Innovative Resource Group d/b/a
APS Healthcare

TBI Provider Agency:	
Review Number:	
WV Provider ID Number:	
Date of Review:	
Provider Educator(s):	
Review Period:	
# Member Files:	
# Staff Files:	
Total # Members Served:	

CEO/Responsible Person to Whom Reports Will Go (include mailing address)	Email Address

The Office of Quality and Program Integrity (OQPI) may be contacted for referral to the Medicaid Fraud Control Unit and disallowances may be recommended for:

*Services delivered to program members who are not medically and/or financially eligible
*Services delivered related to an invalid Service Plan
*Services delivered with no (or insufficient) supporting documentation
*Services delivered by a staff or employee who is not qualified
*Services delivered that exceed service limits
*Services delivered that are not indicated as a need on the program member's Service Plan
*Services delivered outside the scope of the service definition

Items highlighted in Red will be recommended for disallowance.

Items highlighted in Yellow will not be recommended for disallowance; however, will be addressed on the Agency's Plan of Correction and Technical Assistance will be provided.

WV Medicaid TBI Waiver Policy is referenced for all items that may be recommended for a potential disallowance.

Qualified Personnel Identifier				
	Provider First Name	**Provider Last Name**	**Provider Role (CM, PAs, CRT)**	**Hire Date**
P1				
P2				
P3				
P4				
P5				
P6				
P7				
P8				
P9				
P10				

APS Healthcare, Inc.-WV
TBI Waiver Provider Review Tool

	Provider Agency Certification	Score 1 = Yes 0 = No NA
	512.3 Provider Agency Certification	NA
1	A competency based curriculum, including goals/objectives and evaluation system to gauge competencies, for the required training areas for Personal Attendant direct care staff exists. A. Cardiopulmonary Resuscitation (CPR) Training B. First Aid Training C. Occupational Safety and Health Administration (OSHA) Training D. Personal Attendant Skills Training E. Abuse, Neglect and Exploitation Training F. HIPAA Training G. Direct Care Ethics Training H. Member Health and Welfare Training I. Crisis Intervention Training	
1A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
1B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
1C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
1D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
1E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
1F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT	
1G	INDICATE WITH "X" IF "G" WAS NOT COMPLIANT	
1H	INDICATE WITH "X" IF "H" WAS NOT COMPLIANT	
1I	INDICATE WITH "X" IF "I" WAS NOT COMPLIANT	
2	The Personal Attendant direct care training was provided by a qualified staff as directed in policy. A. Cardiopulmonary Resuscitation (CPR) - training by an agency nurse or certified trainer B. First Aid - training by an agency nurse or certified trainer C. Occupational Safety and Health Administration (OSHA) Training - materials used for training must be current OSHA approved material D. Personal Attendant Skills Training - training by Registered Nurse, social worker/counselor, a documented specialist or an approved internet training provider E. Abuse, Neglect and Exploitation Training - training by a Registered Nurse, social worker/counselor, a documented specialist or an approved internet training provider F. HIPAA Training - training by a Registered Nurse, social worker/counselor, a documented specialist or an approved internet training provider G. Direct Care Ethics Training - training by a Registered Nurse, social worker/counselor, a documented specialist or an approved internet training provider H. Member Health and Welfare Training - training by a Registered Nurse, social worker/counselor, a documented specialist or an approved internet training provider I. Crisis Intervention Training - training by a Registered Nurse, social worker/counselor, a documented specialist or an approved internet training provider	
2A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
2B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
2C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
2D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
2E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
2F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT	
2G	INDICATE WITH "X" IF "G" WAS NOT COMPLIANT	
2H	INDICATE WITH "X" IF "H" WAS NOT COMPLIANT	
2I	INDICATE WITH "X" IF "I" WAS NOT COMPLIANT	
3	Agency has a Quality Management Plan that is consistent with CMS quality framework and assurances. A. Participant Access B. Participant-Centered Service Planning C. Provider Capacity and Capabilities D. Participants Safeguards E. Participants Rights and Responsibilities	
3A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
3B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
3C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
3D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
3E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
4	The Agency's Quality Management Plan was available for APS Healthcare monitoring staff during interview.	

