



FY2025 PEER REVIEW

Participant Name: _____

Date: _____

Reviewer Name: _____

1.1. Was the Nursing Facility Level of Care Determination (NFLOCD) adopted from a long-term care provider or conducted within 7 days prior to or the day of initial enrollment and/or re-enrollment and entered into CHAMPS as required by MDHHS and the contract? (New Citation)

Yes No N/A

Comments:

1.2. Did the Waiver Agent (WA) validate the accuracy of the Nursing Facility Level of Care Determination (NFLOCD) assessed Door and ensure the validity of the NFLOCD(s) in CHAMPS? (Recommendation)

Yes No N/A

Comments:

2.1: Is there a valid Freedom of Choice (FOC) form in the record for the review period? (New Citation)

Yes No N/A

Comments:

3.4. Were agency specific forms accurate, complete, and did they conform to MDHHS policy and contract requirements? (New Citation)

Yes No N/A

Comments:

3.5 Were alleged privacy breaches investigated, reported, and conform to MDHHS policy and contract requirements? (New Citation)

Yes No N/A

Comments:

4.4 Did the Waiver Agent use the correct care setting statuses? (Recommendation)

Yes No N/A

Comments:

5.1: Did the Supports Coordinator (SC) contact the participant/guardian prior to assessments, home visits and/or planning meetings to ensure the date(s), time(s) and location(s) were convenient for the participant/guardian? (Multi-Year Citation)

Yes No N/A

Comments:

5.8. Did the record reflect the Supports Coordinator (SC) gave the participant the opportunity to achieve and maintain independence and self-direction, which includes Self-Determination (SD) and the opportunity to direct and engage in the service planning process? (New Citation)

Yes No N/A

Comments:

6.1: Did the Waiver Agency (WA) complete the Initial Assessment (IA) and/or Re-Assessments (RA) in accordance with MDHHS policy and contract requirements? (New Citation)

Yes No N/A

Comments:

6.6: Did the Supports Coordinator (SC) provide the participant the opportunity to manage environmental and home-based risks throughout the care planning and service delivery as required by MDHHS and the contract?

(Recommendation)

Yes No N/A

Comments:

6.7: If the Supports Coordinator (SC) identified the use of restraints or seclusion, did the SC evaluate, address, and offer alternatives to the use of restraints or seclusion? (Multi-Year Citation)

Yes No N/A

Comments:

6.8. Was the information in the assessment consistent, providing a clear picture of the participant's strengths, needs, and abilities, and contained relevant information and explanations? (New Citation)

Yes No N/A

Comments:

7.1: Did the Medication Record include all prescribed medications? (Multi-Year Citation)

Yes No N/A

Comments:

7.2: Did the Medication Record include the name, prescribing physician name (as indicated on the prescription bottle), purpose, strength/dose, frequency, and route for all medications? (Multi-Year Citation)

Yes No N/A

Comments:

7.3. Did the record validate the Clinical Supports Coordinator reviewed the medications and sought resolution for an identified issue(s)? (New Citation)

Yes No N/A

Comments:

7.5. Did the Medication Record identify the participant's known pharmaceutical, environmental, and food allergies, including allergic reactions or identify the participant had no known allergies? (New Citation)

Yes No N/A

Comments:

7.6. Did the Supports Coordinator (SC) assess/document how the participant's medications were managed? (New Citation)

Yes No N/A

Comments:

7.7: Did the Supports Coordinator (SC) address issues the participant had with medication regimen compliance and take action to reduce the risk of medication mismanagement? (Multi-Year Citation)

Yes No N/A

Comments:

8.1. Did the Supports Coordinator (SC) develop, evaluate, and update the Person-Centered Service Plans (PCSP) as required by Federal Regulations and the MDHHS contract? (New Citation)

Yes No N/A

Comments:

8.3. Did the Supports Coordinator ensure the participant was provided education and information to make informed decisions regarding personal choice(s)? (New Citation)

