

CHAPTER VII – RECERTIFICATION, INDIVIDUAL SERVICE PLAN REVIEW AND UPDATE

7.01 Introduction

Ongoing care management and service coordination activities are described in Chapter IV of this manual. They include the activities necessary to establish and maintain program functional and financial eligibility, the determination of level of care, assessment, service plan development, service coordination and plan review. This chapter addresses the required components of Recertification, Individual Service Plan (ISP) Review and the ISP Update, all of which clearly include the care management/support and service coordination responsibilities listed above and outlined in detail in [Chapter IV](#). Section 7.01 (A) below addresses the essential elements, common across the waiver programs in the recertification, plan review and update activities. Subsequent sections of the chapter focus on documentation requirements specific to the individual waiver programs.

A. Annual Recertification Requirements – All Programs

The waiver agency must ensure that an annual recertification for every Medicaid waiver participant occurs, not less than once **every twelve months**. Failure of the waiver program agency to meet the annual recertification requirements may result in a disallowance of waiver funds for the agency for that participant. The annual recertification process has several required components. These include:

1. A face to face meeting with the participant and/or guardian;
2. A review and update of the Individual Service Plan (ISP), including individual preferences and desired outcomes and the development of a new ISP (See [F-20445](#) and [F-20445a](#));
3. A review of participant physical/medical condition(s) noting any changes in overall health, as well as any new treatment/therapies and prescribed medications ordered;
4. A re-determination of functional and financial eligibility;
5. A review of the participant's satisfaction with the services and service providers in place, including the opportunity to choose different providers from the [Medicaid Waivers Provider Registry](#) or select a provider not currently listed;
6. A review of Participant Rights and Responsibilities (See [Appendix M](#));

7. A service review to ensure that all providers utilized remain qualified under the standards outlined in Chapter IV for that waiver service; and
8. The completion of documentation to provide assurance that required recertification activities have been completed.

The completion of the re-determination of functional and financial eligibility need not occur in the same month, but each must be completed annually, no later than the end of the program eligibility anniversary month. Recertification determinations may be conducted prior to the anniversary date of program eligibility but must occur within the twelve-month period to maintain program eligibility. Failure to complete and document required recertification activities may result in a disallowance of waiver funds.

B. Key Components

Health and functional status: While the annual recertification does not require the completion of a new assessment, the recertification should include a review of health and functional status. The CM/SSC should ensure that any changes to the participant's ongoing physical or medical conditions are noted as well as any new conditions or fluctuations in capacity. The review should address as well, any changes to medications, treatments or therapies that have been ordered as a result of the newly identified issues, including who is responsible for managing the related regimens.

Services - Participant satisfaction: As noted above, the plan review and update component of re-certification must address the participant's satisfaction with the services and service providers currently in place. As part of this discussion, the current service package is reviewed in light of the reassessment. Within the review of services and service providers process the participant and/or their guardians must be informed that:

1. They have the right to request new/additional services to meet ongoing or newly identified needs/outcomes;
2. They may request changes in the duration or type of service they now receive (e.g., more or fewer hours, added tasks, etc.);
3. They may request adjustments to the schedule of service provided (e.g. different day(s), time of day, etc.);
4. They have the right to choose among qualified service providers for any service in the plan, including changing the provider(s) currently in place; and
5. As services are added or quantities modified, s/he may choose from the [Medicaid Waivers Provider Registry](#) or select a provider not listed in the directory and ask that this provider be qualified.

C. Individual Service Plan Review Requirements – All Programs

The Individual Service Plan (ISP) represents an agreement between the waiver program agency and the participant as to how the program will meet the assessed needs of the person and in doing so, help the participant reach his/her individual outcomes. The ISP is not a static document, it should continuously evolve to address changes in the participant's individual outcomes, needs and preferences as they occur.

The ISP must be **reviewed every six months in a face to face meeting** with the participant and his/her guardian, if applicable. This review is required and may not be waived, even where there is an approved exception to required contacts in place (See [Chapter IV](#), Care Management/Support and Service Coordination, Service Requirements/Limitations/Exclusions.)