	Provider Agency Certification	Score 1 = Yes 0 = No NA
5	Agency has written policies and procedures for processing member grievances. The written policy includes the following elements: A. Grievance must be in writing B. Written Grievance is documented on the BMS approved Member Grievance Form C. Number of business days to respond in writing to the Member Grievance does not exceed 15 D. Member and/or legal representative is contacted within 10 business days for a meeting in person or by phone E. Agency Director or their designee conducts the meeting F. Number of days for a written response from the Agency does not exceed 5 days from the meeting date	
5A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
5B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
5C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
5D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
5E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
5F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT	
6	Agency has written policies and procedures for processing member complaints. A. Addresses the process for submitting a complaint B. Provides steps for remediation of the complaint including who will be involved in this process C. Steps include the process for notifying the member or employee of the findings and recommendations D. Provides steps for advancing the complaint if the member or employee does not feel the complaint has been resolved	
6A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
6B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
6C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
6D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
7	Agency has written policies and procedures for processing staff complaints. A. Addresses the process for submitting a complaint B. Provides steps for remediation of the complaint including who will be involved in this process C. Steps include the process for notifying the member or employee of the findings and recommendations D. Provides steps for advancing the complaint if the member or employee does not feel the complaint has been resolved	
7A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
7B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
7C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
7D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
8	Agency has written policies and procedures for member transfers that includes the following: A. Any member may request to transfer at any time B. Documentation for transfer must be in writing and on the Member Request to Transfer Form C. Procedures for submission to APS Healthcare D. Statement that services will continue until transfer is complete E. Steps to transfer member's current PAS, Service Plan, and Member enrollment confirmation (CMA only) to the receiving agency F. Steps to receive a transfer member includes face to face contact with the transferred member and/or legal representative within 7 business days of notification	
8A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
8B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
8C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
8D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
8E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
8F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT	
9	Agency has written policies and procedures for discontinuation of member services that include: A. Use of TBI Waiver Program Request for Discontinuation of Service form which identifies reason for request B. Identifies that all discontinuation of services (closures) must be reported on the Case Management Monthly Report C. Provides information about submission of the form to APS Healthcare	
9A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
9B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
9C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	

	Provider Agency Certification	Score 1 = Yes 0 = No NA
10	Agency has written policies and procedures to avoid conflict of interest ***(if agency is providing both Case Management and Personal Attendant Services)*** that: A. Includes a statement that conflicts of interest and self-referral are prohibited B. Identifies separate staff for each service C. Maintains separate member files	
10A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
10B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
10C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
11	Agency has a policy for maintaining 24-hour contact availability (Personal Attendant Agencies only) that: A. Includes regular contact information for normal business hours B. Provides emergency, after-hours contact information	
11A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
11B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
12	Agency has an Emergency Plan to deal with emergencies for members and office operations.	
	512.31 Office Criteria (Each office must meet the following criteria:)	NA
13	Office meets ADA requirements for physical accessibility. A. Maintaining an unobstructed pedestrian passage in the hallways, offices, lobbies, bathrooms, entrance and exits B. The entrance and exits has accessible handicapped curbs, sidewalks and/or ramps C. The restrooms have call lights and grab bars for convenience D. A telephone is accessible for the member E. Drinking fountains and/or refreshments are made available as needed	
13A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
13B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
13C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
13D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
13E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
14	Office has space for securely maintaining member and personnel records. A. The member's files are kept in a secured and locked cabinet or in a locked room B. The member files are maintained in their original form with notation on all services the member received C. The agency has secured area to store the member's files for five years in the office representing the county the member was served D. The personnel files are kept in a secured cabinet or room and there is a secure storage area for these files	
14A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
14B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
14C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
14D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
15	Office space that allows for member confidentiality. A. An office space is available for members, families and/or legal representatives to meet with agency staff in private to discuss medical treatment	
	512.7 Incident Management	NA
16	TBI Waiver provider has policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve.	
17	The policy includes that the provider is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harms, or to prevent further harm, to the health and safety of all members served. Incidents shall be classified by the provider as one of the following: A. Abuse, Neglect, Exploitation B. Critical Incidents C. Simple Incidents	
17A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
17B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
17C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
	512.72 Incident Management Tracking and Reporting	NA
18	Provider agency has a mechanism in place to review and analyze incident reports to identify health and safety trends.	
19	Systemic health and safety trends and issues are reviewed and incorporated into the Agency's Quality Management Plan.	

