

Instructions for using the new (May, 2006) MR/LAH Waiver Plan of Care Format

The new plan of care should be used for the MR and the LAH Waiver effective May 1, 2006 and after. Current plans that are already approved do not have to be changed to the new format until there is a need for a new plan, such as at redetermination. That means that, by May, 2007, all consumers shall have a plan of care in the new format.

The new form has a number of differences that will require case managers to be careful when using the form for the first several applications.

The primary differences between the new form and the old are:

- The new form is designed to operate in both an electronic and hardcopy mode. A plan can be written at the team meeting and signed by all present. That plan will be scanned into the electronic system as a “picture” – it will document the team’s agreement. The case manager will then enter the plan into the electronic system, from which it can be printed out, neatly typed, for future team meetings. The plan can also be created or changed electronically and then printed, to collect signatures. All plans of care, including changes to them, will be subject to review and approval by the Community Service Office and, potentially, by the Alabama Medicaid Agency.
- The new form is designed to be effective for one year. During that year, changes can be made to the plan of care, using codes to indicate what is new. The next year, a new plan of care is required, with new start dates.
- The new form contains one choice statement, which the case manager must be certain the consumer and/or guardian understand. This states that the consumer chooses community services through the waiver as an alternative to services in an ICF/MR and will replace the form called the Certificate of Choice.

Line-by-Line Instructions:

- a. First Line (Left top corner): Check if this is a plan for **MRW or LAH**.
- b. First Line (Right top corner): Enter the **ICAP Service Score** from the Compuscore.
- c. Second Line (Left): Enter **Begin and End** dates for the plan. The purpose is to cover a year (365 days) with the plan, and to synchronize the plan year with the Medicaid auto enrollment process. In order to do this, redetermination plans of care will need to be submitted within the last month of the current plan
 1. For example: current POC dates are 1/1/06 through 12/31/06; new POC should be submitted in 12/06. This will cause the Medicaid auto enrollment system to set up a new eligibility segment from the submission date in 12/06 to 12/31/07). This process will keep the plan of care dates the same from year to year. Case manager needs to enter a 12-month period in the spaces given.
 2. For an initial (first) plan of care, the “begin” and “end” dates can be “on approval”. Write “on approval” in the margin beside the box. The regional office will fill in the dates for you from the LTC-2 once enrollment with EDS has occurred. The Regional Office will then send you a copy of the approved and dated plan of care. Initially, the POC dates may exceed 365 days in order to synchronize the RW dates.
 3. In the MRSIS system the case manager will receive ticklers at 90 day intervals to review the plan of care and at 10.5 months to develop a redetermination plan of care.

- d. Second Line (Center): The next space to the right asks you to enter a check if this is an **Initial/Re-determination** POC. Initial/Re-determination plan just means a plan that starts a new year.
- e. Second Line (Center): If the POC is being updated to reflect changes to services (adding or stopping) during the POC year place a revision number in the **Revision Num** space. This will help keep track of the most current POC. For example, if this is the first time the POC has been updated then enter the number 1 in the **Revision Num.** space.
- f. Second Line (Right): Enter the **Date of Plan Meeting** in which the team developed the Initial/ Re-determination POC. If this is a revised POC then enter the **Date of Plan Meeting** in which the team or part of the team agreed on changes to the current POC.
 - 1. If everyone signed the plan at the same time then the signature dates at the bottom will match the **Date of Plan Meeting** date.
 - 2. If this is a revised POC do not forget to include the **Revision Number**.
- g. Third Line: **Participant’s Name** (last and first), **Social Security Number** and **Medicaid Number** (without the 13th “check” digit) are necessary for entering and maintaining the data in an electronic format, so you will need to enter them here as well.
- h. Fourth Line: Enter **Participant’s Street, City, State** (“AL”) **Zip Code** and **County**.
- i. Fifth Line: Enter the date the person first entered either waiver in the **Year First Eligible for Waiver** line and check **MRW or LAH** to indicate which waiver the person was first enrolled and received services.
 - 1. This entry and date will remain the same regardless of which waiver the person subsequently enters.
 - 2. Even if the person leaves the waiver and is readmitted, this date should be the year the waiver started, not the readmit date.
- j. Sixth Line: see instructions on codes to use inside the GRID.
- k. The GRID: There are 8 rows in which services can be entered on the plan. If you need more rows, use another sheet and enter the page number at the bottom of the form. Each row has 8 columns.
 - 1. First Column, labeled “**Act Code**”— enter the appropriate action code when adding (“A”) or stopping (“T”) services after the initial POC has been developed. Enter an action code only if the POC is being revised during the plan year.
 - 2. Second Column, labeled “**Provider**”—enter the name of the DMHMR contractor and the contractor’s performing provider number. You may abbreviate and use acronyms for the name—the electronic system will need to the performing provider number, so be sure to write it clearly.
 - 3. Third Column, labeled “**Service**”— for waiver services, enter the abbreviated service name as is suggested on the Service Description Chart at the end of these instructions. You do not have to write in the procedure codes. In the electronic version, a drop down menu will let you select the service and will fill in the procedure code and modifiers for you.
 - 4. Fourth and Fifth Columns, together labeled “**Frequency**”— specify the units per a selected period of time for waiver and state only funded services. For Case Management and generic services, you may enter “As Needed” in the unit box, then choose an appropriate period of time. For instance, for Case Management, you might say “as needed” per “qtr.” **For waiver services (and for state only funded services) you need to be sure to calculate the number of units using the HIPAA approved unit measure. Many services which we might think of as “hourly” are in fact, in 15-minute units.**

