

**New Mexico Department of Health / Division of Health Improvement
Case Management
Agency Individual Case File & Billing Field Tool**

Agency/Region:

Individual Name:

Surveyor:

Date/Time:

Required Documents:	MET	NOT MET	N/A	Dates/Notes:
<p>MAD 046 or Med UR Approval Document</p> <p><i>**Use to verify ALL DD Waiver Services the individual receives, as well as Agency who provides the Service</i></p> <p><u>Surveyor:</u> Must Document the dates of ISP & All Services</p>				4C10 (CoP)
<p>Current Emergency & Personal Identification Information <i>(Must include the following:</i></p> <ul style="list-style-type: none"> • Individual's Address • Individual's phone number • Names and phone numbers of relatives, or guardian or conservator • Physician's name(s) & phone number(s) • Pharmacy name, address and phone number • Health Plan (Insurance; Medicaid, Medicare, etc, if appropriate) <p>Document must contain Individual's current information to be considered met.</p> <p><u>Surveyor:</u> Info maybe part of ISP (if all elements are included) or separate document. Team Lead is to verify with Agency what is used. Then proceed.</p>				1A08
Annual ISP				1A08
<p>ISP Assessment Checklist</p> <p><i>As a guide list Assessments Required last date completed & due date.</i></p>				1A08

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<p>ISP Signature Page: <input type="radio"/> Yes <input type="radio"/> No</p> <p>Does the ISP Signature Page Show Evidence of a Fully Constituted IDT? <i>Were all team members present at the ISP meeting, i.e. Guardian, Individual, Therapist Staff, etc. If <u>not</u> is there evidence that they participated in other ways?</i></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>If one area is checked no then this is not met.</p>				1A08
Addendum A				1A08
<p>Individual Specific Training <i>(Addendum B)</i></p> <p><i>List Required Items in the this section, i.e. Specific HCP, crisis plans, other plans etc.</i></p>				1A08
<p>Teaching & Support Strategies <i>(For ALL Services Received by the Individual)</i></p> <p><i>(List Action Plans which require Teaching & Support Strategies)</i></p> <p><i>Paid services must have outcomes, if no Outcome, is there a Decision Justification Form.</i></p> <p>Are Therapy Services Integrated?</p>				1A08
<p>Are Outcomes Measurable?</p> <p><i>Will you know when they are achieved?</i></p> <p>** What are the Criteria for Completion of each Outcome?</p>				4C07

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Documentation of Individualized Meaningful Day <i>(Is part the ISP and other assessment)</i>				4C08 (CoP)
Positive Behavioral Plan <i>Date(s) of Plan:</i>				1A08
Positive Behavioral Crisis Plan <i>(Note: this may not always be require, it is based on PBP)</i> <i>Date(s) of Plan:</i>				1A08
Human Rights Committee Meeting Minutes <i>**This is only required when there is NO Community Living or Community Inclusion Services</i>				1A31
Speech Therapy Plan <i>Date(s) of Plan:</i>				1A08
Occupational Therapy Plan <i>Date(s) of Plan:</i>				1A08
Physical Therapy Plan <i>Date(s) of Plan:</i>				1A08
Parent/Guardian Abuse, Neglect & Exploitation Incident Management Training <i>(Acknowledgement it was received)</i>				
Grievance/Complaint Procedure <i>(Acknowledgement it was received)</i>				1A29
Rights & Responsibilities <i>(Acknowledgement it was received)</i>				4C08 (CoP)
CM Code of Ethics <i>(Acknowledgement it was received)</i>				4C08 (CoP)
MEDICAL				
Health Assessment Tool <i>(Annually. Level 4, 5 & 6 must be signed by Agency Nurse or Physician)</i>				1A08 <i>List HAT Score: _____</i>
Health Care Plans <i>(Required for Individuals with HAT score of 4, 5 or 6) (Must be reviewed quarterly) (LIST EACH ONE APPLICABLE)</i>				1A08 - <i>List plans which are not found, incomplete, etc.</i>