	Qualified Personnel	Score	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
	512.3.8 (Criminal Investigation Background Check)	NA										
1	There is evidence that a CIB background check was initiated prior to providing services and the outcome meets the TBI Waiver program requirements.	1 = Yes 0 = No										
2	There is evidence that a CIB background check was completed every three (3) years and the outcome meets the TBI Waiver program requirements.	1 = Yes 0 = No NA										
	512.3. 8 (Office of the Inspector General)	NA										
3	Monthly documentation is present for the previous twelve months to indicate that staff persons is not on the list of excluded individuals maintained by the Office of the Inspector General.	1 = Yes 0 = No										
	The following subset is applicable only to those providing **Personal Attendant Service**											
	512.3.5 Personal Attendant Service Staff Requirements	NA										
4	There is documentation which verifies the provider is 18 years of age or older.	1 = Yes 0 = No										
5	Personal Attendant Service Staff and Personal Options direct care staff must have completed the following competency based training **before** providing services to TBI Waiver members:	1 = Yes 0 = No										
A.	A current and valid copy of the CPR certification card is present	1 = Yes 0 = No										
B.	A current and valid copy of the First Aid certification card is present	1 = Yes 0 = No										
C.	There is evidence that training in Occupational Safety and Health Administration (OSHA) has occurred	1 = Yes 0 = No										
D.	There is evidence that Personal Attendant Skills training focused on assisting individuals with TBI with ADL's has occurred	1 = Yes 0 = No										
E.	There is evidence that HIPAA compliance training has occurred	1 = Yes 0 = No										
F.	There is evidence that training on Direct Care Ethics including promoting physical and emotional well-being, respect, integrity, responsibility, justice, fairness and equity when working with a member has occurred	1 = Yes 0 = No										
G.	There is evidence that training in Member Health and Welfare including emergency plan response, fall prevention, home and safety risk management and training specific to the member with special needs has occurred initially and frequently as changes occur	1 = Yes 0 = No										
H.	There is evidence that training in Crisis Intervention occurred initially or more frequently as changes occur	1 = Yes 0 = No										
I.	There is evidence that training in the recognition and reporting of Abuse, Neglect and Exploitation has occurred	1 = Yes 0 = No										
6	Personal Attendant Service Staff and Personal Options direct care staff meet all **annual** training requirements:	1 = Yes 0 = No NA										
A.	A current and valid copy of the CPR certification card is present	1 = Yes 0 = No NA										
B.	A current and valid copy of the First Aid certification card is present	1 = Yes 0 = No NA										
C.	There is evidence that training in Occupational Safety and Health Administration (OSHA) has occurred on an annual basis	1 = Yes 0 = No NA										
D.	There is evidence that Personal Attendant Skills training focused on assisting individuals with TBI with ADL's has occurred on an annual basis	1 = Yes 0 = No NA										
E.	There is evidence that HIPAA compliance training has occurred on an annual basis	1 = Yes 0 = No NA										
F.	There is evidence that training in the recognition and reporting of Abuse, Neglect and Exploitation has occurred on an annual basis	1 = Yes 0 = No NA										
G.	There is evidence that four (4) hours of training, focusing on enhancing direct care services delivery knowledge and skills for people with TBI, has occurred on an annual basis	1 = Yes 0 = No NA										
	The following subset is applicable only to those providing **Case Management**											
	512.3.6 Case Manager Qualifications	NA										
7	There is evidence that the case manager meets licensure requirements by a valid copy of license in the personnel file.	1 = Yes 0 = No										
	The following subset is applicable only to those providing **Cognitive Rehabilitation Therapy**											
	512.3.7 Cognitive Rehabilitation Therapist Qualifications	NA										
8	There is evidence that the cognitive rehabilitation therapist meets degree and licensing requirements.	1 = Yes 0 = No										
9	There is evidence that an internal review has been conducted by the agency and a determination of certification level following the Society of Cognitive Rehabilitation Level I, II, has been documented.	1 = Yes 0 = No										

	Qualified Personnel	Score	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
	512.3.3 Record Requirement Personnel Files	NA										
10	Original and/or legible copies of personnel documents are maintained in the personnel file.	1 = Yes 0 = No										
11	Minimum credentials for professional staff is verified upon hire and thereafter based upon their individual professional license requirements.	1 = Yes 0 = No NA										
12	There is evidence that confidentiality agreement is in the file.	1 = Yes 0 = No										
13	All documentation for the staff member is kept in the designated office that represents the county where services were provided.	1 = Yes 0 = No										
14	Prior to use of an internet provider for training, approval was received by APS Healthcare **512.3.5**.	1 = Yes 0 = No NA										
15	Training Documentation includes the training topic, date, beginning and end time of the training, location of the training and signatures of the instructor and trainee or for **Personal Options , the member and/or legal rep. 512.3.5.2**.	1 = Yes 0 = No										
16	Personnel Files contain all documented evidence of staff qualifications including:	1 = Yes 0 = No										
A.	License	1 = Yes 0 = No NA										
B.	Transcript	1 = Yes 0 = No NA										
C.	Certificates	1 = Yes 0 = No NA										
D.	References	1 = Yes 0 = No										
17	There is evidence that the agency has conducted an internal review process to ensure that employees meet the minimum qualifications.	1 = Yes 0 = No										

	Incident Reporting	Score	# Score	# Score	# Score	# Score	# Score
	512.7.1 Reporting Requirements	NA					
1	The following were implemented within 24 hours for incidents that occurred in the past 365 days: A. Incident reporting (into IMS); and to all applicable entities (OHFLAC, Protective Services-48 hrs. to submit written report for Abuse/Neglect/Exploitation) B. Monitoring C. Follow-up by appropriate person(s) D. Notification to legal representative E. Addressed by the team	1 = Yes 0 = No NA					
1A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
1B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
1C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
1D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT						
1E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT						
2	Critical Incidents and reports of Abuse/Neglect/Exploitation are followed up on by the provider within 14 calendar days. Follow-up might include: internal investigation, medical follow-up, staff training, etc.	1 = Yes 0 = No NA					
3	For each incident reported to APS Healthcare, there is an available report in the corresponding administrative file.	1 = Yes 0 = No NA					
4	For each incident report, there is a corresponding report provided to APS Healthcare.	1= Yes 0 = No NA					

