Section VII

RECORD KEEPING

Record Keeping

Introduction

Record keeping is required both for clinical reasons and documentation of the expenditures of Medicaid funds.

Clinically structured record keeping assists the provider in documenting the participant's desired goals and the accomplishment of these goals. The participant and waiver provider work together to develop a Detailed Plan that reflects the participant's goals, identifies strategies for intervention, and reviews the effectiveness of these interventions. This provides a better understanding of whether the goals have been met and when interventions and/or goals need to be revised.

Accurate and up-to-date record keeping is required of all Medicaid providers to substantiate Medicaid billing. The need to maintain the necessary records is described in the Provider Agreement, the eMedNY Provider Manual and in this Program Manual. It is the responsibility of the provider to have clear and accurate documentation to support all Medicaid claims.

Providers must adhere to all Medicaid confidentiality and Health Information Portability and Accountability Act (HIPAA) requirements and ensure the privacy of the waiver participant.

In addition, all waiver providers must maintain a policy and procedure that assures the appropriate safeguard of all records containing any identifiable information regarding waiver applicants and participants. These policies and procedures must be disseminated to all staff.

The policy must include, but is not limited to:

- Maintaining records in a secured environment (e.g. locked files or locked Room) when they are not in use;
- Preventing exposure of information when records are in use;
- Identifying all information transmitted from one location to another as "confidential" in an appropriately secured manner;
- Obtaining prior authorization from the appropriate supervisory staff before records are taken outside the agency, and the return of records within one (1) business day;
- Properly informing applicants/participants of record collection procedures, access, utilization and dissemination of information;
- Specify procedures related to employee access to information; and
- Specify the disciplinary actions for violations of confidentiality statutes, regulations and policies.

All waiver providers must maintain waiver participant records for **at least six (6) years after termination** of waiver services.

Record-Keeping Components

The three major components of the record-keeping responsibilities of the waiver providers are:

1. Detailed Plans
2. Documentation of Encounters/Case Notes
3. Individual Service Reports (ISR)

Note: Waiver service providers of Assistive Technology (AT), Community Transitional Services (CTS), Congregate and Home Delivered Meals, Environmental Modifications Services (E-mods), and Moving Assistance are exempt from these three major components of record keeping but are required to have other types of documentation (Refer to "Record Keeping for Specific Waiver Providers" later in this section).

1. Detailed Plans

Each waiver provider must develop a Detailed Plan for each waiver participant they are serving. The Detailed Plan identifies the participant's goals for each waiver service and describes the interventions to be provided to assist the participant to achieve his/her goals. The Detailed Plan is an essential component of a participant's efforts to remain in his/her community of choice.
The development of the Detailed Plan begins with the provider interviewing the participant to establish the specific goals he/she wants to achieve through this service. Once these goals are established, information must be obtained regarding the participant's current level of functioning. This will occur through discussions between the provider, the participant and others. If the individual has been in a facility or has been receiving services in the community, it is essential to obtain any formal assessments which have been completed including discharge summaries. This may require discussions with staff from nursing homes, hospitals, certified home health agencies and licensed home care service agencies. The method for gathering baseline information may vary according to the particular waiver service. In addition, the provider may utilize information received from these assessments to complete the Detailed Plan. The provider is responsible for completing a thorough evaluation of the participant's basic skills and abilities related to the selected goals.

Even after the Detailed Plan has been developed, there must be an ongoing process where providers must objectively and constantly review the Plan's goals with the participant. This allows the provider to fully evaluate the participant's progress, address any areas of concern and make needed revisions to the Detailed Plan.

The Detailed Plan should include three components:

a. Milestones

Milestones are defined as component, intermediate steps which must be

accomplished to achieve a larger goal. For example, a participant's goal is to resume participation in preparing meals for his/her family. A milestone would be established through the planning, preparing and serving of dinner for three consecutive days.

b. Interventions

Once milestones are established, the provider determines what interventions will assist the participant to achieve the milestones and, eventually, the selected goal. A thorough understanding of the participant's unique strengths, deficits, interests and abilities will help guide the provider in the development of interventions. For example, ILST would work with the participant on the steps needed to plan a meal. This would include creating a menu, making a shopping list for items needed to make the meal, and purchasing needed items.

c. Timeframes

Timeframes include the frequency and length of the interventions and how long the participant and provider expect it will take for the participant to reach the selected goal. It is essential to set realistic timeframes to determine the success of an intervention and the stated goal. It can be equally important to assist a participant to recognize that a particular goal may not be obtainable but that the outcome of the goal can be accomplished through another means. For example, if a participant is not successful in achieving the milestone of planning and preparing one meal within the designated timeframe, re-evaluation of the milestone, interventions and/or timeframe must occur. This includes determining what other means can be utilized to help the participant accomplish the goal of participating in meals with his/her family.

