



Documentation Standards for Home and Community Based Services (HCBS)

Presented by: LeAnn Moskowitz

Agenda

- Introduction
- Medicaid Documentation Standards
- Medical and Financial Records
- Service Plan Documentation
- Service Record Documentation
- Record Retention Requirements

General Principles of Documentation

- If it is not documented, it has not been done
- Federal and State laws require providers to maintain the records necessary to “fully disclose the extent of services,” care, and supplies furnished to beneficiaries, as well as to support claims billed

General Principles of Documentation

- Clear and concise service documentation is critical to providing individuals with quality care and is required for providers to receive accurate and timely payment for furnished services.
- To maintain accurate service documentation, document services during the service or as soon as practical after the service.

HCBS Services and Supports

HCBS Comprehensive Functional Assessment

Assesses an individual's "need" for HCBS services



Interdisciplinary Team Meeting

Develops the Individual Service Plan / Integrated Treatment Plan



Individual Service Plan/ Integrated Treatment Plan

Defines the services and supports the member will receive

Service Plan Documentation

- Reflects individual's strengths and preferences
- Reflects clinical and support needs
- Includes observable and measureable goals and desired outcomes
- Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.
- Identify the staff people, businesses, or organizations responsible for carrying out the interventions or supports.

Service Plan Documentation

- Reflects providers of services/supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS including:
 - a) Name of the provider
 - b) Service authorized
 - c) Units of service authorized
 - d) Period of service authorization
- Includes risk factors and measures in place to minimize risk

Service Plan Documentation

- Includes individualized backup plans and strategies when needed
- Identify any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.
- Identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.
- Providers of applicable services shall provide for emergency backup staff.

Service Plan Documentation

- Documents the informed consent of the individual for any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications, the need for the restriction, and either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
- Any rights restrictions must be implemented in accordance with [441 IAC 77.25\(4\)](#).

Service Plan Documentation

- Includes individuals important in supporting individual
- Includes the names of the individuals responsible for monitoring plan
- Is written in plain language and understandable to the individual
- Documents who is responsible for monitoring the plan

Service Plan Documentation

- Includes the signatures of all individuals and providers responsible
- Is distributed to the individual and others involved in plan
- Includes purchase/control of self-directed services
- Excludes unnecessary or inappropriate services and supports

Basis of HCBS Service Delivery

All services are provided to eligible members according to the member's individualized need as identified in the service plan and based on the type of waiver the member receives.

* Before service provision, the provider must obtain documentation of service authorization. The documentation of service authorization should include a copy of the Notice of Decision (NOD) or Notice of Authorization (NOA) that would include:

- ❖ The name and SID of the member
- ❖ The name of the provider,
- ❖ The provider number,
- ❖ The service and procedure code,
- ❖ The number of units to be provided,
- ❖ The approved rate for each service, and
- ❖ The date span of the specific service.

Service Note Documentation

The following items must be included in each progress note entry, for each Medicaid member, and for each date of service:

1. The specific procedures or treatments performed.

Which service was provided? Day Hab T2021

2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.

Begin Date:10.17.17 End Date: 10.17.17

3. The complete time of the service, including the beginning and ending time (including AM and PM designation) if the service is billed on a time-related basis.

Begin Time: 7:00 am End Time 11:00 am

4. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.

3 hours

Service Note Documentation

5. The location where the service was provided if otherwise required on the billing form, or in:

441 IAC 77.30(5)“c” or “d,”

441 IAC 77.33(6)“d,”

441 IAC 77.34(5)“d,”

441 IAC 77.37(15)“d,”

441 IAC 77.39(13)“e,”

441 IAC 77.39(14)“d,”

441 IAC 77.46(5)“i,”

441 IAC 78.9(10)“a”(1).

i.e. The member’s home, day habilitation center, member’s place of work (i.e. Petco, Lowes etc.)

6. The name, dosage, and route of administration of any medication dispensed or administered as part of the service. Any supplies dispensed as part of the service.

i.e. Administered AM medications see Medication Administration Record) (MAR). Administered topical antibiotic to abrasion on right knee no changes noted.

Service Note Documentation

7. The first and last name and professional credentials, if any, of the person providing the service. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity

For 24-hour care, documentation for **every shift of the services provided**, including the member's response to the services provided and the person who provided the services (daily SCL, daily Home Based Habilitation)

- Most daily SCL staffing hours are split into multiple shifts. Each shift must document a service note.

Service Note Documentation

Daily Supported Community Living Service Documentation Note

Agency Name: _____ Date of Service (mth/dy/yr): _____

Individual's Name: _____ Medicaid ID: _____

Service Location: _____

Enter Service Start Time: _____ Enter Service Stop Time: _____

Total Duration: _____

Description of Services:

Members Response:

Medications or Supplies:

Staff Signature: _____ Date : _____

Staff Title: _____

Service Documentation Using a Checklist

Checklists may be used in addition to service note documentation it does not replace it.

