Special Medical Home Care

- iBudget Handbook -

Special Medical Home Care is provided to individuals with complex medical conditions requiring an intensive level of nursing care residing in a foster or group home. This can include people who are ventilator dependent, require tracheostomy care, or have a need for deep suctioning to maintain optimal health.

Providers of Special Medical Home Care must employ registered nurses, licensed practical nurses, and certified nurse assistants licensed or certified in accordance with Chapter 464, F.S. Certified nurse assistants must work under the supervision of a registered nurse or licensed practical nurse.

This service may only be provided in an APD licensed foster or group home with the designation of Special Medical Home Care.

iBudget Handbook Effective Date: 6/10/18 (1-24, 2-69)

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Service Specific Record Review – Special Medical Home Care

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#	Performance Measure/Standard	Protocol	Not Met Reasons
1	The provider maintains Daily Progress Notes/Service Logs covering services provided and billed during the period under review.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Pages 1-5, 1-10, A-6 COMPLIANCE The Daily Progress Note/Service Logs is summary of support provided during the contact and must include: o Name of individual receiving service o Date of service o Time in/out o Summary of services provided • Review Daily Progress Notes/Service Logs for the entire period of review. • Determine that Daily Progress Notes/Service Logs include all required components. • Review Daily Progress Notes/Service Logs against claims data to ensure accuracy in billing. Notes should be directly related to the recipient's plan of care and treatment **This standard is subject to identification of a potential billing discrepancy**	1) Daily Progress Note/Service Log was not present for the date of service for which the claim was submitted (B) 2) Daily Progress Note/Service Log did not contain the name of the person receiving services. (B) 3) Daily Progress Note/Service Log did not contain the time in/out. (B) 4) Daily Progress Note/Service Log did not contain the date service was rendered. (B) 5) Daily Progress Note/Service Log did not contain a summary or list of services provided. (B) 6) Discrepancies were noted between units billed and services documented. (B)
2	The record includes the current Nursing Care Plan.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Page A-6 COMPLIANCE • Review Nursing Care Plan for period under review. • Review for annual update. • Ensure Nursing Care Plan is done by an RN or ARNP.	1) Provider documentation demonstrated Nursing Care Plan was not completed prior to the initial claim submission. (B) 2) Provider documentation demonstrated Nursing Care Plan had not been updated on an annual basis. (B) 3) Nursing Care Plan was not provided for review. (B) 4) Provider documentation demonstrated

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#	Performance Measure/Standard	Protocol	Not Met Reasons
		This standard is subject to identification of a potential billing discrepancy	Nursing Care Plan was not completed by an RN or ARNP. (B)
3	When applicable Nursing Care Plan contains revisions to reflect current health status.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Page A-6 COMPLIANCE • Review current Nursing Care Plan • If warranted determine if revisions have been made to reflect current health status. If there have been no significant changes to the individual's health status since the last annual update score as N/A.	1) Nursing Care Plan did not contain revisions to reflect current health status.
4	The record includes the Nursing Assessment (completed at the time of the first claim submission and annually thereafter).	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Page A-6 COMPLIANCE • Review the Nursing Assessment is done by an RN or ARNP. • Review for an initial Nursing Assessment done at the start of services. • Review for annual Nursing Assessment. • Review for changes in the individual's health status. **Note:** If initial Nursing Assessment is not in the record but a current Nursing Assessment is available score as not met but with **no** potential recoupment. **This standard is subject to identification of a potential billing discrepancy**	1) Provider documentation demonstrated the Nursing Assessment was not completed by an RN or ARNP. (B) 2) Initial Nursing Assessment was not in the record. (B) 3) Provider documentation demonstrated initial Nursing Assessment was not completed prior to the first claim submission. (B) 4) Provider documentation demonstrated Nursing Assessment was not completed annually. (B) 5) Provider documentation demonstrated Nursing Assessment had not been updated to reflect significant changes in the individual's health status. (B)

