# DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD)
# DEPARTMENT OF HEALTH (DOH)
# Developmental Disabilities Waiver Program

TECHNICAL ASSISTANCE DOCUMENT

## *Service Delivery Documentation*

Effective Date August 15, 2010

### Requirements of Development Disabilities (DD) Waiver Service Providers

*What are provider responsibilities in documentation of direct services?*

These guidelines describe required elements of documentation of direct service delivery in accordance with relevant Medicaid regulations and recommended practices for documentation of direct services. These guidelines focus on the documentation that direct service providers are required to maintain to substantiate the delivery of authorized services. These guidelines are designed to assist the provider agency in understanding the documentation needed to support payment for services rendered and should be used as a tool to assure that providers have adequate documentation to bill in a manner which complies with Medicaid (Human Services Department/Medical Assistance Division, HSD/MAD) regulations as well as DD Waiver Service Standards.

These guidelines do not address documentation for eligibility determination, or the required contents of provider or case management agency case files for individual's receiving service. These guidelines **do not** supersede any other required documentation or reporting requirements, including specific requests from the DOH for ad hoc reporting.

The relevant regulation regarding provider service delivery documentation includes, but is not limited to:

**8.302.1 NMAC, Amended 9-15-08: "Medicaid General Provider Policies"**

| **Record Keeping and Documentation Requirements** | |
|---|---|
| A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past | |
| Citation: 8.302.1.17 Effective Date 9-15-08 | |

| **Detail Required in Records** | |
|---|---|
| Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed, diagnosis and medical necessity of any service . . . Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient. | |
| Citation: 8.302.1.17.A Effective Date 9-15-08 | |

| Services Billed by Units of Time | |
|---|---|
| Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit. | |
| Citation: 8.302.1.17.C Effective Date 9-15-08 | |

| Records Retention | |
|---|---|
| A provider who receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:<br>(1) treatment or care of any eligible recipient<br>(2) services or goods provided to any eligible recipient<br>(3) amounts paid by MAD on behalf of any eligible recipient; and<br>(4) any records required by MAD for the administration of Medicaid. | |
| Citation: 8.302.1.17.E Effective Date 9-15-08 | |

## Data Elements that Document Service Delivery

*What key items must be captured in documentation to assure that the documentation meets the requirements of 8.302.1 NMAC?*

Comprehensive documentation of direct service delivery that complies with 8.302.1 NMAC must include several key items. While the format utilized to document these items may vary, the documentation must, at a minimum, include the following:

1. Agency Name
2. Name of recipient
3. Location of service
4. Date of service
5. Type of Service
6. Start Time of Service
7. End Time of Service
8. Staff Signature/Title (as applicable) for entire period of service (if multiple staff document for different periods of the service, all staff who document must sign for their time period)
9. What did the staff provide (care and treatment) for the individual—in other words, what occurred and what direct support was provided to the individual receiving service
10. Outcomes of the services, including any successes, barriers, or problems that occurred during the provision of services

By documenting the above information, the provider agency will have evidence to support Medicaid billing, provided that the individual's Individual Service Plan (ISP) and/or treatment plans indicate a need for both the level and type of support which is documented. It is essential to assure that the level and type of

service provided is supported in the ISP and/or other treatment plans prior to service delivery and billing.

## RECOMMENDED TYPES OF DOCUMENTATION

*What types of forms support and verify delivery of services for payment from Medicaid?*

**Daily Log or Progress Notes**

These documents should be completed for all face-to-face time spent with the individual served. While for residential or day services, the contact may be daily; these forms may also be used for more intermittent services such as therapies and case management. For every page of Daily Log or Progress Notes, the individual's name and date of service must be clearly marked on the document. The regulation states that "time of service" must be indicated in the service delivery documentation. DDSD and MAD have interpreted this requirement as being successfully documented if a provider includes both a start and end time of service. This requirement cannot be met by just recording time intervals (such as one hour).

Complete Progress Notes will include a description of what activities occurred and what assistance was provided to an individual. This log should document support services or work on outcomes/action plans, even if the individual refused to participate or minimally participated (note these things as well). Also important to note are the responses and reactions from the individual to the activity or treatment that occurred.

