Service Specific Record Review – Residential Habilitation (Standard)

#	Performance Measure/Standard	Protocol	Not Met Reasons	

1	The provider maintains Daily Attendance Logs covering services provided and billed during the period under review.	CMS Assurance – Financial Accountability
		RECORD REVIEW
		
		• Review Daily Attendance Logs for the entire period of review and ensure they contain the required information.
		  o Name of individual
		  o Date of service
		• Determine that Daily Attendance Logs match claims data to ensure accuracy in billing.
		
		This standard is subject to identification of a potential billing discrepancy
			1) Provider did not maintain Daily Attendance Logs covering services provided/billed during the period under review. (B)
			2) Daily Attendance Logs covering services provided/billed during the period under review did not equal dates billed. (B)
			3) Daily Attendance Logs covering services provided/billed during the period under review did not include the individual's name. (B)
			4) Daily Attendance Logs covering services provided/billed during the period under review did not include the date of service. (B)
				B

2	The Implementation Plan covering services provided and billed during the period under review is in the record.	CMS Assurance – Financial Accountability RECORD REVIEW • Review individual record to determine if there is an Implementation Plan for the entire period of review (this may require review of 2 Implementation Plans). • Review record to determine Support Plan(s) effective date and compare with Implementation Plan development date. • Implementation Plan must be developed/completed within 30 calendar days from the Support Plan effective date or within 30 days from the initiation of a new service. **And** • At any time updates and changes are made before they are implemented and annually thereafter. If the provider has not rendered services for more than 30	1) Implementation Plan covering services provided/billed during the period under review was not in the record for the entire period of review. (B) 2) Implementation Plan covering services provided/billed during the period under review was not completed within 30 days following the initiation of the new service. (B) 3) Implementation Plan covering services provided/billed during the period under review was not completed within 30 days following the Support Plan effective date. (B)	B

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		days, score N/A. **This standard is subject to identification of a potential billing discrepancy**		
3	The current Implementation Plan covering services provided and billed during the period under review contains all required components.	CMS Assurance – Financial Accountability RECORD REVIEW NOTE: For the purposes of this standard, only the "current Implementation Plan" will be reviewed. This is defined as the Support Plan in effect at the time of the record review. • Review individual record for current Implementation Plan. • Ask the provider how strategies and methods that will assist individuals in meeting goals are determined. • Review the current Implementation Plan to determine they contain, at a minimum: o Individual Name o Goal(s) from the Support Plan the service will address o The strategies employed to assist the recipient in meeting the support plan goal(s). o System to be used for data collection and assessment of the individual's progress in achieving the Support Plan goal(s) • Review the current Support Plan to determine that Residential Habilitation goals are indicated and are included on the current Implementation Plan.	1) Current Implementation Plan covering services provided/billed during the period under review was not in the record. 2) Current Implementation Plan did not include the name of the individual served. 3) Current Implementation Plan did not include goal(s) from the Support Plan the service will address. 4) Current Implementation Plan did not include the methods employed to assist the recipient in meeting the Support Plan goal(s). 5) Current Implementation Plan did not identify the system to be used for data collection and assessment of the individual's progress in achieving the Support Plan goal(s). 6) Current Implementation Plan was not updated prior to implementing identified changes.	C
4	Provider documentation demonstrates strategies specified on the Implementation Plan are followed.	CMS Assurance - Service Plan RECORD REVIEW • Review individual record for current Implementation Plan. • Review identified strategies and methods employed to assist the individual in meeting the Support Plan goal(s);	1) Current Implementation Plan is not in the record. 2) Provider documentation did not indicate identified strategies were being followed. 3) Provider documentation did not remain	C

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		• If changes were made in the plan does ongoing service documentation demonstrate identified changes?	consistent with changes made to the implementation plan.	
5	The Implementation Plan is provided to the individual and when applicable, the legal representative, within required time frames.	CMS Assurance - Service Plan RECORD REVIEW NOTE: For the purposes of this standard, only the "current Implementation Plan" will be reviewed. This is defined as the Support Plan in effect at the time of the record review. • Ask the provider to demonstrate their method of documenting that the Implementation Plan has been provided to the individual and when applicable, the legal representative. • Review the date the Implementation Plan was provided to the individual and when applicable, the legal representative. • A copy of the Implementation Plan, signed by the individual, shall be furnished to the individual and when applicable, the legal representative within 30 days from the Support Plan effective date or within 30 days from the initiation of a new service.	1) Provider did not have documentation the Implementation Plan was provided to the individual. 2) Provider did not have documentation the Implementation Plan was provided to the legal representative. 3) Provider documentation indicates the Implementation Plan was provided to the individual but not within the 30 day timeframe. 4) Provider documentation indicates the Implementation Plan was provided to the legal representative but not within the 30 day timeframe.	C
6	A Quarterly Summary covering services provided and billed during the period under review is in the record.	CMS Assurance – Financial Accountability RECORD REVIEW • Determine Support Plan effective date to determine Quarterly Summary timeframes for each individual to be reviewed. • Ask provider if provider completes Monthly Summaries or Quarterly Summaries. Monthly Summaries in lieu of Quarterly Summaries are acceptable. • Determine if the provider is aware of the person's recent progress towards or achievement of personal goals the	1) Quarterly/Monthly Summary covering services provided/billed during the period under review was not in the record. 2) Quarterly/Monthly Summaries covering services provided/billed during the period under review were present but were not reflective of progress toward Support Plan goals. 3) Some, but not all Quarterly/Monthly	C

