

Claim and Service Documentation Requirements for Providers of Consolidated and Person/Family Directed Support Waiver Services and Targeted Services Management (TSM)

Office of Developmental Programs
April 5, 2017

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Clarification Documents

- ODP Communication #021-17 *Chapter 51: Office of Developmental Programs Home and Community-Based Services Regulation Questions and Answers* updated and published on 3/31/2017
- Draft Bulletin: *Office of Developmental Programs Claim and Service Documentation Requirements for Providers of Consolidated and Person/Family Directed Support Waiver Services and Targeted Services Management (TSM)*
 - Attachment 1: Technical Guide

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Overview: Documentation Purposes

- Provide an audit trail / claim record
- Maintain a record of service related information
 - Record of essential information
 - Communication tool for support team
 - Monitor, assess and adjust service delivery
 - Quality Assurance and Improvement

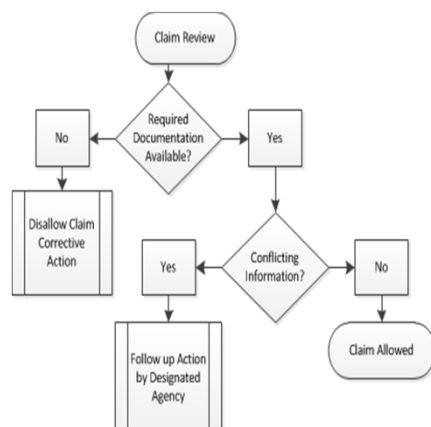
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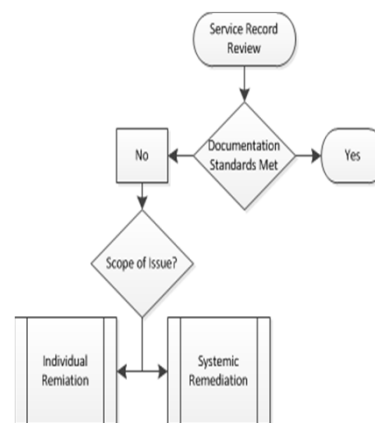


Overview: Documentation Components

Audit Trail



Quality Review



➤ Approach: Review Regulatory Authority

- Federal Regulations
- Waiver Application Technical Guide
- Federal Department of Health and Human Services (HHS) Departmental Appeals Board (DAB) Decisions on Disallowance due to documentation
- CMS Technical Guidance
- PA Code
- PA Bulletins

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➤ Approach: Review Regulatory Authority

- **State Medicaid Manual, Pub.45, § 2500.2** specifying that *documentation includes at a minimum the following: date of service; name of recipient; Medicaid identification number, name of provider agency and person providing the service; **nature, extent, or units of service**; and the place of service.*
- **§ 2497.2 Availability of Documentation** that requires *accounting records be supported by appropriate source documentation....and...readily available for audit.*

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➤ Approach: Review Regulatory Authority

55 PA Code 51 § 51.16 Progress notes specify that a *provider*

- Shall complete a monthly progress note that substantiates the claim for the provision of an HCBS it provides at least monthly
- Shall maintain the progress note in the participant's record
- If the service occurs less than month, a progress note should be provided each time the service is rendered
- May complete a progress note for multiple HCBS rendered to the same participant on the same form when the service is rendered in the same location;
- Must complete a progress note if there is a recommended change to the HCBS that requires an ISP team discussion.

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➤ Approach: Review Regulatory Authority

55 PA Code 51 § 51.16 Progress notes (continued)

Progress notes must include:

- the name of the participant, provider, and service,
- name, title and signature of the person completing the progress note
- amount, frequency and duration of the authorized and delivered HCBS,
- description and outcome of the HCBS;

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➤ Approach: Review Regulatory Authority

ODP Class 00-07-01, Billing Documentation Requirements for Waiver

Services (4/26/07) requires providers to maintain documents that include the participants name, date of service, *and information that substantiates that the service authorized in the ISP are the services provided and billed* and when applicable, provide evidence (time sheets) of the provision of service by multiple staff. The bulletin clarifies that documentation of service activity support for each unit is not necessary and that the ISP Signature page can be utilized in lieu of a signature from the participant for each service. The bulletin provides a detailed description of progress note requirements:

- *Activity for intermittent services requires the provider to document a progress note each time non-consecutive services are rendered; or*
- *Activity for non-intermittent services can be supported by a single monthly note if documentation substantiates that the services were provided within the billing period.*
- *Progress notes are required for each calendar month at minimum.*