	Member Record	Score	# Score	# Score	# Score	# Score	# Score
	512.10 Member Assessment	NA					
1	Member Assessment was completed within seven (7) calendar days from receipt of Member Enrollment Confirmation Notice.	1 = Yes 0 = No NA					
2	Original, signed Member Assessment is in the member's record and includes the member and/or his/her legal representative signature.	1 = Yes 0 = No NA					
3	A new member assessment was completed as the member's needs change, when one or more of the following conditions were recorded on the Case Manager's Monthly Contact Document: A. Did you get all the services you were supposed to get last month? If not, then what services did you not receive? INDICATE with " X " IF Q 1 WAS CHECKED NO B. Are there times when you needed help and you didn't get it? If yes, what happened? INDICATE WITH "X" IF Q 3 WAS CHECKED YES C. Have your needs for assistance changed since we last talked? If so, how? INDICATE WITH "X" IF Q 4 WAS CHECKED YES D. Do you need any additional medical equipment, services or resources? If yes, what? INDICATE WITH "X" IF Q 7 WAS CHECKED YES E. Are you having any problems paying for or getting food, housing, utilities or medications? INDICATE WITH "X" IF Q 8 WAS CHECKED YES F. Have there been any changes in your life that affect your need for service (death, loss, divorce, etc.)? INDICATE WITH "X" IF Q 9 WAS CHECKED YES G. Have there been any changes to your prescribed medications? INDICATE WITH "X" IF Q 13 WAS CHECKED YES	1 = Yes 0 = No NA					
3A	INDICATE WITH "X" IF CIRCUMSTANCE "A" WAS PRESENT						
3B	INDICATE WITH "X" IF CIRCUMSTANCE "B" WAS PRESENT						
3C	INDICATE WITH "X" IF CIRCUMSTANCE "C" WAS PRESENT						
3D	INDICATE WITH "X" IF CIRCUMSTANCE "D" WAS PRESENT						
3E	INDICATE WITH "X" IF CIRCUMSTANCE "E" WAS PRESENT						
3F	INDICATE WITH "X" IF CIRCUMSTANCE "F" WAS PRESENT						
3G	INDICATE WITH "X" IF CIRCUMSTANCE "G" WAS PRESENT						
4	Documentation is in the Member record that indicates the Member Assessment was provided to the member and/or their legal representative.	1 = Yes 0 = No					
5	Documentation is in the Member record that indicates that the Member Assessment was shared with all service providers.	1 = Yes 0 = No					

APS Healthcare, Inc.-WV
TBI Waiver Provider Review Tool

	Member Record	Score	# Score	# Score	# Score	# Score	# Score
	512.11 Service Plan Development	NA					
1	Original, signed Service Plan is in the member's record and includes the member and/or his/her legal representative signature.	1= Yes 0=No					
2	Member's service plan (in effect at the time of the review) comprehensively addresses his or her identified needs, health care and other services in accordance with his or her expressed personal preferences and goals. A. Detail of all services are in the member's Service Plan including, Service Type, Provider of Service, frequency. B. Informal Supports that provide assistance are documented in the member's Service Plan. C. Needs identified in the Pre Admission Screening are addressed in the member's Service Plan. D. Needs identified in the Member's Assessment are addressed in the member's Service Plan. E. The member's goals and preferences are addressed in the Service Plan. F. Signature Sheet (and rationale for disagreement if necessary). G. Service Plan contains reference to any other services regardless of payment issues.	1= Yes 0=No					
2A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
2B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
2C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
2D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT						
2E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT						
2F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT						
2G	INDICATE WITH "X" IF "G" WAS NOT COMPLIANT						
3	100 % of the member's Health and Safety Factors issues (as identified through the Member Assessment) were addressed and documented on page 4 of the member's Service Plan.	1 = Yes 0 = No					
4	Significant changes in the member's needs or circumstances promptly trigger consideration of modifications in his or her service plan. During the review period, if the following questions from the Case Management Monthly Contact form was "yes", look to see if consideration for a service plan modification was made. Not all members Service Plans will need revision during the review period. A. Did you get all the services you were supposed to get last month? If not, then what services did you not receive? INDICATE with " X " IF Q 1 WAS CHECKED NO. B. Are there times when you needed help and you didn't get it? If yes, what happened? INDICATE WITH "X" IF Q 3 WAS CHECKED YES. C. Have your needs for assistance changed since we last talked? If so, how? INDICATE WITH "X" IF Q 4 WAS CHECKED YES. D. Do you need any additional medical equipment, services or resources? If yes, what? INDICATE WITH "X" IF Q 7 WAS CHECKED YES. E. Are you having any problems paying for or getting food, housing, utilities or medications? INDICATE WITH "X" IF Q 8 WAS CHECKED YES. F. Have there been any changes in your life that affect your need for service (death, loss, divorce, etc.)? INDICATE WITH "X" IF Q 9 WAS CHECKED YES. G. Have there been any changes to your prescribed medications? INDICATE WITH "X" IF Q 13 WAS CHECKED YES.	1 = Yes 0 = No NA					
4A	INDICATE WITH "X" IF CIRCUMSTANCE "A" WAS PRESENT						
4B	INDICATE WITH "X" IF CIRCUMSTANCE "B" WAS PRESENT						
4C	INDICATE WITH "X" IF CIRCUMSTANCE "C" WAS PRESENT						
4D	INDICATE WITH "X" IF CIRCUMSTANCE "D" WAS PRESENT						
4E	INDICATE WITH "X" IF CIRCUMSTANCE "E" WAS PRESENT						
4F	INDICATE WITH "X" IF CIRCUMSTANCE "F" WAS PRESENT						
4G	INDICATE WITH "X" IF CIRCUMSTANCE "G" WAS PRESENT						
	512.11.1 512.11.2 6-month, On-going, and Interim Service Planning	NA					
5	Member attended (in person) and signed his/her six month service plan.	1 = Yes 0 = No NA					
6	Legal Representative (if applicable) attended (in person) and signed the six (6) month Service Plan.	1 = Yes 0 = No NA					
7	Case Manager attended (in person) and signed the six (6) month Service Plan.	1 = Yes 0 = No					
8	The Personal Attendant Service provider agency representative attended (in person) and signed the six (6) month Service Plan.	1 = Yes 0 = No					
9	The member attended (in person) and signed his/her Annual Service Plan.	1 = Yes 0 = No NA					
10	Legal representative (if applicable) attended (in person) and signed the Annual Service Plan.	1 = Yes 0 = No NA					
11	Case Manager attended (in person) and signed the Annual Service Plan.	1 = Yes 0 = No NA					
12	The Personal Attendant Service provider agency representative attended (in person) and signed the Annual Service Plan.	1 = Yes 0 = No NA					
13	An Interim Service Plan was developed immediately to address any health and safety concerns. A. The Interim Service Plan was in effect for up to 21 calendars days from the date of the Member Enrollment Confirmation Notice B. Direct Care Services (Personal Attendant) were initiated with 3 business days	1 = Yes 0 = No NA					
13A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
13B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						

