iBudget Service Specific Record Review – Respite

#	Standard	Protocol	Not Met Reasons	Weights	CMS Assurance
1	The provider has copies of claim(s) submitted for payment for the period of review.	*Rule Development 2011 H A-3* *RECORD REVIEW*	1)		
2 R	The provider has service logs for each date of service during the review period.	*IBudget DRAFT - Rule Development 2011 A-3* May 2010 H 2-13; H 2-71; H 2-72 RECORD REVIEW • Review Services Log(s) for the entire period of review. • Determine that Service Log (s) include all required components. • Review Service Log (s) against claims data to ensure accuracy in billing. • If necessary, request Remittance Vouchers to compare. • Review logs for content to ensure they relate to an outcome on individual's Support Plan. **This standard is subject to potential recoupment.**	1) Provider did not have service logs for some/all dates of services for which claims were submitted. 2) Service logs did not contain the recipient's name. 3) Service logs did not contain the recipient's Medicaid ID number. 4) Service logs did not contain time/duration. 5) Service logs did not contain the date service was rendered. 6) Service logs did not contain summary of the service provided. 7) Significant discrepancies noted between documentation and billing.	3	5

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#	Standard	Protocol	Not Met Reasons	Weights	CMS Assurance
3	The provider maintains correct service authorization(s) for the service being rendered and billed for entire period of review.	*IBudget DRAFT - Rule Development 2011 2 -12, , 3-8, 3-26* May 2010 H 1-6; H 2-5 RECORD REVIEW It is the provider's responsibility to determine whether a service authorization has been issued, revised, or cancelled for an individual served by the provider before providing services. Waiver support coordinators 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 notify the waiver support coordinator for resolution • Determine if provider is a solo or employ's additional staff • Review provider records for a service authorization(s). • Determine that service authorization(s) is available for the entire period of review. • Determine that service authorization(s) is in approved status. Determine that service authorization(s) has the correct rate based Agency vs. Solo	1) Provider did not have approved service authorizations for the services being rendered. 2) The service authorization was not in approved status. 3) The provider had service authorizations for some, but not all of the period of review. 4) The service authorization had an incorrect rate.	1	5, 2d

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		status and ratio.			
4 R	The provider renders the service in accordance with the service authorization and the handbook.	*IBudget DRAFT - Rule Development 2011 3-7, 3-26* May 2010 H 1-6; H 2-7; H 3-3; H 3-4; CA 3.6.E.; CA 3.7.H.; CA 2.0 RECORD REVIEW The provider shall provide and bill only for those services that have been authorized and approved by APD on the individual's cost plan. These supports and services shall be provided within the amount, frequency, scope, intensity and duration specified on the individual's support plan, approved cost plan, and service authorizations. The provider agrees not to bill for services until rendered as authorized • Review provider records for a service authorization(s). • Determine service authorization(s) are available for entire period of review.	1) Staffing ratios were not provided in accordance with the service authorization. 2) Documentation indicated services were being rendered to an individual living in a licensed facility. 3) Unable to determine because one or more service authorizations were not present. 4) The provider billed for travel time to and from a recipient location.	3	5, 2d

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		• Determine service authorization(s) are in approved status. • Verify service authorization(s) have the correct rate based on provider status of agency or independent. . • Determine if services are being provided in accordance with service authorization(s). • Determine where the service is occurring. • Review the service authorization and service logs to assure the approved ratio of 1:1, 1:2, or 1:3 is being utilized for all dates within the period of review. • Individuals who receive respite services in a licensed residential facility must be billed at the ratio of 1-1 in the stepped rate of the service. • Determine if provider is only billing for hours of service where there is direct contact with the individual receiving services. Note: Recipients living in licensed group homes are not eligible to receive respite care services. **This standard is subject to potential recoupment.**			

