This action takes the user to the *Service Delivery Model Selection* screen. Here, the user should select the new or updated **Service Delivery Model** selected by the member on the I/DD-01 Freedom of Choice form. The user should then select the **Reason For Selection**. Annual updates should have a reason of "other." The user will enter the **Referral Date** as indicated on the Freedom of Choice form, enter any applicable **Comments** to the entity to which the member is being referred, and click **Submit**.

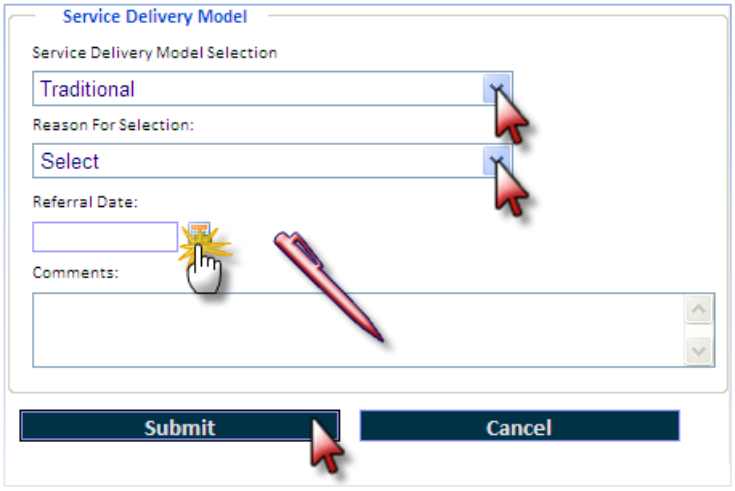
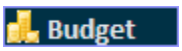


Figure 67-Edit Service Model

7.8.9. Budget 

By selecting the **Budget** button from the **Consumer Navigation Menu**, the user is directed to the *Assign Budget* screen. In addition to the **Consumer Snapshot** and the **Consumer Navigation Menu**,

the user can also view the **Budget History** table. This table contains a history of Individualized Waiver Budgets, cost of authorized services and member assessment information per member's service year. The user may also view the list of services requested/authorized per year by selecting the year's **View** link in the Budget History table and view Assessment results by selecting the link in the Assessment box.

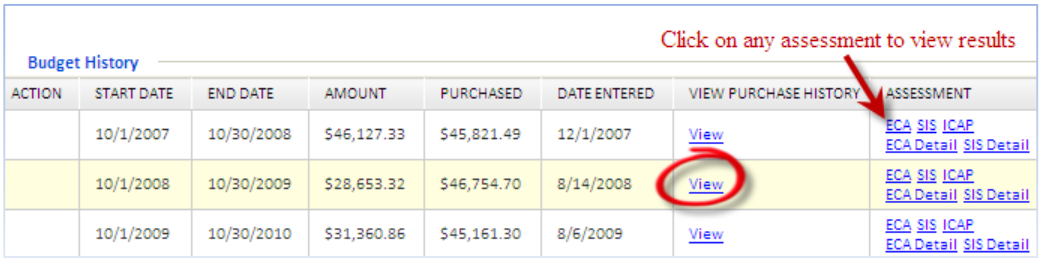


Figure 68-SC Budget History Grid

7.8.10. Start Purchase Start Purchase

NOTE: In order for the **Start Purchase** button to be available, the SC must verify Medicaid number on the *Edit Consumer* screen Edit Consumer and submit **Demographic** Create Demographics and **Medical** Create Medical information. Submissions of these items, along with a functional assessment having been completed will prompt KEPRO to enter a budget amount with which I/DD Waiver services can be purchased/requested).

Once KEPRO has entered a budget amount, the user will receive a **Budget Created** notification. The user should share the budget amount (and annual functional assessment results) with the interdisciplinary team. These items should be used to plan for and prioritize I/DD Waiver service needs.

The user should first pull up the member's record for which they wish to request authorization for services. The user will access the **Start Purchase** button from the **Consumer Navigation Menu**.

7.8.10.1. Purchase Step 1: Configure Purchase Step 1: Configure Purchase

On the *Configure Purchase* screen, the user should first identify the **Budget Year** for which they are requesting services. As interdisciplinary teams are able to meet up to 30 days prior to Anchor date for annuals, and any time throughout the year for a Critical Juncture meeting, the system will need to know for which year the request is being submitted. For new members, only one Budget Year will be an option in the drop-down. Next, the user should enter the date the member's interdisciplinary team met and decided on necessary I/DD Waiver Services or the **IDT Date**. Next, the user should select the **Purchase Type**.

Purchase Type

- **Initial**-Generates a 30-day authorization for approved services. Initial Purchase Type should be selected if the member is new to I/DD Waiver services, and the agency/team recommends purchasing an initial set of services with which to perform assessments so that they have enough information to purchase services at the Annual team meeting.

- **Annual**-Generates a 365-day authorization for approved services. Annual should be used following an annual interdisciplinary team meeting to reflect all services the member will need for an entire service year.
- **Quarterly**-Updates existing authorizations; Quarterly should occur with quarterly meetings, if new/changes to auths are needed. Quarterly Purchase Type will only be available after an Annual Purchase has been made.
- **Critical Juncture**-Updates existing authorizations or adds new authorization requests if necessary; Critical Juncture Purchase Type should occur with a member's Critical Juncture indicated by a newly-identified service need that occurs outside of a typical Annual or Quarterly interdisciplinary team meeting. Critical Juncture Purchase Type will only be available after an Annual Purchase has been made.

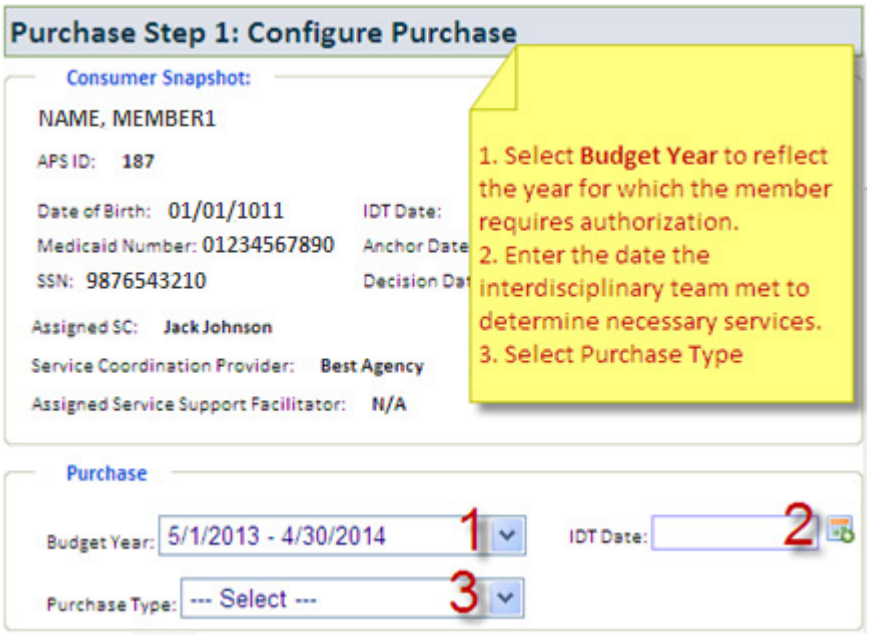
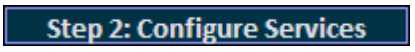


Figure 69-Purchase Step 1: Configure Purchase

After identifying fields above, the user should check the boxes ☑ beside all services for which the interdisciplinary team has agreed, and then click **Step 2: Configure Services**.

7.8.10.2. Purchase Step 2: Configure Services



On Purchase Step 2, the user will enter the number of **Units** and select the service **Providers** as agreed upon by the interdisciplinary team and click **Step 3: Review Purchase**.

- The **Start Date, End Date and Auth Number** columns will populate only after services are authorized by KEPRO.
- The **Status** column will keep the user apprised of the status of the authorization.
- **Update Totals** will update each service row as well as the overall cost for services in the Budget box.
- Exceeding a budget amount will prompt the user to enter an **over-budget justification**.
- **Delete** allows the user to delete a row in the event of an error.

- **Duplicate** allows the user to duplicate a row to allow for two or more providers of the same service.

