Procedure for Completing the HCBS Waiver Plan of Treatment

The Home and Community-Based Services (HCBS) Waiver Plan of Treatment (POT) is a Word-based document that can be filled out either electronically or manually. Please contact the In-Home Operations (IHO) Section to receive a copy of the electronic version of this document We can either e-mail you a copy, or if you mail us a blank 3¼-inch floppy disk or CD with a self-addressed envelope we will mail you a copy. IHO has included a manual version of the POT in this packet. (See Enclosure 4A - HCBS Manual POT.)

This POT can be used for Medi-Cal beneficiaries receiving services through one of the HCBS Waivers administered by IHO and/or Private Duty Nursing (PDN) services through the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Benefit. Below are general directions for completing each section of the form.

The **Comments** section may be used throughout the document to provide explanatory information as necessary.

The completed POT must contain original signatures from:

- the beneficiary and/or the legal representative,
- primary care physician, **and**
- for **HCBS Waiver beneficiaries**, each HCBS Waiver service provider; i.e., primary caregiver, home health agency (HHA), or Independent Provider (IP), or
- for **EPSDT beneficiaries**, each IP.

Once all signatures have been obtained, keep the original and return a signed copy of the POT to the appropriate IHO Regional Office.

Step 1: (For the Electronic POT only)
*(**Note:** For the manual version go to Step 1A)*

1. **Unlock** the document;
2. Go to the **View** menu;
3. Click on **Toolbars**;
4. Click on **Forms**;
   (A √ should appear next to **Forms**. The Forms toolbar will appear with the **LOCK** button turned on. In the "Locked" mode the button will have a light gray background.)
5. Click on the **LOCK** button. In the "Unlocked" mode the button will have a medium gray background; and,
6. Complete the header (see below to access header) at the top of Page 2 by entering the beneficiary's name and the treatment period "from and to" dates;
7. Relock the document prior to entering data in the form fields;
8. Complete the POT as instructed in Step 3 below.

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How to access the header (2 methods):

Method A: Go to Page 2. Using your mouse, double-click on the header and enter the information. To exit this function using your mouse, double-click on any area outside of the header. This information will then auto-fill on the subsequent pages.

or

Method B: Go to the **View** menu, click on **Header and Footer** and scroll down to Page 2. Enter the information in the Header. To exit this function, go back to the menu bar, click on **View,** and click on the √ next to **Header and Footer**.

Helpful hints for using the electronic version

1. Important: Use the **Tab** key to navigate the fields. **Do not use the ENTER/RETURN key, as it will alter the formatting and disrupt the spacing throughout the document**.

2. This document has been developed with check boxes, drop-down menus, and locked fields.
   - **Check boxes** can be marked with an X by placing the cursor over the box and using the mouse to single-click on it.
   - **Drop-down menus** (Section 7, Waiver Specific Services) can be accessed by:
     * placing the cursor over the box;
     * single-clicking it with the mouse; and,
     * selecting the appropriate response.
   - **Locked fields** appear as gray-shaded areas and are preset so the user can tab through the document from one to the next. You can also use your mouse to maneuver around the document.

3. Be sure that the **Lock** button is turned **ON** prior to entering information. If the **Lock** button is turned off prior to completion, the form will not work properly.

   To **lock the document**, click on the **LOCK** button. The button background will change to light gray.

IMPORTANT: If the **Lock** button is turned back **ON** after any information has been entered on the POT, it will delete **all** of the information you have entered on the POT.

4. In order to spell check the document, the POT must be entirely completed and the **Lock** button must be turned **Off**. Go to the **Tools** drop-down menu and click on **Spelling and Grammar**. Once the spell check is complete, you can save the document by going to the **File** drop-down menu, click **Save As**. Remember, if you then relock the document, all entries will be lost!

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Step 1A: (For the Manual POT only)

On Pages 2 through 13, complete the header by entering the beneficiary's name and the treatment period "from and to" dates, then complete the POT as instructed in Step 2.

Step 2: Completing the HCBS POT (For both the Electronic and Manual POT)

Collaborate with the beneficiary, their representative, and the physician in the development of the POT to ensure the beneficiary's medical needs are addressed.

