Service Specific Record Review – Respite (under 21 only)

#	Performance Measure/Standard	Protocol	Not Met Reasons	CMS Assurance
1	The provider has complete Service Logs covering services provided and billed during the period under review.	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW • Review Services Log(s) for the entire period of review. • Determine that Service Log (s) include all required components. ▪ Name of the service rendered ▪ Name of individual receiving service ▪ Name of individual providing service ▪ Date of service ▪ Time in/out ▪ Brief synopsis of the goal(s) addressed/service provided. • Review Service Log (s) against claims data to ensure accuracy in billing. • If necessary, request Remittance Vouchers to compare. **This standard is subject to identification of a potential billing discrepancy**	1) Provider did not have Service Logs for some/all dates of services for which claims were submitted. (B) 2) (New) Service Logs covering services provided and billed during the period under review did not contain the name of the service. 3) Service Logs covering services provided and billed during the period under review did not contain the recipient's name. (B) 4) Service Logs covering services provided and billed during the period under review did not contain the date service was rendered. (B) 5) Service Logs covering services provided and billed during the period under review did not contain time in/out. (B) 6) (New) Service Logs covering services provided and billed during the period under review did not contain name of individual providing the service. 7) Service Logs covering services provided and billed during the period under review did not contain a brief synopsis of the goal(s) addressed/service provided. (B) 8) Discrepancies were noted between units billed and services documented. (B)	Financial Account.
2	The provider maintains accurate Service Authorization(s) covering services provided and billed during the period under review.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW Service Authorizations are provided quarterly or more frequently as changes dictate.	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	Service Plan

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		• Review the Service Authorization for Respite to 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 <u>and</u> 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.	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.	
3	The provider renders the service in accordance with the Handbook.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW • Review provider records for Service Authorizations. • Determine Service Authorization(s) are available covering services provided and billed during the period under review. • Determine if services are being provided in accordance with the Handbook. • Review data collection documentation and Service	1) Provider documentation indicated services were rendered in groups larger than the authorized ratio. (B) 2) Provider documentation indicated services were rendered in a group larger than 3 recipients. (B) 3) Service is not being rendered in accordance with the Handbook. (B) 4) Unable to determine due to absence of supporting documentation.	Service Plan

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		Logs for information that supports frequency of service provision approved ratio. (Days per week/month, etc.) • 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. • If service authorizations are not present for some or all of the period under review other documentation such as service logs, daily progress note, implementation plans, support plans, etc. can be used. If service is being routinely rendered at a frequency less than or greater than the Service Authorization, score as Met and add a discovery. **This standard is subject to identification of a potential billing discrepancy**		
4	The Provider is in compliance with billing procedures and the Medicaid provider agreement.	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW Provider is not to bill for services prior to rendering. • Review Claims data for date billed. • Review dates on Service Logs. • 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 • Approved ratio of 1:1, 1:2, or 1:3	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) 3) Provider billed at an incorrect rate. (B)	Financial Account.

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		This standard is subject to identification of a potential billing discrepancy		
5	When 10 or more hours of service are rendered a day (40 QH/Day) service is billed at the daily rate.	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW Respite services are billed by the quarter hour up to 39 quarter hours or by the day if the individual is receiving 10 hours (40 quarter hours) or more per day. • Review Service Log (s) and Claims Data to determine if services rendered in excess of 39 qh/day are billed at the Respite daily rate. • If necessary, request Remittance Vouchers to compare **This standard is subject to identification of a potential billing discrepancy**	1) Respite services rendered and billed in excess of 39 quarter hours were not billed at the daily rate. (B)	Financial Account.
6	Provider renders service only to individuals under age 21 who live in the family home.	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW • Review Support Plan and/or other provider documentation to determine the individual receiving service is under the age of 21. • Review Support Plan and/or other provider documentation to determine the individual receiving service lives in the family home. **This standard is subject to identification of a potential billing discrepancy**	1) Provider rendered services to an individual 21 years of age or older. (B) 2) Provider rendered services to an individual living in a licensed residential facility. (B) 3) Provider rendered services to an individual living in supported living. (B) 4) Provider rendered services to an individual living in their own home. (B) 5) Unable to determine due to absence of supporting documentation.	Financial Account.

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7	Services are rendered only in the recipient's family home, while involved with activities in the community, in a licensed group home, foster home, or assisted living facility (ALF).	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW • Ask the provider where services are rendered • Review Service Log (s) to determine where service occurs. • Look for indications the provider is rendering the service in the individual's home, community or licensed facility. • Recipients may not receive this service while in the provider's personal residence at any time. **This standard is subject to identification of a potential billing discrepancy**	1) Provider documentation indicates services are provided in the personal residence of provider. (B) 2) Unable to determine due to absence of supporting documentation.	
8	The provider addresses the individual's choices and preferences.	CMS Assurance - Service Plan iBudget Handbook 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 Service Log (s) to determine if choices and preferences are solicited and addressed within documentation. • Review Support Plan to determine if person's choices	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) Provider was aware of but had not documented the individual's choices and preferences.	Service Plan

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#	Performance Measure/Standard	Protocol	Not Met Reasons	CMS Assurance
		and preferences are identified and match provider activities. If service rendered under 45 days by provider, score N/A.		
9	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 iBudget Handbook 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 file 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 record. 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 record. 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.	Health & Welfare
10	The Provider submits documents to the Waiver Support Coordinator as required.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW • Ask the provider about their method of submitting required documents to the Support Coordinator. ▪ Service Logs • Review Service Logs or other available documentation for proof of submission to the Support	1) Provider did not have evidence of submitting copies of Service Log (s).	Service Plan

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#	Performance Measure/Standard	Protocol	Not Met Reasons	CMS Assurance
		Coordinator. • 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.		