Review Content

The six-month review should include a review of **health and functional status**, including any changes in treatments, therapies or medications to address new or changing conditions. To assure participant health and safety, the CM/SSC should ensure that assistance is in place to monitor and/or manage the prescribed treatment regimens, where indicated.

The six month plan review also includes a **discussion of all services** currently in place addressing participant satisfaction with the amount, frequency and quality of the services and the service provider(s) involved. During the review participants must be informed that they may:

1. Request a change in type, amount or frequency of service;
2. Request new or additional service(s) not currently provided, or
3. Choose to change providers of current services by selecting another provider from the [Medicaid Waivers Provider Registry](#) or by asking that the waiver agency qualify a provider not currently listed.

D. Individual Service Plan Update Requirements – All Programs

The ISP ([F-20445](#)) should be updated **at any time** the person's assessed needs change, when new desired individual outcomes are identified or when a change in status of an existing outcome occurs. In addition, an ISP update is necessary when a change among either formal or informal waiver program service providers occurs. The individual service plan must reflect a **current, accurate** description of the waiver program interaction with the participant. The Individual Outcomes form ([F-20445a](#)) should change correspondingly to remain consistent with the Individual Service Plan. See Section 7.05 for more details about service plan update documentation requirements.

7.02 Recertification: Program Specific Requirements

A. ~~Brain Injury Waiver (BIW)~~

~~The Brain Injury Waiver program rules require that waiver agencies complete a review of program eligibility for each participant on at least an annual basis. The annual recertification includes a face to face meeting with the participant and the completion of required recertification documentation. The annual “recertification” verifies that the conditions necessary to meet the established eligibility standards for BIW participation continue to be present. The month in which recertification occurs may not exceed 12 months from the previous recertification or the original BIW start date.~~

~~During a face to face meeting, waiver agencies must review current services in place and determine whether the participant continues to be satisfied with his or her providers. The participant may choose to continue to use the entities or individuals in place or seek to change providers or adjust the amount, schedule or frequency of services. When changes are sought participants should be offered a choice of all qualified providers available. The [Medicaid Waivers Provider Registry](#) should be used to support the choice process. Participants may select from the registry or choose another preferred provider. See [Chapter 4](#), Section 403.~~

~~The waiver agency has the responsibility to ensure that the appropriate activities occur and that they are documented. Annual BIW recertification packets are sent to the Bureau of Long Term Support – Developmental Disabilities Services Section (DDSS.) In the case of the BIW, the DDSS assigns level of care. The packet should include a cover letter outlining the request so that BLTS is better able to complete the process. If the annual recertification packet is not submitted by the due date, DDSS will send the waiver agency an “overdue recertification report” or notice listing the waiver participant or participants who must be recertified. A corrective action process will be initiated with a form reflecting the deficiency, action needed, expectations and due date sent to the agency DD/LTS coordinator and support and service coordinator.~~

~~**The BIW recertification packet sent to BLTS – DDSS at DHS central office must include:**~~

~~1. New Request for Level of Care Forms F 62256 and F 62256a~~

~~The support and service coordinator arranges for forms [F62256](#) and [F62256a](#) to be completed, and that the forms are signed by a physician or by a registered nurse. Additional information that documents the functional and health status of the participant may be included. The BLTS reviews the forms along with other appropriate supporting documentation and assigns the BIW Level of Care rating. The Level of Care forms are available at the links above or in [Appendix A](#) of this manual.~~

~~For the BLTS to assign a level of care compatible with the BIW, the waiver participant’s condition must meet the definition of “Brain Injury” as described in Wisconsin Statute s. 51.01 (5)(a) (See also [Chapter II](#)) and the participant must also be eligible for treatment of his/her brain injury in a Brain Injury Rehabilitation Facility. When in doubt as to whether or not to include clinical information and supporting documentation along with the request for BIW level of care, waiver~~