In the fifth column, under the “Per___”, choose an accurate period of time in which to specify the units. Options are a) **calday** (calendar day; means 7 days a

week during the period of the plan), b) **busday** (business day; means every work day, generally 5 days per week), c) **week** (just means units per week), d) **mon** (means units per month), e) **qtr** (means units per quarter) and f) **year** (means units per year). Where you previously might have entered an hourly service (LPN nursing) as 4 hours/day, 3 days/week, you will now enter 12 hours per week. Where you previously might have entered personal care as 2 hours per day, 4 days per week, you would now enter 32 (15-minute) units per week. **We recognize that calculating the 15 minutes is more difficult than writing hours, but the plan of care will feed the prior authorization, and the actual units to be paid must be accurate.**

Use the shortest measure of time you can: in other words if you are entering frequency for residential habilitation, don't enter 365 units per year; enter 1 unit per calday. Another example would be to enter 1 unit per busday for day habilitation. Only use the per month measurement if you cannot accurately express the measurement in terms of units per week. For example a person may need a unit six times per month, and that would not be able to be described with one unit per week, so the per month measure would be appropriate.

5. Sixth Column, labeled **Service Start Date**—this date should be no sooner than the plan “Begin” date in row one. However, it can be later, if the service is planned to begin at a later date. For a first plan for an individual, the start date can be “on approval” so long as the date gets updated “on approval” to reflect an accurate date for beginning service.
 6. Seventh Column, labeled **Service End Date**—this date is not entered until and unless the person is terminating that service.
 7. Eighth Column, labeled **Funding Source**—enter a code to designate the funding source for the service: 1) Waiver, 2) Medicaid Regular, 3) Medicaid EPSDT, or 4) Other.
- l. The FREEDOM OF CHOICE STATEMENT is to be read by or to the consumer, and explained. The consumer should sign and date the statement, and if his/her signature is not perfectly clear, a witness should also sign and date under the statement.
 - m. **Signatures of Others/Team Members:** The team, consisting of the case manager and program QMRP(s), together with other people who know and care about the person, should sign the plan of care. They should also identify their role or relationship to the person, and date their signature.
 - n. The plan of care form has a field, on the right side underneath the signatures, to denote the page number if the plan extends to more than one page.
 - o. The plan of care form has another set of fields, at the very bottom of the page, in which the case manager should indicate the dates of his or her quarterly reviews of the plan, and should document the review with his or her initials.