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		person has recently achieved. • Review Summaries. Each Summary must contain: A summary of the individual's progress toward achieving Support Plan goals for services billed in the applicable month/quarter. If service has not been rendered long enough for a Quarterly Summary to be required, score N/A.	Summaries covering services provided/billed during the period under review were present. 4) Quarterly Summaries covering services provided/billed during the period under review were completed but were not aligned with the Support Plan effective date.	
7	The third Quarterly/Annual Report covering services provided and billed during the period under review is in the record.	CMS Assurance – Financial Accountability RECORD REVIEW • Review record to determine Support Plan effective date. • Determine if the Annual Report is a component of the third Quarterly Report or a separate document (which is acceptable). • Determine if the third Quarterly/Annual Summary was completed prior to the Support Plan effective date. If the provider was providing services to the person at the time the last Annual Report would have been due an Annual Report is required even if the provider has served the person less than one full year. If the provider was not providing services at the time of the last annual, score as N/A. **This standard is subject to identification of a potential billing discrepancy**	1) Current third Quarterly/Annual Report covering services provided/billed during the period under review was not in the record. (B) 2) Third Quarterly/Annual Report covering services provided/billed during the period under review was completed, but not prior to the Support Plan effective date. (B)	B
8	The third Quarterly/Annual Report covering services provided and billed during the period under review contains all required components.	CMS Assurance – Financial Accountability RECORD REVIEW • Review record to determine Support Plan effective date. • Determine if the Annual Report is a component of the third quarterly report or a separate document (which is	1) Current third Quarterly/Annual Report covering services provided/billed during the period under review was not in the record. 2) Third Quarterly/Annual Report	C

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		acceptable). • Review Annual Report for content to ensure it includes at a minimum: o A summary of the first three quarters of the Support Plan o Description of the person's progress, or lack thereof, toward achieving each of the goals identified on the Support Plan based service rendered • Determine if progress statements are consistent with supporting data in documentation. If the provider was providing services to the person at the time the last Annual Report would have been due an annual report is required even if the provider has served the person less than one full year. If the provider was not providing services at the time of the last annual, score as N/A.	covering services provided/billed during the period under review did not contain a summary of the recipient's progress toward achieving Support Plan goal(s). 3) Third Quarterly/Annual Report covering services provided/billed during the period under review did not contain a summary of the first three quarters of the Support Plan year.	
9	The provider maintains Service Authorization(s) covering services provided and billed during the period under review.	CMS Assurance - Service Plan RECORD REVIEW Service Authorizations are provided quarterly or more frequently as changes dictate. • Review the Service Authorization for Residential Habilitation (Standard) and ensure: o A Service Authorization is available to cover all services provided and billed during the period under review; o The Service Authorization(s) is in approved status; o The Service Authorization(s) is for the correct rate (agency vs. solo – geographic vs. non-geographic, ratio). • Refer to the current APD Provider rate table as needed.	1) No Service Authorizations were in the record covering services provided and billed during the period under review. 2) One or more Service Authorizations covering services provided and billed during the period under review were not in the record. 3) One or more Service Authorizations covering services provided and billed during the period under review were not in approved status. 4) One or more Service Authorizations covering services provided and billed during the period under review did not indicate the correct rate.	C

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		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. o Consider provider due diligence in securing corrected Service Authorizations when incorrect ones are received.		
10	The provider renders the service in accordance with the Handbook.	CMS Assurance - Service Plan RECORD REVIEW • If Service Authorizations are not present for some or all of the period under review, other documentation such as Daily Attendance Logs, Service Logs, Implementation Plans, Support Plans, etc. can be used. • Review provider records for Service Authorizations. • Determine Service Authorizations are available for entire period of review. • Determine if services are being provided in accordance with Service Authorizations. • Check Service Authorizations for individuals receiving supported living to determine if in excess of 90 days. Compare Service Authorizations with claims data to ensure provider bills at the proper rate and limits. **This standard is subject to identification of a potential billing discrepancy**	1) Documentation indicated receipt of Residential Habilitation and Supported Living Coaching beyond 90 days. (B) 2) Service is not being rendered in accordance with the Handbook. (B)	B
11	The Provider is in compliance with billing procedures and the Medicaid provider agreement.	CMS Assurance – Financial Accountability RECORD REVIEW Provider bills the appropriate rate:	1) Provider is a solo provider but is billing at the agency rate. (B) 2) Provider billed the monthly rate when less than 24 days of service were	B