- agency staff are asked to err on the side of inclusion. Refer to [Appendix A 7](#) of this manual for additional information concerning the Brain Injury definition, and also Brain Injury Level of Care.
- 2. Individual Service Plan Form (F-20445) and (F-20445A)
- A new updated Individual Service Plan form (F-20445) and the accompanying Individual Outcomes form (F-20445A) must be completed as a part of the recertification process. The new ISP may call for changes to the type and amount of services or may describe a continuation of the same services and supports previously in place. New completed forms must also include a new current, completed signature page. Copies of the F-20445 and the F-20445A forms may be accessed through [Appendix I](#) of this manual, or the DHS forms library at [F-20445](#) or at [F-20445a](#)

- 3. Eligibility and Cost Sharing Worksheet (F-20919) or CARES Community Waivers Budget screens provided by Income Maintenance.
- A new financial eligibility worksheet (F-20919) is completed by the CM/SSC. All **current** financial eligibility information must be documented on this form. Copies of the F-20919 are available in [Appendix C](#) of this manual or at [F-20919](#). For those BIW participants whose Medicaid financial eligibility is established through financial eligibility groups B or C, the recertification documents must include a copy of the CARES Community Waivers Budget screen, obtained from the county Income Maintenance Worker.

All forms submitted to BLTS must be current, complete, and dated verifying that they were completed no later than the same month the annual recertification is due. After the recertification documents are received and approved by BLTS, the Bureau sends a letter to the waiver agency with information indicating the assigned level of care. The BLTS letter also acknowledges the person's continued participation in the BIW program and indicates the calendar month in which any subsequent annual recertification must occur.

4. Provider Standards

- As part of the recertification process, the support and service coordinator must determine whether the service providers utilized continue to meet the standards and requirements applying to each waiver service. The applicable provider standards can be found under each specific service in [Chapter IV](#), Section 4.10 of this manual. The results of this determination must be noted in the cover letter to the Bureau that accompanies the BIW recertification packet.

B. Community Integration Program (CIP 1A and CIP 1B)

Each waiver participant must have his/her CIP 1A/B Waiver eligibility reviewed at least annually. The annual recertification process verifies that the conditions necessary

to meet the established standards for CIP 1 waiver program participation are present. The month in which recertification occurs may not exceed 12 months from the initial application approval or previous recertification month.

Annual recertification includes a face to face meeting with the participant and the completion of all required recertification activities described in Section 7.01 (A). During this face to face meeting, waiver agencies must explore whether or not the participant continues to be satisfied with his or her providers. Participants must be informed that they may request a change in provider, seek changes in the amount, schedule or frequency of services or request new/additional supports. Participants should be given the opportunity to review the [Medicaid Waivers Provider Registry](#) as they explore changes to the service package. They must also be informed that they may select a provider not currently listed.

The CIP 1A/1B Recertification Process:

The BLTS Developmental Disabilities Services Section sends each agency a County Monthly Recertification Assurance Report on a monthly basis for each CIP 1 waiver participant who must be recertified within the next thirty (30) days. This form is to be completed and signed by the participant's support and service coordinator and upon completion is returned to the Developmental Disabilities Services Section. The form serves as documentation that the support and service coordinator has concluded all activities involved in the waiver recertification process.

If the completed report is not submitted by the due date for the recertification, the waiver agency will receive an "overdue recertification report" or notification listing each waiver participant whose recertification is overdue. A corrective action process will be initiated with a form reflecting the deficiency, action needed, expectations and due date sent to the agency DD/LTS coordinator and support and service coordinator.

The recertification process completed by the support and service coordinator includes the following steps:

1. New Level of Care (LOC) Determination and Verification

The functional/level of care eligibility of persons served by the CIP 1 waivers must be reviewed and verified each year. The verification must be completed by an individual who meets the definition of Qualified Mental Retardation Professional (QMRP). (See [Appendix A](#) of this manual for the QMRP definition.) The QMRP, often a qualified support and service coordinator, completes the DHFS Long Term Care Functional Screen ([LTC-FS PaperFormV3.pdf](#)) for each waiver participant, not less than annually. This tool assures that the waiver participant's level of care eligibility remains appropriate to meet the CIP 1 Waiver requirements. The completed LTC-FS must be made available for inspection during audits or monitoring reviews if requested.