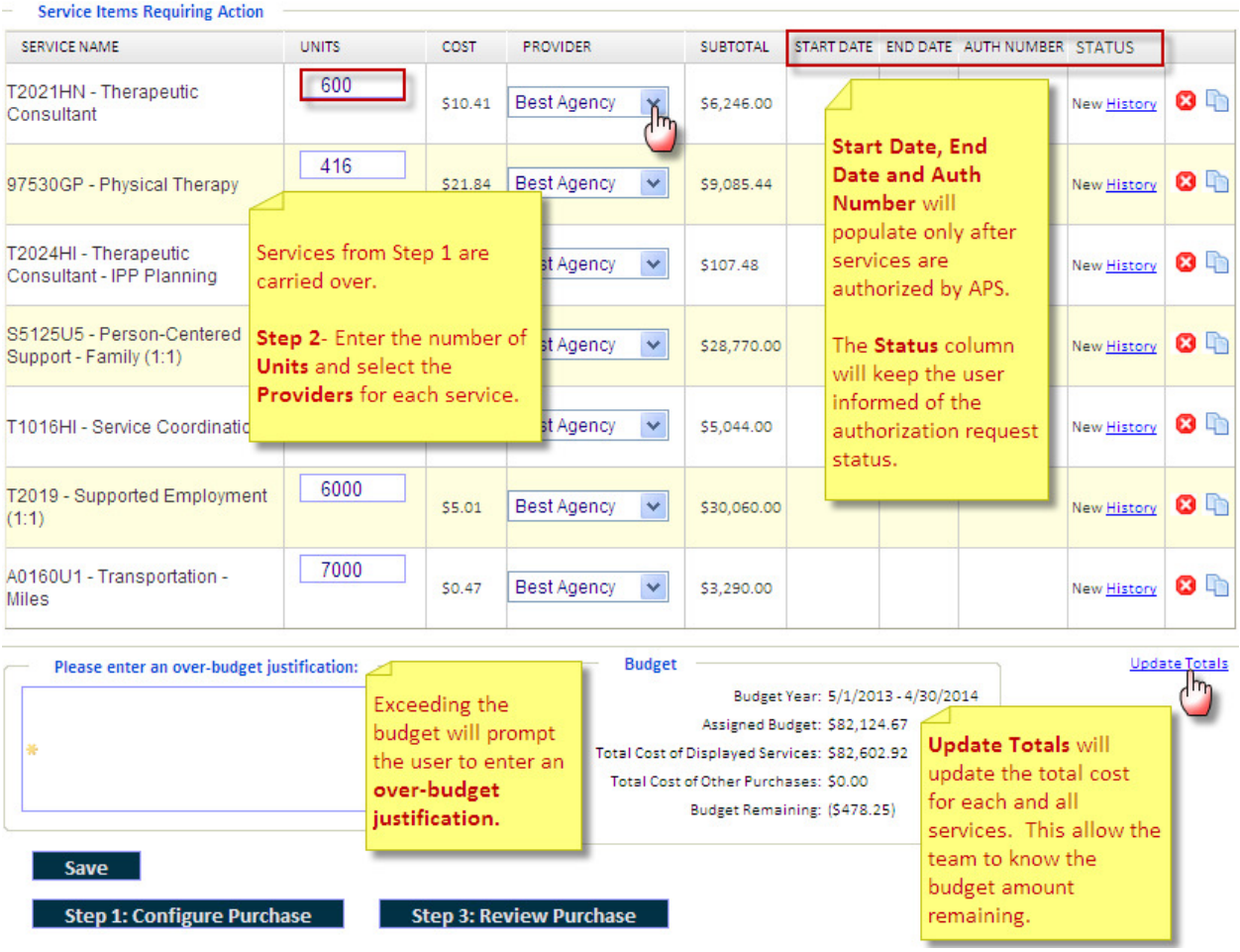


Figure 70-Purchase Step 2: Configure Services

7.8.10.3. Purchase Step 3: Review Purchase Step 3: Review Purchase

Purchase Step 3 allows the user a final opportunity to review the services, units and providers entered into the system in previous steps. The user should review service name, units and provider to verify accuracy. The system requires the user to check ☑ and confirm that the member's D*emographic* and *Medical* information entered into the system is current. Demographic and Medical information will be referenced by KEPRO staff in determining the need for requested services, so it is imperative this information is kept accurate and current. If while on Step 3 the user notices a mistake, he/she may return to **Step 1: Configure Purchase** or **Step 2: Configure Services**. If all information as displayed in Step 3 is accurate, the user should click **Submit**.

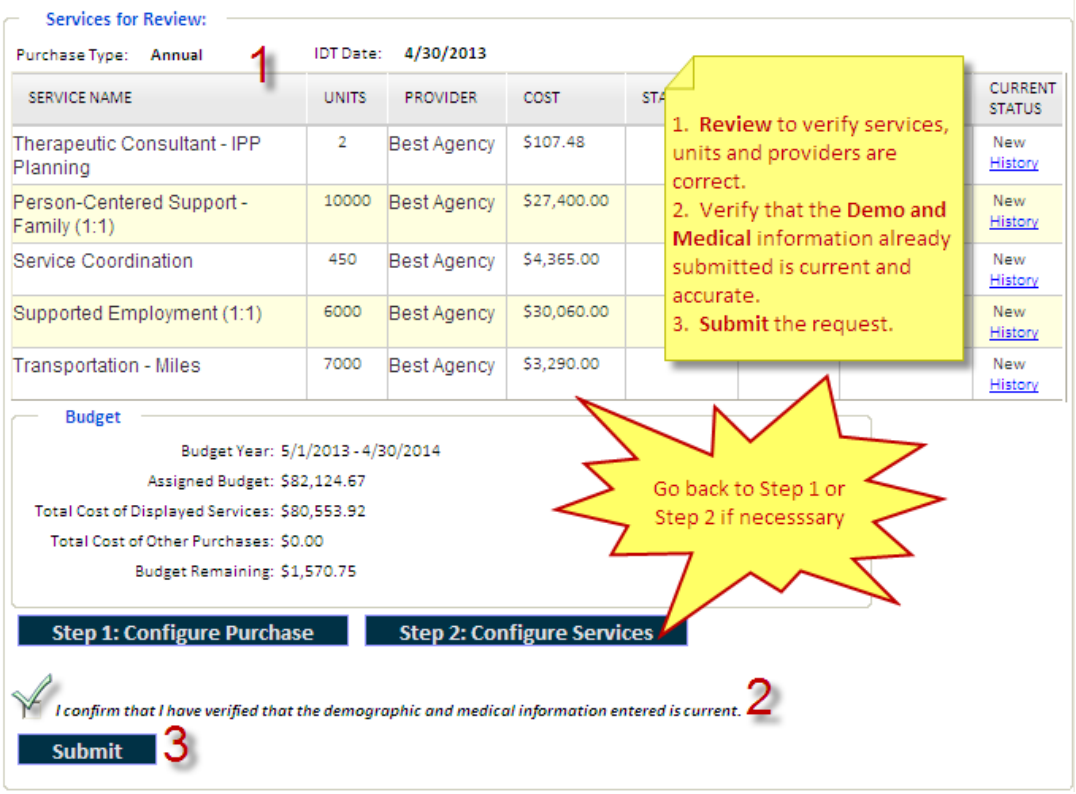


Figure 71-Purchase Step 3 Review Purchase

If the user submitting is a Provider Administrator or a Service Coordinator with Read/Write/Submit privileges, the request will go immediately to KEPRO for review and determination. Once this happens, the **Current Status** column will reflect a status of **Pend**. KEPRO has five business days in which to make authorization determinations. Users will receive notification through the system if KEPRO requires additional documentation, or if the request is authorized or denied and ultimately if an authorized service is accepted by the servicing provider. Users should reference the **Status** column of the **Service Items** grid to ascertain the status of the authorization request.

Each Purchase Request (comprised of all requested services) can be easily retrieved by selecting the **View** hyperlink on the **Recent Purchases** table in the member's *Consumer Detail* screen.