For each Daily Log or Progress Note, it is required that the person delivering the service include their signature (and title when applicable) for the entire period of service. If the notes are kept electronically, an electronically verified signature is permissible. A note that is not signed (and/or without signature and title when applicable) is not complete according to Medicaid regulations. (Please note that each note requires the full signature of the person delivering the service. Initials will not be accepted.)

Depending on the type of service, the format of Daily Logs/Progress Notes may greatly vary. For example, the form may capture activities of daily living (for residential services) or be in the form of clinical notes (for therapies). The Daily Logs/Progress Notes format must include the type of service being provided (i.e. supported living, case management, etc.) It is important that this type of documentation describes service delivery that is consistent with the Individual Service Plan and the Service Definitions/Standards for the type of service. It is important to note that a provider may only document one service on each piece of documentation. If a provider provides multiple services to an individual (i.e. community access AND adult habilitation), the provider must use two separate documents to capture the daily activities. DOH/DDSD and HSD do not accept the documentation of multiple services on the same form.

DOH/DDSD does not require a specific format to capture documentation of service deliver for any service,, however DOH/DDSD has posted examples of

documentation on their website located at http://www.health.state.nm.us/ddsd/rules/TA/TAGuideForSvcDeliv.htm#Sec3. A provider is free to choose to use any of the formats on the website or must receive formal approval from DDSD to use an alternate format.

Upon request of DOH, MAD or other relevant state agency the provider must submit the complete note which includes all forms covering all components. **Failure to submit requested documentation to Medicaid to support services billed may result in recoupment**.

**ISP Implementation Data Collection**

The Individual Service Plan for each individual should indicate how Outcome and Action Step data will be recorded in the documentation column of the Action Plan in each individual's ISP. If regular written documentation of Outcome, Action Step and Meaningful Day information is necessary to document ISP implementation, the Daily Logs/Progress Notes can also be used to collect this information.

Alternately, the ISP may indicate an alternate methodology to collect information on implementation of the ISP or other service plans. Some examples of this alternate documentation include the collection of pictures, receipts, bank statements, or other tangible evidence of implementation. It is necessary for the responsible service provider to collect data as stated in the ISP or other types of support plans.

It is important to note that while a provider may use an alternate methodology to provide evidence of ISP implementation, in no case can a provider bill for service if the provider does not have Daily Logs/Progress Notes detailing service provision. **Failure to maintain this evidence, and provide upon request to Medicaid may result in recoupment of funds.**

**Quarterly Progress Reports**

The Quarterly Progress Report answers questions about how Outcomes and Actions Steps are being met, and how the data of the past few months supports the need and recommendation for future provision of services. The focus is on progress—and therefore, quality of services. This form also provides information to the IDT on when to continue, discontinue, or revise outcomes and action steps. It is important to assure that the Quarterly Progress Report focuses on progress and quality of services.

Every DD Waiver service provider, except for respite, case management, and certain therapies, must prepare a comprehensive and analytic written quarterly progress report. (See DD Waiver Service Standards for specific requirements for quarterly reports by service.) This report is submitted to the case manager for review and may guide actions taken by the individual's IDT if necessary.

**Annual Report**

The Annual Report is a document provided to the entire team **two weeks prior** to the annual ISP meeting. This report must include justification for continuation

of services and summary of service delivery for the previous year. The annual report or annual summary is not merely a summary of the four quarterly reports; it is a tool to assist the team to plan effectively for the upcoming year. In addition to summarizing progress for the past year, the annual report should also include: what worked for the individual, what did not work for the individual, ideas to address barriers, and implications for planning for the next year (e.g. observed preferences, motivation and interests). If a provider chooses, they can attach the annual report to the third quarterly report for the individual's ISP term. In this case, it must incorporate data from the fourth quarter of the previous ISP term and the first three quarters of the current ISP term. This information must be clearly described in the report.

