Good Afternoon. My name is Rita Munoz and I am a Benefits and Eligibility Specialist for the Home and Community-Based Services Section of the Division of Healthcare Financing (Division). Today we will be discussing the standards and expectations that case managers must meet in order to submit a quality individualized plan of care (IPC) so they don’t have an IPC roll back as a result of a quality improvement review.
The purpose of this training is to explain the reasons that IPCs are typically rolled back to case managers as a result of a quality improvement review (QIR), and what is required so that IPCs don’t fail a QIR in the future.

Please note that a full training on what is required in an IPC will be conducted as part of the Provider Training Series offered by the Division. This training will be presented on February 22, 2021, and will be available on the Training page of the Division website, under the Provider Training Series toggle after that date.
At the end of this training, the following topics will have been introduced and explained:

- We will introduce the Quality Improvement Review Process, and the case manager’s responsibilities in this process;
- We will discuss the reasons that plans typically fail a QIR; and
- We will outline the expectations that, if met, should reduce the number of IPCs that fail a QIR.
Choice is a basic tenet of home and community-based waiver services. Waiver participants must have the freedom to exercise choice in who provides their services, where they live, with whom they spend time, and what they want for their future. Having choice is paramount to human dignity.

Case managers are obligated to submit complete and accurate IPCs that reflect the participant’s choice in services, providers, activities, and what they want in their life. Most of the reasons that IPCs fail QIRs are directly related to a participant’s choice, whether it be a restriction of a participant’s rights, verification that a participant had choice, or service definition violations that could impede choice.
Chapters 44, 45, and 46 of the Department of Health’s Medicaid Rules provide authority for the Division’s expectations of what constitutes a complete IPC.

Chapter 44 establishes rules for environmental modifications and specialized equipment, and provides criteria for what is and is not covered under these services.

Chapter 45 establishes rules that govern DD Waiver provider standards, certifications, and adverse actions. This Chapter provides guidance on rights restrictions. More information on the topic of rights restrictions can be found in Module #2 of the Provider Training Series offered by the Division. This training is available on the Training page of the Division website, under the DD Initial Provider Training toggle. An additional training that addresses the Rights Restriction Review Tool can be found on the same page, under the Initial Case Manager Training toggle.

Chapter 45, Section 10 specifically outlines what is required in an IPC. As mentioned earlier in this training, a detailed training on this Section of rule will be available on the Training page of the Division website, under the Provider Training Series toggle (Module #8).

Finally, Chapter 46, Section 12 establishes rules related to participant-directed services.
So what is the Quality Improvement Review, or QIR, process, and what is the case manager’s responsibility in this process?
What is a QIR?

A quality improvement review (QIR) is a manual review of a random selection of IPCs in order to ensure that IPCs meet the minimum standards required by federal regulations and Department of Health Medicaid Rules.

When an IPC is submitted through EMWS, the system automatically reviews certain data points, such as making sure documents have been uploaded, required fields have been completed, and appropriate boxes have been checked. However, the system is not able to determine if the correct document was uploaded, if the completed fields include all of the required information, or if the box that was checked actually represents the detail that is included in the IPC.

A QIR is a manual review of a random selection of IPCs and IPC modifications. The review is conducted by a Benefits and Eligibility Specialist (BES), who focuses on specific IPC requirements established in Chapter 45 and accuracy of required documentation and signatures. This review is intended to ensure that IPCs meet the minimum standards required by federal regulation and Department of Health Medicaid Rules.
Before an IPC is submitted, case managers have an obligation to review the information that they are submitting to ensure it is accurate, meets the requirements outlined in the Department of Health’s Medicaid Rules, and is specific to the participant for whom the IPC is written. As an example, case managers should double check to ensure that the documents they upload are the most current version of the document, are for the correct participant, and include all of the required signatures. They should review the content of the IPC to ensure it accurately reflects what is happening in the participant’s life now, and is not just a repeat of previous IPCs. Additionally, case managers should be knowledgeable of the rule requirements and be able to verify that the IPC include all components that have been established by rule.