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5	The record includes prescription for the service.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Page A-6 COMPLIANCE • A new prescription needs to be obtained every 12 months. • Review record to ensure an original prescription(s) (not a copy) is on file for entire period of review. This may require review of two prescriptions in order to cover the period of review. **This standard is subject to identification of a potential billing discrepancy**	1) The original prescription covering some or all services provided/billed during the period under review was not in the record. (B) 2) The prescription covering services provided/billed during the period under review was a copy/not original. (B)
6	The record includes the list of duties to be performed by the nurse.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Page A-6 COMPLIANCE • Review the Nursing Assessment and Care Plan • Review record for a current list of specific nursing duties. • Determine if the list of duties is specific to the identified needs of the person	1) Provider documentation did not include a list of duties to be performed by the nurse. 2) Provider documentation demonstrated the list of duties to be performed by the nurse was generic and not specific to the needs of the person.
7	The provider maintains current Service Authorization(s) for the service being rendered and billed.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Pages 1-10, 3-4, 3-5 COMPLIANCE Service Authorizations are provided quarterly or more frequently as changes dictate. • Review the Service Authorization for Special Medical Home	1) Service Authorizations were not present in the record. 2) One or more Service Authorizations were not present in the record. 3) One or more Service Authorizations were not in approved status.

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		Care and ensure: ○ A Service Authorization is available to cover all services provided and billed during the period under review. ○ The Service Authorization(s) is in approved status; ○ Service Rate for Special Medical Home Care is a negotiated day rate. ❖ Refer to the current APD Provider rate table as needed. WSCs **and** service providers must verify the Service Authorization is correct according to the authorized amount of services in the iBudget system. If corrections are needed the service provider should immediately contact the WSC for resolution. ○ Consider provider due diligence in securing corrected Service Authorizations when incorrect ones are received.	
8	The provider is in compliance with billing procedures and the Medicaid provider agreement.	CMS Assurance - Service Plan iBudget Handbook – June 2018 COMPLIANCE Determine if services are being provided in accordance with the Handbook. • Compare Service Authorizations with claims data to determine if provider bills at the proper rate and limits. • Review provider records for Service Authorizations, Support Plan, Daily Attendance Logs, Nursing Care Plans, Nursing Assessments, Progress Notes and/or other provider documentation to assist in determining if the provider is in compliance with billing procedures and the Medicaid Waiver Services Agreement.	1) Service is not being rendered in accordance with the Handbook. (B)

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#	Performance Measure/Standard	Protocol	Not Met Reasons
		This standard is subject to identification of a potential billing discrepancy	
9	Provider bills for services after service are rendered.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Pages 2-49, 3-2 COMPLIANCE Provider is not to bill for services prior to rendering service. • Review Claims data for date billed. • Review dates on Daily Progress Notes/Service Logs. • Determine if services were rendered prior to billing for each date of service in the period of review.	1) Provider documentation demonstrated provider billed for services prior to rendering on one or more dates during the period under review.
10	The provider does not receive reimbursement for Residential Habilitation or Residential Nursing services.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Page 2-61 RECORD REVIEW Review claims data to determine if the provider has received payment for Residential Habilitation or Residential Nursing services. **This standard is subject to identification of a potential billing discrepancy**	1) Provider documentation demonstrated the provider received reimbursement for Residential Habilitation services. (B) 2) Provider documentation demonstrated the provider received reimbursement for Residential Nursing services. (B)
11	The provider documents ongoing efforts to ensure the person's health and health care needs are addressed.	CMS Assurance – Health and Welfare iBudget Handbook – June 2018 Pages 2-7, 2-10, 2-45 PERSON CENTERED PRACTICE Ask the provider to describe method used to gather and document knowledge of person's health and health care needs. • Ask the provider how this information is maintained and	1) Provider documentation did not demonstrate efforts to gather information about the person's health and health care needs. 2) Provider documentation demonstrated knowledge of the person's health and health care needs but not ongoing efforts to address identified needs.

