# Home and Community-Based Services Internal Records Review for Providers

The Centers for Medicare & Medicaid Services (CMS) continues to implement activities focused on reducing payment errors and fraud, waste, and abuse in the Medicaid program. Through analysis of data produced by the Payment Error Rate Measurement (PERM) program, CMS identified payment errors for Home and Community-Based Services (HCBS). CMS has developed educational materials for beneficiaries and providers to address the major causes of error.

The quality of documentation is often a vital factor in providing services that meet beneficiary needs, demonstrate compliance with State and Federal policy, and support payment for services; therefore, every entity should have an established format and process for the internal review of documentation. In order for proper payment to be made for HCBS, Federal guidelines require that documentation exists to support:

- That the HCBS recipient is eligible;
- That the services are in accordance with the person-centered plan; and
- That the services were provided.[1]

State Medicaid agencies may require additional documentation for waiver programs, may require documentation be in specific formats, or may require documentation be submitted with some types of claims for payment to be made. This job aid has been developed to assist providers in a review of internal records to ensure that appropriate documentation exists to support claims for services billed.

## Defining Review Objectives

The first step in any review process is to define the objectives of your review. PERM data was analyzed and common errors were identified to create the elements used in the Quality Review Checklist.

The next steps are to decide the method you will use to select the records for review (for example, the records of all beneficiaries whose person-centered plan was reviewed and updated between X and Y dates, or the records for all beneficiaries who have had a change in provider between X and Y dates, etc.), then determine the number of records that will be reviewed. Be sure to choose a reasonable number of records to allow for a thorough review. For example, by allocating one hour per day, 20 records could be reviewed in a week. If you have not previously completed a records review, you may want to set a goal to review the records of all current beneficiaries. You will still want to choose a method to divide them into smaller groups so that the goal is obtainable over a period of time while still providing a thorough review.

## Elements of a Review

Complete a quality check of the documentation to ensure it supports the services billed. There are several criteria that will globally apply to all the records and documentation you review. These include:

- The beneficiary is identified according to standards on every page of each document;
- Plans of care or service plans have been verified to be active and up-to-date with all required signatures for authorization;
- Plans of care or service plans specifically identify the amount, duration, scope, cost limits, time frames, etc., of the services to be provided;
- Services provided are verified as legitimate, within the amount, duration, scope, time frames, and costs established in the person-centered plan and were provided by a person with the proper credentials to perform that type of service; and

- Progress notes/logs are legible and complete with correct descriptions of services provided, in-out times, correct number of units, required signatures, and the identity of the service providers.

The Quality Review Checklist has documentation requirements for proper payment. Use this for an internal quality review of records. The list is not intended to be comprehensive. Please check your State Medicaid agency provider website for additional elements required in your State.

## Quality Review Checklist

| Elements | Example Client | Client A | Client B |
|---|---|---|---|
| Beneficiary has been verified as eligible for any and all services provided. | ☑ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: |
| Beneficiary is identified on each page of each document describing the services provided. | ☑ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: |
| The person-centered plan is current (validated by dates and authorized signature; or, if held by a State agency, by a proper notification that includes date and signature). | ☐ Yes<br>☑ No<br>If No, explain: The person-centered plan does not include a date and signature. | ☐ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: |
| The person-centered plan includes current physician orders for the services, equipment, supplies, and appliances provided. (State Medicaid Plan home health benefit). | ☑ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: |
| Signed authorization for environmental modifications provided. | ☑ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: |

## Quality Review Checklist

| Elements | Example Client | Client A | Client B |
|---|---|---|---|
| All progress notes and documentation are completed on time, are clear, authenticated with proper signatures, and cover only the services prescribed in the person-centered plan. | ☑ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: |
| All service dates fall within time frames established in the person-centered plan. | ☑ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: |
| All units of service have been validated as correct and fall within the parameters prescribed in the person-centered plan. | ☑ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: |
| Other: | ☑ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: | ☐ Yes<br>☐ No<br>If No, explain: |

## Analysis of Findings and Identification of Solutions

After you have reviewed your selected records, the next step is to use the findings to improve your documentation format and records retention process to reduce future errors. If an error found resulted in improper payment, a corrected billing should be submitted. Claim adjustments not initiated within 60 days of claim payment will be identified as a PERM error. Start by identifying the findings in each element area and the possible causes and effects of the errors. Then identify any changes you can implement that will eliminate future errors. An example of this process is provided in "Finding 1" using the findings identified in the "example client" column of the Quality Review Checklist.

