pennsylvania
DEPARTMENT OF HUMAN SERVICES

OFFICE OF DEVELOPMENTAL PROGRAMS BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
XX-XX-XXXX	XX-XX-XXXX	00-XX-17

SUBJECT	BY
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)	Nancy Thaler, Deputy Secretary for Developmental Programs

SCOPE:

Administrative Entity Administrators or Directors
County Mental Health and Intellectual Disability Administrators
Supports Coordination Organizations
Providers of TSM
Providers of Consolidated and Person/Family Directed Support (P/FDS) Waiver Services
Common-Law Employers in the Vendor/Fiscal Employer Agent Financial Management Services Model

PURPOSE:

The purpose of this bulletin is to communicate and provide direction regarding expectations for claim and service documentation for services provided through the Consolidated and P/FDS waivers and TSM.

BACKGROUND:

This bulletin is intended to provide guidance about the Department's regulations and procedures for claim and service documentation requirements. Claim and service documentation requirements for services provided through the Consolidated and P/FDS waivers are currently specified in 55 Pa. Code Chapter 51, *Office of Developmental Programs Home and Community-based Services* and 55 Pa. Code Chapter 1101, *General Provisions*. In addition, the Health Care Financing Administration's State Medicaid Manual (Pub 45), Chapter 2 (relating to state organization) provides guidance about documentation requirements.

DISCUSSION:

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate Regional Office of Developmental Programs

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Documentation of waiver services and Targeted Service Management (TSM) serves multiple purposes, including but not limited to:

1. Provide a claim record to support the claiming of Federal Financial Participation (FFP); and
2. Maintain a record of service-related information that provides a:
    - Record of essential information.
    - Communication tool for support team.
    - Document to monitor, assess, and adjust service delivery to ensure individual progress toward preferred outcomes.
    - Resource for quality assurance and improvement.

Claim Records and Service Documentation

Claims documentation requirements ensure that necessary measures are in place to verify that the services that are billed to the Department are delivered to the individuals approved to receive the services. Providers must maintain the documentation used to generate a claim. If the provider does not have this documentation, the claim is not eligible for FFP.

To justify FFP claiming of waiver services and TSM, each claim must be supported by documentation that demonstrates that the service is:

- Provided to a Medicaid-eligible individual;
- Provided by a qualified provider meeting licensing and/or other standards for authorized services, and qualifications have been verified and documented;
- Authorized based on assessed need;
- Rendered as authorized in the person-centered support plan; and
- In accordance with the State Medicaid Manual, each claim for service must include the:
    - Date the service was rendered;
    - Name of the recipient;
    - Medicaid identification number also known as the Master Client Index (MCI) number;
    - Name of the provider agency and person providing the service;
    - Nature, extent, or units of service. (Attachment 1 provides guidance about how these elements should be documented for each service.); and
    - The place(s) the service was rendered.

The State Medicaid Manual in §2497.2 (relating to the availability of documentation) requires accounting records to be supported by appropriate source documentation and be readily available for audit. There are federal and state requirements that documentation is to be available at and subsequent to the time of claim submission.

Pennsylvania requirements in 55 Pa. Code Chapter 1101 specify the documentation requirements for clinical services for the treatment of a medical diagnosis. These requirements must be followed as home and community based-services are covered under the

scope of Chapter 1101. This bulletin describes how the requirements outlined in Chapter 1101 apply to the home and community based services in the approved waivers.

Service documentation includes non-clinical information related to the provision of home and community-based services. Service documentation is completed by the person providing the service and is used to record information related to service delivery. The completion of this documentation is typically done during or immediately after the provision of a service. As an example, service documentation is completed by staff when they leave their shift or after an individual arrives at home when a service such as home and community habilitation is provided in the community.

A service note must be completed for each encounter on each specific date. The service note should cover the total number of units of service provided from the beginning to the end of the service on the specified date. If there is an interruption of service on that date, a new service note should be completed when the service is again initiated on that date. If there is a change in staff providing the service on the specific date, a new service note should be completed. A service note is not required for each unit of service that is provided.

Service documentation describes service activities and is intended to share important information so that there is communication among team members and service providers. This information is used in the assessment of progress to determine if the service is meeting participant needs.

When an individual is self-directing services through the Vendor Fiscal/Employer Agent model, the common law employer, also known as employer of record, is responsible to ensure service documentation is completed. The service documentation shall be maintained in the individual's record by the common law employer. When an individual is self-directing services through the Agency with Choice Model, the managing employer, or if necessary, the Agency with Choice organization will ensure that service documentation is completed. The service documentation shall be maintained in the individual's and Agency with Choice organization's records.

Progress Notes

ODP regulation at 55 Pa. Code Chapter 51.16 (relating to progress notes) describes progress note requirements. Progress notes are typically an assessment done by a service coordinator, program specialist, or other provider staff who conduct routine reviews or oversight of staff or in the course of service monitoring. This is done when an individual's services are assessed to ensure services are meeting the individual's needs. To formulate a progress note the person monitoring the service reviews documentation, observes service delivery, talks to the individual, his or her parent or legal guardian, staff, etc. As a result, the documentation indicates progress or lack of progress towards the individual's desired outcomes. Because this happens after the provision of services and submission of billing, it is not a requirement for submission of billing to claim FFP.

Progress notes, however, provide information essential for provider review and self-monitoring of services to ensure services are rendered as authorized in the participant's person-centered support plan. Progress notes also provide information that ODP and the Administrative Entity reviews to ensure services are meeting the individual's needs and that qualified providers are meeting expectations of service quality. :

- To meet Centers for Medicare and Medicaid Services (CMS) expectations regarding the periodic monitoring of services.
- For provider review and self-monitoring of services to ensure services are rendered as authorized in the participant's person-centered support plan; and
- For ODP and Administrative Entity review of services which is intended to ensure services are meeting the individual's needs and that qualified providers are meeting expectations of service quality.

Progress notes must be completed in accordance with guidance provided in Attachment 1. The column titled "Other Documentation" provides information about progress notes including when a progress note is not required for a particular service. When a service is provided periodically or intermittently that means that the service occurs less frequently than a calendar month. For example, the service is provided every 6 weeks or every 90 days.

When an individual is self-directing services through the Vendor Fiscal/Employer Agent model, the common law employer is responsible to ensure the progress notes are completed. The progress notes shall be maintained in the individual's record by the common law employer. When an individual is self-directing services through the Agency with Choice Model, the managing employer, or if necessary, the Agency with Choice organization will complete the progress notes. The progress notes shall be maintained in the individual's and Agency with Choice organization's records.

Service Monitoring and Documentation Standards

The guidelines provided in Attachment 1 provide clarification to providers and to agencies responsible for the provision and administration of waiver services. In order to document the "nature, extent or units of service," requirements are specified by procedure code. These requirements align with CMS expectations regarding state efforts to prevent fraud, waste, and abuse.

The monitoring of services requires face-to-face contact with the individual and may include interviews with staff and people who know the individual well, as well as direct observation of service delivery. Agencies that administer the waivers must ensure that monitoring occurs consistently and that problems are identified and addressed. Data gathered should be aggregated and used to demonstrate compliance with CMS assurances. This information should also be used to assess performance for both licensed and unlicensed waiver providers. Corrective action plans are used to ensure that providers who fail to meet documentation requirements take remedial action. However, if the issue is not corrected or the problem persists, directed corrective action occurs or sanctions are initiated. The column titled "Other

Documentation" includes information that providers must document because it is critical to the provision of services and will be reviewed when services are monitored as discussed above. However, the information included in this column is not required for billing.

The monitoring of claims and service documentation are components of a quality improvement strategy (QIS). Fiscal audits ensure claims are paid only for services authorized in a service plan and are an essential component of QIS. However, missing, incomplete, inconsistent, or incorrect progress notes shall require further investigation by ODP or its designee to determine appropriate corrective action. Monitoring ensures billed services are delivered as specified in an approved person-centered support plan, assess whether services are meeting the individual's needs, and ensure proper remediation of individual specific and systemic issues.

States must rely on multiple quality assurance and improvement systems to ensure basic health and safety of individuals, as well as, demonstrate continuous quality improvement. There are components of a QIS that are designed to assess the quality of service delivery.

The guidelines provided in Attachment 1 include:

- Expectations for documentation of technical services provided by licensed professionals such as behavioral specialists, nurses, and therapists.
- Guidance for licensed day services such as inclusion of start/end times that occur within a day. The guidelines indicate that billing cannot occur for time an individual is absent.
- Guidance for residential and licensed day services that billing documentation must include confirmation that the individual is in attendance rather than an assumption the individual is present. Documentation may include information that the individual is absent.
- Guidance that licensed providers must ensure documentation is available to support claims for enhanced staffing ratios.
- Guidance for Participant-directed Services and responsibilities of the Agency With Choice Financial Management Services (FMS) organization, Vendor Fiscal/Employer Agent FMS organization, Managing Employers and Common Law Employers.
- Guidance for Respite Camps and Education Support Services.
- Procedure code specific recommendations for the contents of service documentation to enable providers to use checklists to meet these requirements.
- Guidance for 55 Pa. Code Chapter 51.16 (relating to progress notes) which specifies when a progress note is not required due to the nature of the service.

The proposed guidelines in Attachment 1 clearly delineate requirements that providers must meet and auditors must assess with determining whether a claim is appropriate for FFP.

OBSOLETE Documents:
Bulletin 00-07-01, *Billing Documentation Requirements for Waiver Services*