Checklists may be used to document the ongoing supports provided during the course of service provision. i.e. personal care supports, range of motion, routine daily tasks

Service Documentation Using a Checklist

HCBS WAIVER SERVICE DOCUMENTATION

Day Habilitation T2020

AGENCY: _____

CONSUMER NAME: _____

MCO ID: _____ MEDICAID #: _____

MONTH/YEAR OF SERVICE DELIVERY: _____

Staff initialing below must sign and initial the member's Signature Log contained in the member's service record

DESCRIPTION OF THE INDIVIDUALIZED SERVICE / ACTION PROVIDED based on the consumer's Residential Habilitation Plan	DAY OF MONTH	Service staff delivering the service or action initials the date the service or action was provided. [Note: By entering initials, staff person is attesting that the service or action was provided on that day. Initialing must occur at the same time as service delivery.]																																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
Service or action : <i>Provided UE ROM per PT POC 10:00am</i>																																			
Service or action : <i>Provided LE ROM per PT POC 2:00 pm</i>																																			
Service or action : <i>Changed dressing on stoma</i>																																			
Service or action :																																			
Service or action :																																			

VERIFICATION STATEMENT

By signing and dating, I attest that the Daily Checklist has been, to the best of my knowledge, completed accurately.

Director Signature

Date

EXCEPTIONS FOR HOSPITALIZATION, NURSING HOME PLACEMENT, ICF/DD OR OTHER LEAVES

Location

Dates

Medical Record Requirements

Outcome of the Service

The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of plan of care, or diagnosis

Basis of Service

The medical record must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it).

Record Requirements

The medical record for HCBS Waiver or State Plan HCBS service recipient must contain the basis for service requirements for specific services which includes:

1. Notice of decision for service authorization.
2. Provider specific service plan and the Comprehensive Person Centered Service Plan (initial and subsequent plans).
3. Service logs, notes, or narratives.
4. Mileage and transportation logs.
5. Log of meal delivery. (as applicable)
6. Invoices or receipts.
7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389,
8. Consumer-Directed Attendant Care (CDAC) Service Record.
9. Other service documentation as applicable. (i.e. checklists, MARs)

Note: These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review

Record Requirements

Providers must maintain medical records for five years from the date of service as evidence that the services provided were:

- ◆ Medically necessary,
- ◆ Consistent with the diagnosis of the member's condition, and
- ◆ Consistent with evidence-based practice.

Each page of the medical record shall contain the member's:

- ◆ Full name.
- ◆ Date of birth.
- ◆ Medicaid state identification number

HCBS Quality Management

HCBS quality reviewers may evaluate the following provider documentation in conjunction with quality reviews:

- Personnel records,
- Member service records,
- Agency policies and procedures,
- Evidence to support implementation of agency policy and quality improvement activities, and
- Other information as requested.

Audits or Reviews

Any Medicaid provider may be audited or reviewed at any time at the discretion of the Department.

Authorized representatives of the Department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

- ◆ The Department has correctly paid claims for goods or services.
- ◆ The provider has furnished the services to Medicaid members.
- ◆ The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- ◆ The goods or services provided were in accordance with Iowa Medicaid policy.

Requests for provider records by the IME Program Integrity Unit shall include form 470-4479, *Program Integrity Unit Documentation Checklist*,

Audits or Reviews

Audit or review procedures may include, but are not limited to, the following:

- Comparing clinical and fiscal records with each claim.
- Interviewing members who received goods or services and employees of providers.
- Examining third-party payment records.
- Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.
- Examining all documents related to the services for which Medicaid was billed.

*If the Department concludes from an audit or review that an overpayment has occurred, the Department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

Fraud, Waste and Abuse

CMS defines Fraud, Waste and Abuse

Fraud

- A knowing misrepresentation of the truth or concealment of a material fact to induce another to act to his or her detriment. Includes any intentional or deliberate act to deprive another of property or money by guile, deception, or other unfair means.
- Example: Knowingly submitting claims for services that were not rendered.

Waste

- Overutilization, underutilization, or misuse of resources. Waste typically is not an intentional act.
- Example: Costs incurred when an individual is receiving more units or hours of service than needed, e.g., when an individual's health improves but their intensity of supports remains the same.

Fraud, Waste and Abuse

CMS defines Fraud, Waste and Abuse

Abuse

- Provider practices that are inconsistent with sound fiscal, business, or medical practice, and results in unnecessary cost to the Medicaid program or payment for services that are not medically necessary or fail to meet professionally recognized health care standards.
- Example: An HCBS provider bills for services during an individual's institutional stay. This is abuse because the HCBS provider should have been aware of the rules, which specify that services cannot be billed during an institutional stay.

Biggest difference between Fraud vs. Waste and Abuse:

- Intent to deceive

Tips for HCBS Providers

Knowing and following these tips help Medicaid providers and referring physicians meet Medicaid requirements for HCBS services and referrals, improve billing and help strengthen the integrity of the Medicaid program.

- Check beneficiary eligibility regularly;
- Ensure the beneficiary has the required person-centered service plan (service plan) and that it is current and complete;
- Ensure the beneficiary has the required service specific plan of care (provider service plan) and that it is current and complete ;
- Make sure that service documentation is complete and supports services provided;
- Use the appropriate procedure or service code and number of units when billing;
- Use the appropriate billing form when billing; and
- Only submit claims for dates of service when the service documentation substantiates that services were delivered.

Resources

Medicaid Documentation Record Resource Guide

<https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-recorddoc-resourceguide.pdf>

Department of Human Services: <http://www.dhs.iowa.gov/>

Iowa Medicaid Enterprises: <http://dhs.iowa.gov/ime/about>

Iowa Medicaid Enterprise Member Information:

<http://dhs.iowa.gov/ime/members>

HCBS Home: <http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers>

DHS Office of Policy Analysis (Rules):

<http://dhs.iowa.gov/ime/providers/rulesandpolicies>