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		updated on an ongoing basis. • Review record for documentation supporting stated method. • Review record for documentation supporting provider efforts to learn about and solicit information regarding the person's health and health care needs; steps taken to address the person's needs. ○ For example scheduled medical appointments, provided education, and procured medical services/devices. • Review the record for documentation related to routine and preventive medical and dental care. • Review Daily Progress Notes/Service Logs, Nursing Assessment, Nursing Care Plan and any other available provider documentation for evidence the provider identifies and addresses the person's health and healthcare needs on a routine basis. • For Special Medical Home Care a well-written and updated Nursing Care Plan may meet this requirement. *Key/Critical health and health care information will vary by person, and could include, but not be limited to diagnosis, certain environmental factors, medications and related information, required follow-up with specialists, food allergies, dietary needs, specialized equipment needs, medical/physical/emotional conditions, and any other information critical to the health and healthcare needs of the person and relevant to the service being provided.	3) Key and critical health and/or healthcare needs have not been addressed.
12	The provider documents ongoing efforts to ensure the person's behavioral/emotional health needs are addressed.	CMS Assurance – Health and Welfare iBudget Handbook – June 2018 Pages 2-7, 2-10, 2-45, 2-56 PERSON CENTERED PRACTICE	1) Provider documentation did not demonstrate efforts to gather information about the person's behavioral/emotional health needs. 2) Provider documentation demonstrated

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		Ask the provider to describe method used to gain and document knowledge of person's behavioral/emotional health information relevant to the service provided. • Ask the provider how information related to behavioral/emotional health is maintained and updated on an ongoing basis. • Review record for documentation supporting stated method. • Supporting documentation may be found in Daily Progress Notes/Service Logs, intake forms, Nursing Assessment, Nursing Care Plan, stand-alone forms, and other available provider documentation. • Based on review of the current Support Plan and provider documentation, there are no behavioral/emotional health concerns indicated, score N/A. *Key/critical behavioral/emotional health information will vary by person and could include, but not be limited to diagnosis, certain environmental factors, medication and related information, Behavior Plans, emotional well-being (stress, anxiety, depression, grief, other emotional issues, or diagnosis) and any other information critical to the behavioral/emotional health of the person relevant to the service being provided.	knowledge of the person's behavioral/emotional health needs but not ongoing efforts to address identified needs. 3) Key and critical behavioral/emotional health information was absent from the record.
13	The provider submits documents to the Waiver Support Coordinator as required.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Page A-6 COMPLIANCE Ask the provider to describe method used to submit required documents to the Support Coordinator. • Review provider documentation for proof of submission to the Support Coordinator.	1) The provider did not have documented evidence of submitting Daily Progress Note/Service Logs. 2) Provider had documented evidence of submitting some but not all copies of Service Log(s). 3) The provider had documented evidence of submitting copies of Daily Progress Notes/Service Log(s) but not within 10

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#	Performance Measure/Standard	Protocol	Not Met Reasons
		○ Examples could include fax transmittal reports with cover sheet indicating descriptions of what was faxed, submission tracking logs, date stamps, or indication of date of submission and method sent on the documentation. Items below must be provided to the WSC prior to billing or within 10 calendar days of billing at the latest unless otherwise indicated. ○ If billing more than once a month, information with an asterisk (*) and indicated as "(sent monthly)*" may be submitted to the WSC at the time of the last billing in the month. The following documentation is required to be provided to the WSC within the timeframes indicated: • Copy of service log (sent monthly)* • Nursing Care Plan and revisions.* • Nursing Assessment (must be completed at the time of the first claim submission and annually thereafter).* • Daily progress notes (sent monthly).* • Prescription for service and annually thereafter.*	days of billing each month. 4) The provider had documented evidence of submitting copies of some but not all Daily Progress Notes/Service Log(s) within 10 days of billing each month. 5) The provider did not have documented evidence of submitting the Nursing Care Plan at time of initial claim submission. 6) The provider did not have documented evidence of submitting the Nursing Care Plan and revisions annually. 7) The provider did not have documented evidence of submitting the Nursing Assessment prior to or at time of first claim submission. 8) The provider did not have documented evidence of submitting the Nursing Assessment annually. 9) The provider did not have documented evidence of submitting a copy of the original prescription for the service.

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