If an IPC developed by a case manager is selected and subsequently fails a QIR, the BES will notify the case manager of the failure, and what needs to be done in order to bring the IPC into compliance. It is the case manager’s responsibility to review the feedback, make the necessary adjustments, and submit IPC modifications within the required timeframes. This may require the case manager to call a plan of care team meeting or to obtain new signatures from the plan of care team.

It is essential that case managers learn from their mistakes. If an IPC fails because the Rights Screen does not include all of the necessary information, the case manager should use the guidance from the QIR and apply it to future IPC submissions so that future IPCs don’t fail the QIR.
The majority of the IPCs that undergo a QIR fail the review. The Division has identified several reasons why IPCs *typically* fail, and has some specific steps that case managers can take to avoid failures in the future.
Restricting a participant’s rights is a really big deal. It should never be taken lightly, and should never be the only response to a challenging situation. Home and community-based waivers are intended to help people develop, learn, and keep skills, so plan of care teams should look at challenging situations as an opportunity for participants to develop meaningful goals and objectives that can help them cope with the situation, rather than immediately restricting a participant’s rights. In order to impose a rights restriction, there must be a specific health or safety concern. A rights restriction can never be imposed as a convenience for the provider or the legally authorized representative, or just because the legally authorized representative feels it would be in the best interest of the participant.
Chapter 45, Section 4(h)(i) establishes specific criteria that must be met before a restriction on a participant’s rights can be imposed. The team must discuss these items, and the case manager must include them in the participant’s IPC. These criteria include:

- Identification of the specific and individualized assessed need;
- Documentation of the positive interventions and supports used prior to any modification to the IPC;
- Documentation of less intrusive methods of meeting the need that have been tried but did not work;
- A clear description of the condition that is directly proportionate to the specific assessed need;
- A system of regular data collection and review to measure the ongoing effectiveness of the modification;
- Established time limits for periodic reviews, not to exceed six (6) months, to determine if the modification is still necessary or can be terminated;
- Informed consent of the individual; and
- Assurance that the interventions and supports will cause no harm to the individual.

Chapter 45, Section 4(h)(ii) also requires that the IPC address how the team will work to restore any right that has been limited or denied.
The Rights screen in EMWS mirrors the Rights Restriction Review Tool. Case managers are expected to complete all sections of this screen for each restriction imposed on a participant’s rights. Remember, imposing a restriction on a participant’s rights is a really big deal. If a plan of care team can justify such a restriction, there must be enough evidence and explanation to answer each question completely.

These boxes often contain only a sentence or two, or are left completely blank. If there isn’t enough evidence in these boxes to justify a rights restriction, the IPC will fail a QIR. “Not applicable”, or “N/A” is not an appropriate response and will not be accepted.

The full plan of care team must be able to agree to the rights restriction in order for the restriction to be successful. If the plan of care team is unable to agree to the necessity of a rights restriction, then a rights restriction should not be implemented and the team should continue to explore other options. At the end of each rights restriction section, the case manager will be required to verify that the entire IPC team agrees to the restriction. This question defaults to No, so if the case manager doesn’t select Yes for each rights restriction, the IPC will fail the QIR.
Required Documentation for a Rights Restriction

- Guardianship paperwork
- Representative Payee paperwork
- Legal document or court order
- Medical order
- For restraints, letters from the medical and behavioral professional

In order for a rights restriction to be imposed, a document that allows a person the impose the restriction must be uploaded. Please be aware that although guardianship paperwork will be sufficient for some restrictions, such as the participant’s right to choose where to live, guardians do not have the authority to restrict all rights of the participant. For example, if a restriction on a participant’s access to food is necessary, a medical order from a licensed medical professional must be uploaded.

Required documentation is often missing, and is one of the main reasons that an IPC will fail a QIR.
The Comprehensive and Supports Waiver Service Index (Service Index), which can be found on the Service Definitions and Rates page of the Division website, clearly outlines the definition of each service, as well as required documentation needed for each service and limitations that are applicable to the service.
Medicaid is the payer of last resort. The DD Waivers are Medicaid programs, which means that services cannot be paid by the DD Waivers if the service can be paid through any other program. Before a participant can receive therapy or supported employment services through the DD Waivers, there must be a Third-Party Liability form on file that demonstrates that the services are not covered through programs offered by the Division of Vocational Rehabilitation, the Medicaid State Plan, or another funding source. Case managers should review the IPC Guide and Comprehensive and Supports Waiver Service Index to ensure they submit all documentation required for the service.