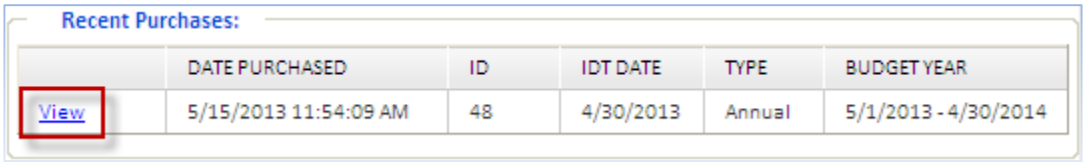


Figure 72- Consumer Detail View Recent Purchases

7.8.11. Modify Service Authorization

In the event the interdisciplinary team recognizes the need to modify characteristics of the current authorization, the user should access the **Modify** feature in CareConnection©. All services (including modifications) must be documented by the Service Coordinator on the member's Individual Program

Plan (IPP). Services/Authorizations/Modifications made in CareConnection© must match those documented and approved by the member's interdisciplinary team on the IPP. A modification can only be requested for a service in which an authorization already exists.

To make a modification, the user will access the **Purchase Request** for which a service will require modification. From **Consumer Detail**, the user should click on the **View** hyperlink in the **Recent Purchases** grid. This action will take the user to **Purchase Step 2: Configure Services**. The user will click on the Modify - **MOD** Icon.

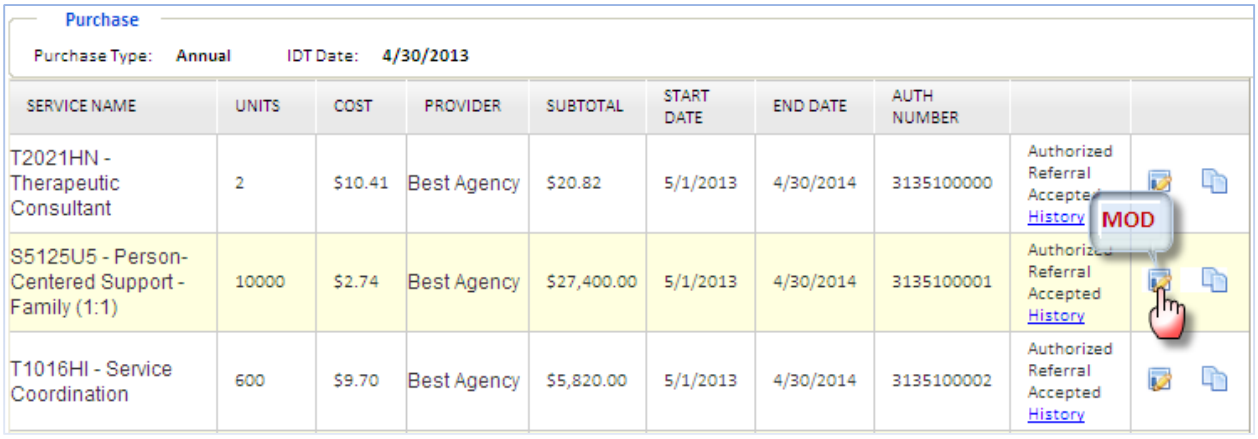


Figure 73-Modify Service Authorization

The user is taken to the **Create Modification** page. The user should **Select a Modification Type** which includes the following options: Consumer Medicaid Number, Provider Medicaid Number, Service Units and Service End Date. Once type is selected, the user will select **Reason** for modification, view the existing value, and input a new or requested value. The user will then click **Request Modification**. KEPRO will review and make a determination on the request once submitted. The provider will be notified of the authorization modification request decision via notification.

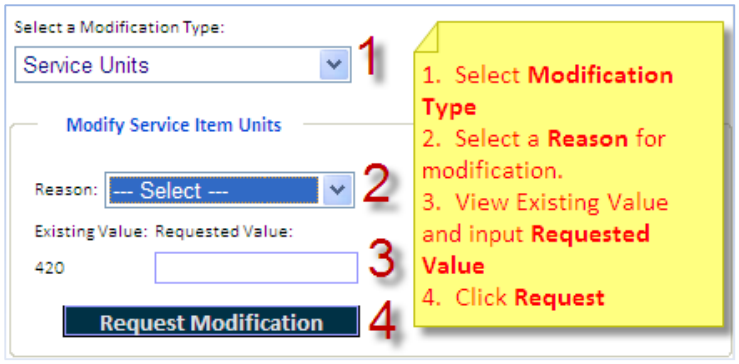


Figure 74-Create Modification

7.8.12. Transfer SC Agency

In the event that a member served requests to be transferred to another Service Coordination agency, the originating Service Coordination agency is responsible to initiate the transfer in the CareConnection© system. From the **Consumer Navigation Menu**, the user should select **Transfer SC**

Agency. Once on the *Transfer Consumer* screen, the user should select the new or **Transfer To** agency, select the **Reason For Transfer**, enter a **Transfer Date**, **Final Access Date** and any **Comments** applicable to the member's transfer to a new Service Coordination agency.

- **Transfer To**- Select the Service Coordination agency to which the member requests transfer.
- **Reason For Transfer**- Select the reason the member is transferring Service Coordination. Options include Consumer Requests New SC Provider, Consumer Moved to New Geographic Area, Provider No Longer offers Service Coordination, and Provider Initiated Transfer.
- **Transfer Date**- Enter the date the new SC Provider will have access to the member's record in CareConnection©. This is also the date the interdisciplinary team determined appropriate for a transfer of Service Coordination to occur.
- **Final Access Date**- Reflects the final date the existing (Transfer From) agency will be providing or billing for Service Coordination services. NOTE: The I/DD Waiver Manual allows for up to a 30-day overlap of Service Coordination providers during a transfer for the purposes of finalizing and establishing new services.

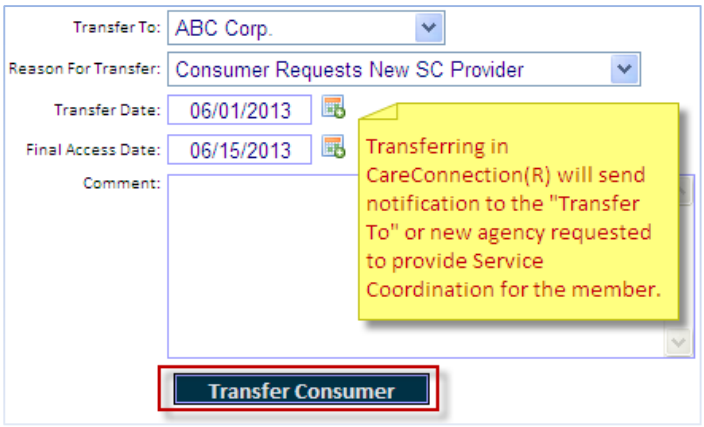


Figure 75-Transfer Consumer

7.8.13. Discharge 

If an active member requires complete and total discharge from the I/DD Waiver program, the user should initiate discharge in CareConnection© by clicking the **Discharge** button from the member's **Consumer Navigation Menu**. This action will take the user to the *Discharge Consumer* screen. The user should select a **Reason for Discharge**, indicate an **Effective Discharge Date**, and enter any **Comments** applicable to the member being discharged.

The Discharge feature in the system was updated to ascertain whether or not a member accessed services within the current fiscal year. This update allows for more efficient management of the Wait List and allocation of slots to eligible applicants. Members who have not accessed services within the fiscal year do not count as an unduplicated slot. This means a discharged member's slot (if he or she has not accessed services) can be awarded to another eligible applicant on the Wait List.

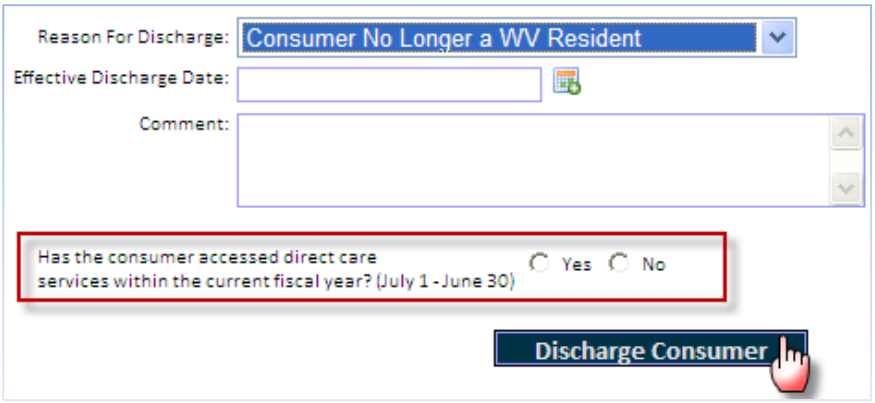


Figure 76-Discharge Consumer

7.9. Service Coordinator Read/Write (SC-RW)

The SC-RW User can search/view/edit all information pertaining to members assigned to his/her caseload. When this user selects "submit" on any page in CareConnection©, the system sends a notification to the agency's Provider Administrators for their review and approval prior to information being forwarded to KEPRO.

