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)

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)

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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 Methods employed to assist the individual 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.
4	The Implementation Plan is provided to the	CMS Assurance - Service Plan RECORD REVIEW	1) Provider did not have documentation the Implementation Plan was provided to the

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	individual and when applicable, the legal representative, within required time frames.	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.	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.
5	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 person has recently achieved.	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 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

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		• 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.	Support Plan effective date.
6	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). • Review Annual Report for content to ensure it includes at a minimum: o A summary of the first three quarters of the Support Plan year o Description of the person's progress, or lack thereof, toward achieving each of the goals identified on the Support Plan based on service rendered. o • Determine if progress statements are consistent with supporting data in documentation. • 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	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 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. 4) 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)

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		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**	
7	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). o 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.	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.

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		o Consider provider due diligence in securing corrected Service Authorizations when incorrect ones are received.	
8	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. If necessary, request Remittance Vouchers to compare. **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) 3) Unable to determine due to absence of supporting documentation.
9	The Provider is in compliance with billing procedures and the Medicaid provider	CMS Assurance – Financial Accountability RECORD REVIEW Provider is not to bill for services prior to rendering. • Review Claims data for date billed.	1) Provider billed for services prior to rendering services on one or more dates during the period under review. 2) Provider is a solo provider but is billing at the agency rate. (B)

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	agreement.	• Review dates on Daily Attendance Logs. • 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. Determine whether or not services were rendered prior to billing for each month in the review period. Provider bills the appropriate rate: • Solo vs. Agency (Daily live-in rate) • Non-Geographical, Geographical, Monroe rates **This standard is subject to identification of a potential billing discrepancy**	3) Provider billed the monthly rate when less than 24 days of service were rendered. (B)
10	The provider addresses the individual's choices and preferences.	CMS Assurance - Service Plan RECORD REVIEW/PROVIDER INTERVIEW • Ask the provider to explain method of soliciting and documenting individual's choices and preferences as related to this service. • 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.	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 individual's choices and preferences related to this service. 3) Provider was aware of but had not documented the individual's choices and preferences related to Residential Habilitation.

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		If service rendered under 45 days by provider, score N/A.	
11	The provider assists 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 could not describe efforts and documentation did not reflect evidence of assisting the individual to increase community participation and involvement based on his/her interests. 2) Provider was able to describe efforts to assist the individual to increase community participation and involvement based on his/her interests, but had not documented the information. 3) Documentation indicated the provider was aware of community interests, but had not addressed the individual's interests regarding community participation and involvement.
12	The provider assists the individual/legal representative to know about rights.	CMS Assurance - Service Plan RECORD REVIEW/PROVIDER INTERVIEW • 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 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.	1) Provider documentation did not reflect evidence of assisting the individual/legal representative to know about rights related to this service. 2) Provider was able to describe efforts to assist the individual/legal representative to know about rights related to this service, but had not documented efforts.

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13	The provider has a method in place to gather information about the individual's physical and, behavioral/emotional health on an ongoing basis.	CMS Assurance – Health and Welfare RECORD REVIEW/PROVIDER INTERVIEW • Ask the provider for method of documenting historical physical and behavioral/emotional health. • Ask the provider for method of collecting and documenting current information about the individual's physical and 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 gather information about the individual's physical, health. 2) Provider has no method in place to gather information about the individual's behavioral/emotional health. 3) The provider is knowledgeable of the individual's physical health but documentation does not demonstrate provider's efforts to gather information for their records 4) The provider is knowledgeable of the individual's behavioral/emotional health but documentation does not demonstrate provider's efforts to gather information for their records. 5) Key/Critical pieces of physical health information were absent from the record. 6) Key/Critical pieces of behavioral/emotional health information were absent from the record.
14	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). • 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	1) Provider did not have evidence of submitting copies of Daily Attendance Logs. 2) Provider did not have evidence of submitting a copy of the Implementation Plan within 30 days following the Support Plan effective date. 3) Provider had evidence of submitting a copy of Implementation Plan but not within 30 days of the Support Plan effective date. 4) Provider did not have evidence of submitting a copy of the Implementation Plan within 30 days following initiation of new service. 5) Provider did have evidence of submitting a copy of the Implementation Plan but not within 30 days

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		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.	following initiation of new service. 6) Provider did not have evidence of submitting Quarterly/Monthly summaries. 7) Provider did not have evidence of submitting the third Quarterly/Annual Report at least 30 days prior to the annual Support Plan effective date. 8) Provider had evidence of submitting the third Quarterly/Annual Report but not at least 30 days prior to the annual Support Plan effective date.