2. Individual Service Plan (F-20445) and (F-20445A)

A new, updated Individual Service Plan form ([F-20445](#)) and the accompanying Individual Outcomes form ([F-20445A](#)) must be completed as a part of the CIP 1 annual recertification process. This process should start with a review of the participant's current assessment to see if that needs to be updated. The reassessment must conform to the same requirements as discussed in Chapter VI. The participant and his/her guardian (as applicable) should be active participants in this process. The new plan may call for changes to the type or amount of services, changes to service provider(s) or it may call for providing the same services and supports by providers currently in place.

After the review of services and a discussion of the terms of participation and participant rights, the ISP is completed and signed. (See [Appendix I](#) of this manual or the DHS forms library at [DLTCnum.asp](#) for copies of the F-20445 and the F-20445A.) Substitution of this form with a BLTS approved agency version is allowable. The individual service plan forms are maintained in the participant record and need not be sent to the BLTS as a part of the annual recertification process. Submission of the Recertification Assurance Report documents the completion of the process.

3. Medicaid Waiver Eligibility and Cost-Sharing Worksheet/CARES Screens

Annually, following the initial certification of eligibility, the waiver agency must complete a new Medicaid Waiver Eligibility and Cost-Sharing Worksheet (the [F-20919](#)) or obtain new, current CARES Community Waivers Budget Screens. The financial eligibility documentation must be maintained by the waiver agency in an easily accessed location and be made available for inspection during individual monitoring reviews or program or provider audits. The completed F-20919 form or CARES budget screens serve as documentation that the waiver participant continues to meet the CIP 1 financial eligibility program requirements. The forms need not be sent to the BLTS.

4. Provider Standards Assurance

As part of the recertification process, the support and service coordinator must determine whether the service providers utilized continue to meet the standards and requirements applying to each waiver service. The applicable provider standards can be found under each specific service in [Chapter IV](#), Section 4.10 of this manual. The results of this determination must be noted in the recertification assurance report.

C. Community Integration Program II (CIP II) and Community Options Program Waiver (COP – W)

Annual recertification requirements must be met in order to assure the participant's

continued eligibility for CIP II/COP-W program participation. Annual recertification includes a **face to face** review of the service plan with the participant and the completion of required recertification documentation. The annual review may involve meeting with the participant's guardian or other legal representative (e.g., activated POA-HC). However, even in circumstances where someone other than the participant signs the service plan, **the annual recertification must always include a face to face meeting with the participant.** Regardless of whether the annual recertification is internally or externally monitored (See 7.02 C (1) and (2) below), it must include the activities outlined in Section 7.01 above.

Documenting the CIP II/COP-W Recertification

1. Externally Monitored Annual Recertification

Externally monitored recertification of program eligibility for COP-W and CIP II includes the preparation of the following documentation:

- a. A **current** Medicaid Waiver Program Health Report ([F-20810](#)) completed by the care manager and by the physician, or by a physician's assistant, or a registered nurse.
- b. A **current** Long Term Care Functional Screen (LTC-FS) Eligibility Report, indicating an eligible level of care.
- c. A **current** Medicaid Waiver Eligibility and Cost Sharing Worksheet (F-20919) or **current** CARES Community Waivers Budget screen printouts, as applicable and, if required, the current Income Allocation worksheet. The F-20919 form is available in Appendix C of this manual or at [F-20919](#).
- d. A **new**, complete and updated Individual Service Plan ([F-20445](#) and [F-20445a](#)) signed by the CM/SSC and by the participant or by his/her guardian or legal/authorized representative.

The documentation of health status, the Medicaid Waiver Program Health Report (F-20810) must be **current**, completed no more than 90 days before or after the recertification month. The Long Term Care Functional Screen completed for recertification must contain **current**, complete and accurate information and should be completed **not later than** twelve months from the previous screen completion date.