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<p>Crisis Plans (<i>Crisis Plans for Chronic Conditions: i.e. Life threatening conditions (Must be reviewed quarterly) (LIST EACH ONE APPLICABLE)</i>)</p>			<p>1A08 - List plans which are not found, incomplete, etc.</p>
<p>Special Health Care Needs (<i>i.e. Nutritional Plans, Meal Time Plans, Special Diets, Medical Orders and/or Special Precautions, etc.</i>)</p>			<p>1A08 - List plans which are not found, incomplete, etc.</p>
<p>Quarterly Nursing Report <i>(Review of Progress with update on HCP & Crisis Plans)</i></p>			<p>4C15 (<i>Document dates which are not found</i>)</p>
<p>• Annual Physical Exam <i>If recommendations were made, document the recommendation and look for follow-up</i></p>			<p>4C04 (CoP)</p>
<p>• Dental Exam (<i>Per Matrix Annually or as Recommended by PCP, ISP, IDT or Specialist</i>) <i>ID the document & date it was found on. If follow-up required, look for & document if follow-up was completed.</i></p>			<p>1A08</p>
<p align="center">***The following are as indicated or recommended by the ISP, IDT, Primary Care Physician and/or other Medical Specialist. Must document why exam is required, i.e. ISP, doctor's note, etc.***</p>			
<p>• Psychiatric Evaluation (<i>As indicated or recommended</i>)</p>			<p>1A08</p>
<p>• Neurology Evaluation (<i>As indicated or recommended</i>)</p>			<p>1A08</p>
<p>• Nutritional Evaluation (<i>As indicated or recommended</i>)</p>			<p>1A08</p>
<p>• Auditory Exam (<i>recommended every 3 years or as called for by hearing professional</i>)</p>			<p>1A08 - Include date completed; next date due; what document indicated it was required.</p>
<p>• Vision Exam (<i>recommended every 3 years or as called for by vision professional</i>) (<i>If Diabetic a Must</i>)</p>			<p>1A08 - Include date completed; next date due; what document indicated it was required.</p>
<p>• Pap (<i>recommended for women over 19 or as called for by physician</i>)</p>			<p>1A08 - Include date completed; next date due; what document indicated it was required.</p>

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<ul style="list-style-type: none"> • Mammogram <i>(recommended for women 40-year old or as called for by physician)</i> 				1A08 - Include date completed; next date due; what document indicated it was required.
<ul style="list-style-type: none"> • Prostate Check <i>(recommended for men over 40 or as called for by physician)</i> 				1A08 - Include date completed; next date due; what document indicated it was required.
<ul style="list-style-type: none"> • Prostate Specific Antigen (PSA) <i>(recommended for men over 50 or as called for by physician)</i> 				1A08 - Include date completed; next date due; what document indicated it was required.
<ul style="list-style-type: none"> • Bone Density <i>(recommended. if diagnosed with osteoporosis/Osteopenia or as called for by physician)</i> 				1A08 - Include date completed; next date due; what document indicated it was required.
<ul style="list-style-type: none"> • Colonoscopy <i>(recommended over 50 years old & every 10 years after unless otherwise indicated or as called for by physician)</i> 				1A08 - Include date completed; next date due; what document indicated it was required.
<ul style="list-style-type: none"> • Cholesterol & Blood Glucose <i>(i.e. every 5 years and required for those on medication or as called for)</i> 				1A08 - Include date completed; next date due; what document indicated it was required.
<ul style="list-style-type: none"> • Blood Levels <i>(i.e. any medications that require it, including thyroid or as called for by a physician)</i> 				1A08 - Include date completed; next date due; what document indicated it was required.
CARRER DEVELOPMENT				
Documentation of Employment being offered 1 st prior to any other Community Inclusion Service <i>(Included in ISP)</i>				4C08 (CoP)
Vocational Assessment Profile <i>(If Interested in Work)</i> <i>Initial (1st time) would be completed as stand alone document and updates would be incorporated into the Narrative of Work/Learn Strategies with in ISP.</i>				1A08
Career Development Plan <i>(Does It Contain the Following)</i> <ul style="list-style-type: none"> • <i>Work Strategies</i> • <i>Action Plans</i> 				1A08

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REQUIRED ASSESSMENTS				
Level of Care Regional Office Pre-Review Request Form for <i>Increases in LOC Only</i>				
Level of Care (Annually) Long Term Care Assessment Abstract (LTCAA) <i>**Ensure that Case Managers conduct a complete and comprehensive LOC review for the intervening two years that the NMMUR is not required to review and approve the LTCAA</i>				4C04 (CoP)
Level of Care (Re-Admit) Long Term Care Assessment Abstract (LTCAA) <i>If hospitalization is more than 3-Day LOC must be re-assessed, as needed.</i> <i>**If Individual was Hospitalized (medical, mental, or otherwise) Case Manager must re-assess</i>				4C05
Adaptive Behavior Scale (ABS) <i>(current within 3 years)</i> <i>**Ensure that Case Managers conduct a complete and comprehensive LOC review for the intervening two years that the NMMUR is not required to review and approve the LTCAA</i>				4C06 (CoP)
Client Individual Assessment (CIA) <i>(Updated Annually)</i> <i>**Ensure that Case Managers conduct a complete and comprehensive LOC review for the intervening two years that the NMMUR is not required to review and approve the LTCAA</i>				4C06 (CoP)
THERAPIES REQUIREMENTS				
Positive Behavior Support Assessment				1A08
Positive Behavior Support Quarterlies <i>** Must list specific quarters if not found or not current.</i>				4C15
Speech/Language Therapy Evaluation <i>(As indicated or recommended)</i> <i>** May be part of the Annual/Bi-Annual Report.</i>				1A08
SLP Bi-annual progress report <i>** May be part of the Annual Assessment/Evaluation, verify.</i>				4C15
Occupational Therapy Evaluation <i>(As indicated or recommended)</i> <i>** May be part of the Annual/Bi-Annual Report.</i>				1A08