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#	Standard	Protocol	Not Met Reasons	Weights	CMS Assurance
5 R	The provider bills at the correct rate.	*IBudget DRAFT - Rule Development 2011 3-7, 3-26, 4-71* May 2010 H 1-7; CA 3.8 B RECORD REVIEW • Review provider records for a service authorization(s). • Determine if provider is a solo or employ's additional staff • Review claims data to determine rate billed. • If necessary, request Remittance Vouchers to compare. • Refer to APD provider rate table as needed. **This standard is subject to potential recoupment.**	1) The provider is a solo provider but billed the agency rate. 2) The provider billed at a non-standard rate.	1	5
6 R	Provider bills the daily rate when service is rendered in excess of 39 quarter hours a day.	*IBudget DRAFT - Rule Development 2011 4-73* May 209H 2-73; CA 3.8 RECORD REVIEW • Review Service Log (s) and Claims Data to determine that if service is rendered	1) Services rendered in excess of 39 qh in a day were not billed at the daily rate.	1	5

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#	Standard	Protocol	Not Met Reasons	Weights	CMS Assurance
		for 40 quarter hours or more the daily rate is billed. Note: If the provider bills by the quarter hour rate of service, service should be a maximum of 39 quarter hours in a day. If respite services are provided for 40 Quarter Hours (10 hours) or more a day, the provider must bill by the daily rate. Score N/A if the service was not rendered or billed in excess of 39qh per day. **This standard is subject to potential recoupment.**			
7 ~~R~~	~~Service does not exceed the 30 days/720 hour maximum per year.~~	~~May 2010 H 2-71; CA 3.8 B RECORD REVIEW~~ • ~~Review Service Log (s) and Claims Data to determine service does not exceed 30days/720 hours (2880 quarter hour) maximum per year.~~ ~~Note: The provider cannot bill for more than 30 days (720 hours) of service per fiscal year, per recipient.~~ ~~**This standard is subject to potential recoupment.**~~	1) ~~Services were rendered in excess of 30 days/720 hours per year.~~	~~1~~	~~1~~

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#	Standard	Protocol	Not Met Reasons	Weights	CMS Assurance
8	Provider renders service only to individuals under age 21.	*IBudget DRAFT* - Rule Development 2011 4-70, 4-71 • Determine the individual receiving service is under age 21 **This standard is subject to potential recoupment.**	1) The provider rendered services to an individual age 21 or older.		5
9	The provider renders services only in certain locations as specified in the handbook.	*IBudget DRAFT - Rule Development 2011 4-72* May 2010 H 2-72 RECORD REVIEW • Respite care can only be provided in the individual's own home, family home, while involved with activities in the community, a licensed foster home, group home or ALF. • Ask the provider where the service occurs. • Review Service Log(s) to determine where the service occurs. • Review Support Plan to confirm where individual resides. • Determine that services are not rendered in the home of the provider. • Determine that service is not occurring in	1) Documentation indicated services were rendered in the provider's home. 2) Documentation did not indicate where service occurs. 3) Unable to determine due to absence of supporting documentation.	3	5

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#	Standard	Protocol	Not Met Reasons	Weights	CMS Assurance
		the provider's home. If PCR, ask the individual where the service occurs.			
10	The provider has a method in place to gather information about the person's physical, behavioral and emotional health on an ongoing basis.	*IBudget DRAFT - Rule Development 2011 3-5* May 2010 CA 2.0 RECORD REVIEW/PROVIDER INTERVIEW • Ask the provider for method of documenting historical physical, behavioral, and emotional health. • Ask the provider for method of collecting and documenting current information about the individual's physical, behavioral and emotional health. • Review file for documentation supporting stated method. • Documentation may include intake forms, stand-alone forms, or other available documentation.	1) The provider did not have methods in place to gather physical health information. 2) The provider did not have methods in place to gather behavioral health information. 3) The provider did not have methods in place to gather emotional health information. 4) The provider documentation did not demonstrate provider efforts to gather physical health information. 5) The provider documentation did not demonstrate provider efforts to gather behavioral health information. 6) The provider documentation did not demonstrate provider efforts to gather emotional health information. 7) Unable to determine due to absence of supporting documentation.	5	4
11	Documented services are directly related to an	*IBudget DRAFT - Rule Development 2011 4-71*	1) The provider did not have a copy of the Support Plan (s). 2) Documented services did not relate to an	4	2d