Every DD Waiver service provider, except for respite and case management, must prepare a comprehensive and analytic written annual report. (See DD Waiver Service Standards for specific requirements for annual reports by service.) This report is submitted to the entire IDT at least two weeks prior to the annual ISP meeting and is used to support development of the ISP for the coming year.

## WHAT REQUIREMENTS ARE COVERED BY DIFFERENT FORM TYPES

*What types of forms are recommended to meet the requirements of 8.302.1 NMAC and what areas of the Medicaid regulation are covered by these forms?*

The table below identifies the forms which providers may develop and utilize to meet the requirements outlined above for documentation of direct service delivery. For each form, the specific items to be included and the specific requirements which will be met by these documents is explained.

Other forms may be required by DDSD for specific service requirements (For Example: Supported Employment Quarterly Report, individual assessments to support eligibility, IR Form to report an incident of suspected abuse/neglect.) Those forms are not described herein.

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| FORM AND ITEMS | MANDATEDREQUIREMENT |
|---|---|
| **1. Daily Log/Progress Note/Exception Report**<br>➢ Individual Name<br>➢ Agency Name<br>➢ Date<br>➢ Time (start/end)<br>➢ Type of Service<br>➢ Specific information about the services provided for the time of the service documented<br>➢ Responsible Staff (signature/Title (as applicable) | *Date*<br>*Time In*<br>*Time Out*<br>*Eligible Recipient Name*<br>*Service Information*<br>*Care Provided*<br>*Level of Support Provided*<br>*Name (Signature) of Provider Staff*<br>*Outcome/Action Step Tracking*<br>*Meaningful Day Implementation*<br>*Location of Service* |
| **2. ISP Implementation Data Collection**<br>➢ Progress (e.g. level of prompting, response)<br>➢ Frequency (dates, number of attempts) | *Service Provided*<br>*Level of Support Needed*<br>*Outcome/Action Step Tracking,success, barriers or problems encountered* |

| | *Meaningful Day Implementation* |
|---|---|
| **3. Quarterly or Progress Reports**<br>➢ Progress on Outcomes/Action Steps<br>➢ Link progress to the Individual Service Plan (ISP) | *Care and treatment provided*<br>*Necessity of Service* |
| **4. Annual Report**<br>➢ Justification for Continuation of Service<br>➢ Summary of Previous Year<br>➢ Implications for Planning for Service | *Necessity of Service*<br>*Implications for Planning* |

It is essential is to assure that all documents which are being utilized to meet the requirements are fully completed and available upon request by DOH, HSD/MAD or other relevant state agency.

## DOCUMENTATION MISTAKES TO AVOID

*What common mistakes do providers make with documenting service delivery?*

**Mistake 1—Failure to have a Time in and Time out for each period of service**
8.302.1.17.A. NMAC clearly states that "Provider Records must be sufficiently detailed to substantiate the . . . time . . ."

The regulation requires that the exact time of each service is to be documented. The way to document the exact time (or period of time if broken into smaller units) is to clearly state the in and out time for the service. It is not adequate to merely state a length of time (i.e. one hour, forty-five minutes, etc.). Failure to provide a clearly stated in and out time results in inadequate documentation to support billing. When documents are reviewed by DOH, HSD/MAD, or another state agency, failure to have a clearly stated in and out time for the service may result in recoupment of funds and a Corrective Action Plan (CAP) by Medicaid.

**Mistake 2—Failure to have a Signature/Title for each uninterrupted period of service**
8.302.1.17.A. NMAC states "Provider Records must be sufficiently detailed to substantiate the . . . rendering . . . provider . . ."

The regulation requires that the service delivery and documentation is verified by the person providing the service. The accepted verification is either hand-written or electronic signature. This signature and title must be documented for each period of time for which the service is billed. It is not adequate to sign at the end of the month or the end of a page. The signature must be made for each note for a period of unbroken service (i.e. it can be made at 3 p.m. for traditional day habilitation or 9 a.m. for traditional residential.) If reviewed by DOH, MAD, or other state agency, failure to have either a hand-written or electronic signature for each period of uninterrupted service may result in recoupment of funds and CAP.