When completed, the COP-W and CIP II recertification documentation is sent, with a cover letter, to the Bureau of Long Term Support – Community Options Section or its quality assurance designee for review. Upon completion of the review, if the recertification is approved, a letter certifying the participant's continued eligibility will be sent to the waiver agency including, if requested, a No Active Treatment re-determination.

2. Internally Monitored Annual Recertification

Beginning in 2003 CIP II/COP-Waiver agencies were required to develop a local process to complete internally monitored recertification (self-recertification) for all Group A participants. CIP II/COP-W agencies also have the option to complete internally monitored recertification of Group B and C participants.

Internally monitored annual recertification of program eligibility for COP-W and CIP II participants includes the preparation of the following documentation:

- a. A current Medicaid Waiver Program Health Report ([F-20810](#)) completed by the care manager and by the physician or the physician assistant or registered nurse and signed by the doctor, physician assistant or registered nurse.
- b. A current and complete Long Term Care Functional Screen – Eligibility Report indicating an eligible level of care.
- c. A current Medicaid Waiver Eligibility and Cost Sharing Worksheet (F-20919) or current CARES Community Waivers Budget screen printouts as applicable and, if required for Group C, a current Income Allocation worksheet. (See [Appendix C](#))
- d. A new, complete and updated individual service plan (F-20445 and F-20445A) signed by the CM/SSC and by the participant or by his/her guardian or legal/authorized representative.

The documentation of health status, the Medicaid Waiver Program Health Report ([F-20810](#)) must be **current**, completed no more than 90 days before or after the recertification month. The Long Term Care Functional Screen completed for recertification must contain **current**, complete and accurate information and should be completed **not later than** twelve months from the previous screen completion date.

The internally monitored recertification documentation is forwarded to the locally designated recertification reviewer (unit supervisor, lead worker, etc.) In those circumstances where a No Active Treatment determination is required, the NAT may be completed by a QMRP at the waiver agency or requested from the BLTS Community Option Section quality assurance designee. At the agency's option, after the local internal review is finished a recertification assurance form (See [F-20946](#)) may be completed and filed with the required recertification documentation in the participant record.

D. Children's Long Term Support Waivers (CLTS)

Annual recertification is required to assure the participant's continued eligibility for the waiver program. All waiver agencies are required to complete and submit the

Children's Long-Term Support (CLTS) Waivers Recertification Checklist (See form [F-21080](#).) The annual recertification process includes completion of the following:

1. An updated CLTS Functional Screen with eligibility results.
2. An updated assessment, reflecting the child and family's current abilities, preferences, and needs, either as a component of the notes section of the CLTS Functional Screen or another assessment tool.
3. A new, updated individual service plan signed by the participant, by his/her guardian or by his/her legal representative.
4. A current Medicaid Waiver Eligibility and Cost Sharing Worksheet ([F-20919](#)) or current CARES Community Waivers Budget screens, as applicable.
5. A new, updated copy of the Participants Rights and Responsibilities document, signed by the participant and guardian, as well as information about client rights as outlined under HFS 94, Wis. Admin. Code.
6. If applicable, written notification to the family if the child is receiving Intensive In-Home Autism Treatment Services and due to transition to on-going services during the next year.

When completed, a copy of the signed CLTS Waivers Recertification Checklist, the current CLTS Functional Screen eligibility page, and a copy of the current signed ISP is sent to the Bureau of Long Term Support's Children's Services Section. Upon receipt and approval of the recertification, a letter certifying the participant's continued eligibility will be sent by e-mail to the waiver agency CLTS contact.