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#	Performance Measure/Standard	Protocol	Not Met Reasons	
		• Solo vs. Agency (Daily Live-in rate) • Non-Geographical, Geographical, Monroe rates • Daily Rate vs. monthly rate (when individual is present less than 24 days in a month) o Review Daily Attendance Logs. o Determine the number of days rendered. If less than 24, determine if the daily rate was billed in lieu of the monthly rate (Day rate multiplied by the number of days present billed as one unit at the end of the month is acceptable) o Daily rate must be used when individual is present less than 24 days in the month. (Does not apply to the RH live-in rate – Procedure Code H0043UCSC) **This standard is subject to identification of a potential billing discrepancy**	rendered. (B)	
12	Provider Bills for services only after service is rendered.	CMS Assurance – Financial Accountability RECORD REVIEW Provider is not to bill for services prior to rendering. • Review Claims data for date billed. • Review dates on Daily Attendance Logs. • Determine whether or not the individual was present at least 24 days each month in the review period prior to the provider billing for services rendered.	1) Provider billed for services prior to rendering services on one or more dates during the period under review.	C
13	The provider documents efforts to address the individual's choices and preferences.	CMS Assurance - Service Plan RECORD REVIEW • Ask the provider to explain method of soliciting and documenting individual's choices and preferences as related to this service.	1) Documentation did not indicate the provider was aware of the individual's choices and preferences related to this service. 2) Documentation indicated the provider was aware, but had not addressed the	C

#	Performance Measure/Standard	Protocol	Not Met Reasons	
		• 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 provider documentation to determine if choices and preferences are solicited and addressed. • Review Support Plan to determine if person's choices and preferences are identified and match provider activities. If service rendered under 45 days by provider, score N/A.	individual's choices and preferences related to this service.	
14	The provider documents efforts to assist the individual to increase community participation and involvement based on his/her interests.	CMS Assurance - Service Plan RECORD REVIEW • Ask the provider for method of documenting the person's interests regarding community participation and involvement. • Review file for documentation supporting method of addressing person's interests regarding community participation and involvement. • Ask the provider for description of recent community activities and connections. • Review Support Plan to determine if person's interests are identified and match provider activities. If service rendered under 45 days by provider, score N/A.	1) Provider documentation did not reflect evidence of assisting the individual to increase community participation and involvement based on his/her interests. 2) Documentation indicated the provider was aware of community interests, but had not addressed the individual's interests regarding community participation and involvement.	C
15	The provider documents efforts to assist the individual/legal representative to know about rights.	CMS Assurance - Service Plan RECORD REVIEW • Ask the provider how they inform individuals and their families or guardians of their rights and responsibilities as related to this service and how frequently. • Ask the provider for examples of how they have assisted	1) Provider documentation did not reflect evidence of assisting the individual/legal representative to know about rights related to this service.	C

#	Performance Measure/Standard	Protocol	Not Met Reasons	
		individuals to fully exercise their rights and make informed choices. • Review documentation supporting discussion with the provider. • Ask the provider for examples of how they observe the rights and responsibilities of individuals.		
16	The provider has a method in place to document information about the individual's physical health on an ongoing basis.	CMS Assurance – Health and Welfare RECORD REVIEW • Ask the provider for method of collecting and documenting historical physical health information relevant to the service being provided. • Ask the provider for method of collecting and documenting current information about the individual's physical health. • Review record for documentation supporting stated method. • Documentation may include intake forms, stand-alone forms, or other available documentation.	1) Provider has no method in place to document information about the individual's physical, health. 2) Key/Critical pieces of physical health information were absent from the record.	C
17	The provider has a method in place to document information about the individual's behavioral/emotional health on an ongoing basis.	CMS Assurance – Health and Welfare RECORD REVIEW • Ask the provider for method of collecting and documenting historical behavioral/emotional health information relevant to the service being provided. • Ask the provider for method of collecting and documenting current information about the individual's behavioral/emotional health. • Review record for documentation supporting stated method. • Documentation may include intake forms, stand-alone forms, or other available documentation.	1) Provider has no method in place to document information about the individual's behavioral/emotional health. 2) Key/Critical pieces of behavioral/emotional health information were absent from the record.	C