	Member Record	Score	# Score	# Score	# Score	# Score	# Score
14	Initial Service Plan is completed prior to the initiation of ANY services being billed.	1 = Yes 0 = No NA					
15	Documentation exists that shows that the member received the services specified in the Service Plan.	1 = Yes 0 = No					
16	Documentation exists that the Case Management agency has forwarded copies of Service Plan to ALL participating members/agencies within 14 calendar days.	1 = Yes 0 = No					
	512.15 Transfers	NA					
17	If the Member requested a transfer to another CMA or PASA during the review period, the initiating agency attempted to complete transfer with 45 days from the receipt of request to transfer.	1 = Yes 0 = No NA					
18	Transferring Agency - Case Management: A. Services were provided until transfer was complete B. Documentation exist that the member's current PAS, the Service Plan, Member Enrollment Confirmation Notice was provided to the receiving agency	1 = Yes 0 = No NA					
18A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
18B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
19	Transferring Agency - Personal Attendant Services: A. Services were provided until transfer was complete B. Documentation exist that the member's current PAS, the Service Plan was provided to the receiving agency	1 = Yes 0 = No NA					
19A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
19B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
20	Receiving Agency - Case Management: A. Member Assessment was conducted within seven (7) business days of the transfer effective date B. Member Service Plan was developed within seven (7) business days of transfer effective date.	1 = Yes 0 = No NA					
20A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
20B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
21	Receiving Agency - Personal Attendant Services: Documentation exist that a face to face meeting with the member and /or legal representative occurred within 7 business to review the Service Plan.	1 = Yes 0 = No NA					
	512.17 Dual Provision of Service	NA					
22	Is the member receiving dual services (TBI and PC) according to the Service Plan? If yes, the following documents must be included: A. Traumatic Brain Injury Waiver and Personal Care Dual Service Provision Request B. RN Personal Care Plan of Care C. Prior Authorization Notice - Approval	1 = Yes 0 = No NA					
22A	INDICATE WITH "X" IF "A" IS NOT VERIFIED						
22B	INDICATE WITH "X" IF "B" IS NOT VERIFIED						
22C	INDICATE WITH "X" IF "C" IS NOT VERIFIED						
23	Total number of member claims (within the review period) reflected in the member's Service Plan.	#					
24	Total number of claims for the review period.	#					