### Finding 1 (from "example client" column): The person-centered plan was not in effect on the dates services were provided.

**Expectation:** Federal regulations require a written person-centered plan for HCBS, whether services are provided through the State Medicaid Plan or through a waiver program.[2] The individual service plan must be established and periodically reviewed by the beneficiary's treating physician or qualified case manager at least annually or when the beneficiary experiences a change in circumstances. Check with your State

Medicaid agency, as they may have additional monitoring requirements for a person-centered plan, including review of the person-centered plan at more frequent intervals.

**Error:** The provider submitted a claim for 84 units of procedure code H2012-Behavioral Health Day Treatment, per hour, for services provided 05/01–05/31/2010. The individual service plan submitted to support the claim was for the time period 03/14/2007–03/13/2008 and had expired two years prior.

**Possible Solutions:** The following processes could be implemented to obtain the required information:

- Use a reminder calendar or monthly log that indicates due dates for assessments, reassessments, plans of care, or service plans for each beneficiary;
- Contact the case manager at the State Medicaid agency or State sister agency to see if a reassessment has been scheduled;
- Obtain pertinent information in the person-centered plan from the Case Manager (for example, eligibility information, other insurance, effective dates, amount, duration, and scope of services); and
- In the event changes were made to the person-centered plan and you have not yet obtained a new copy, add a form to the file that contains the pertinent information that was obtained, with validation.

In addition to findings in individual beneficiary files, look for common errors and identify methods to address them. For example, analysis of PERM data identified a significant number of errors for procedure code T2016-Habilitation, Residential, Waiver per diem, in instances where the beneficiary received services in a day program:

**Expectation:** Since T2016 is a per diem code, some form of daily documentation is needed to substantiate a daily presence in the facility.

**Error:** The person-centered plan authorized the services, however there was no documentation, such as a daily census log from the facility, to show the beneficiary was present at the facility on the dates of service on the claim.

**Possible Solutions:** Good practices include:

- Collecting copies of daily census or attendance logs for each date of service represented on the claim to verify the beneficiary's presence and submitting them with the claim;
- Using the information provided through your State Medicaid agency or State Sister agency, create a checklist of documentation necessary to support a claim;
- Establishing processes for quality review of claims prior to submission;
- Performing internal records reviews on a regular basis to make sure you have all of the documentation required; and
- Monitoring your State Medicaid agency and State Sister agency websites on a regular basis for current information.

Providers can play a significant role in the fight against Medicaid fraud, waste and abuse. For further information about how you can strengthen the integrity of the Medicaid Program and reduce improper payments made for HCBS, review the toolkits available at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

## Additional Resources

The items for this quality checklist are derived from the CMS State Medicaid Manual and the State Medicaid Provider Manual Sections that address documentation, recordkeeping, claims, and billing from the States of Utah, Vermont, and New Mexico.[3, 4, 5] Check your State Medicaid provider manual for additional requirements.

Links to State Medicaid agency websites are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html on the Medicaid website.

Information about Medicaid HCBS is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html on the Medicaid website.

Information about payment accuracy and improper payments is available at https://paymentaccuracy.gov/about-improper-payments on the Internet.

To see the electronic version of this job aid and the other products included in the "Home and Community-Based Services" Toolkit, visit the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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## References


1 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual: Chapter 4, Services, Section 4442.11. Retrieved September 10, 2015, from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html

2 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual: Chapter 4, Services, Section 4442.2. Retrieved September 14, 2015, from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html

3 Utah Division of Medicaid and Health Financing. (2015, January). Utah Medicaid Provider Manual. Section I: General Information. Part 10 Recordkeeping and Disclosure and Part 11 Billing Claims. Retrieved September 10, 2015, from https://medicaid.utah.gov/Documents/pdfs/SECTION1.pdf

4 New Mexico Human Services Department. (2004, August 13). 8.315.4.9–.11 Personal Care Option Services and subsequent subsections. Retrieved September 10, 2015, from http://www.nmcpr.state.nm.us/nmregister/xv/xv15/8.315.4amend.pdf

5 Department of Vermont Health Access. (2015, October 1). Green Mountain Care Provider Manual. Section 5.4: Documentation of Services. Retrieved October 7, 2015, from http://www.vtmedicaid.com/Downloads/manuals/New%20Consolidated%20Manual/ProvManual_Consolidated10-01-15.pdf


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October 2015