7.10. Service Coordinator Read Only (SC-R)

The SC-R User has access to search/view all information about members assigned to his/her caseload. This user cannot edit or submit any information in CareConnection©.

8. ADMINISTRATIVE (UMC) USERS

8.1. Administrator

The KEPRO Administrator User has ability to perform all administrative functions in CareConnection© and search/view all information relevant to all members, users and providers and make authorization decisions. The KEPRO Super Administrator cannot make service selections for authorization on behalf of the Service Coordinator agency, and cannot accept/reject referrals on behalf of an agency.

8.2. Eligibility Admin User

The Eligibility Admin User can perform all functions of the Administrator but can also manage the I/DD Waiver Wait List.

8.3. Service Support Facilitator (SSF)

The Service Support Facilitator User can view all information about all members, providers and users in CareConnection©. The KEPRO SSF gets notification of due dates for upcoming Annual Functional Assessment appointments so they can contact the member/Service Coordinator and schedule assessments. The KEPRO SSF tracks their appointments in CareConnection©.

9. APPENDIX A: TRANSFERRING SERVICES

There are a number of options providers may choose in transferring service authorizations within the KEPRO I/DD Waiver CareConnection© application. This Appendix offers best practice suggestions for various scenarios including: 1) How to transfer an authorization for Service Coordination only and 2) How transfer authorizations for Service Coordination and all other services, and 3) How to transfer authorizations for only services other than Service Coordination. It is hoped that these suggestions will standardize provider transfers and ensure consistency in expectation and practice amongst providers.

9.1. Definitions

The following definitions are offered to clarify procedures as suggested in Appendix A.

Agency 1: The agency from which services are being transferred

Agency 2: The agency to whom services are being transferred

Authorization or Authorization Number or Auth: An approval from the UMC, Kepro, based on the appropriateness and efficacy of a service request. Upon approval, KEPRO' I/DD Waiver CareConnection© will generate an authorization number for each service. This authorization number will be forwarded to the WV Medicaid claims payer and to the provider of service.

MOD or Modification: A request submitted to Kepro to modify an existing and accepted authorization for service.

Transfer: In the I/DD Waiver CareConnection©, transfer refers to the transfer of Service Coordination from one agency to another.

9.2. Transfer Service Coordination Only

The following is an example to illustrate a best practice timeline for provider agencies.

A member indicates intent to transfer Service Coordination from Agency 1 to Agency 2. Agency 1 will continue to provide all other services. After preliminary contact and/or meetings, a Transfer IPP meeting has been scheduled for May 15, 2008. At the Transfer meeting, the interdisciplinary team determines that the effective date of the transfer will be June 1, 2008. At that time, Agency 2 will resume all Service Coordination responsibilities. After June 1, 2008 Agency 1 will have no ability to edit/update the member's demographic, medical, purchase and authorization information within I/DD Waiver CareConnection©.

9.2.1. Agency 1 Transfer SC Agency

Prior to June 1, 2008, Agency 1 will submit a Transfer within I/DD CareConnection©. See SC-RWS User section of this manual for complete details on Transferring SC Agency.

9.2.2. Agency 1 Request Modification of Authorization End Date

Prior to the Transfer date, Agency 1 will submit a request to KEPRO to modify the end date of the authorization for Service Coordination. The user will retrieve the member's information on the web application and click **View** in the **Recent Purchases** panel. See SC-RWS User section of this manual for complete details on making a service authorization modification request.

The reason for modification should be selected to reflect: **Service was authorized then a different provider was requested and approved** under **Reason**.

9.2.3. Agency 1 Request Modification of Service Units

It is imperative that each agency providing services implement an effective and accurate utilization management system, keeping track of the number of units provided for each service for a given span of time.

Following the example from above, Agency 1 would be required to modify the number of units to the total number of units provided during the time span in which Agency 1 held the authorization for Service Coordination. Agency 1 should take the following into consideration:

- The original authorization period was from 10/01/2007 through 09/30/2008
- During the original authorization period, the IDT anticipated the consumer to need, and Agency 1 to provide 460 units
- Upon transfer, Agency 1 will have provided Service Coordination from 10/01/2007 through 6/30/2008
- Agency 1 calculated the number of units from 10/01/2007 through 6/30/2008 to be 270 units

Upon the effective date of transfer, 7/1/2008, Agency 2 will have access to the system as the member's Service Coordination provider. In order to ensure Agency 1 has an adequate number of units to bill for services provided through 6/30/2008, Agency 1 should take the actions to modify their own units and end dates prior to the effective date of transfer. If Agency 1 does not complete these tasks, Agency 2 will be required to do so prior to submitting a request for authorization of Service Coordination under Agency 2.

Directly after submitting the request to change the end date for Agency 1's authorization for Service Coordination, the web user will click **Service Units** in the **Select a Modification Type** drop-down list to initiate the second modification.

The user will then select **Service was authorized, then a different provider was requested and approved** as the Reason for modification.

After selecting the **Reason** for service unit modification, the user will review the **Existing Value** displayed. The Existing Value lists 460 as the current authorization units for this member, service, and provider. The **Requested Value** in this example would be entered as **270**. Upon KEPRO approval of the modification, Agency 1's Service Coordination authorization for this member would be modified to 270 units. After entering the Requested Value, the user will select **Request Modification**.

Upon receipt of notification, the KEPRO User will be able to see that both modification requests (end date and service units) have been made.

9.2.4. Agency 2 Responsibilities

Continuing with the example: As of 7/1/2008, Agency 2 has Service Coordination provider user rights for the member who has transferred. After Agency 2 has conducted the appropriate assessments, and the member's IDT has determined an appropriate number of units for Service Coordination, Agency 2's Service Coordination user can purchase Service Coordination to obtain an authorization for Agency 2. Keep in mind that all authorizations will have a start date corresponding with the member's fixed Annual IPP date, regardless of the transfer effective date. Agency 2 cannot bill Service Coordination prior to the transfer effective date.

IT IS RECOMMENDED THAT AGENCY 1 REQUEST THEIR OWN MODIFICATIONS

PRIOR TO THE SERVICE COORDINATION TRANSFER DATE.

If Agency 1 has not followed the steps to modify their authorization end date and service units, Agency 2 must do so prior to requesting a new authorization. The end date and service units must be modified prior to KEPRO granting authorization to a new provider. The service limits as set forth in the I/DD Waiver manual must be adhered to, as well as the member's Individualized Waiver Budget. KEPRO cannot authorize request to exceed the budget just because Agency 1's authorizations have not been modified.

9.2.4.1. Agency 2-Obtaining a New Authorization

Upon the Service Coordination effective transfer date, the new Service Coordination agency has the ability and responsibility to purchase necessary services as identified by the member's interdisciplinary team. This will be done through the **Start Purchase** button in the **Member Navigation** panel, as the transfer of services is a Critical Juncture.

The member's interdisciplinary team must only request the number of units Agency 2 will required to meet the member's needs for the remainder of the member's service year (7/1/2008 through 09/30/2008). If the team typically meets prior to 09/30/2008 (within the 30-day grace period prior to the member's fixed Annual IPP date of 10/01/2008), they should purchase services needed only through the fixed IPP date. Authorizations received will have a start date concurrent with the member's fixed Annual IPP date, regardless the date the new agency begins providing services.

9.3. Transfer All Services

Transferring all services refers to a transfer of Service Coordination and any other services that will be provided by a new agency. Transferring authorization for any service follows suit with the instructions listed above. It is important to note that only the agency that holds an active authorization for Service Coordination has access to make changes to the member's demographic, medical, purchase, and authorization information.

9.3.1. Agency 1 Transfer Member

Agency 1 (or the original Service Coordination agency) will submit a Transfer through the KEPRO I/DD Waiver CareConnection©. See SC-RWS User section of this manual for complete details on Transferring SC Agency.