Adult Day, Community Living, and Community Support Services are tiered services, and the different levels of these services have different requirements. If an identified service level is not demonstrated in the IPC, or if the participant is receiving a tier level that doesn’t align with their Level of Service score, the IPC will fail the QIR.

Many of the services have specific age limits or service caps. If a participant is too old or young for a service, or if the IPC exceeds the service cap, the IPC will fail the QIR.

Employers of record for participant-directed services must ensure that their employees meet the service definitions when they provide participant-directed services. Even though the participant directs the service, the service is still paid through Medicaid and must meet the minimum requirements for the service. For example, every habilitative service, such as Community Living and Supported
Employment Services, requires training on objectives as part of the service. Participants who choose participant-direction for these services must have an objective listed in the IPC.

Specialized Equipment Services is intended for the purchase of equipment that is just that... specialized. Specialized equipment must be functionally necessary for the participant, and must meet the criteria that is established in Chapter 44, Section 6. Items of general use, such as corrective lenses, human-powered and motorized vehicles, and household items such as toys, furniture, and games, are not covered. If items of general use are purchased through specialized equipment, the IPC will fail the quality improvement review. Additionally, the participant’s budget will need to be adjusted to allow for the State to be paid back, or the provider will have to pay the State back directly. The provider may then bill the participant directly for the cost of the equipment. Case managers must pay close attention to these requests and make sure the equipment meets the definition of specialized equipment.
Outdated, Inaccurate or Missing Forms

We’ve already discussed some of the forms that case managers typically neglect to upload. However, there are other forms or information that is often outdated, inaccurate, or missing altogether.
Outdated, Inaccurate, or Missing Forms

- Positive Behavior Support Plan
- Medication Consent form
- Participant and Legally Authorized Representative Verification form
- Team Signature and Verification form
- Relative Disclosure form
- Information transferred to EMWS from forms

The Division reviews required forms at least once a year to ensure that the forms are accurate, are capturing relevant information, and continue to align with our federal and state authorities. As we make changes to forms and other required documents, such as the Positive Behavior Support Plan template, we upload the most current version on the Division website or, in some cases, EMWS. It is the case manager’s responsibility to ensure they are using current forms, so it is important that case managers visit the Forms and Documents Library page of the Division website, as well as review the documents in EMWS, on a regular basis to ensure they are using the correct forms. If an outdated form is uploaded, the IPC may fail a QIR.

On several occasions forms for one participant have been uploaded as a part of another participant’s IPC. For instance, Sally’s Medication Consent form has been uploaded as Jenny’s form. Case managers must be very careful and ensure that they are uploading the correct forms into a participant’s file to avoid the IPC failing the QIR.

Often, we have found that forms are missing necessary signatures. This an especially prevalent problem with the Participant and Legally Authorized Representative form and Team signature and Verification form. Case managers must ensure that they are using the correct form, which they will download directly from EMWS, and collect all of the necessary signatures.

In order for a relative, who is defined as a parent, stepparent, or adoptive parent, to provide services for their child, they must disclose their relationship with the participant and receive authorization from the Division. The relative must complete
the Relative Disclosure form, and the case manager must submit the form for approval from the Division before the IPC is submitted. These forms are often uploaded without the required Division approval. Not only will this situation cause an IPC to fail a QIR, but if the relative does not meet the requirements to be a relative provider, they will be subject to a recovery of payments.