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#	Standard	Protocol	Not Met Reasons	Weights	CMS Assurance
	outcome on the individual's Support Plan for the entire period of review.	May 2010 H 2-71; H 2-72; CA 1.0 B.6; CA 2 RECORD REVIEW/PROVIDER INTERVIEW • Review Support Plan(s) for Respite goal and/or reference under "other supports/services needed" on the goal page. • Review Service Log (s) for direct relation to an outcome on the individual's Support Plan (s). • Ask the provider about the stated outcomes and goals. If PCR, ask individuals about the activities in which they are involved. Ask if they feel service received relates to their stated Support Plan outcome. **Scoring Consideration:** If provider does not have copy of SP but can show documentation of efforts to obtain it and can show how it is determined from person and/or supports what goals they wanted assistance with, score as met. Note: Consider "overall" documentation for the period of review. An isolated occurrence of documentation not relating to a goal would not make this a "not met".	outcome on the individual's Support Plan 3) The provider had a copy of the Support Plan (s), but it did not identify this service. 4) Unable to determine due to absence of supporting documentation.		

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#	Standard	Protocol	Not Met Reasons	Weights	CMS Assurance
12	The provider addresses the individual's choices and preferences.	*IBudget DRAFT – Rule Development 2011 3-5* May 2010 CA 1.0.B.6; CA 2.0 RECORD REVIEW/PROVIDER INTERVIEW • Ask the provider for method of soliciting and documenting individual's choices and preferences. • Review file for documentation supporting stated method of addressing individual's choices and preferences. • Ask the provider for description of individual's choices and preferences. • Review Service Log (s) to determine if choices and preferences are solicited and addressed within documentation. • Review Support Plan to determine if it includes choices and preferences. If PCR, ask individual for desired choices and preferences. If service rendered under 45 days by provider, score N/A.	1) Documentation did not indicate the provider was aware of the individual's choices and preferences. 2) Documentation indicated the provider was aware, but had not addressed the individual's choices and preferences. 3) The provider was aware of but had not addressed the individual's choices and preferences. 4) The provider was aware of but had not documented the individual's choices and preferences. 5) Unable to determine due to absence of supporting documentation.	1	2e

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#	Standard	Protocol	Not Met Reasons	Weights	CMS Assurance
13	~~The provider addresses the person's/legal representative's expectations regarding the service.~~	~~May 2010 CA 1.0.B.6.b; CA 2.0 RECORD REVIEW/PROVIDER INTERVIEW~~ ~~• Ask the provider for method of gaining knowledge of person's/legal representative's expectations.~~ ~~• Review file for documentation of gaining knowledge of person's/legal representative's expectations.~~ ~~• Ask the provider for individual specific definitions of expectations.~~ ~~• Review Service Log (s) to determine if expectations are being addressed.~~ ~~If PCR, ask individual for expectations regarding the services being received.~~	~~1) Documentation did not indicate the provider was aware of the person's/legal representative's expectations regarding the service being received.~~ ~~2) Documentation indicated the provider was aware, but had not addressed the person's/legal representative's expectations regarding the service being received.~~ ~~3) The provider was able to describe person's/legal representative's expectations regarding the service being received, but had not documented the information.~~ ~~4)~~1) ~~Unable to determine due to absence of supporting documentation.~~	~~1~~	
14	The provider has evidence of teaching individual/legal representative about rights.	*IBudget DRAFT – Rule Development 2011* 3-5 May 2010 H A-8 2.0 RECORD REVIEW/PROVIDER INTERVIEW • Ask the provider how they inform individuals and their families or guardians of their rights and responsibilities and how frequently. • Ask the provider for examples of how	1) Provider documentation did not reflect evidence of teaching individual/legal representative about rights.	4	4