	Health & Welfare	Score	# Score	# Score	# Score	# Score	# Score
	512.9 Member Enrollment	NA					
1	There is evidence of the Member Enrollment Confirmation Notice located in the member record for CRT providers.	1 = Yes 0 = No NA					
2	There is evidence of the following required items located in the member record for Personal Attendant Services providers: A. Member Enrollment Confirmation Notice B. A copy of the completed initial/annual PAS C. A copy of the completed initial/annual Rancho LOC Assessment	1 = Yes 0 = No NA					
2A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
2B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
2C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
	512.12.1.3 Reporting	NA					
3	The Case Management Agency has submitted the required monthly report to APS Healthcare during the review period. Monthly reports were submitted by the sixth (6th) business day of every month. A. Case Management Agency B. Monthly Incident Report	1 = Yes 0 = No NA					
	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
	512.12.1 Case Management	NA					
4	Initial contact by the Case Manager to the member was conducted within 7 calendar days after the start of direct care services from the Personal Attendant . **Document the start date for each reviewed member.**	1 = Yes 0 = No NA	Start Date:	Start Date:	Start Date:	Start Date:	Start Date:
5	Documentation exists which indicates that the changes in the members' needs are shared with all service providers listed on the member's service plan.	1 = Yes 0 = No NA					
6	The member has all needed specialists and health professionals as identified in the Member Assessment and in the Service Plan.	1 = Yes 0 = No NA					
7	Case Manager or agency designee informs members/legal representatives of their rights, including: A. Information about grievance procedures B. Fair Hearing processes	1 = Yes 0 = No NA					
7A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
7B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
8	The member's Initial Service Planning Meeting was scheduled within seven (7) calendar days of the Member Assessment.	1 = Yes 0 = No NA					
9	The member's Initial Service Plan was completed within 14 days from the completion of the Member Assessment.	1 = Yes 0 = No NA					
10	Documentation exists that the CM disseminated copies of the Service Plan to the Service Planning members and Participant-Directed Service Option providers (if applicable) within 14 calendar days from the date that the Service Plan meeting was held. A. Annual SP meeting B. 6 month SP meeting	1 = Yes 0 = No NA					
10A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
10B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
	512.12.1.2 On-going Case Management	NA					
11	Monthly contact was made by the CM to the member each month during the review period.	1 = Yes 0 = No NA					
12	The Case Management Monthly Contact Form was completed and located in the member file for each month during the review period.	1 = Yes 0 = No NA					
	512.3.3 Record Requirements	NA					
13	Member file contains all original documentation for services provided to the member by the CM Agency. A. Completed, signed and current PAS is in the member's record B. Completed, signed Informed Consent Form is in the member's record C. Completed, signed Agency/Provider Selection Form is in the member's record D. Completed, signed Service Delivery Model Selection Form is in the member's record	1= Yes 0 = No NA					
13A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
13B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
13C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
13D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT						
	512.3.5 Personal Attendant Service Staff Requirements	NA					
14	Personal Attendant Service Staff Requirements: A. The member's service plan should reflect his or her needs. If special needs are evident that requires specific training to assist in caring for the member, that training was provided to the Personal Attendant Service Staff B. An agency is responsible to ensure that the Personal Attendant Service staff is properly trained; this may include standardized crisis intervention training curriculums. The level of crisis intervention training must meet the member's needs	1= Yes 0 = No NA					
14A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
14B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						

	Case Management Notes	Score	# Score	# Score	# Score	# Score	# Score
	512.12.1, 512.12.1.1, 512.12.1.2	NA					
	# of Notes Reviewed:	#					
	# of Notes Reviewed that Meet Requirements:	#					
	# of Notes Reviewed Found to be Deficient (if an item is found to be deficient, specific information will be documented below):	#					
1	Service is indicated on the member's Service Plan.	1 = Yes 0 = No	**ALL NOTES REVIEWED WERE COMPLIANT WITH POLICY STANDARDS.** **___OR___** **THERE ARE RECOMMENDATIONS FOR DISALLOWANCE AND/OR TECHNICAL ASSISTANCE FOR THIS SECTION. FOR ADDITIONAL INFORMATION ON APS ID#S: (ENTER ALL APPLICABLE APS ID#s HERE) SEE BELOW.**				
2	Prior Authorization for each service was obtained **before** services were delivered.	1 = Yes 0 = No					
3	Name of TBI Waiver Member.	1 = Yes 0 = No					
4	Date of Service.	1 = Yes 0 = No					
5	Start time/Stop time.	1 = Yes 0 = No					
6	Signatures and Credentials of Case Manager.	1 = Yes 0 = No					
7	Activity documented reflects a valid Case Management service and is provided within the guidelines identified in the TBI Waiver Manual.	1 = Yes 0 = No					
8	Type of contact (face-to-face, phone, written).	1 = Yes 0 = No					