Service Description Chart

Service Name	Abbreviated Service Name	MR Waiver Code	LAH Waiver Code	Unit "per"
Day Habilitation Level 1	Day Hab L1	T2020 UC HW	T2020 UD	day
Day Habilitation Level 2	Day Hab L2	T2020 UC TF	T2020 UD TF	day
Day Habilitation Level 3	Day Hab L3	T2020 UC TG	T2020 UD TG	day
Day Habilitation Level 4	Day Hab L4	T2020 UC HK	NA	day
Day Habilitation Level 1 w/ transportation	Day Hab L1 w/transp.	T2020 UC HW SE	NA	day
Day Habilitation Level 2 w/ transportation	Day Hab L2 w/transp.	T2020 UC TF SE	NA	day
Day Habilitation Level 3 w/ transportation	Day Hab L3 w/transp.	T2020 UC TG SE	NA	day
Day Habilitation Level 4 w/ transportation	Day Hab L4 w/transp.	T2020 UC HK SE	NA	day
Residential Services	Res Hab	T2016 UC	NA	day
In-home Respite Care	IH Respite	S5150 UC	S5150 UD	15 minutes
Out-of-home Respite	OH Respite	T1005 UC	T1005 UD	15 minutes
Institutional Respite	Inst Respite	T2044 UC	NA	day
Residential Services - Other Living Arrangements	Res Hab OLA	T2017 UC	T2017 UD	15 minutes
Supported Employment Services	Sup Employment	T2018 UC	T2018 UD	day
Prevocational Services	Prevoc. Svcs	T2014 UC	T2014 UD	day
Physical Therapy	PT	97110 UC	97110 UD	15 minutes
Occupational Therapy	OT	97535 UC	97535 UD	15 minutes
Speech Therapy	Speech Therapy	92507 UC	92507 UD	15 minutes
Personal Care	Personal Care	T1019 UC	T1019 UD	15 minutes
Personal Care Transportation	PC Transportation	T2001 UC	T2001 UD	mile
Companion Care	Companion Care	S5135 UC	NA	15 minutes
Environmental Accessibility Adaptations	Env Acc Adaptation	S5165 UC	S5165 UD	job
Specialized Med Equip and Supplies	Spec Med Equip / Supl	T2028 UC	T2029 UD	item
Assistive Technology	Assistive Tech	T2029 UC	NA	item
RN Nursing per hour	RN	S9123 UC	S9123 UD	hour
LPN Nursing per hour	LPN	S9124 UC	NA	hour
Community Specialist	Comm Specialist	H2015 UC	H2015 UD	15 minutes
Crisis Intervention	Crisis Intervention	H2011 UC	H2011 UD	15 minutes
Behavior Management	Beh Mgmt LAH	NA	H2019 UD	15 minutes
Behavior Therapy L3 Technician	Beh Ther L3	H2019 UC HM	NA	15 minutes
Behavior Therapy L2 Professional	Beh Ther L2	H2019 UC HN	NA	15 minutes
Behavior Therapy L1 Prof Board Certification	Beh Ther L1	H2019 UC HP	NA	15 minutes
State Only Funded Services				
	Note: all are manually priced			
Service Name	Use in Plan of Care	Service Code		Unit "per"
Residential Supports	Res Supports State Only	T2016 UC U8		day
Subsidized Living per day	Subsidized Living per day	T2016 UC U8		day
Subsidized Living per month	Subsidized Living per month	T2016 UC U9		month
Day Supports	Day Supports State Only	T2020 UC U8		day
Hourly Services				
Respite	Respite State Only	H2022 UC U6		15 minutes
Personal Care	Personal Care State Only	H2022 UC U6		15 minutes
Companion Care	Companion State Only	H2022 UC U6		15 minutes
ResOLA	ResOLA State Only	H2022 UC U6		15 minutes
Therapy Services				
Physical Therapy	PT State Only	97110 UC U6		15 minutes
Occupational Therapy	OT State Only	97535 UC U6		15 minutes
Speech Therapy	Speech T State Only	92507 UC U6		15 minutes
Behavior Therapy	Beh Therapy State Only	H2019 UC U6		15 minutes
Medical Supports (Dental, Psychiatric, Nursing, Physician)	Med Supports State Only	S9123 UC U7		hour
Physical Supports (Assistive Tech, Env Mod, Medical Supplies and Equipment, Eyeglasses, Hearing Aids, etc...)	Phys. Supports State Only (and specify)	S5165 UC U5		item or job
Case Management	Case Mgt State Only	G9008 UC U4		5 minutes
Diagnosis and Evaluation	D and E State Only	90801 UC U5		Service
Transportation	Transport State Only	A0425 UC U5		Trip
ICAP Score Range For Day Habilitation				
Day Habilitation Level 1: 61-85; Day Habilitation Level 2: 36-60; Day Habilitation Level 3: 01-35				

Instructions for Completing the MSWord Plan of Care Form

You may either tab or use your mouse to move to different segments on the form.

