Service Specific Record Review – Special Medical Home Care

#	Performance Measure/Standard	Protocol	Not Met Reasons	CMS Assurance
1	The provider maintains Daily Progress Notes covering services provided and billed during the period under review.	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW The Daily Progress Note is summary of support provided during the contact and must include: • Name of individual receiving service • Name of the person providing the service • Date of service • Time in/out • Notes should be directly related to the individual's plan of care and treatment. • Progress toward achievement of Support Plan goals • Review Daily Progress Notes for the entire period of review. • Determine that Daily Progress Notes include all required components. • Review Daily Progress Notes 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 maintain Daily Progress Notes covering services provided/billed during the period under review. (B) 2) Daily Progress Notes covering services provided/billed during the period under review did not include the individual's name. (B) 3) (New) Daily Progress Notes covering services provided/billed during the period under review did not include the name of the person providing the service. 4) Daily Progress Notes covering services provided/billed during the period under review did not include a time in/out. (B) 5) Daily Progress Notes covering services provided/billed during the period under review did not include the date service was provided. (B) 6) Daily Progress Notes covering services provided/billed during the period under review were not directly related to the plan of care and treatment. (B) 7) Daily Progress Notes covering services provided/billed during the period under review did not address support plan goals with progress noted. (B) 8) Discrepancies were noted between units billed and services documented. (B)	Financial Account.
2	The record includes the current Nursing Care Plan and revisions.	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW	1) Nursing Care Plan did not contain revisions to reflect current health status. 2) Nursing Care Plan was not completed prior to the initial claim submission. (B)	Financial Account.

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		• Review Nursing Care Plan for period under review. • Review for revisions to reflect current health status. • Review for annual update. • Ensure Nursing Care Plan is done by an RN or ARNP. **This standard is subject to identification of a potential billing discrepancy**	3) Nursing Care Plan had not been updated on an annual basis. (B) 4) Nursing Care Plan was not provided for review. (B) 5) Nursing Care Plan was not completed by an RN or ARNP. (B)	
3	The record includes the Nursing Assessment (completed at the time of the first claim submission and annually thereafter).	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW • 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) Nursing Assessment was not completed by an RN or ARNP. (B) 2) Initial Nursing Assessment was not in the record. (B) 3) Initial Nursing Assessment was not completed prior to the first claim submission. (B) 4) Nursing Assessment was not completed annually. (B) 5) Nursing Assessment had not been updated to reflect significant changes in the individual's health status. (B)	Financial Account.
4	The record includes prescription for the service.	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW • A new prescription needs to be obtained every 12 months.	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)	Financial Account.

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		• Review record to ensure an original prescription(s) (not a copy) is on file for entire period of review. This may require review of 2 prescriptions in order to cover the period of review. **This standard is subject to identification of a potential billing discrepancy**		
5	The record includes the list of duties to be performed by the nurse.	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW • Review record for a current list of specific nursing duties.	1) There was no list of duties to be performed by the nurse in the record. 2) List of duties was generic and not specific to the individual's needs.	Financial Account.
6	The provider maintains current Service Authorization(s) for the service being rendered and billed.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW Service Authorizations are provided quarterly or more frequently as changes dictate. • Review the Service Authorization for Special Medical Home Care 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.	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.	Service Plan

#	Performance Measure/Standard	Protocol	Not Met Reasons	CMS Assurance
		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.		
7	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. • Review data collection documentation and Daily Progress Notes for information that supports frequency of service provision. • If service authorizations are not present for some or all of the period under review other documentation such as service logs, daily progress note, Nursing Care Plan, support plans, etc. can be used. **This standard is subject to identification of a potential billing discrepancy**	1) Unable to determine due to absence of supporting documentation. 2) Service is not being rendered in accordance with the Handbook. (B)	Service Plan
8	The provider is in compliance with billing procedures and the	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW	1) Provider billed for services prior to rendering services on one or more dates during the period under review.	Financial Account.

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#	Performance Measure/Standard	Protocol	Not Met Reasons	CMS Assurance
	Medicaid provider agreement.	Provider is not to bill for services prior to rendering service. • Review Claims data for date billed. • Review dates on Daily Progress Notes. • Determine whether or not services were rendered prior to billing for each month in the review period.	2) Provider billed at an incorrect rate. (B)	
9	The provider does not receive reimbursement for Residential Habilitation or Residential Nursing services.	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW • Review to ensure that the provider is not receiving payment for Residential Habilitation or Residential Nursing.	1) The provider received reimbursement for Residential Habilitation services. (B) 2) The provider received reimbursement for Residential Nursing services. (B)	Financial Account.
10	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. • For Special Medical Home Care a well written and updated Nursing Care Plan may meet this requirement.	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 the 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 the records. 5) Key/Critical pieces of physical health and	Health & Welfare

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			information were absent from the record. 6) Key/Critical pieces of behavioral/emotional information were absent from the record.	
11	The provider submits documents to the Waiver Support Coordinator as required.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW Review documentation to assure: • Daily Progress Notes are submitted. • Nursing Care Plan is done at the time of initial claim submission and annually. • Nursing Assessments are completed prior to or at the time of claim submission and annually. • Copy of original prescription for services was turned in.	1) The provider did not have evidence of document submission of Daily Progress Notes. 2) The provider did not have evidence of document submission of Nursing Care Plan at time of initial claim submission and annually thereafter. 3) The provider did not have evidence of document submission of Nursing Assessment prior to or at time of first claim submission and annually thereafter. 4) The provider did not have evidence of document submission of a copy of original prescription for the service.	Service Plan