**Mistake 3—Blending of services in Progress Note/Billing Documentation**

**8.302.1.17. NMAC states "**Services billed . . . must be sufficiently detailed to document . . . the services provided during that time unit."

All DD Waiver services must be documented in a format that clearly shows the specific service and the calculated number of hours to be billed. It is not acceptable to document two separate services on one form. The provider must use separate documentation to support each service, even if the services are provided as a combined service delivery model. For example, many providers offer a combination of adult habilitation and community access or family living with respite. Each of these services must be documented using separate forms.

**Mistake 4—Failure to include sufficient information to document the service**

8.302.1.17.C. NMAC states "Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document . . . the services provided during that time unit."

All DD Waiver services are billed on the basis of time units and must have detailed notes to explain the services provided. This detail includes general descriptions of what occurred, how much assistance the individual required, individual reaction, etc. This regulation does not require a comprehensive explanation of every single occurrence throughout the billing period, but it does require more than a single one line statement that must include the date. Adequate documentation will allow the reader to have a general impression of how the period of service went, including both routine and non-routine events, and any ISP implementation information. If reviewed by DOH, HSD/MAD, or other state agency, failure to have sufficient detail in documentation may result in recoupment of funds and a CAP.

**Mistake 5—Over-documentation**

Many providers require their direct service staff to complete unnecessary documentation or to include specificity which is not required by the standards or regulations. Some examples of over documentation include:

- Documentation of what occurs for each 15 minute period throughout the day – the requirement (as stated previously in this document) is to include the start time and end time of a period of uninterrupted service delivery. For example: 6 a.m. to 9 a.m. with a description of what occurred during the three hours is sufficient, there would be no need to specify what occurred every 15 minutes during the three-hour timeframe.
- An individual's response to each activity throughout the day may not be helpful. – Alternately, capturing an individual's response to a new activity, their response to work towards their ISP Action Plans, or including a different response than is typical for the individual would be very helpful for further planning and support provision. For example if the individual typically enjoys the morning shower routine but today became aggressive with staff, it would be important to include this unusual response to the activity in the documentation. Another example would be if an individual attended a concert, this was a new activity for them, it would be helpful to

know how they responded to this activity; whereas if an individual regularly attends a Tuesday evening coffee house and it is already part of their meaningful day the documentation would not need additional detail of their response to the outing (unless it was different than was typical for them).

- Listing all activities of daily living (ADLs) and the level of prompting required can be tedious and repetitive. The more this information is included in the daily documentation the less time and space is available for meaningful information to assist in future planning and support provision. The required level of support for an individual with their ADLs should already be documented throughout their ISP as well as in required assessments (i.e. HAT, MAAT, ABS, etc…). Another source of this information is health tracking (i.e. bowel tracking, fluid intake, etc…). If the individual is showing a change in the level of supports needed or has a condition that requires close monitoring for change it would make sense to include that information in the daily documentation. For example, if the individual has a history of bowel obstruction it may be necessary to include more detail in the documentation around supports provided during personal care. Another example would be if the individual is requiring more support than is typical for them with walking to prevent falls and/or injury. Any change in this area should be included in the daily documentation; on the contrary, all supports provided with ADLs is excessive documentation and may not be helpful or meaningful.

This specificity in daily documentation is not necessary and may not be helpful with documenting service delivery or assisting in planning. Direct service providers should document what has been outlined as required in this document, the NMAC regulations, DDSD Standards, Performance Contracts for Community Inclusion Services, or additional requirements from the individual's IDT. It is important to remember that daily documentation is to capture what services and supports were provided to the individual during the documented timeframe of service delivery, rather than a reiteration of the individual's ISP and related support plans.

## SAMPLE FORMATS

Links to sample templates to document each of the service types referenced above can be found on the DDSD Website on the Provider Information tab under the heading Sample Formats for Documenting Services (http://www.nmhealth.org/ddsd/providerinformation/providerinfopg1/htm) and on the Rules Tab under DDSD Guidelines (http://www.health.state.nm.us/ddsd/rules/TA/TAGuideForSvcDeliv.htm#Sec3). These forms will be updated as necessary to reflect expectations or new formats which may be adapted by providers.