9.3.2. Agency 1 Request Modification of Authorization End Date

Prior to the Transfer date, Agency 1 will submit a request to KEPRO to modify the end date of the authorization for all services that will be provided by a new agency. See SC-RWS User section of this manual for complete details on making a service authorization modification request. The user will select a modification type from the available options. In this example, the user would select **Service End Date**. The **Modify Service Item End Date** panel appears. The user will select **Service was authorized then a different provider was requested and approved** under **Reason**.

9.3.3. Agency 1 Request Modification of Service Units

It is imperative that each agency providing services implement an effective and accurate utilization management system. Each agency must keep track of the number of units provided for each service for a given span of time.

Upon the effective date of transfer, Agency 2 (new Service Coordination agency) will have access to the system as the member's Service Coordination provider. Agency 1 will no longer have the ability to request any modifications of either units or end dates. In order to ensure Agency 1 has an adequate number of units to bill for services provided through the modified end date, Agency 1 should take the actions to modify their own units and end dates. If Agency 1 does not complete these tasks, Agency 2 will be required to do so prior to submitting a request for authorization of Service Coordination under Agency 2.

Directly after submitting the request to change the end date for a service authorization for, the web user will click **Service Units** in the **Select a Modification Type** drop-down list. The user will then select **Service was authorized, then a different provider was requested and approved** as the Reason for modification.

When the KEPRO User receives notification, s/he will be able to see that both modification requests (end date and service units) have been made.

The Service Coordination agency should **Request Modification of Authorization End Date** and **Request Modification of Service Units** for each service that will transfer to a new agency prior to the new agency initiating service.

ALL I/DD SERVICE AGENCIES MUST MAINTAIN APPROPRIATE UTILIZATION MANAGEMENT PROCESSES AND RECORDS SO THAT ANY NEW AGENCY IS AWARE OF THE NUMBER OF UNITS UTILIZED PRIOR TO THE TRANSFER OF SERVICE AUTHORIZATION.

9.3.4. Agency 2 Responsibilities

IT IS RECOMMENDED THAT AGENCY 1 REQUEST THEIR OWN MODIFICATIONS PRIOR TO THE SERVICE COORDINATION TRANSFER DATE.

If Agency 1 has not followed the steps to modify their authorization end date and service units, Agency 2 must do so prior to requesting new authorizations. The end date and service units must be modified prior to KEPRO granting authorization to a new provider. The service limits as set forth in the I/DD Waiver manual must be adhered to, as well as the member's Individualized Waiver Budget. KEPRO cannot authorize request to exceed the budget just because Agency 1's authorizations have not been modified.

9.3.4.1. Agency 2 Obtaining New Authorizations

Upon the Service Coordination effective transfer date, the new Service Coordination agency has the ability and responsibility to purchase necessary services as identified by the member's interdisciplinary team. This will be done through the **Start Purchase** button in the **Consumer Navigation Menu**, as the transfer of services is a Critical Juncture.

The member's interdisciplinary team must only request the number of units the new agency will require to meet the member's needs for the remainder of the member's service year. Authorizations received will have a start date concurrent with the member's fixed annual IPP date, regardless the date the new agency begins providing services.

9.4. Transfer Service(s) Other than Service Coordination

Transferring service(s) other than Service Coordination refers to a transfer of any service from one agency to another while the Service Coordination agency remains the same. Examples would include:

- Transferring residential services (ISS or Group Home) from one agency to another or
- Transferring Facility-based Day Habilitation services from one agency to another.

Because the member is not transferring Service Coordination agencies, there is no need to submit a Transfer (Transfer SC Provider) through the KEPRO I/DD Waiver CareConnection©. The Service Coordination agency, however, will be required to submit a request to **Modify Authorization End Dates** and **Modify Service Units**.

9.4.1. Request Modification of Authorization End Dates

Prior to the date the new service agency will initiate services, the Service Coordination agency will submit a request to KEPRO to modify the end date of the authorization for all services that will be provided by the new agency. The user will retrieve the member's information on the web application and click **View** in the **Recent Purchases** panel. See SC-RWS User section of this manual for complete details on making a service authorization modification request.

The user will select **Service was authorized then a different provider was requested and approved** under **Reason** on the *Modification* screen.

9.4.2. Request Modification of Service Units

Directly after submitting the request to change the end date for a service authorization, the Service Coordination agency web user will click **Service Units** in the **Select a Modification Type** drop-down list. The user will then select **Service was authorized, then a different provider was requested and approved** as the Reason for modification.

When an KEPRO Registration Coordinator receives notification, s/he will be able to see that both modification requests (end date and service units) have been made.

The Service Coordination agency should **Request Modification of Authorization End Date** and **Request Modification of Service Units** for each service that will transfer to a new agency prior to the new agency initiating services.

9.4.3. Request Authorization(s) for New Service Provider(s)

The Service Coordination agency has the responsibility to purchase necessary services as identified by the member's interdisciplinary team. This will be done through the **Start Purchase** button in the **Consumer Navigation Menu**, as the transfer of service providers is a Critical Juncture.

The member's interdisciplinary team must only request the number of units the new agency will require to meet the member's needs for the remainder of the member's service year. Authorizations received will have a start date concurrent with the member's fixed Annual IPP date, regardless the date the new agency begins providing services.

10. APPENDIX B: MEMBER ELIGIBILITY STATUS DEFINITIONS

Status	Definition
Initial Applicant	DD-1 Application has been received for the Applicant and KEPRO is awaiting receipt of the completed IPN Response Form.
Applicant - IPE	The IPN Response Form has been received and the referral generated to the chosen Independent Psychologist (IP). Applicants will stay in this status until the Independent Psychological Evaluation (IPE) is attached by the IP.
Applicant - IPE Extension	An extension has been granted for an applicant whose IPE cannot be attached within 60 days of receipt of the IPN Response Form.
Applicant - MECA Review	The IPE has been attached and is being reviewed by the Medical Eligibility Contract Agent for eligibility determination.
Applicant - Closed	The applicant no longer wishes to pursue application with the I/DD Waiver Program and is withdrawing their application.
Applicant - Eligible	Applicant is Medically Eligible for the I/DD Waiver Program. If a slot is not available when eligibility determination is made the Applicant is placed on the Waitlist and will remain in this status until their slot is released.
Applicant - Denied	Applicant is not Medically Eligible for the I/DD Waiver Program.
Active	Program Member is accessing I/DD Waiver services.
Annual Extension	Program Member is not accessing services on the I/DD Waiver Program and cannot receive Annual Eligibility Determination by the Anchor Date. Annual Extension is also granted for Program Member's assessing services, but the Annual Functional Assessment completion and/or Medical Eligibility Determination cannot occur prior to the Anchor Date.
Member Hold - Extension	Program Member is not accessing services on the I/DD Waiver Program and their slot is being held until services can be accessed.
Terminated	Program Member is not Medically Eligible for the I/DD Waiver Program based on review of the Annual Functional Assessments.
Terminated - IPE	Terminated Program Member is pursuing Second Medical Exam through completion of an Independent Psychological Examination and the referral has been generated to the chosen Psychologist.
Discharged	Program Member is opting off the program and will no longer access services.