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➤ Approach: Review Regulatory Authority

Additional Authority w/ Limited Applicability

- 55 PA Code Chapter 1101 specifies the nature of documentation of clinical services – does not clearly specify requirements for HCBS
- Draft 55 PA Code 6100 requires documentation of progress toward outcomes for each consecutive series of bill units – based on Federal regulations related to case management monitoring

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➤ Approach: Review Regulatory Authority

Presumption of requirements for FFP claiming

- ✓ The participant is Medicaid eligible
- ✓ Assessed Need / Service authorized in the plan
- ✓ Qualified Provider

Presumption of requirements in **§ 2500.2:**

- ✓ *Date of service;*
- ✓ *Name of recipient;*
- ✓ *Medicaid identification number,*
- ✓ *Name of provider agency and person providing the service;*
- ✓ *and the place of service*

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➤ Approach: Stakeholder Input

§ 2500.2 requiring documentation of the ***nature, extent, or units of service***

- *Correspondence with families and providers;*
- *Interview with a parent (primary) caregiver;*
- *Ad hoc provider workgroup (Philadelphia)*
 - *Meeting 1: April 27, 2016*
 - *Meeting 2: May 10, 2016*
 - *Meeting 3: September 25, 2016*

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► “Summary of Activities”

Insufficient Documentation

Insufficient documentation errors occur when the documentation submitted by a provider does not fully support the procedure code billed. The root causes of payment errors for “insufficient documentation” for HCBS include:

- Service logs missing date(s) of service delivery, in-out times , activities performed, and signatures for validation;
- Incomplete and out-of-date person-centered plans; or
- Failing to submit attendance logs if services were provided while the beneficiary was in another facility such as adult daycare.

- CMS TA indicates that states have the flexibility to prescribe expectations
- Comprehensive nature of I/DD services can lead to quantity without quality

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► Distinguish Progress notes from Service Notes

Progress Notes

- A review done by a supports coordinator or program specialist in the course of service monitoring.
- Completed when a participant's services are reviewed to ensure the provision of services as prescribed in plan.
- Person monitoring the service reviews documentation, observes service delivery, talks to the participant or guardian, etc.
- Assesses and documents the presence (or not) of progress
- Very specific federal requirements regarding what must be documented
- Because this happens well after the provision of services and submission of billing, it is not an appropriate requirement for submission of billing/FFP claiming.

Service Notes

- Used to record information related to service delivery.
- Typically done immediately proceeding service delivery...this is the documentation that staff might do when they leave their shift or before they leave a person's home.
- May include an assessment of progress – but is not required.
- Used to note important information so that there is communication amongst team members and service providers
- Used as one of multiple sources of information used in the assessment of “progress.”

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Draft: Enhancements and Clarifications

- Clarification of heightened expectations for documentation of technical services provided by licensed professionals such as behavioral specialists, nurses and therapists;
- Specification of requirements for licensed day services, ensuring billing documentation includes start/end times that occur within a day, clarifying that billing cannot occur for time a time the participant is absent, for example, to go to a doctor's appointment;
- Clarification for residential and licensed day services that billing documentation must include affirmative action to denote the participant's attendance rather than an assumption the participant is present unless there is information documenting his/her absence;
- Clarification that licensed providers must ensure documentation is available to support claims for enhanced staffing ratios;
- Clarification of requirements for Participant Directed Services and responsibilities of AWC, VF/EA, Managing Employers and Common Law Employers;



Draft: Enhancements and Clarifications

- Clarification of requirements for Respite Camps and Education Support Services;
- Progress Note requirements specifying services that do not require a progress note when, due to the nature of the service, a progress note is not a practical expectation
 - Respite care (Service notes require documentation of caregiver relief)
 - Homemaker / Chore
 - Assistive Technology
 - Home and Vehicle Accessibility and Adaptations
 - Respite Camp
 - Education Support Services
 - Transportation



▶ Draft: Enhancements and Clarifications

- Procedure code specific recommendations for the contents of service notes to enable providers to use checklists to meet service note requirements for:
 - Behavior Supports
 - Home and Community Habilitation
 - Companion Services
 - Homemaker / Chore
 - Supported Employment
 - Supports Broker Services

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▶ Next Steps

- Draft 6100s
- Publish Class 1 – comment period ends 4/27/2017
 - **OBSOLETE** Bulletin 00-07-01, *Billing Documentation Requirements for Waiver Services*
- Revise technical guide to include new service definitions publish July 2017
- Class 3 Bulletin – public comment fall 2017

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Comments and Questions

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