E. Community Opportunities and Recovery (COR) Waiver

~~Annual recertification requirements must be met in order to assure the participant's continuous eligibility for COR participation. Annual recertification includes a face to face review of the service plan with the participant and the completion of required recertification documentation. The annual review may involve meeting with the participant's guardian or other legal representative (e.g., activated POA-HC). However, even in circumstances where someone other than the participant signs the service plan, the annual review must always include a **face to face** meeting with the participant.~~

~~Recertification of program eligibility for COR includes the preparation of the following documentation:~~

- ~~1. A **current** Medicaid Waiver Program Health Report (See [F-20810](#)) completed by the care manager and by the physician, or by a physician's assistant, or by a registered nurse.~~

- ~~2. A **current** Long Term Care Functional Screen (LTC-FS) Eligibility Report, indicating an eligible level of care.~~
- ~~3. A **current** Medicaid Waiver Eligibility and Cost Sharing Worksheet ([F-20919](#)) or current CARES screen printouts, as applicable and, if required, the current Income Allocation worksheet.~~
- ~~4. A new, complete and updated individual service plan, the [F-20445](#) and [F-20445a](#) signed by the CM/SSC and by the participant or by his/her guardian or legal/authorized representative.~~
- ~~5. A new, updated **Crisis Back-up Plan** for periods of intense supervision and supports to keep the person in the community.~~

The documentation of health status, the Medicaid Waiver Program Health Report (F-20810) must be **current**, completed no more than 90 days before or after the recertification month. The Long Term Care Functional Screen completed for recertification must contain **current**, complete and accurate information and should be completed **not later than** twelve months from the previous screen completion date. When completed, the recertification documentation is forwarded to the Division of Mental Health and Substance Abuse Services, Bureau of Prevention Treatment and Recovery.

7.03 Timeliness of the Recertification and Documentation

Federal standards and state program requirements require that eligibility for all Medicaid waiver program participation be re-established annually, no more than **twelve months** from the initial certification or from the previous recertification. There can be no exceptions made to this requirement. The process assures that the participant continues to be both financially and functionally eligible for the waiver program at the time of recertification. Therefore, the documentation completed to certify continued eligibility must be **current**.

The **individual service plan** must be **complete** and **current** and include **accurate** individual outcome statements. It must contain a complete list of waiver funded and non-waiver funded services/supports; specify both the daily, on-going costs as well as any one-time expenses and include funding source information for each provided service or support. In addition, the completed service plan must document that the participant has been informed of their rights, including their right to choose a preferred living arrangement or service provider and assure that formal participant rights and responsibilities have been explained as outlined in [Appendix M](#).

The **financial** eligibility documentation must accurately reflect the participant's **current** financial situation and must be completed within twelve months of the initial financial eligibility determination. Thereafter, recertification of financial eligibility must be

completed annually, within twelve months of the previous recertification. Completion of the financial eligibility redetermination later than the annual anniversary month of eligibility may result in a loss of waiver funds.

The **functional** eligibility documentation must accurately reflect the participant's **current** functional status. Functional eligibility must be re-determined and documented annually and must occur within twelve months of the initial (or last recertification) eligibility screen. The completion of functional eligibility re-determinations later than every twelve months may result in a loss of waiver funds.

While annual recertification is required, the waiver agency may determine that the recertification month should be changed. Changing the recertification month is permissible but the agency must maintain no more than a twelve-month interval between recertifications to maintain participant eligibility. To change a recertification month the review must be conducted **prior** to the month it is due. For example, the recertification that is due in July may be conducted in the month of March or May, or another month, as long as it occurs **before** the recertification is due.

Changing the recertification month, as in the example described above, moves the annual recertification to the selected earlier month the following year. Local waiver agencies are encouraged to manage their system for meeting annual recertification requirements in a manner so as to have the Medicaid financial review occur in the same month as does the level of care and service plan review.

7.04 Individual Service Plan Review – Documentation

At a minimum, the individual service plan ([F-20445](#) and [F-20445a](#).) must be reviewed **every six months** during a **face to face meeting** with the participant. No exceptions to the six month review may be granted. This review is documented by having the participant re-sign the individual service plan or sign a new updated ISP **and** by a case note in the participant record.

The **case note** documenting the service plan review should indicate, at a minimum, that the identified individual outcomes and the services/supports put in place to address those outcomes were discussed with the participant and, when applicable, the guardian/legal representative. The case note should describe any changes that have occurred, including changes in participant health, functional capacities or needs that might indicate a reassessment is necessary. Correspondingly, **the case note** should outline any changes that will be made to the planned services or supports as a result of the review.