11. APPENDIX C: IPN USER NOTIFICATIONS

Notification	Message	Dismissible	Action in the System Removing Notification
IPE Requested	An IPE is requested for <Applicant Name>.	No	IPE is Attached or Applicant Closed
IPE Requested (30 Days)	REMINDER: An IPE has not been attached for 30 days since the IPN Response Received Date: <MM/DD/YYYY>.	No	IPE is Attached or Applicant Closed
IPE Requested (60 Days)	2nd REMINDER: An IPE has not been attached for <Applicant Name>. It has been 50 or more days since the IPN Response Form Received Date: <MM/DD/YYYY>.	No	IPE is Attached or Applicant Closed
IPE Requested (90 Days)	Final Reminder: An IPE has not been attached for <Applicant Name>. It has been 80 or more days since the IPN Response Received Date: <MM/DD/YYYY>.	No	IPE is Attached or Applicant Closed
Applicant Closed	<Applicant Name> has been moved to closed status and does not require review. Please close any open appointments.	Yes	Dismiss this Notice
Extension Requested	A 30/60/90 or 180 day extension has been approved for <Applicant Name>.	Yes	Dismiss this Notice
Scheduling Follow-up Contact Reminder	Follow-up reminder to schedule appointment for <Applicant Name> on <MM/DD/YYYY>.	Yes	Dismiss this Notice
Appointment Outcome Alert	An appointment outcome will need to be completed for <Applicant Name>.	No	Appointment Outcome Entered
Appointment Outcome Unsuccessful	An appointment for <Applicant Name> is unsuccessful and requires rescheduling.	Yes	Dismiss this Notice
IPE Approved for Invoice	IPE for <Applicant Name> has been approved with authorization number: [##########]	Yes	Dismiss this Notice
IPE Denied for Invoice/Other Reason	IPE for <Applicant Name> has been denied for invoice for other reason.	Yes	Dismiss this Notice
IPE Reassigned	IPE for <Applicant Name> has been reassigned to a different IPN.	Yes	Dismiss this Notice
Appointment Reassigned	An appointment for <Applicant Name> OR <Member Name> has been reassigned to you.	No	Appointment Outcome Entered

Appointment Reassigned to New Assessor	An appointment for <Applicant Name> OR <Member Name> has been reassigned from you to another assessor.	Yes	Dismiss this Notice

12. APPENDIX D: PCA ADMIN USER NOTIFICATIONS

Notification	Message	Dismissible	Action in the System Removing Notification
IPE Requested	An IPE is requested for <Applicant Name>.	No	Notification will be removed after a successful appointment has occurred and the IPE has been attached –OR- the applicant has withdrawn from the application process and is moved to 'Applicant-Closed' Status by KEPRO User.
IPE Requested (30 Days)	REMINDER: An IPE has not been attached for <Applicant Name>. It's been more than 30 days since the IPN Response Received Date: 'Date IPN Response Form Received.	No	Notification will be removed after a successful appointment has occurred and the IPE has been attached –OR- the applicant has withdrawn from the application process and is moved to 'Applicant-Closed' Status by KEPRO User.
IPE Requested (60 Days)	2nd REMINDER: An IPE has not been attached for <Applicant Name>. It's been 50 or more days since the IPN Response Received Date: <Date IPN Response Form Received>.	No	Notification will be removed after a successful appointment has occurred and the IPE has been attached –OR- the applicant has withdrawn from the application process and are moved to 'Applicant-Closed' Status by KEPRO User.
Extension Requested	A 30/60/90 or 180 day extension has been approved for <Applicant Name>.	Yes	Dismiss this Notice

Applicant Closed	<Applicant Name> has been moved to closed status and does not require review. Please close any open appointments.	Yes	Dismiss this Notice
IPE Completed	An IPE has been completed for <Applicant Name>. Please complete the administrative review.	No	Notification will be removed after the MECA Administrative Review Outcome and Date have been entered.
Administrative IPE Review Complete	An Administrative IPE Review for <Applicant Name> has been completed with an outcome of 'Selected Outcome.	Yes	Dismiss this Notice
Annual Assessment Uploaded	An assessment has been uploaded for <Member Name>. Please assign a MECA reviewer.	No	Notification will be removed after the MECA Reviewer has been assigned.
Second Medical Evaluation Complete	2nd Medical IPE attached for <Applicant Name> OR <Member Name>. Please complete the administrative review.	No	Notification will be removed after the Administrative Outcome has been complete.
Second Medical Admin Review Complete	The 2nd Medical Administrative Review for <Applicant Name> OR <Member Name> has been completed and a MECA Reviewer will need to be assigned.	No	Notification will be removed after the MECA Reviewer has been assigned.

13. APPENDIX E: PCA USER NOTIFICATIONS

Notification	Message	Dismissible	Action in the System Removing Notification
Assessment Review Requested	<Applicant Name's> Assessment needs to be reviewed.	No	Notification will be removed only when the MECA Eligibility Review Outcome and Date of Outcome have been entered.
Annual Assessment Review Requested	<Member Name> needs an annual assessment review.	No	Notification will be removed only when MECA Redetermination Outcome and MECA Redetermination Date have been entered.

14. APPENDIX F: CREATE/EDIT DEMOGRAPHIC DATA SET

I/DD Waiver Care Connection® Demographic Screen Field	Definition – Demo can only be created or edited by UMC users. Providers should contact KEPRO staff for necessary updates.
Consumer Medicaid	Enter the member's 11 Digit Medicaid ID Number. Do not include hyphens when entering.
Marital Status (Select One)	Select member's Current Marital Status.
Never Married	Select if member is single or has never been married.
Married	Select if member is married.
Separated	Select if member is married, but has a legal decree identifying them as separated from their spouse.
Divorced	Select if member is divorced.
Widow	Select if member is widowed.
Education Level (Select One)	Select the highest level of education the member has completed. For example: If the member is in High School, select "Middle School" as the highest level of education completed.
None	Select if member has never been in school or is currently in preschool or elementary school, but has not completed preschool or elementary school.
Preschool	Select if member has completed a Preschool Program.
Elementary School	Select if member has completed an Elementary School Program.
Middle School	Select if member has completed a Middle School Program.
High School GED	Select if member has completed High School with either a standard or modified diploma or has completed a GED Program.
Post High School Tech Trade College	Select if member has completed a Technical, 2-year, 4-year, Master's Degree or any college program.
Current Day Setting (Mark All that Apply)	Select any and all day settings that apply to the member.
Competitive Employment	Select if member currently participates in a paid competitive employment setting with no job coach. This setting does not apply to a non-paid or volunteer position or if Supportive Employment is provided.
Prevocational Training	Select if the member's day includes participation in prevocational training activities.
Supported Employment	Select if the member's day includes participation in Supported Employment activities.
Technical Education	Select if member is currently enrolled in a trade, vocational or technical school program focusing on job skill training rather than academics.
Community Day Habilitation	Select if the member's day includes participation in Day Habilitation activities that take place in a community (non-facility) setting.

Facility Day Habilitation	Select if the member's day includes participation in Day Habilitation activities that take place in a facility-based setting.
Current School (Select One)	Select the member's current school setting. If the member participates in more than one setting, select the option in which the member spends the most time.
Preschool Program	Select if member is currently enrolled in a Pre School program.
Head Start	Select if member is currently enrolled in a Head Start program.
Special Education	Select if the member has an IEP and is receiving Special Education Services for the majority of the school day.
Alternative School	Select if member is currently enrolled in an Alternative School program designed to accommodate educational, behavioral or medical needs of children or adolescents that cannot be adequately addressed in the traditional school environment.
GED Program	Select if member is currently enrolled in a GED program.
Home Schooled	Select if member receives academic instruction in the home by his/her parents.
Homebound	Select if member receives services through the board of education in the home.
Trade/Voc/Technical	Select if member is currently enrolled in a Trade/Vocational or Technical school.
College (2-4 yr Prgm)	Select if member is currently enrolled in a 2 or 4 year college program.
Graduate School	Select if member is currently enrolled in a Graduate School Program.
Not in School	Select if member is not enrolled in any formal educational program or school. If member is enrolled in a Division of Rehabilitation Services program, select "Not in School."
Regular Education	Select if member is receiving regular education instruction for the majority of the school day.
Primary Language (Select One)	Select the spoken or written language the member best understands. If the member does not appear to understand any languages then select the language spoken in the home.
English	Select if member's primary language is English.
Spanish	Select if member's primary language is Spanish
Other	Select if member understands two languages equally or if primary language is not listed above.
Residential Provider Phone	Enter the phone number (including area code) of the Agency providing residential services. This field is required when "Residential Provider" is selected below.
Residential Provider (Select One)	Select the Agency providing services in the member's residential (home) setting (includes PCS Agency and PCS Family services). Make no selection when the member's residential services are provided via natural supports and not through an Agency.
Type of Residence (Select One)	Select the type of Residence in which the member currently resides.