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#	Standard	Protocol	Not Met Reasons	Weights	CMS Assurance
		they have assisted individuals to fully exercise their rights and make informed choices. • Interactively, with the provider, review documentation supporting discussion. • Ask the provider for examples of how they observe the rights and responsibilities of individuals.			
15	The provider has evidence of teaching the individual/legal representative about the grievance policy.	*IBudget DRAFT* - Rule Development 2011 3-14 May 2010 H A-16 RECORD REVIEW/PROVIDER INTERVIEW • Interactively, with the provider, review a sample of individuals' records to determine that a copy of the signed grievance procedure is available. • Ask the provider how they communicate the grievance procedure to individuals, their families or guardians. • Ask if the procedure is available and can be communicated in other languages.	1) The provider did not have evidence of teaching the individual/legal representative about the grievance policy.	1	4
16	~~Individual signs the provider's grievance policy within 30 days of beginning~~	~~May 2010 H A-16 RECORD REVIEW/ PROVIDER INTERVIEW~~	~~1) Individual did not sign the provider's grievance policy within 30 days of beginning services.~~ ~~2) Individual did not sign the provider's~~	1	

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#	Standard	Protocol	Not Met Reasons	Weights	CMS Assurance
	~~services and annually thereafter.~~	~~• Interactively, with the provider, review a sample of individuals' records to determine that a copy of the signed grievance procedure is available.~~ ~~• Grievance procedures for a new participant to the program are to be reviewed and signed within 30 days of admission and annually thereafter.~~ ~~• Grievance procedures are to be reviewed and signed annually thereafter~~ ~~If provider has been serving the person longer than a year only look for annual updates.~~	~~grievance policy annually.~~ ~~3)~~1) ~~Individual did sign the provider's grievance policy but not within 30 days of beginning services.~~		
17	Services are provided at mutually agreed upon times and settings.	*IBudget DRAFT* - Rule Development 2011 3-1 May 2010 CA 1.0.B.6.e RECORD REVIEW/PROVIDER INTERVIEW • Ask the provider for method of showing that services are rendered at times and settings mutually agreed upon by the provider and the person. • Review file for documentation of	1) Documentation did not indicate that services are provided at times mutually agreed upon with the individual. 2) Documentation did not indicate that services are provided in settings mutually agreed upon with the individual. 3) Documentation indicated provider determined hours and days on which individual may receive services. 4) Support Plan indicated a desire for service times that did not match service times within service logs. 5) Documentation did not indicate preferences were explored. 6) Unable to determine due to absence of	~~1~~	2d

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		mutually agreed upon times and settings. • This may be in intake forms, stand alone forms or other available documentation. • Review Support Plan to determine if document states times and settings of service. • Review Service Authorization to determine if times are indicated on document. • Review Service Log (s) to ensure mutually agreed times and settings are being utilized for service delivery. If PCR, ask individual if services are at preferred times and settings.	supporting documentation.		
18	~~The provider submits documents to the Waiver Support Coordinator as required.~~	~~May 2010 H 2-72 RECORD REVIEW/PROVIDER INTERVIEW~~ • ~~Ask the provider for method of submitting documents to the Waiver Support Coordinator (WSC).~~ • ~~Review Service logs or other available documentation for proof of submission to the WSC.~~ • ~~Examples could include fax transmittal reports with cover sheet indicating exact descriptions of what was faxed,~~	~~1) The provider did not have evidence of document submission of Service Log (s). monthly.~~ ~~2) The provider did have evidence of document submission of Service Log(s) but not monthly.~~ ~~3)~~1) ~~Unable to determine due to absence of supporting documentation.~~	~~1~~	

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#	Standard	Protocol	Not Met Reasons	Weights	CMS Assurance
		~~submission tracking logs, date stamps, or indication of date of submission and method sent on the documentation.~~ ~~If PCR, ask the WSC for proof of receipt of documentation from the provider.~~			