At times, the information that case managers enter into EMWS comes directly from a form, such as an ICAP or the Participant and Legally Authorized Representative Verification form. Case managers must ensure that the information that is captured from these forms is up to date. If the Behavior Supports screen includes ICAP behaviors that are not indicated on the current ICAP, or if the Verification form lists answers that are different than those indicated on the Verification screen, the IPC may fail the QIR.
The Case Management Monthly Review (CMMR) form is the mechanism that case managers must use to document the services they provide. This form is reviewed as part of a QIR.
The CMMR should be completed as close to the completion of the service as possible. Currently the Division states “The monthly case management review must be completed prior to billing for services, and must be submitted within 60 calendar days of the service being provided.” Although this is the minimum standard established by the Division, it is expected that case managers will complete all CMMR documentation as timely as possible. In accordance with Chapter 45, Section 8(b) of the Department of Health’s Medicaid Rules, *A provider shall complete all required documentation, including the required signatures, before or at the time the provider submits a claim. Documentation prepared or completed after the submission of a claim is prohibited. The Division shall deem the documentation to be insufficient to substantiate the claim, and Medicaid funds shall be withheld or recovered.*

As required in rule, the case manager MUST submit the completed CMMR into EMWS prior to billing for these services.
Throughout the IPC development process, case managers are required to verify the accuracy of the information that is included in the IPC.
Case Managers Verify Accuracy of the IPC

- **Plan Status Screen**
  - Verification that documents are signed and current

- **Rights Screen**
  - Rights have been updated
  - Rights have been reviewed with the legally authorized representative and participants
  - Rights will do no harm to the participant

- **Service Authorization Screen**
  - All service caps and definitions have been followed

On the *Plan Status* screen, the case manager must verify that required documents are signed and current. On the *Rights* screen, the case manager must verify that a participant’s rights have been updated in the plan, that rights and any restrictions to those rights have been reviewed with the legally authorized representative and participants, and the rights will do no harm to the participant. On the *Service Authorization* screen, the case manager must verify that the service caps and definitions have been followed, and that the information on the Plan of Care Team Signature and Verification form is consistent with what is in EMWS.

Case managers need to understand that when they click the box that verifies these activities, they are not simply clicking a box. They are verifying, as part of a legal document, that they have actually completed the activities they have verified. If a case manager verifies the activities and hasn’t completed the activities, this may be considered fraud, and the case manager may be subject to a referral to the Medicaid Fraud Control Unit.
Submission of the plan of care

■ Once final verifications have occurred, submit the IPC
  ○ Chapter 45, Section 10(d) states “The individualized plan of care shall not exceed twelve (12) months and shall be developed in accordance with state and federal rules, which include the submission of the complete individualized plan of care to the Division at least thirty (30) days prior to the plan start date.”

■ IPCs must be complete, accurate, and require no further modifications.

It is the case manager’s responsibility to submit a plan of care that is complete with no missing pieces. It is never acceptable to submit a plan of care that is incomplete. When the case manager hits the submit button they are acknowledging that they have submitted a complete and accurate plan of care that meets Division requirements. The case manager is encouraged to plan annual plan of care team meetings far enough in advance to ensure that all components of the IPC can be completed and supporting documentation can be obtained in plenty of time to ensure compliance with Division rules.
Before we end today, we’d like to remind case managers of the key takeaways of today’s training.

1. A quality IPC is necessary in order for the participant to live the life they choose. A quality plan is one that contains all of the necessary components, and is detailed enough for the participant, plan of care team, and providers who will be offering services to easily understand what the participant wants and needs in their life, and how services should be delivered.

2. If the case manager has questions, they should contact their BES prior to submitting the IPC. The Division website has several resources that case managers can use, including trainings on rights restrictions and components of the IPC.

3. The case manager must submit an IPC that is complete, accurate, and comply with Medicaid Rules prior to submission.

4. Once an IPC is submitted, it is a legal document and case managers will be held accountable for the IPCs contents. If a case manager verifies information that isn't accurate or complete, this may be considered fraud and the case manager may be subject to a referral to the Medicaid Fraud Control Unit.
Questions???
Contact your Provider Support or Benefits and Eligibility Specialist

https://health.wyo.gov/healthcarefin/dd/contacts-and-important-links/

Thank you for taking time to participate in today’s training on submitting quality plans. If you have questions related to the information in this training, please contact your Provider Support or Benefits and Eligibility Specialist. Contact information can be found by clicking on the link provided in the slide.