Biological or Adoptive Family	Select if member resides in the home with one or more than one biological or adoptive family members.
Specialized Family Care Home	Select if member resides in a specialized family care or foster care home where supports are provided in a family-like environment.
Individual Support Setting 1 Person	Select if member lives in a 1-person 24-hour/day staffed/supported residential setting where no biological, adoptive or other family members reside in the home setting with the member.
Individual Support Setting 2 Person	Select if member lives in a 2-person 24-hour/day staffed/supported residential setting where no biological, adoptive or other family members reside in the home setting with the member. An exception would be when siblings who are also I/DD Waiver members reside in a setting without any other family members.
Individual Support Setting 3 Person	Select if member lives in a 3-person, 24-hour/day staffed/supported residential setting where no biological, adoptive or other family members reside in the home setting with the member. An exception would be when siblings who are also I/DD Waiver members reside in a setting without any other family members.
Waiver Group Home 4 People	Select if member lives in a 4 or more person, 24-hour/day staffed/supported agency-run residential setting where no biological, adoptive or other family members reside in the home setting with the member. An exception would be when siblings who are also I/DD Waiver members reside in a setting without any other family members.
# Of Waiver Consumers Living w/ This Consumer	Enter the Number of Individuals living with the member who also receive services through the I/DD Waiver Program.
Race (Select One)	Select the Race most applicable to the member.
African American	Select if member is an American of African and especially of black African descent.
Alaskan Native	Select if member is a person having origins in any of the original peoples of North and South America (Including Central America) and who maintains tribal affiliation or community attachment.
Asian	Select if member is a person having origins of any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand and Vietnam.
Hawaiian Pacific	Select if member is a person having origins of any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.
White	Select if member is a person having origins of any other original peoples of Europe, the Middle East, or North Africa.
Other	Select if member is a person having origins not included in the other race designations.

Hispanic Latino	Select if member is a person having origins of peoples of Cuba, Mexico, Puerto Rico, South or Central America or other Spanish Origins regardless of race.
Driving Directions (Text Field)	Enter directions to the member's home beginning with the closest major road (e.g. interstate, state highway county route, city main street).
Respondent 1-4 (Text Fields)	Detail Information for Respondents Participating in the Annual Functional Assessment Process. Respondent Data is required for respondents 1-3. KEPRO may use this information to contact respondents relevant to assessments.
First Name	Enter the first name of the respondent(s) designated to participate in the Annual Functional Assessment Process.
Last Name	Enter the last name of the respondent(s) designated to participate in the Annual Functional Assessment Process.
Phone Number	Enter the phone number for the respondent(s) participating in the Annual Functional Assessment.
Relationship	Enter the respondent's relationship to the individual being assessed.
Discussion (Text Box)	Enter any additional information relevant to the member's demographic characteristics.

15. APPENDIX G: CREATE/EDIT MEDICAL DATA SET

I/DD Waiver Care Connection® Medical Screen - Medical Evaluation Field	Definition
Arm Hand Assessment (Select One)	Select the response describing the arm/hand limitation(s) the member experiences affecting daily activities. If the member uses an aid or prosthesis, rate the level of functioning with use of the aid.
No Limitation Daily Activities	Select if arm/hand can be used normally with no limitations in all daily activities.
Some Daily Activities Limited	Select if arm/hand can be used normally with limitations to some daily activities.
Most Daily Activities Limited	Select if arm/hand cannot be used normally because limitations are experienced with most daily activities.
Frequency of Care by RN/Physician (Select One)	Select the response describing the frequency of services provided to the member by a Physician or RN. Field does not represent the frequency of services provided by an LPN.
Less than Monthly	Select if, on average, member requires the care of an RN or Physician less than once a month.
Monthly	Select if, on average, member requires the care of an RN or Physician monthly.
Weekly	Select if, on average, member requires the care of an RN or Physician weekly.
Daily	Select if member requires the care of an RN or Physician daily.
24 Hour Immediate Access	Select if member requires the care of an RN or Physician at any time within 24 hours requiring immediate access.
None	Select if member does not require the care of an RN or a Physician.
Continence Assessment (Select One)	Select the response that describes the member's voluntary control over bowel and bladder movements.
Continent	Select if member is able to voluntarily control movements of the bowel and bladder.
Incontinent	Select if member has either insufficient or no control over movements of the bowel and bladder.
Not Toilet Trained	Select if member does not initiate going to the bathroom independently to control movements of the bowel and bladder.
Date of Most Recent Medical Evaluation (Date Field)	Enter the date of the most recent medical evaluation.
Feeding Assessment (Select One)	Select the response that describes the member's ability to feed him/herself. This item does not include assistance required to prepare food.
Feeds Self	Select if member is able to feed him/herself with minimal assistance such as cutting up food.

Needs to be Fed	Select if member is unable to feed him/herself with requires assistance from another person.
Gastric Jtube	Select if member requires a medical device used to provide nutrition (requires use of G Tube or J Tube, for example).
Special Diet	Select if member requires a specific meal plan prescribed by a physician or dietician.
Required Medical Care (Mark All that Apply)	Select the medical care the member currently requires.
Traction/Casts	Select if member is currently in a cast used to immobilize a fracture or dislocated joint for proper positioning and/or to facilitate healing. Select if member requires traction to alleviate pressure.
Catheter	Select if member requires tubular instrument be inserted into a cavity of the body to withdraw or introduce fluids. Examples of catheters are: cardiac catheters, angiographic catheter, atherectomy catheter, central venus catheter, condom catheter, female catheter, prostatic catheter
Colostomy	Select if member has had a surgical procedure where a portion of the large intestine is brought through the abdominal wall to carry stool out of the body.
Diagnostic Services	Select if member requires imaging and laboratory procedures used in diagnosing an illness.
Dietician	Select if member is receiving dietary services by a health professional with specialized training in diet and nutrition. May otherwise be known as a nutritionist.
Soaks | Dressings	Select if member has a wound requiring the application of therapeutic or protective materials to assist in protecting and healing a wound.
Ileostomy	Select if member has undergone a surgical procedure where the small intestine is attached to the abdominal wall in order to bypass the large intestine to facilitate waste exiting the body through an artificial opening.
IV Fluids	Select if member requires the administration of fluids through a vein that facilitates fluids going directly into the circulatory system.
Medications: Health Maintenance	Select if member takes over-the-counter medication on a regular basis to maintain health and well-being (i.e.: laxatives, vitamins, herbals and aspirin).
Medications: Health Problems	Select if member takes medications prescribed for a specific health problem or condition such as high blood pressure, arthritis or diabetes. Seizure medications are included elsewhere.
Medications: Mood/Behavior	Select if member takes medications for mood, behavior or psychiatric symptoms.
Medications: Seizures	Select if member takes medications to control a seizure disorder.

Medications: General	Select if member regularly takes prescribed medication to maintain health and well-being such as vitamins, herbals, aspirin or laxatives.
Occupational Therapy	Select if member receives services from an occupational therapist that uses therapeutic techniques including self-care, work and play activities to increase function, enhance development and prevent disabilities.
Oxygen	Select if member receives the administration of oxygen as a medical intervention, which can be for a variety of purposes in both chronic and acute care.
Physical Therapy	Select if member receives services from a physical therapist that treats an injury or physical dysfunction through physical treatment modalities such as massage, manipulation, therapeutic exercises, cold and heat therapy, hydrotherapy and electrical stimulation.
Special Diet	Select if member is on a special diet to aid in weight loss or to aid in the prevention and treatment of health problems including but not limited to: high blood pressure, diabetes, food allergies, high cholesterol, cancer, seizure disorders, renal disease, and osteoporosis.
Speech Therapy	Select if member receives services from a Speech/Language Pathologist to aid in the prevention or correction of speech and language, voice and/or swallowing disorders.
Suctioning	Select if member requires suctioning of the respiratory passages to remove secretions obstructing the nasal or oral passages that cannot be removed through coughing.
Tracheostomy	Select if member has had a surgical procedure creating opening into the trachea through the neck in which a catheter or tube can be inserted to facilitate breathing through an open airway.
Ventilator	Select if member requires assistance with respiration through a device that provides artificial respiration. May also be known as a respirator.
Vision Therapy	Select if member receives services from a vision therapist who works to improve visual abilities such as visual perception (range of vision), spatial localization (define locality in space), heterophoria (deviation of the eyes from parallelism), hand/eye coordination, etc. to achieve optimal visual performance and comfort.
Health Assessment (Select One)	Select the response that best describes how the member's physical health affects his/her everyday activities.
No Limitation	Select if member experiences no limitations in daily activities due to chronic illness or medical problems.
Few Limitations	Select if member experiences few or slight limitations in daily activities due to chronic illness or medical problems.