Provider Educator Notes	APS ID	Item #	Date/Time

	Personal Attendant Worksheet	Score	# Score	# Score	# Score	# Score	# Score
	512.12.2, 512.12.2.1	NA					
	# of Worksheets Reviewed:	#					
	# of Worksheets Reviewed that Meet Requirements:	#					
	# of Worksheets Reviewed Found to be Deficient (if an item is found to be deficient, specific information will be documented below):	#					
1	Service is indicated on the member's Service Plan (For F/EA services provided must be reflected on the spending plan).	1 = Yes 0 = No					
2	Prior authorization for each service was obtained **before** services were delivered (For F/EA, items billed must be reflected on the Service Plan).	1 = Yes 0 = No					
3	The member's record includes a completed and signed Personal Attendant Worksheet for each month during the review period. Worksheets are 2 weeks in duration. Worksheet includes Supervisor signature, personal attendant signature , and member or legal representative signature. All three (3) signatures must be present on the worksheet for a score of 1.	1 = Yes 0 = No					
4	The completed and signed Personal Attendant Worksheet contains all of the following require elements: A. Name of the TBI Waiver member B. Personal Attendant Name C. Begin Date D. End Date E. Personal Attendant Services on the worksheet are identified on the member's service plan F. Personal Attendant's time of arrival G. Personal Attendant's time of departure H. Total # of hours worked that day I. Member or Legal Representative initials J. Personal Attendant's initials	1 = Yes 0 = No					
4A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
4B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
4C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
4D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT						
4E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT						
4F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT						
4G	INDICATE WITH "X" IF "G" WAS NOT COMPLIANT						
4H	INDICATE WITH "X" IF "H" WAS NOT COMPLIANT						
4I	INDICATE WITH "X" IF "I" WAS NOT COMPLIANT						
4J	INDICATE WITH "X" IF "J" WAS NOT COMPLIANT						
	512.12.2.2, 512.12.2.3 Transportation	NA					
5	Service is indicated on the member's Service Plan (For F/EA services provided must be reflected on the spending plan.)	1 = Yes 0 = No					
6	Prior authorization for each service was obtained **before** services were delivered. (For F/EA items billed must be reflected on the Service Plan.)	1 = Yes 0 = No					
7	Transportation services provided must be documented in the member record and include the following: A. Date of Service B. Total Miles driven C. Travel Time D. Destination E. Purpose of Travel F. Type of travel indicated	1 = Yes 0 = No					
7A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
7B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
7C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
7D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT						
7E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT						
7F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT						
8	Member must be present if transportation was used for community activities.	1 = Yes 0 = No NA					

ALL WORKSHEETS REVIEWED WERE COMPLIANT WITH POLICY STANDARDS.
___OR___
THERE ARE RECOMMENDATIONS FOR DISALLOWANCE AND/OR TECHNICAL ASSISTANCE FOR THIS SECTION. FOR ADDITIONAL INFORMATION ON APS ID#s: (ENTER ALL APPLICABLE APS ID#s HERE) SEE BELOW.

Provider Educator Notes	APS ID	Item #	Date/Time

	Cognitive Rehabilitation Therapy Notes	Score	# Score	# Score	# Score	# Score	# Score
	512.12.3 Cognitive Rehabilitation Therapy	NA					
	# of Notes Reviewed:	#					
	# of Notes Reviewed that Meet Requirements:	#					
	# of Notes Reviewed Found to be Deficient (if an item is found to be deficient, specific information will be documented below):	#					
1	Service is indicated on the member's Service Plan.	1 = Yes 0 = No NA	ALL NOTES REVIEWED WERE COMPLIANT WITH POLICY STANDARDS. __OR__ THERE ARE RECOMMENDATIONS FOR DISALLOWANCE AND/OR TECHNICAL ASSISTANCE FOR THIS SECTION. FOR ADDITIONAL INFORMATION ON APS#s: (ENTER ALL APPLICABLE APS ID#s HERE) SEE BELOW.				
2	Units of service are prior authorized prior to being provided.	1 = Yes 0 = No					
3	Activity documented reflects a valid Cognitive Rehabilitation Therapy service and is provided within the guidelines identified in the TBI Waiver Manual. A. Name of Member B. Reflects if service was provided with/or on behalf of the member C. Date of Contact D. Start time/Stop time E. Signature and credentials of the CRT	1 = Yes 0 = No					
3A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
3B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
3C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
3D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT						
3E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT						
4	The service was directed to achieve functional changes by the development of cognitive skills to improve: A. functional attention, B. memory and/or C. problem solving	1 = Yes 0 = No					
4A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
4B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
4C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						

Provider Educator Notes	APS ID	Item #	Date/Time

	Participant Directed Goods and Services (PDGS)	Score	# Score	# Score	# Score	# Score	# Score
	512.12.4, 512.12.4.1	NA					
	# of Notes Reviewed:	#					
	# of Notes Reviewed that Meet Requirements:	#					
	# of Notes Reviewed Found to be Deficient (if an item is found to be deficient, specific information will be documented below):	#					
1	PDGS is indicated on the member's Service Plan.	1 = Yes 0 = No NA	ALL NOTES REVIEWED WERE COMPLIANT WITH POLICY STANDARDS. __OR__ THERE ARE RECOMMENDATIONS FOR DISALLOWANCE AND/OR TECHNICAL ASSISTANCE FOR THIS SECTION. FOR ADDITIONAL INFORMATION ON APS ID#s: (ENTER ALL APPLICABLE APS ID#s HERE) SEE BELOW.				
2	PDGS is indicated on the member's Spending Plan.	1 = Yes 0 = No					
3	Activity documented reflects a valid PDGS service and is provided within the guidelines identified in the TBI Waiver Manual (F/EA only). A. Amount used is within the allocated budget ($1000 or less) B. Addresses an identified need on the Service Plan C. Is for equipment, supplies or services not covered through the State Medicaid Plan	1 = Yes 0 = No					
3A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
3B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
3C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
4	Purchase is documented by receipts or other documentation of the PDGS from the established business or otherwise qualified entity or individual. (F/EA only).	1 = Yes 0 = No					

