Wellness Coordination
Frequently Asked Questions

1) How do providers know the health score of an individual they are serving?

The health scores can be found in the Advocare system through the Provider Portal.

2) How do providers sign up for the Advocare Provider Portal?

Nora Loechel, an Advocare representative, is working with providers to enroll in the Provider Portal. She can be reached at **n.loechel@uadvocare.com**.

3) What documentation is required for Wellness Coordination?

The tools providers will utilize in Advocare will include the Wellness Assessment, the Risk Assessment Tool and the Wellness Plan. These are not available in Advocare at this time.

Each of these tools will be available for full use by providers in the Advocare system on July 7, 2014.

4) Since the required documentation for Wellness Coordination is not yet available in Advocare – what processes are providers to follow until Advocare is ready?

For documentation purposes providers shall:

- Develop and implement a Risk Plan for each individual receiving Wellness Coordination. There is no State requirement or template for what these plans will look like. Providers shall develop risk plans that are person centered and address the specific needs of an individual in all risk areas.

- Assessment of the health and wellness of each individual being served:
  - Providers may choose to use the Wellness Assessment template posted in Advocare.
  - Providers may choose to use their own assessments but these must include the data points and information outlined in the Wellness Assessment.
- Develop a Wellness Plan. At this time the State does not have a required template.
- Include Wellness Coordination services within the Individual Service Plan (ISP).

For more information on Risk Plans, Wellness Assessment and Wellness plans please refer to the Wellness Coordination Service Definition on the DDRS Announcements webpage.

5) When will providers be responsible for entering information into Advocare Provider Portal?

The Advocare system will be available July 7, 2014. Providers will be required to complete the following information by September 1, 2014.

- Baseline data points:
  - Height,
  - Weight
  - BMI
  - Annual flu vaccination date
  - Annual physical date
  - Annual dental visit date
- Risk Assessment Tool
  - The Wellness Coordinator will not be responsible for completing the entire Risk Assessment Tool – only the portion related to Wellness.
  - Advocare will clearly delineate the sections that the Wellness Coordinator will need to complete
  - Case Managers will continue to be responsible for the non-wellness related areas of the Tool.
- Nursing Assessment
  - Advocare will provide an intuitive tool with the system to enter the required information for the Wellness Assessment.

Advocare will be providing comprehensive training modules on each of these areas when the system is fully developed.

Contact Nora Loechel, at Advocare, at **n.loechel@unadvocare.com** to sign up for the Advocare Provider Portal.

6) What specific data points should providers collect?

- Height
- Weight
- BMI
- Annual flu vaccination date
- Annual physician/exam date
- Annual dental visit date

7) Can providers bill for those individuals who were automatically enrolled in Wellness Coordination in April?

Yes, as long as a provider has adhered to the standards, outlined below, for each respective Tier:

Tier I: Health care needs require at least weekly consultation/review with RN/LPN including face to face visits once a month

Tier II: Health care needs require at least weekly consultation/review with RN/LPN including face to face visits at least twice monthly.

Tier III: Health care needs require at least twice weekly consultation/review with RN/LPN including face to face visits once a week

8) How will providers bill for Wellness Coordination?

Wellness Coordination the face to face visits and individual consultations must have taken place and be documented in the individual's records.

It is important to note that if any one of the required component for a specific Tier are not met within the month then the service will not be reimbursed. For example, if a provider was unable to do a face to face visit twice during the month under Tier II then the service cannot be billed for that month.

Approved Medicaid enrolled Wellness Coordinators can bill Indiana Medicaid in the same way as other Medicaid Waiver Claims. IHCP published a bulletin on the rates for each tier of wellness coordination. Billing for Wellness Coordination must be approved on the Notice of Action and provided within the scope of the authorized tier. Providers are required to keep thorough records of the services.

9) What should providers do if they believe that an individual's health score is incorrect?

As medical events occur and/or a participant's medical needs change, the Individualized Support Team is expected to obtain reassessment for potential revision to the health score and to ensure utilization of the appropriate tier of services. If a team believes that an individual's health score is incorrect they should work with the entire team to submit a Budget Review Questionnaire (BRQ) to DDRS/BDDS requesting a review of the health score. The case manager will submit the BRQ based on the team's agreement and recommendation.

Reviews that result in a change to the health score, leading to a change in the Tier, will be reflected in the Cost Comparison Budget (CCB) the month following the approval. No mid-month changes to the Tiers on the CCB will be made.

10) What are the requirements of each Tier?

Tier I: Health care needs require at least weekly consultation/review with RN/LPN including face to face visits once a month

Tier II: Health care needs require at least weekly consultation/review with RN/LPN including face to face visits at least twice monthly.

Tier III: Health care needs require at least twice weekly consultation/review with RN/LPN including face to face visits once a week

11) If there is a change in the NOA during the month – either a change in the Wellness Score or a change in provider when will the change be effective?

All changes to Wellness Coordination NOA's will take place the first of the month following the approval.

- Reviews that result in a change to the health score, leading to a change in the Tier, will be reflected on the Cost Comparison Budget (CCB) the month following the approval. No mid-month changes to the Tiers on the CCB will be made.
- DDRS/BDDS would expect that the provision of service will continue until the end of the month.

12) Where should face to face interactions with individuals served occur?

In order to bill for Wellness services the nurse must have a face to face visit with the individual being served based on the Tier the individual has been placed in. Face to face meetings are to occur in a home or community based setting that the individual commonly spends time in this setting may vary based on individual needs. For example, individuals could be visited in their homes, at their jobs or out in the community. It is expected that the nursing visits will take place in the natural environment of the individual so that observations and assessments of how their environment is affecting their wellness can be made.

13) What are the responsibilities of the Wellness Coordinator who does not work for the individual's residential provider?

Wellness Coordination providers and Residential Service providers are key members of the individual's team. They each have clear roles and responsibilities as defined in the service definition within the CIH waiver It is the expectation of DDRS/BDDS that providers will work very closely together to meet the individual's health and wellness needs. This includes collaborating on visits to an individual's home and other environments where the individual may spend time.

14) How will the Bureau of Quality Improvement Services (BQIS) monitor Wellness Coordination?

BQIS will include Wellness Coordination in the same processes as all other services it monitors. Wellness will not differ from the current processes BQIS has in place.

15) What happens when an individual is in the hospital for an extended period of time?

Medicaid Waiver services cannot be reimbursed during the time an individual is hospitalized. Once an individual leaves the hospital Wellness Coordination, and other waiver services, can resume.

16) How long can a To Be Determined (TBD) designation remain on a CCB/NOA?

DDRS/BDDS expects that Case Managers will meet with individuals to either select a provider or to opt out of Wellness services at the next regularly scheduled 90 day meeting or within 90 days of the NOA date. Once documentation is provided to DDRS, the TBD status will be changed accordingly.

17) Can an unlicensed person help a licensed person under this service?

Per the Centers for Medicare &Medicaid Services (CMS) approved service definition, only those individuals who meet the requirements for Wellness Coordination may perform the services.

18) With regards to RN signing off on LPN paperwork, is a face to face required each quarter?

RN supervision of an LPN should follow the Indiana State Board of Nursing Guide or refer to the Indiana Professional Licensing Agency.