The six month review includes a discussion addressing the participant's satisfaction with the planned services and the service providers. Participants and/or their guardians must be informed that they have the right to choose among qualified providers and, that on request

they can view a registry of providers willing and potentially able to provide these same services ([Medicaid Waivers Provider Registry](#).)

For persons with a guardian or other legal representative, the care manager/support and service coordinator, the participant and the guardian (or other legal representative) should all participate in the plan development and plan review process. However, in these cases the guardian/legal representative signs the updated ISP. The contact with the guardian/legal representative should be face to face as well. If this is not feasible the guardian contact may be done by telephone and the updated plan mailed to the guardian/legal representative for his/her signature. When the plan review is completed by telephone, the case note should indicate that a **reasonable effort** was made to meet face to face with the guardian/legal representative and explain why such a meeting was not feasible

Important: For participants who have a guardian, activated power of attorney for health care, or another legal representative; even though the guardian or another representative actually signs the ISP, **the six month face to face plan review meeting with the participant remains mandatory.** All other care management/ support and service coordinator contact requirements must be met.

7.05 Service Plan Updates

There are certain circumstances where the individual service plan must be updated (other than at the six month review or annual recertification) and a new participant or guardian/legal representative signature obtained. In general, the service plan must be updated when:

- There is a significant change in the person's assessment or condition;
- A variance is requested or prior approval sought;
- A new service is added or a previous service is ended;
- When individual outcomes change;
- When the participant chooses to change their service provider; or
- Upon participant request.

~~**For the COR Waiver only: All proposed changes to the plan, including changes in services provided, services costs, and the payment source(s) to be billed must be submitted for prior approval from the Bureau of Prevention Treatment and Recovery.**~~

Applies to All Waiver Programs: Because the plan serves as an agreement between the agency and the participant and is a record of Medicaid waiver services which may be subject to estate recovery, it should be kept up to date, listing all services and supports that are **currently** in place. To ensure the document is current, **within six months of any change** to the individual service plan, an updated, completed and signed ISP (F-20445 and F-20445A) should be placed in the participant record. A copy of the updated ISP must be provided to the participant and if applicable, to his/her guardian/legal representative.

Reference Guide

The table on the following page provides a quick reference guide that care manager/support and service coordinators may refer to when deciding if an ISP update ([F-20445](#) and [F-20445a](#).) should be completed or if a variance approval or a service prior approval should be requested.

Reference guide: Updating the ISP¹

| CM/SSC ACTIVITY→ | CASE NOTE | COMPLETE AN ISP UPDATE | SEND NEW ISP TO BLTS/QA DESIGNEE | BLTS PRIOR APPROVAL/ VARIANCE | WRITTEN NOTICE TO PARTICIPANT | BPTR PRIOR APPROVAL (COR) |
|--|------------------|-------------------------------|--|---|--------------------------------------|----------------------------------|
| Event ↓ | | | | | | |
| Outcomes: Add New or Modify Existing | YES | YES | NO | NO | NO | YES |
| Service Ends | YES | YES | NO | NO | YES | NO |
| Service Is Significantly Increased/ Decreased | YES | YES | NO | NO | YES (For service reduction) | YES |
| Start New Service | YES | YES | NO | NO Except Home Modification or Institutional Respite or ADC provided in a nursing home. | NO | YES |
| CBRF Placement | YES | YES | YES In CIP 1A/B In CIP II, COP-W → <i>YES Only if a variance is required.</i> | YES (CIP II/COP-W ONLY) CBRF larger than 20 beds and all CBRFs connected to a Nursing Home. | YES | YES |
| Institutional Respite | YES | YES | NO | YES | NO | YES |
| Home Modification | YES | YES | YES Required for all ramps & fences, or home modification over \$2,000 | YES Required for all ramps & fences and home modifications exceeding \$2,000 | YES Notice Required For Denial | YES |

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¹ **Reminder:** Any time an ISP is updated the completed service plan document must include an updated Outcomes page and a newly signed signature page.