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#	Performance Measure/Standard	Protocol	Not Met Reasons	
18	The provider documents efforts to ensure the individual's health and health care needs are addressed.	CMS Assurance – Health and Welfare RECORD REVIEW Health and health care includes medical conditions, medications (prescription and over-the-counter), preventive healthcare, wellness exams, therapeutic intervention, medical device/apparatus. • Ask the provider to describe the method used to gain knowledge of individual's health needs. • Review file for documentation of gaining knowledge of person's health needs. • Look for evidence the provider has solicited information regarding the person's health and health care needs; the provider has taken steps to address the person's needs – medical appointments, education, procuring medical services/devices. • Ask the provider how he/she has addressed the individual's health and health care needs. • Review the record for documentation the person obtains routine and preventative medical and dental care. • Review Implementation Plan, Service Logs, quarterly meeting notes and any other documentation for evidence the provider addresses the individual's health and healthcare needs on a routine basis. • Some of this information may be found in the Functional Community Assessment, quarterly Housing Survey and/or Quarterly Summary.	1) Documentation did not indicate the provider was aware of the person's health and health care needs. 2) Documentation indicated the provider was aware of the person's health and health care needs but had not addressed them.	C
19	The provider documents efforts to assess and address safety skills and safety needs of the individual.	CMS Assurance – Health and Welfare RECORD REVIEW • Ask the provider to describe the method used to gain and	1) Documentation did not indicate the provider was aware of the individual's safety needs and safety skills. 2) Documentation indicated the provider	C

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		document knowledge related to the safety skills of the person. What are areas of need regarding safety (i.e. natural disasters, community safety, home safety, etc.)? • Review the record for Functional Community Assessment, Implementation Plan, Housing Survey's, Service Logs, disaster plan, Quarterly Summaries and any other documentation for evidence the method is being implemented and the information is being documented.	was aware but had not addressed the individual's safety needs and safety skills.	
20	Provider documents efforts to assist the individual to define abuse, neglect, and exploitation including how the individual would report any incidents.	CMS Assurance - Health and Welfare RECORD REVIEW • Ask the Provider to describe the process used to gather information on how the person receiving services defines abuse. • Ask the Provider how the person receiving services would report abuse if it were to occur. • Ask the Provider how the person receiving services has been educated on the definition of abuse neglect and/or exploitation. • Review the Support Plan, Progress Notes and other documentation for documentation on the person's definition of abuse. • Review the Support Plan, Progress Notes and other documentation for documentation on education the Provider has provided regarding abuse, neglect and/or exploitation.	1) Documentation indicated the Provider had no knowledge of how the person receiving services would define abuse, neglect, and/or exploitation. 2) Documentation indicated the Provider had no knowledge of how the person receiving services would report any incidents of abuse, neglect, and exploitation. 3) Documentation did not indicate efforts to provide education to the person receiving services in this area.	C
21	The provider submits documents to the Waiver Support Coordinator as required.	CMS Assurance - Service Plan RECORD REVIEW • Ask the provider to describe the method used to submit documents to the Waiver Support Coordinator (WSC).	1) Provider did not have documented evidence of submitting copies of Daily Attendance Logs. 2) Provider did not have documented evidence of submitting a copy of the	C

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		• Review 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, submission tracking logs, date stamps, or indication of date of submission and method sent on the documentation. • Review the Implementation Plan to determine date mailed to Waiver Support Coordinator (WSC). o Within 30 days following the effective date of the Support Plan or initiation of new service. • Review Daily Attendance Logs for evidence of submission to the WSC. • Review Quarterly Summary to determine date mailed to Waiver Support Coordinator (WSC). • Review third Quarterly Summary/Annual Report to determine date mailed to Waiver Support Coordinator (WSC). o At least 30 days prior to the effective date of the Support Plan. If the provider has not rendered services for 30 days or more, score N/A.	Implementation Plan within 30 days following the Support Plan effective date. 3) Provider had documented evidence of submitting a copy of Implementation Plan but not within 30 days of the Support Plan effective date. 4) Provider did not have documented evidence of submitting a copy of the Implementation Plan within 30 days following initiation of new service. 5) Provider did have documented evidence of submitting a copy of the Implementation Plan but not within 30 days following initiation of new service. 6) Provider did not have documented evidence of submitting Quarterly/Monthly summaries. 7) Provider did not have documented evidence of submitting the third Quarterly/Annual Report at least 30 days prior to the annual Support Plan effective date. 8) Provider had documented evidence of submitting the third Quarterly/Annual Report but not at least 30 days prior to the annual Support Plan effective date.	