DDD – PLAN OF CARE (IPC) REVIEW FORM INSTRUCTIONS

Purpose: The Individualized Plan of Care is the cornerstone for all waiver services. It should be a thorough representation of the participant's needs, wants, preferences, health, medical and behavioral conditions. Services, supports, and life activities should be person-centered and align with the Division's rules, IPC instructions, and other Division directives. When approving a plan, the Division uses the Medicaid rules in Chapters 41 through 45, Chapter 1 of the DDD rules for case managers, and the performance measures in the waiver documents as approved by CMS July 1, 2009.

Compliance Areas (Per Rule, IPC Instructions, Wvr performance measures)	Concern Identified and Action Needed (items Division staff review)
1. **Plan of care submitted on time**	Plan submitted within 30-day rule with all accompanying documentation. Late plans are referred to Survey/Cert for the CM's certification file, unless the waiver specialist excuses the tardiness or exception to the rule.
2. **Pre-Approval form is accurate and within IBA**	Name, SSN, b-date, and plan date are checked for accuracy. Service lines should be within IBA and have correct codes, historical units, and current rates. Items listed here need correction. NOTE: After separate case manager NPI #s go into effect, check that CM name and number is on top and organization CM NPI # is on service line.
3. **Waiver Service Justification Form**	On the form, a field is similar to the question in the About me section, "What the participant wants to accomplish this plan year." Summarize the goals or plans the participant would like to accomplish in the next year. List all of the waiver services and overall goals for each waiver service during the plan year. These goals shall align with the participant's desired accomplishments for the plan year.
4. **Plan includes necessary signatures**	Signatures on all pages must be present. If no signature is found, then a concern is identified and the review form sent up to this point. Plan is not reviewed unless there is an exceptional reason for the missing signature. Document the reason on this form if it is acceptable and develop a timeline for the case manager to submit the signatures to DDD <u>before</u> the plan is approved.
5. **About Me is person-centered and answers questions**	Answers should follow the questions and italics. Objective progress shall be listed. Personal goals listed. Ask CM for more information where needed.
6. **Demographics page complete and accurate**	Numbers are checked with MMIS, preapproval, LT-104 for consistency. Physical address shall not be P.O. Box, or provider's main address (unless it is accurate.) list concerns or inconsistencies here. Make sure at least 3 boxes are checked in functional limitations.
7. **Each Right Restriction applicable to the participant addresses all requirements**	Each right restricted for a participant includes the reason, how it is imposed and a plan to exercise the right to its fullest. Concerns in this area must be identified, such as a restriction in the PBS that is not listed on the rights page.
8. **Non-waiver services are listed that help cover participant's needs**	Non-waiver services should be marked or listed as applicable for the participant. Compare information to MMIS, demographic page, about me answers, etc. WS may recommend a non-waiver service if one is not listed that should be available to the participant.
9. **Medical Services**	Medical Services are filled out with all applicable services noted. Recommendations are listed and reflected elsewhere in plan or on schedules as needed. Last and next visits are listed. If a service is being considered, an action plan is listed in the recommendations area.
10. **Medical Information**	Information is listed completely and is updated as needed. Page could be used when emergency services are accessed for a participant. Medication info shall be listed thoroughly with all requested fields of information.
11. **Medication Assistance**	All assistance a participant needs to successfully take medications or get to medical appointments shall be listed. The IPC Instructions detail directions on filling out this new section thoroughly.
12. **Protocols (Seizure, Medical)**	Address protocols for seizures, medical reasons, or medication in a manner that details how to perform each step, warnings, side effects, etc.
13. **Plan identifies health and safety risks in each area**	Address concerns relating to all risk areas: medical, transportation financial, mobility, behaviors, home safety, etc.
14. **Plan addresses risks through supports & accommodations**	If a risk is identified in an area on the plan, but a safety plan is not included or is inadequate, then identify the area of risk here and the problem with safety found.