1. Check if this POC is for **MR or LAH** waiver. Place the mouse over appropriate check box and click once.
2. Enter the **ICAP Service Score**. Enter the 2 digit ICAP Service Score from the ICAP CompuScore. This field must be numeric.
3. **Enter Begin and End Dates**. Enter the begin date and end date for the POC. This field must be a date. Once you have moved to the next segment the form will automatically format the date to appear as mm/dd/yy.
4. Check if the POC is an **Initial Plan/Redetermination Plan**. Place the mouse over the check box and click once. If this is a revision enter the **Revision Number** in the field. This field must be numeric.
5. **Date of Plan Meeting**. Enter the date of the team meeting. This field must be a date. Once you have moved to the next segment the form will automatically format the date to appear as mm/dd/yy.
6. **Participant Name**. Enter the participant name as it appears on the Medicaid card.
7. **Social Security Number**. Enter the participant Social Security Number. This field must be numeric. There is enough space to allow for 2 hyphens to separate the number.
8. **Medicaid Number**: Enter the participant Medicaid Number. This field must be numeric. Do not enter the 13th check digit and do not use hyphens to separate the number.
9. **Participant address**. Enter the participant current street address or projected address if he/she will be moving soon. Enter the city and the 2 digit state abbreviation. Enter the 5 digit zip code. You may enter an extended zip code number if you choose by using a hyphen and 4 more digits (for example, 12345-1234). Finally, enter the county name.
10. **Year First Eligible**. Enter the year the person was first eligible for the MR Waiver or the LAH Waiver. This field must be numeric and must be 4 characters long. Indicate which waiver by placing the mouse over the appropriate check box and clicking once.
11. **The Grid**: There are 3 drop down menus in the grid: Action Code, Frequency “per” and Fund Source.
 - a. **Action Code Column**. Place the mouse over the gray box and click once. The action code list should appear. Point and click on the appropriate action code.
 - b. **Provider**. Enter the contract provider name and performing provider number.
 - c. **Service**. Enter the Abbreviated Service Name for waiver services or services paid by the state. For services that are not paid by the state or waiver enter the service description.
 - d. **Frequency**. Enter the number of units in the “unit” field. This field is numeric. You may also leave this field blank, but only if you do not know the number of units and the service is NOT state or federally funded or Targeted Case Management. Once you have entered the unit place the mouse over the gray box under “per” period of time and click once. The “per” period of time list should appear (calday, busday, week, etc.). Point and click on the appropriate period of time. You may choose PRN for Targeted Case Management and other non-waiver services or NA for non-waiver and non state/federal funded services if you are not sure of the appropriate “per” period of time. There must be a “unit” and “per” for all **waiver services**.

- e. **Service Start Date.** Enter the service begin date. This field must be a date. Once you have moved to the next segment the form will automatically format the date to appear as mm/dd/yy.
 - f. **Service End Date.** Enter the service end date. This field must be a date. Once you have moved to the next segment the form will automatically format the date to appear as mm/dd/yy.
 - g. **Fund Source.** Place the mouse over the number gray box and click once. The Fund Source list should appear. Point and click on the appropriate Fund Source Code.
12. **Signature of Participant.** Requires the signature or mark of the participant.
13. **Signature of Witness.** Requires the signature of a witness (guardian, if one is present) if the participant signature is not legible.
14. **Signatures of Team Members.** Requires signatures of all team members.
15. **Page of Pages.** If you need to use more than one page, type the current page number and then the total number of pages (exp: Page 2 of 3).
16. **Case Manager Review.** Enter quarterly review date. This field must be a date. Once you have moved to the next segment the form will automatically format the date to appear as mm/dd/yy.