Section 1: Beneficiary Information

Please complete as indicated. The **medical record number** of the beneficiary is optional and is used for the provider's filing purposes. The **primary language** may include the primary caregiver's primary language, if different from that of the beneficiary.

Section 2: HCBS Provider Information

Please complete as indicated. The **provider** name is the name of the agency, individual or organization who is primarily responsible for the services described on the POT. This would include the Home Health Agency, HCBS Waiver Service Provider, Professional Corporation (PC), Personal Care Agency (PCA), Nonprofit Organization or the lead Provider (for beneficiaries receiving services without Case Management). The **treatment period** may vary depending upon licensure and/or certification requirements of the provider.

Section 3: Primary Care Physician

Please complete as indicated. The community-based **Primary Care Physician** should be the physician signing the POT.

Section 4: Medical Information

Please complete as indicated. Include all **ICD-9 codes** or diagnosis codes where appropriate. The **other diagnosis** section may be used if there are other diagnoses pertaining to the beneficiary. You may contact the Primary Care Physician to obtain the diagnosis and ICD-9 codes. For the **prognosis**, please check *only one* of the boxes provided for you, i.e., excellent, good, fair, or poor.

Section 5: Medi-Cal Home- and Community-Based Program

Please check all of the appropriate programs for which services are being requested. Please contact your IHO Case Manager to obtain the appropriate program information.

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Section 6: Level of Care (LOC)

The **level of care determination will be made by the Medi-Cal In-Home Operations Section** and given to the provider. Please contact your IHO Case Manager for the level of care. Check ***only one box*** once a determination has been provided.

Section 7: Waiver Specific Services

Do not complete this section for beneficiaries receiving only EPSDT PDN services.

Please complete as indicated. All the **Waiver Specific Services** are listed in this section. Please check all of the services the beneficiary is utilizing. If using the document electronically, please click on the arrow under the **Frequency Key Code**, and double-click on the appropriate **Key Code**. If **other** is used, please provide frequency.

Section 8: Treatment Plan for Home Program

Identify all of the services required to meet the needs of the beneficiary in this section. M.D. orders must identify **all waiver services** rendered by **all providers**. Please list/describe all waiver services provided, including the:

- provider(s) of service;
- provider type(s);
- amount and frequency of the services;
- type of services provided; and,
- expected outcomes

Identify the beneficiary's support network, i.e.;, who will provide care to the beneficiary in the absence of the scheduled caregivers.

Section 8a: Treatment Plan for Home Program – Additional page if needed

Section 9: Non-Waiver Services

For beneficiaries enrolled in one of the HCBS Waivers, federal regulations require that all non-waiver services the beneficiary is receiving be described in the POT. The description of the services should include the amount, frequency, and the provider of services. **Non-waiver services** may include services funded by:

- Medi-Cal
- Private Insurance
- Regional Centers
- Respite
- Department of Mental Health
- In-Home Supportive Services
- Independent Living Centers
- Housing referrals
- California Children's Service
- Department of Rehabilitation
- Social Services Referrals
- Medical Therapy Program

This may also include school-based services, such as:

- Adult Day Health Care
- Vocational Rehabilitation
- Pediatric Day Health Care
- Medical Therapy program

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Section 10: Medication Plan for Home Program

Please complete as indicated. This includes prescription and nonprescription medications. Space for additional medications has been provided for you on Page 5 of the POT.

Section 10a: Medication Plan for Home Program – Additional page if needed

Section 11: Nutritional Requirements

Please describe any nutritional requirements for the beneficiary, as ordered by the physician. Please indicate the type of diet, method of feeding, amount, and frequency.

M.D. orders must identify **all services** rendered by **all providers**. Please list/describe all services provided, including the:

- provider(s) of service;
- provider type(s);
- amount and frequency of the services; and,
- type of services provided.

Space for additional orders has been provided for you on Page 7 of the POT.

Section 12: Functional Limitations

Please describe functional limitations, per the physician's order, within each category.
If no limitations are noted, please check the appropriate boxes and proceed to Section 13.

