Authorization Check-List

Below you will find a list items that are doc requested. Please use this information as a check-list when reviewing IPPs to ensure authorizations are obtained without a doc request. Each item will also indicate whether or not an addendum is required to correct the error. ***Any addendum requirements are subject to situational information, and an addendum may be requested at any time via the doc request if more information is needed***

→ IPP Demographics Page

	Addendum Required?
☐ Correct member name and ID in header	No
☐ Date in header is date meeting occurred	No
☐ IPP service year correct	No
☐ Type of IDT meeting is indicated; may be more than one type	No
☐ Demographics correct - Legal Representative's **mailing** address **MUST** match what is listed in CareConnection©	No
☐ Attachments are selected correctly – Crisis Plan attached to 6M and Annual IPPs – Behavior Support Plan attached to 6M and Annual IPPs (as applicable) – Behavior Protocol and/or Guideline attached to 6M and Annual IPPs (as applicable) – Task Analysis attached to **all** IPPs (as applicable) – If attachments are selected, the corresponding document must be attached or you will be doc requested	No

→ Service Evaluation

	Addendum Required?
☐ Initial purchase request must be under budget. Doc request will indicate to agree to an array of services under-budget.	Yes
☐ All services in excess of the budget should be outlined in the over-budget service evaluation table (as applicable)	Yes
☐ Service code must be correct for each service description	Yes
☐ Direct-care services must not exceed caps in under-budget table. – 35,040 for group-home/ISS – 7,320 for NF under 18 – 11,680 for NF over 18 – 17,520 for NF over 18 with day-services	Yes

☐ Services must be purchased in the correct order – Direct Care (PCS services, day services, electronic monitoring, LPN direct-care, and respite services) • Respite services do not count towards the direct-care cap, but are prioritized in the purchase order before professional services – Professional Services (RN, BSP, Indirect-LPN, any specialty therapies (ST, PT, OT, DT), and transportation)	Yes
☐ Any service codes/units that are listed in meeting minutes or other areas of the IPP (including attached docs like DD8 and DD9) **must** match units/codes outlined in the Service Evaluation section. If they do not match, you will be doc requested – Best practice would be to only list service codes/units in the Service Evaluation section to limit possibility of numbers/codes not matching.	Yes
☐ Under and Over-budget service evaluation tables must be present even if services are not being requested above the budget.	No

→ IPP Meeting Minutes

	Addendum Required?
☐ A representative from **all** agencies must attend IPP meetings	Yes - if <u>did not</u> sign signature sheet No - if signed signature sheet
☐ Healthcare Surrogates are required to attend **all** IPP meetings	Yes - if <u>did not</u> sign signature sheet No - if signed signature sheet
☐ Medley Class Advocates are required to attend Annual and 6M IPP meetings – Will need Medley Class Advocate signature and agreement for *any* meeting they attend	Yes - if <u>did not</u> sign signature sheet No - if signed signature sheet
☐ If units/codes are outlined in meeting minutes, they **must** match all other locations where units/codes are listed – Best practice would be to only list service codes/units in the Service Evaluation section to limit possibility of numbers/codes not matching.	Yes

→ IPP Individual Service Plan (ISP)

	Addendum Required?
☐ Service name	No
☐ Name of provider agency	No
☐ Staff providing service must be indicated – Specific names **must** be listed for Home-Based PCS, Family PCS, In-Home Respite, and Out-of-Home Respite (unless out-of-home respite is accessed through a facility based day hab) – For services that do not have one consistent provider (URPCS/LGH, professional staff, day hab, etc), you may indicate Provider Agency Name – RN/BSP/Direct-Care, etc.	No
☐ Start/Stop date of service must be indicated – Most will correspond with anchor dates – Services purchased mid-year should begin with date of team agreement – Services discontinued mid-year should end on date of team agreement and/or date of transfer/final access	Yes – if related to transfer/final access date No – if related to regular annual purchase
☐ If units/codes are outlined in ISP boxes, they **must** match all other locations where units/codes are listed – Best practice would be to only list service codes/units in the Service Evaluation section to limit possibility of numbers/codes not matching.	Yes

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→ IPP Signature Sheet

	Addendum Required?
☐ Required attendees signed – Member and/or legal representative (guardian, Health Care Surrogate) – Representative from each provider agency – Case Manager – Medley Advocate – If member cannot/will not sign, indicate why	Yes – if required reps name is <u>not</u> in the meeting minutes No – if required reps name <u>is</u> in the meeting minutes
☐ Any non-required attendees (listed above) signed	No
☐ Each signature reflects agree/disagree	Yes – if member and/or legal representative No – if any other signature

→ Additional Information

	Addendum Required?
☐ Tentative schedules **must** be attached to **all** IPP's regardless of type	No
☐ If the member lives in a NF setting with roommates on the Waiver program, there cannot be an overlap of services provided on the tentative schedule	No
☐ If LPN is being requested, a matching DD9 **must** be uploaded to CareConnection© and be completed correctly. **See DD9 check-list**	No
☐ If EAA/Goods and Services is being requested, a matching DD8 **must** be uploaded to CareConnection© and be completed correctly	No
☐ If multiple IPPs are uploaded to CareConnection© and units have been changed throughout the IPP – you will be doc requested for clarification.	Yes – to clarify which IPP/units are correct and should be reviewed for auths
☐ DSSLAs and DD12s are **not** substitutes for team agreement. Having an approved DSSLA or DD12 only allows for (with regards to authorization): – Purchasing codes for a different setting (i.e. URPCS when member was previously classified as Natural Family) – Purchase/modification up to the amount of services specified in recommendations – Meetings to be held without member/guardian – Meeting to be considered valid outside of timelines **If you attempt to make purchases/modifications in CareConnection© based upon a DSSLA or DD12 decision without also having team agreement, the request will be closed and/or doc requested. Services will not be pro-rated and/or authorized retrospective to the date of team agreement, except for in circumstances prior authorized by BMS.**	Will require either: Face-to-face meeting (for new services) Or Addendum (for existing services)