2. Documentation of Encounters

The provider must document each face-to-face encounter with the participant as required by Medicaid for reimbursement. This documentation should provide a measure of how effective the intervention has been in supporting the participant in meeting their goals. It should contain a clear description of the staff's action, the participant's response to that action and progress toward the goals /milestone. Documentation of this encounter must include:

- the date,
- the location,
- the time and
- a description of the services provided, which are related to the goals established in the Detailed Plan.

This information must be recorded as soon as possible after each contact and reviewed for completeness each month.

In addition to documenting encounters, providers must keep case notes that reflect:

- communication with participants' family, friends, waiver and non-waiver providers;
- health and welfare issues and follow-up; and
- concerns expressed by the participant or others and the actions taken to address them.

All providers are responsible for maintaining open communication with other providers when concerns or changes with the participant occur that potentially affect the provision of services. However, each provider must be respectful of the participant's right to privacy and confidentiality regarding the sharing of information and have in place policies and procedures that support this.

3. Individual Service Reports (ISR)

The ISR (refer to Appendix C – form C.16) is an opportunity for the provider to describe its activities during the past six months and to describe the participant's future goals.

Waiver service providers are required to submit an ISR to the Service Coordinator (SC) for inclusion in each Revised Service Plan (RSP) (refer to Appendix C – form C.13). The ISR must be submitted to the participant's SC at least six (6) weeks prior to the end of each Service Plan (SP) period or at the Team Meeting held to discuss the development of each RSP. Failure to provide a timely ISR may result in provider Vendor Hold or Disenrollment (refer to Section V – The Service Plan of this Program Manual).

The following waiver service providers are required to submit ISR(s):

- Community Integration Counseling;
- Home and Community Support Services;
- Home Visits by Medical Personnel;
- Independent Living Skills Training Services;
- Nutritional Counseling/Educational Services;
- Peer Mentoring;
- Positive Behavioral Interventions and Supports;
- Respiratory Therapy;
- Respite Services;
- Service Coordination;
- Structured Day Program Services; and
- Wellness Counseling Services.

The ISR is directly related to the Detailed Plan and ongoing documentation of encounters with the participant. The Detailed Plan sets the overall design of the interventions to be implemented. The notes regarding ongoing interactions with the participant provide the information necessary to complete the ISR.

The ISR documents the progress of the participant in relation to the provided service, describes if there is a need for the continuation of the service and represents the provider's request for continued approval to provide the service. The completion of the ISR relies on a thorough review of the Detailed Plan by the provider with the participant.

To justify re-approval/continuation of a service, the ISR must clearly describe how the continuation of this service is needed to assure health and welfare of the participant in the community.

The ISR must identify responses to the following questions:

a. What were the participant's goals identified in the current SP?
b. What interventions were used to address goals?
c. How successful were the interventions utilized and what progress has been made towards the goals?
d. Did any barriers occur in the progress towards meeting the goals?
e. What will be the goals, expected interventions and outcomes for the next six (6) months?
f. What are the recommendations for frequency and duration of this service?
g. Why is this service needed to assure health and welfare in the next service plan?

Providers of the following waiver services are not required to complete an ISR for these services:

- Assistive Technology (AT);
- Community Transitional Services (CTS);
- Congregate and Home Delivered Meals;
- Environmental Modifications Services (E-mods); and
- Moving Assistance.

However, the SC must complete an ISR for each of these services with the participant and input from the waiver provider. The SC must clearly describe the anticipated costs and need for each of these services in the Service Plan. The approval process as outlined in Section VI - Waiver Services of this Program Manual and the required forms must be completed and submitted with each RSP.

Record Keeping for Specific Waiver Providers

1. <u>Requirements for Service Coordinators</u>

In addition to the three components of the record keeping responsibilities listed above (i.e. Detailed Plans, documentation of encounters/case notes and ISR), the SC shall maintain a file for each participant that includes:

a. The Application Packet including the ISP;
b. All completed Insurance, Resources and Funding Information

forms;

c. The original and all subsequent PRI and SCREENS;
d. All RSP(s), including all required documentation attached and ISR(s) submitted from other waiver service providers;
e. All Addendums;
f. All copies of Notices of Decision (NOD) forms and documentation that the participant has been informed about the NOD(s), including the right to an Informal Conference and/or Fair Hearing (as appropriate);
g. Summaries of all Team Meetings (refer to Appendix C – form C.17);
h. Initial and annual Waiver Participant's Rights and Responsibilities form (refer to Appendix C – form C.5) with the original signature and date;
i. Current Waiver Contact List (refer to Appendix C – form C.6);
j. All Plan for Protective Oversight (PPO) (refer to Appendix C – form C. 4);
k. Documentation of proof of the participant's current Medicaid eligibility each time the SP is submitted to the RRDS;
l. Documentation of Release of Information forms;
m. Documentation of the provision of Service Coordination services; and
n. Documentation of all other contacts with:
    - The participant;
    - Family and informal supports;
    - Local Departments of Social Services (LDSS);
    - Providers of waiver services;
    - Providers of non-waiver services;
    - Regional Resource Development Specialists (RRDS);
    - Nurse Evaluator (NE);
    - Quality Management Specialist (QMS);
    - DOH Waiver Management Staff (WMS); and
    - Any other significant contacts which affect the SP or reflect a change in the participant's situation.

