Comprehensive & Supports Waivers Provider Documentation Standards

HOME AND COMMUNITY-BASED SERVICES
WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

Below is a summary of the current documentation standards required for providers of the HCBS Comprehensive and Supports Waiver programs. Additional information on these requirements can be found in Chapter 3 and Chapter 45, Section 8 of the Wyoming Medicaid Rules, which governs the Comprehensive and Supports Waivers. Please review these standards and distribute them to all staff who are responsible for documentation. Providers are required to develop a system for reviewing documentation *prior to billing* to assure these standards are met. **Documentation that does not conform to these standards may be forwarded to Program Integrity for recovery of funds.**

Requirements

The following information must be included on <u>each page</u> of documentation:

1) Full, legal name of participant.
2) Start date of the plan of care (IPC).
3) Name of service provided (service name, billing code).
4) Legible signature of staff person providing the service.
   - If using initials, the initials and signature must be included on each page to identify to whom the initials belong.

The following information must be included <u>each time</u> a service is documented:

1) Date of service, including year, month, and day.
2) Legible initial or signature of person performing the service.
3) Location of services. Document physical address where the service is being provided, unless the service was provided in the community.
4) Detailed description of services provided.
   - Service descriptions may be included on a schedule, task analysis, therapy notes, or case manager monthly form.

To assist with tracking service plan units used, include:

5) Time services begin and end, consistently using either AM and PM or military time, and <u>totaled by day</u>.
   - Time services begin and end shall be documented for *each calendar day*, even if services span more than one calendar day.
6) Total number of service units used per day, <u>totaled monthly</u>, and remaining units.

Additional Standards

1) Document for *each participant* on a separate form or schedule.

2) Document *each service type* on a separate form or schedule.
   - Electronic Visit Verification (EVV) records will not be accepted as an alternative to daily schedules.

3) All electronic documentation shall have automated tracking of all attempts to alter or delete information, and include automatic date stamps and electronic signatures.

4) Assure that the documentation of services is legible and permanent. The use of pencils, whiteout, and erasable pens is prohibited.

5) Bill for only one service during a specific period of time, unless allowed by the service definition and specifically identified in the participant's service plan (*for example, Crisis Intervention*).

6) If service is billed at a daily or monthly rate, other services may be billed on the same day as the service, but documentation of services must include a beginning and ending time.

7) Assure that services being provided meet the definition of the service and are provided pursuant to the participant's unique plan of care. Service definitions and limitations can be found on the HCBS Section website - https://health.wyo.gov/healthcarefin/hcbs/servicesandrates/ .

8) Provide *direct services* to participants. Exceptions to this requirement are homemaker, environmental modification, specialized equipment, and supported employment follow along services.

9) Do **not** round up total service time to the next unit. The exception to this requirement is skilled nursing services.

10) Submit service documentation to the case manager by the 10th business day of the following month, even if no services were provided.

11) Submit unit billing information to the case manager by the 10th business day of the month after billing has been submitted for payment.

12) Complete all required documentation, including signatures, before or at the time the claim is submitted for payment. Documentation prepared or completed after the submission of the claim will be deemed insufficient to substantiate the claim, which will result in recovery of funds.

I, _____, have read and understand the Documentation Standards. I shall ensure all standards and requirements are met for the documentation used to substantiate services billed. I understand that, if documentation does not meet the standards and requirements listed above, funds that were paid for these services may be recovered by Medicaid Program Integrity.

_____ _____

Signature of Provider (or Designee) Date

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Provider Agency