Many Limitations	Select if member experiences many or significant limitations in daily activities due to chronic illness or medical problems.
Hearing Assessment (Select One)	Select the response that most accurately describes how the member's hearing affects activities on a typical day. If the member uses a hearing aid or another type of hearing device rate the functioning with the use of the device.
Hears Normal Voices	Select if member can hear voices speaking in a normal tone, even if a hearing aid is necessary to do so.
Hears Only Loud Voices	Select if member can only hear loud voices, even if with a hearing aid.
Little or No Useful Hearing	Select if member has little or no useful hearing, even with a hearing aid.
Height	Enter the member's current height in inches.
Hygiene Assessment (Select One)	Rate the member's ability to bathe, wash hair, brush teeth, dress him/herself, and complete other hygiene and grooming activities on a daily basis.
Independent	Select if member does not require assistance and is independent with most hygiene activities on a daily basis.
Needs Assistance	Select if member requires some assistance with most hygiene activities on a daily basis.
Needs Total Care	Select if member requires the total assistance of another person for hygiene activities on a daily basis.
Mobility Assessment (Select One)	Select the response that describes the member's mobility for the largest part of the day.
Ambulatory	Select if member is capable of ambulating without assistance.
Ambulatory with Human Help	Select if member is capable of ambulating, but requires some assistance from another person such as when going up and down stairs or when on uneven surfaces, etc.
Ambulatory with Mechanical Help	Select if member is capable of ambulating with the help of a mechanical device (such as a walker, crutches or a wheelchair).
Wheelchair Self Propelled	Select if member utilizes a self-propelled wheelchair or device for mobility.
Transfer with Assistance	Select if member requires assistance of another person to change body location such as moving from a chair, the car, the bed, etc.
Bedfast	Select if member is not ambulatory and is confined to the bed most of the time due to an illness or infirmity.
Seizure Assessment (Select One)	Select the response describing the typical frequency of seizures.
None or Controlled	Select if member does not have seizures or if seizures are typically controlled with medication.

Less than Monthly	Select if member typically experiences seizures less than monthly regardless of medication.
Monthly	Select if member typically experiences seizures at least monthly regardless of medication.
Weekly or More Often	Select if member typically experiences seizures weekly or more often regardless of medication.
Vision Assessment (Select One)	Select the response that most accurately describes how the member's vision affects activities on a typical day. If the member uses corrective lenses, rate the level of functioning with the use of the aid.
Sees Well	Select if member can see well (even with corrective lenses).
Vision Problems	Select if member has vision problems that may affect reading or travel (even with corrective lenses).
Little or no Useful Vision	Select if member has little or no useful vision (even with corrective lenses).
Weight	Enter the member's current weight in pounds.
Discussion (Text Box)	Enter any additional information relevant to the member's health or medical condition.
I/DD Waiver Care Connection® Medical Screen - Psychological Evaluation Field	Definition
Axis I Primary Diagnosis (Select One)	Select the Axis I Primary diagnosis as reported by the psychologist/psychiatrist on the most recent evaluation. Note: Any rule out diagnosis or clinical impression should not be coded in this field. These may be noted in the Psychological Evaluation Discussion text box as appropriate.
Axis I Secondary Diagnosis (Select One)	Select any Axis I Secondary diagnosis as reported by the psychologist/psychiatrist on the most recent evaluation.
Axis II Primary Diagnosis (Select One)	Select any Axis II Primary diagnosis as reported by the psychologist/psychiatrist on the most recent evaluation.
Axis II Secondary Diagnosis (Select One)	Select any Axis II Secondary diagnosis as reported by the psychologist/psychiatrist on the most recent evaluation.
Axis III Diagnosis (Text Box)	Enter the diagnosis of any general medical condition(s) that are relevant to the member as diagnosed by the physician. This field may be completed with a description of the medical condition or the appropriate ICD-9 numeric code. If no relevant medical conditions exist this can be left blank.
Axis IV Diagnosis (Select One): Values 0-9	Select the primary social stressor impacting the member as reported on the most recent evaluation.
Axis V Diagnosis (Test Field): 3-Digit Value	This field should identify the member's Global Assessment of Functioning (GAF) score as identified on the most recent evaluation. A description of this scale can be found in the DSM-IV-TR Manual. The scale ranges from 000 - 100 and is reported in whole numbers.

Date of Most Recent Psychological Evaluation	Enter the date of the most recent psychological or psychiatric evaluation.
Primary Expression (Select One)	Select the response that most accurately describes the member's primary means of expression/communication.
None	Select if member has no method of communication and is completely unable to communicate.
Gestures	Select if member communicates through non-verbal gestures in which visible bodily actions communicate particular messages (movements may be through the use of hands, face, or other parts of the body).
Speaks	Select if member is able to verbalize or talk.
Sign Language	Select if member uses American Sign Language, Fingerspelling or places their hand on the speaker's hand to tactually receive or give the message.
Communication Device	Select if member uses a device to convey language and messages in an environmentally specific manner. This can be an electronic communication device, the use of pictograph symbols, art or tactile symbols.
Other	Select if member communicates in a way that is not listed above.
Current Behavioral Information (Mark All that Apply)	Select all that apply to the Program member's current behavioral information. Requested treatment interventions should take into account the member's current mental status.
Behavior Plan	Select if the psychologist's recommended interventions for an identified maladaptive behavior(s) include development of a new behavior plan.
Maladaptive Behavior	Select if the member exhibits any of the behaviors identified on the overall measure of problem behaviors based on the eight (8) combined ratings of problem behavior areas of the Inventory for Client and Agency Planning (ICAP) and the psychologist has identified this as a concern.
Continue Behavior Plan/Protocol	Select if the psychologist's recommended interventions for the identified maladaptive behavior(s) include continuation of the current behavior plan or protocol.
Hurtful to Others	Select if member exhibits problem behaviors that cause physical pain to other people or animals (e.g., hitting, kicking, biting, pinching, scratching, pulling hair or striking with an object).
Uncooperative	Select if member exhibits problem behaviors that are uncooperative, which is defined as behaviors reflecting difficulty following rules or working with others (e.g., refusing to obey, do chores, follow rules, acting defiant or pouting, refusing to attend school or go to work, arriving late at school or work, refusing to take turns or share, cheating, stealing or breaking laws).

Behavior Protocol	Select if the psychologist's recommended interventions for maladaptive behavior(s) include a behavior protocol.
Maladaptive Habits	Select if member exhibits problem behaviors identified as unusual or repetitive habits involving excessive repetition of unusual stereotypical actions (e.g., pacing, rocking, twirling fingers, sucking hands or objects, twitching, talking to self, grinding teeth, eating dirt or other objects, eating too much or too little, staring at an object or into space, or making odd faces or noises).
Destructive to Property	Select if member exhibits problem behaviors identified as destructive to property by deliberately breaking, defacing or destroying things (e.g., hitting, tearing, and cutting, throwing, burning, marking or scratching things).
Hurtful to Self	Select if member exhibits problem behaviors that cause injury to their own body (e.g., hitting self, banging head, scratching, cutting or puncturing, biting, rubbing skin, pulling out hair, picking on skin, biting nails or pinching).
Withdrawn	Select if member exhibits problem behaviors identified as difficulty associating with other people or maintaining attention (e.g., keeping away from others, expressing unusual fears, showing little interest in activities, appearing sad or worried, showing little concentration on a task, sleeping too much, or talking negatively about self).
Functional Behavior Assessment	Select if the psychologists recommended interventions for maladaptive behavior(s) include a functional behavioral analysis/assessment.
Psychological Referral	Select if the psychologist recommended interventions for identified maladaptive behavior(s) include a referral for psychological or psychiatric services including evaluation and/or therapy.
Disruptive	Select if member exhibits problem behaviors that interfere with the activities of others (e.g., clinging, pestering or teasing, arguing or complaining, picking fights, laughing or crying without reason, interrupting, yelling or screaming).
Offensive	Select if member exhibits problem behaviors identified as behavior that is offensive to others (e.g., talking too loud, swearing or using vulgar language, lying, standing too close or touching others too much, threatening, talking nonsense, spitting at others, picking nose, belching, expelling gas, touching genitals, or urinating in inappropriate places).
Psychological Evaluation Discussion (Text Box)	Enter any additional information relevant to the member's psychological/psychiatric health or maladaptive behaviors.