**New Mexico Department of Health / Division of Health Improvement
Case Management
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OT Bi-annual progress report ** May be part of the Annual Assessment/Evaluation, verify.				4C15
Physical Therapy Evaluation (As indicated or recommended) ** May be part of the Annual/Bi-Annual Report.				1A08
PT Bi-annual progress report ** May be part of the Annual Assessment/Evaluation, verify.				4C15
Therapy Closing Reports (as needed), i.e. discharged from therapy services <i>If not met must list therapy this pertains to.</i>				1A08
CL & CI QUARTERLIES				
Community Living Quarterly Reports <i>(Must see minimum of 4 quarters - Current & Prior ISP year if necessary)</i> Indicate type of CL Service:				4C15 <i>(Document dates which are not found)</i>
Community Living Annual Assessment <i>(If individual is in middle of ISP year look for Annual Assessment from previous year)</i>				4C15 <i>(Document dates which are not found)</i>
Community Inclusion Quarterly Reports (Adult Habilitation) <i>(Must see minimum of 4 quarters - Current & Prior ISP year if necessary)</i>				4C15 <i>(Document dates which are not found)</i>
Community Inclusion Quarterly Reports (Supported Employment) <i>(Must see minimum of 4 quarters - Current & Prior ISP year if necessary)</i>				4C15 <i>(Document dates which are not found)</i>
Community Inclusion Quarterly Reports (Community Access) <i>(Must see minimum of 4 quarters - Current & Prior ISP year if necessary)</i>				4C15 <i>(Document dates which are not found)</i>
Community Access Annual Assessment <i>(If individual is in middle of ISP year look for Annual Assessment from previous year)</i>				4C15 <i>(Document dates which are not found)</i>

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CASE MANAGER MONITORING			
<p>Case Manager Case Notes</p> <p><i>Is there a note for each month? (Must look for at least six month - one years worth)</i></p>			<p>4C12 (CoP)</p>
<p>Monthly Face-to-Face Site Visit <i>(Jackson 2 visits per month. 1 of these visits must occur where the individual spend the majority of their day and the other at home. Children may receive a minimum of 4 visits per year. All others 1x month, at least every other month the visit shall occur in the home).</i></p> <p><i>** Jackson 2 visits per month. 1 of these visits must occur where the individual spend the majority of their day and the other at home.</i></p> <p><i>For non-Jackson Class members who receive Community Living Services, at least every other month, one of the face-to-face visits shall occur in the individual's residence;</i></p> <p><i>For adults who are not Jackson Class members and who do not receive Community Living Services, at least one face-to-face visit per quarter shall be in his or her home.</i></p> <p><i>Children may receive a minimum of 4 visits per year. All others 1x month, at least every other month the visit shall occur in the home).</i></p> <p><i>Must look for at least six month - one year worth.</i></p> <p style="color: red;"><i>Do Visits Alternate As Required by Standards? Note: Due to H1N1 some visits may be conducted by phone, if this is the case verify.</i></p> <p style="color: red;"><i>If visits DO NOT ALTERNATE is there documentation to why not. If there is may not be a deficiency.</i></p>			<p>4C12 (CoP) <i>Must document date, time & location of visits for 6 months - 1 year.</i></p>

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OTHER REQUIRED DOCUMENTS				
Primary Freedom of Choice <i>(Must be signed by individual or guardian)</i>				4C02
Secondary Freedom of Choice <i>(Must be signed by individual or guardian)</i> <ul style="list-style-type: none"> • <i>List services</i> • <i>Need to have one for each service listed on the individual's budget.</i> 				4C09
IDT Meeting Minutes <i>Not needed for Annual ISP meeting, list when one is required.</i>				1A08
Decision Justification Forms <i>(as relevant)</i> <i>Document why form is necessary</i>				1A08
Transition Plan <i>(As applicable for change in provider in the past year)</i>				1A08
Guardianship				1A08
Programmatic Correspondence				4C02
Other:				

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Agency/Region:	Service: DD Waiver Case Management
Individual:	
Surveyor:	Date/Time:

DDSD DDW Service Std. Chapter 4.V.A. - C.(1-5) TAG # 4C21

	<i>Dates of face-to-face contact & location (Home-HV or Site-SV)</i>	<i>Time of each visit</i>	<i>Total billable service time per month</i>	<i>Units Billed By AGENCY - Examine billing documentation; does it match the total service time listed in column to the left. IS IT JUSTIFIED? If not, why?</i>
<u>MONTH 1</u>				
<u>MONTH 2</u>				
<u>MONTH 3</u>				

Additional Notes: