pennsylvania
DEPARTMENT OF HUMAN SERVICES

OFFICE OF DEVELOPMENTAL PROGRAMS BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
July 25, 2018	July 25, 2018	00-18-04

SUBJECT	BY
Interim Technical Guidance for Claim and Service Documentation	Nancy Thaler, Deputy Secretary for Developmental Programs

SCOPE:
Administrative Entity Administrators or Directors
Agency With Choice Financial Management Services
Common-Law Employers in the Vendor/Fiscal Employer Agent Financial Management Services Model
County Mental Health and Intellectual Disability Administrators
Providers of Targeted Support Management
Providers of Consolidated, Community Living and Person/Family Directed Support (P/FDS) Waiver Services, including Supports Coordination Organizations

PURPOSE:

The purpose of this bulletin is to provide interim guidance to providers regarding claim and service documentation processes. This guidance is applicable to providers of Consolidated, Community Living and P/FDS Waiver services as well as Targeted Support Management (TSM).

BACKGROUND:

Claims documentation processes ensure that necessary measures are in place to verify that the services that are billed to the Department of Human Services 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 Federal Financial Participation (FFP). In anticipation of new regulatory provisions being promulgated and in order to respond to providers' requests for guidance until the final

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate Regional Office of Developmental Programs

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rulemaking is effective, the Office of Developmental Programs (ODP) is providing interim guidance on claims documentation processes.

DISCUSSION:

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 (Medicaid eligibility can be verified by checking the Eligibility Verification System (EVS));
- Provided by a qualified provider of that service meeting licensing standards;
- Authorized based on assessed need;
- Rendered as authorized in the Individual Support Plan (ISP); and
- Compliant with the Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual, which states that each claim for service must include the following:
    - Date the service was rendered;
    - Name of the recipient;
    - Medicaid identification number, if applicable;
    - Name of the provider agency and person providing the service;
    - Nature, extent, or units of service; and
    - The place(s) the service was rendered.

The CMS 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 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.

<u>Claim Record and Billing</u>

Documentation to provide a record of services delivered to an individual must be prepared and kept by the provider or common-law employer for the purposes of substantiating a claim. The provider or common-law employer shall maintain a record of the time worked or the time that a service was delivered to support the claim.

One major component of a claim record is service notes. The provider or common-law employer is responsible for ensuring that service notes are completed for each service delivered to an individual. Service notes include 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, a service note is completed by staff when they leave their shift or after an individual arrives at home when a service such as in-home and community support is provided in the community.

A service note is to be completed on the day the service is delivered[1]. The provider may choose to enter multiple service notes for multiple services for one individual in the same document or form if all required information is included.

For services that are billed in 15 minute or hour units, a service note is to be completed when services are provided by the same staff person(s) for a continuous span of 15 minute or hour billing units. A continuous span of 15 minute or hour billing units is defined as the uninterrupted provision of a service by the same staff person(s) that is not stopped or discontinued. A new service note must be completed when there is an interruption of service or a change in staff person(s) providing the service within the calendar day.

For services that are billed in day units, a service note must be completed for each day unit that documents the provision of direct or indirect services (such as staff on-call or the use of remote monitoring) for the minimum number of hours required to bill for the day unit. For residential services (Residential Habilitation, Life Sharing and Supported Living) and Respite provided in licensed or unlicensed residential settings or other licensed settings (private ICFs/ID, or nursing homes), a service note must be completed for each day unit that documents the provision of at least 8 hours of direct or indirect services. For Respite services provided in private homes that are billed as a day unit, a service note must be completed for each day unit that documents the provision of more than 16 hours of service. When the provider is not rendering direct services to the individual, (the individual is at work, visiting friends, etc.) a new service note is not required to be completed. When there is a change in staff providing a service billed in day units, a new service note is not required when there is a change in the staff providing the service.

The service notes describe service activities and are intended to be an information source to be used by provider staff, the provider, the common-law employer or managing employer and the Supports Coordinator. This information is used to document that the service is being delivered as required in the ISP.

When an individual is self-directing services through the Vendor Fiscal/Employer Agent model, the common-law employer is responsible to ensure service notes are completed. The service 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 ensure that service notes are completed. The service notes shall be maintained in the individual's and Agency with Choice organization's records.

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[1] Exceptions will be made for extraordinary circumstances or emergencies when the provider documents the extraordinary circumstance or emergency and why it precluded a service note from being completed on the day the service was delivered.

Supports Coordinators and Targeted Support Managers document service activities that occur with or on behalf of individuals within one business day of the activity. ODP is aware that various methods are used to document these activities such as logs, electronic notes, and recorded documentation completed during service provision and that this documentation is used to complete the Home and Community Services Information System (HCSIS) service notes. Supports Coordination Organizations and TSM providers will continue to complete HCSIS service notes in accordance with ODP guidance and training. Supports Coordinators and Targeted Support Managers have 7 days from the date of contact to enter their service notes into HCSIS.

Practitioners who order, refer or prescribe applicable services must enroll in the Medical Assistance (MA) Program and receive an MA provider number for the services they order, refer or prescribe to be paid. When a service is ordered, referred, or prescribed, this information must be reported on the claim in the fields designated for ordering, referring, or prescribing providers. Please refer to the following Office of Medical Assistance Programs bulletins regarding this requirement:

- 99-17-02, Submission of Claims that Require the National Provider Identifier (NPI) of a Medical Assistance enrolled Ordering, Referring or Prescribing Provider; and
- 99-18-06, Update to Submission of Claims that Require the National Provider Identifier (NPI) of a Medical Assistance Enrolled Ordering, Referring or Prescribing Provider.

Progress Notes

Current ODP regulations, 55 Pa. Code § 51.16 (relating to progress notes) describe progress note requirements. Progress notes are typically an assessment written by a program specialist or other provider staff who conduct routine reviews or oversight of staff or during service monitoring. To formulate a progress note[2], the person preparing the progress notes should review service notes, observe service delivery and speak with the individual, the individual's parent or legal guardian as appropriate, staff, and other team members or people involved with the individual as appropriate. The documentation will indicate whether there has been progress or lack of progress toward the individual's desired outcomes as stated in the ISP. In addition, documentation of restrictive intervention usage as part of the progress notes are to be completed by provider staff. Because a progress note is completed after the provision of services and submission of billing, it is not a requirement for the submission of a claim.

In accordance with 55 Pa. Code § 51.16(d) and applicable licensing regulations, progress notes are used to determine:

- Whether the service is being provided as specified in the ISP;
- Whether the service is meeting the individual's assessed needs and preferences;
- Whether there is progress toward or maintenance of ISP specified outcomes and actions; and

[2] Progress notes are not required for all services; please refer to the service charts in Attachment 1 to determine if progress notes are needed. When progress notes are not required, service notes satisfy the progress notes requirements for 55 Pa. Code Chapter 51.

- When there is an identified lack of progress, how the lack of progress will be addressed.

Progress notes provide information for ODP, Administrative Entities (AEs), or other reviewers to ensure services are meeting the individual's needs and that qualified providers are meeting expectations of service quality. Progress notes also provide information essential for provider review and self-monitoring to ensure services are rendered as authorized in the individual's ISP. Further, progress notes are critical documentation reviewed in the Quality Assessment and Improvement (QA&I) process.

The provider, in cooperation with the Supports Coordinator, Targeted Support Manager, and the individual will review service documentation and will complete a progress note at least every three months beginning with the date the provider submitted the initial claim. Please note that while 55 Pa. Code Chapter 51 regulations require monthly progress notes, ODP is implementing the requirement that progress notes must be completed, at a minimum, every three months. The progress note documents the progress made toward achieving the desired outcome of the service provided. The time period covered by the progress note should start on the day following the previous progress note and end on the date that the current progress note is completed.

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.

Attachment 1, *Technical Guidance for Claim and Service Documentation,* provides clarification to providers of Consolidated, Community Living and P/FDS Waiver services as well as TSM. Outlined in the document is each service including the billing code, the service and progress notes guidance, and other documentation specific to the service to support the claim. Attachment 1 also contains a section at the end of the document with billing definitions to help guide the provider with procedure code definitions. This guidance applies to services rendered by providers that have enrolled directly with ODP to render services, organized health care delivery systems and services delivered through both self-directed services models, Agency with Choice and Vendor Fiscal/Employer Agent.

ATTACHMENTS:

Attachment 1, *Interim Technical Guidance for Claim and Service Documentation*

OBSOLETE DOCUMENTS:

ODP Informational Packet 035-14, *Waiver Service Claim Documentation and Remediation Process*

ODP Informational Packet 077-14, *Service Delivery Documentation for Unlicensed Residential Habilitation*