Provider Educator Notes	APS ID	Item #	Date/Time

Narrative:

APS or Staff ID	Section of Review	Date/Time	Item #	Provider Educator Notes

TBI Waiver Provider Review
Draft Disallowance Report

TBI Provider Agency _____ **Review Number** _____
Provider Number _____ **Date of Review** _____
Provider Educator(s) _____ **Review Period** _____
 # Member Files Reviewed _____ **# Staff Files Reviewed** _____ **Total # Members Served** _____

Member ID	Review Tool Section	APS Healthcare Recommendation	Provider Comments	Service Date (highlighted cells to be completed by provider)	Service Code	Service Rate	Units Billed (highlighted cells to be completed by provider)	Units Disallowed (highlighted cells to be completed by provider)	Amount Paid (highlighted cells to be completed by provider)	Amount Disallowed (TBD by BMS)	Auth # (highlighted cells to be completed by provider)	Claim # (highlighted cells to be completed by provider)	Paid Date (highlighted cells to be completed by provider)

TBI Waiver Provider Review
Plan of Correction

TBI Provider Agency:	**Review Period:** **Date of Review:** **# Member Files Reviewed:** **# Staff Files Reviewed:** **# Members Served:**
Provider Educator(s):	**Submit POC to Barbara Recknagel at: brecknagel@apshealthcare.com**
Person(s) Completing this POC:	
Date POC is Submitted:	

This preliminary Plan of Correction contains any items found to be deficient during your agency's TBI Provider Review. Deficient items/notes are indicated in red. A completed Plan of Correction will be due within 30 calendar days of receipt of the DRAFT Reports and letter from the IRG/APS Lead Provider Educator or BMS. After you receive your letter, submit your agency's Plan of Correction to the Manager, indicated above. The Plan of Correction must be submitted on this form electronically. Any corrections/additions requested will be communicated via this POC form. BMS will review your comments and completed/approved Plan of Correction prior to issuing a final report.

A Plan of Correction must include:

1. How will the deficient practice **for the participants cited in the deficiency** be corrected?
2. What **system** will be put into place to prevent recurrence of the deficient practice?
3. How will the provider **monitor to assure future compliance**, and **who** will be responsible for the monitoring?
4. What is the **date** by which the Plan of Correction will be implemented?

Please indicate any technical assistance and/or training needs you may have related to the provision of TBI Waiver services?

Member or Staff ID	Sub-section of UR Tool	Issue Found on Quality and Utilization Review (Include PE Notes)
1. How will the deficient practice be corrected?		
2. What system will be put into place to prevent recurrence of the deficient practice?		
3. How will you monitor to assure future compliance? Who will be responsible?		
4. When will this plan of Correction be implemented?		

Member or Staff ID	Sub-section of UR Tool	Issue Found on Quality and Utilization Review (Include PE Notes)
1. How will the deficient practice be corrected?		
2. What system will be put into place to prevent recurrence of the deficient practice?		
3. How will you monitor to assure future compliance? Who will be responsible?		
4. When will this plan of Correction be implemented?		

Member or Staff ID	Sub-section of UR Tool	Issue Found on Quality and Utilization Review (Include PE Notes)
1. How will the deficient practice be corrected?		
2. What system will be put into place to prevent recurrence of the deficient practice?		
3. How will you monitor to assure future compliance? Who will be responsible?		
4. When will this plan of Correction be implemented?		

Member or Staff ID	Sub-section of UR Tool	Issue Found on Quality and Utilization Review (Include PE Notes)
1. How will the deficient practice be corrected?		
2. What system will be put into place to prevent recurrence of the deficient practice?		
3. How will you monitor to assure future compliance? Who will be responsible?		
4. When will this plan of Correction be implemented?		

Member or Staff ID	Sub-section of UR Tool	Issue Found on Quality and Utilization Review (Include PE Notes)
1. How will the deficient practice be corrected?		
2. What system will be put into place to prevent recurrence of the deficient practice?		
3. How will you monitor to assure future compliance? Who will be responsible?		
4. When will this plan of Correction be implemented?		

Member or Staff ID	Sub-section of UR Tool	Issue Found on Quality and Utilization Review (Include PE Notes)
1. How will the deficient practice be corrected?		
2. What system will be put into place to prevent recurrence of the deficient practice?		
3. How will you monitor to assure future compliance? Who will be responsible?		
4. When will this plan of Correction be implemented?		

Member or Staff ID	Sub-section of UR Tool	Issue Found on Quality and Utilization Review (Include PE Notes)
1. How will the deficient practice be corrected?		
2. What system will be put into place to prevent recurrence of the deficient practice?		
3. How will you monitor to assure future compliance? Who will be responsible?		
4. When will this plan of Correction be implemented?		

Member or Staff ID	Sub-section of UR Tool	Issue Found on Quality and Utilization Review (Include PE Notes)
1. How will the deficient practice be corrected?		
2. What system will be put into place to prevent recurrence of the deficient practice?		
3. How will you monitor to assure future compliance? Who will be responsible?		
4. When will this plan of Correction be implemented?		