In addition, providers of Service Coordination must maintain the following separate from the participant's record:

a. Provider Satisfaction Surveys regarding the participant's satisfaction with service(s) provided;
b. Documentation of any complaints or grievances received and the outcome of these situations; and
c. Documentation reflecting any involvement in the Serious Reportable and Recordable Incident processes.

Note: If the current Service Coordination agency was not the agency involved in

the development of the Application Packet, a copy of the Application Packet must be obtained from the previous Service Coordination agency or the RRDS and maintained by the current Service Coordination agency in the participant's record. For all other information, the SC is responsible for maintaining information which was obtained and/or written since involvement as the Service Coordination agency with the participant.

The SC is responsible for distributing the approved Service Plans to all waiver providers and ensuring each provider receives information that impacts the delivery of his/her services.

2. Requirements for AT, CTS, Congregate and Home Delivered Meals, E-mods, and Moving Assistance

These waiver service providers are responsible to maintain the following in the participant's record:

a. Bid(s) submitted to the SC, corresponding documentation regarding acceptance of bid(s), and RRDS final approval;
b. Services provided to any waiver participant;
c. Copy of page one of the SP and the pages regarding the need for the waiver service that is sent from the Service Coordinator;
d. The Notice of Decision (NOD) (refer to Appendix B – NOD.1 to NOD.9) sent from the SC;
e. Copy of the Initial and annual Participant's Rights and Responsibilities form, as applicable;
f. Documentation of Release of Information forms; and
g. Documentation of all contacts (through an encounter, or verbal/written communication) with:
    - The Participant;
    - Family and informal supports;
    - Providers of waiver services;
    - RRDS;
    - NE;
    - QMS;
    - DOH WMS; and
    - Any other significant contacts which affect the SP or reflect a change in the participant's situation involving the waiver service provider.

In addition, these waiver service providers must maintain the following separate from the participant's record:

a. Provider Satisfaction Surveys regarding the participant's satisfaction with service(s) provided;
b. Documentation of any complaints or grievances received and

the outcome of these situations; and

c. Documentation reflecting any involvement in the Serious Reportable and Recordable Incident process.

3. <u>Requirements for All Other Waiver Service Providers</u>

As noted earlier in this section, waiver service providers are responsible to maintain the three major components of Record Keeping (i.e. Detailed Plans, documentation of encounters/case notes and ISR). In addition to the documentation required by those components, providers must maintain in participant record:

a. ISP (refer to Appendix C – form C.1);
b. All RSP(s);
c. All Addendum(s) (refer to Appendix C – form C.15), if applicable;
d. All copies of Notices of Decision (NOD) forms;
e. Documentation of all Team Meetings attended and a copy of the completed Team Meeting Summary received from the SC;
f. Initial, as applicable and Annual Participant's Rights and Responsibilities form;
g. Current Waiver Contact List;
h. All Plan for Protective Oversight (PPO) forms received during provision of service(s);
i. Release of Information forms, as appropriate;
j. Documentation of the provision of services;
k. Documentation of all other contacts with:
   - The participant;
   - Family and informal supports;
   - Local Departments of Social Services;
   - Providers of waiver services;
   - Providers of non-waiver services;
   - RRDS;
   - NE;
   - QMS;
   - DOH WMS; and
   - Any other significant contacts which affect the SP or reflect a change in the participant's situation.
l. Service-specific assessments conducted or acquired, if applicable; and
m. Physician Orders (for providers of HCSS, Respiratory Therapy, Wellness Counseling, and Nutritional Counseling/Educational Services only).

In addition, other waiver service providers must maintain the following separate from the participant's record:

a. Provider Satisfaction Surveys regarding the participant's

satisfaction with service(s) provided;

b. Documentation of any complaints or grievances received and the outcome of these situations; and

c. Documentation reflecting any involvement in the Serious Reportable and Recordable Incident process.

Note: If a current waiver service provider was not the original waiver service provider agency involved at the time the ISP was approved, a copy of the ISP, current PPO, current RSP, any Addendum issued during the current RSP period, and NOD form(s) must be obtained from the Service Coordination agency and maintained in the waiver service provider's record for the waiver participant. For all other information, the waiver service provider is responsible for maintaining information which has been obtained and/or written since becoming involved as a waiver service provider agency for the participant.