15. Plan describes participant's supports in various settings	The response shall be detailed and fully describe the supports and supervision needed in various settings…including when a person can have NO supervision.
16. Positive Behavior Support Plan complies with Ch 45 Sec 29	Check ICAP, psych, and about me to see if PBS Is required. If not, address problem here. If PBS is included, use Ch 45, Sec 29 to ensure the PBS meets criteria in our rule. If concerns are found, reference the rule and section of PBS that is concerning and explain the action needed to make the PBS in compliance.
17. Restraint information complies with Ch 45 Sec 28	If a restraint is listed in the Rights page or in the PBS, then it must comply with Ch 45, Sec 28. It needs an order, other less restrictive measures listed, face to face evaluator identified, and contain other items in rule.
18. Service Forms include all necessary information	Service forms shall have accurate descriptions of the service, detailed recommendations, invoices, and/or training components. Skilled nursing forms must include only medically necessary services. Must have physician signature, units listed, and expiration date.
19. LT-104 (level of care form) Correct	LT-104 received with plan, screening within 365 days, meets criteria for ICF/MR, WS signs/dates the form.
20. Meets ICF/MR Level of Care	The information on the LT-104 meets the criteria for ICF/MR level of care.
21. Eligibility assessments are current and qualify	Psych and ICAP must be within required timelines, contain eligible diagnosis, and ICAP scores. WS completes eligibility worksheet each year as needed. If assessments are out of date, identify the compliance and set a deadline for submission of a new assessment. If current assessment shows the participant is ineligible, then work the waiver manager on notifying the participant of ineligibility for the waiver.
22. Plan verifies participant /guardian participated in development of the plan	On the Participant/Guardian Verification Form in IPC, if signatures were not affixed to plan, but box is marked, then require proof that the participant and/or guardian were a part of developing the plan. If no proof is submitted, then the plan cannot be approved.
23. Rights restrictions were explained and agreed to by the participant/guardian	Verification similar to box above. If "no" is marked then there must be an explanation submitted. If there is no explanation or an inadequate explanation, then the plan cannot be approved until they are explained, changed, and agreed upon by the participant/guardian or a reasonable explanation is accepted by the Division.
24. Plan includes verification of choice offered to participant/guardian	Verification similar to box above. If "no" is marked, refer the matter in IMPROV to Survey/Certification and an ARS to look into. Not offering choice is a case manager/provider compliance issue and must be followed up. Do not approve a plan if choice was not offered, unless otherwise approved by a DDD manager.
25. Adequate conflict of interest safeguards in place	If a conflict applies, does the plan have a fair and adequate way for the participant/guardian to address issues or concerns they have. Does the section address the conflict with a checks and balance system in place to protect the participant? Do not approve plans that do not adequately address the conflict of interest.
26. Plan reflects personal goals identified in "About Me"	Concerns in this area will be visible after whole plan is reviewed. If objectives, supports, reinforcements, activities and schedules do not reflect personal goals, then address those items in this section.
27. Services and supports align with participant's assessed needs	The needs identified in assessments, about me, risk areas, supports sections, and in PBS shall align with the services chosen on the plan and non-waiver services listed. Concerns with "over-serving" or "under-serving" a participant shall be listed here, if another service should be used instead of the one listed on the plan.
28. Unmet needs identified	Unmet needs may be identified in various places on the plan or in assessments. Some may be discussed at a team meeting. If an unmet need is identified by the CM or DDD, then an action plan shall be submitted to address the unmet need.
29. Unmet needs addressed	An unmet need can be addressed through working with other agencies, team members, community groups, natural supports, or by accessing other Medicaid/Medicare services. Some unmet needs are difficult to meet, but the CM should always have an action plan for continuing to try to meet needs.
30. Other Plan Corrections or Comments	List other concerns resulting in non-compliance with rule or the IPC Instructions. If the concern does not need action or identify a compliance issue, do not include it in this box.