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Case managers are required to evaluate and monitor the individualized plan of care (IPC), which includes the review of documentation of service delivery as outlined in the IPC. Chapter 45, Section 9(e)(viii) of the Department of Health’s Medicaid Rules requires case managers to: “…monitor and evaluate the implementation of the participant’s individualized plan of care including a review of the type, scope, frequency, duration, and effectiveness of services, as well as the participant’s satisfaction with the supports and services…” Additionally, Section 9(e)(x) requires the case manager to “...send the Division and the provider or employer of record written notification of noncompliance with these rules, the health, safety, or rights of the participant specified in the individualized plan of care, or when documentation is not received by the tenth (10th) business day of the month after services were provided.”

Please note Chapter 45, Section 8 – Documentation Standards, outlines the provider’s responsibility to make documentation and billing information available to the case manager.

**If the provider does not make the required documentation available to the case manager by the 10th business day of the month, the case manager shall submit this form to the provider/employer of record and Provider Support Specialist by the end of the month in which the documentation was to be submitted. Separate reports shall be filed for each participant, for each month documentation is late.**

**The following required documentation submission has not been received by the Case Manager:**

|  |  |  |  |
| --- | --- | --- | --- |
| Documentation Month: | | | Click here to enter text. |
| Provider: | Click here to enter text. | | |
| Participant Name: | | Click here to enter text. | |

The documentation listed below was late, but received on: Click here to enter text..

The documentation listed below was not received as of the date this form was submitted to the Division.

Late documentation submission is a recurring concern.

|  |  |
| --- | --- |
| **Service Provided**  *(Billing Code/Name of Service)* | **Missing Documentation**  *(i.e., Medication Assistance Record, tracking, schedules)* |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |

|  |  |
| --- | --- |
| Case Manager: | Click here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| Case Manager Signature: | Click here to enter text. | Date: | Date |