Yes No N/A

Comments:

8.4. Did the Person-Centered Service Plan (PCSP) identify the participant's issues that are triggered and require continued monitoring by the Supports Coordinator (SC)? (New Citation)

Yes No N/A

Comments:

8.5: Did the Person-Centered Service Plan (PCSP) include the process for minimizing risk factors, planning, and supporting the participant? (Multi-Year Citation)

Yes No N/A

Comments:

8.7: Did the services and supports on the Person-Centered Service Plan (PCSP) include the details of the intervention (provider name, type of provider, type of service, service amount/frequency/duration)?

(Recommendation)

Yes No N/A

Comments:

8.9: Did the Supports Coordinator (SC) contact and collaborate in accordance with MDHHS policy and contract requirements? (Multi-Year Citation)

Yes No N/A

Comments:

8.10: Did the Person-Centered Service Plan (PCSP) include outcome evaluations for each goal in accordance with MDHHS policy and contract requirements? (New Citation)

Yes No N/A

Comments:

8.13. Did the participant approve the Person-Centered Service Plan (PCSP)? (New Citation)

Yes No N/A

Comments:

8.14: Did the participant receive a copy of their Person-Centered Service Plan (PCSP) as required by Federal Regulations and the MDHHS contract? If no, were they offered a copy and declined? (Recommendation)

Yes No N/A

Comments:

9.2: Is the Service Summary accurate and complete? (Recommendation)

Yes No N/A

Comments:

9.4. Did the record validate the participant was offered all appropriate services? (New Citation)

Yes No N/A

Comments:

9.5: Did the Supports Coordinator (SC) authorize a change in a MI Choice Program service(s) in accordance with MDHHS policy and contract requirements, or provide the participant/guardian with appropriate alternatives? (New Citation)

Yes No N/A

Comments:

9.6: Did the authorized MI Choice Program services meet requirements as defined in the MI Choice chapter of the Medicaid Provider Manual? (Recommendation)

Yes No N/A

Comments:

10.2: Did the Supports Coordinator (SC) assess the presence of, or the need for, non-waiver services, and then, as preferred by the participant, provide the participant/guardian with information and/or assistance linking to non-waiver services or resources, and/or provide ongoing coordination and monitoring? (Multi-Year Citation)

Yes No N/A

Comments:

11.1: Did the Supports Coordinator (SC) contact the newly-enrolled participant/guardian to ensure service delivery in accordance with MDHHS policy and contract requirements? (Multi-Year Citation)

Yes No N/A

Comments:

11.2: Did the Supports Coordinator (SC) contact the participant/guardian/designated person for follow-up and monitoring as specified in the Person-Centered Service Plan (PCSP) in accordance with MDHHS policy and contract requirements? (Multi-Year Citation)

Yes No N/A

Comments:

11.3. Did the Supports Coordinator (SC) ensure service delivery in accordance with the PCSP, including the use of the participant’s back-up plan or an out-of-network provider, as required by Federal Regulations and the MDHHS contract? (New Citation)

Yes No N/A

Comments:

13.1: Did the record contain a complete and up-to-date contingency plan in accordance with MDHHS policy and contract requirements? (Multi-Year Citation)

Yes No N/A

Comments:

13.2: Did the participant/guardian receive a copy of the contingency plan in accordance with MDHHS policy and contract requirements? If no, were they offered a copy and declined? (Multi-Year Citation)

Yes No N/A

Comments:

15.2: Was the Adverse (Advance) Action Notice (AAN) and/or Adverse Benefit Determination (ABD) complete, and accurate? (Multi-Year Citation)

Yes No N/A

Comments:

Supports Coordinator must sign this form confirming they have reviewed the results of peer review and corrected any omissions, errors, and followed through with any recommendations.

RN Supports Coordinator: _____ Date: _____

SW Supports Coordinator: _____ Date: _____