A. **MOTOR** may include but is not limited to:

- ambulation
- amputation
- paralysis
- contracture
- partial weight bearing
- wheelchair
- crutches
- cane
- walker

B. **SELF-HELP** may include but is not limited to:

- independent
- requires feeding
- personal hygiene assist
- incontinent of bowel or bladder
- requires verbal cueing for tasks
- requires moderate assist with dressing

C. **COMMUNICATION/SENSORY** i.e., hearing, speech, legal blindness, or glasses

- hearing
- speech
- vision
- pain

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Section 13: Activities

Describe all activities performed by the beneficiary, as per the physician's order, such as:

- up as tolerated
- endurance
- dyspnea with exertion
- complete bed rest
- bed rest with BRP
- exercises as prescribed

If no restrictions on activities are noted, please check the appropriate box and proceed to Section 14.

Section 14: Mental Status

Summarize the mental status of the beneficiary, such as:

- comatose
- depressed
- lethargic
- easily confused
- poor short-term memory
- disoriented to date, time and place, oriented to person
- agitated
- developmentally delayed with moderate retardation

If no limitations are noted, please check the appropriate box and proceed to Section 15.

Section 15: Durable Medical Equipment

Please list all types of equipment used, providers of equipment, and funding sources (if known), such as Medi-Cal, Medicare, private insurance, or private pay. Example:

Type	Provider Name	Funding Source
Zippy wheelchair, serial # XXXXXX	Acme Healthcare	Medicare
Alternating pressure mattress overlay	Acme Healthcare	Medi-Cal
LTV 800 ventilator	Acme Respiratory	Red Cross Insurance

Section 16: Medical Supplies

Please list all types of supplies used, providers of supplies, and funding sources (if known), such as Medi-Cal, Medicare, private insurance, or private pay. Example:

Type	Provider Name	Funding Source
G-tube feeding supplies	Acme Healthcare	Medi-Cal
Huggies diapers	Acme Healthcare	Private pay

Section 17: Therapies/Referrals

Please check all types of therapy that apply. Provide the date of each referral and the reason(s) why the referral was made. If **therapy is ongoing**, please indicate the current progress/status in Section 20. If the type of therapy is not listed, please use the other/list.

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Section 18: Treatment Goals/Discharge Plans

Please check the appropriate box. If you select anything other than "Upon completion of treatment plan, the beneficiary will be able to function independently…" you **must** check the level of support needed (minimal, moderate, or maximum), and describe specific goals and discharge plans as identified on the POT such as:

- beneficiary will be able to self-direct caregivers in trach care,
- primary caregivers will be knowledgeable in diabetic management,
- caregivers will be knowledgeable in pressure relief.

Section 19: Training Needs for Beneficiary/Family

Please check **only one** box for training needs. If you choose **yes**, use the area provided to describe the training needs of the beneficiary/family and list the name(s) of the provider(s). Beneficiary/family training must be preauthorized by your IHO Case Manager.

Section 20: Summary of Beneficiary's Status During This Treatment Period

Please summarize the **status of the beneficiary** during the treatment period for this POT. This area may also be used, as stated in Section 17, to describe the current progress/status of ongoing therapy. Each INP is to provide a summary of the care he/she provided, the overall status of the beneficiary, and include the beneficiary's response to the POT and any significant changes.

Section 21: Signatures page

Please complete the POT Form, then print, and **obtain original signatures** from the following:

- Primary Care Physician who oversees the beneficiary's home program;
- Beneficiary and/or the legal representative;
- Primary Caregiver (i.e., parent, spouse, or family member);
- All providers of **HCBS Waiver services** (this includes HHA, Waiver Personal Care Services Providers, Independent Providers, Professional Corporation, and the Case Manager); and,
- For beneficiaries receiving only Medi-Cal **EPSDT** INP services, all INPs.

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Upon completion of the POT, keep the original, place a copy in the beneficiary's home chart, and mail a copy with the Treatment Authorization Request (TAR) and any other required documents to the attention of the beneficiary's IHO Case Manager at the address selected below:

☐ Department of Health Care Services
In-Home Operations Section
1501 Capitol Avenue, MS 4502
P.O. Box 997437
Sacramento, CA 95899-7437

☐ Department of Health Care Services
In-Home Operations Section
311 South Spring Street, Suite 313
Los Angeles, CA 90013-1211