



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Matthew G. Bevin**  
Governor

275 E Main St, 6W-B  
Frankfort, KY 40621  
www.chfs.ky.gov

**Vickie Yates Brown Glisson**  
Secretary

**Stephen P. Miller**  
Commissioner

March 1, 2017

SCL Providers (33)  
Provider Letter # A-49

Dear Provider,

The Department for Medicaid Services (DMS), along with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) and the Department for Aging and Independent Living (DAIL) are working with stakeholders on a Waiver redesign to address issues within the 1915c waivers. DMS is also working with the Centers for Medicare and Medicaid Services (CMS) for guidance and approval.

Further, the Departments have worked closely with providers to identify areas where system efficiencies can be operationalized prior to finalizing the Waiver redesign. These areas are listed below:

1. Service Documentation. Clarification on documentation requirements which includes allowing providers to utilize a monthly note for certain specific services;
2. Recoupment and Technical Assistance. Guidance on what may generate a recoupment during a billing audit and increase technical assistance efforts; and
3. Exceptional Supports. Simplify the exceptional support process.

For dates of service beginning March 15, 2017, DMS will follow the documentation requirements illustrated in Attachment A. Attachment B outlines the Exceptional Supports Protocol that will be followed and Attachment C provides guidance on billing audits and information on technical assistance. **Please maintain this letter and the attached documents for your records.**

Should you have questions, please contact the QA for your region or DMS.

Sincerely,

Stephen P. Miller  
Commissioner  
Department for Medicaid Services

Deborah Anderson  
Commissioner  
Department for Aging and Independent Living

Wendy Morris  
Commissioner  
Department for Behavioral Health, Developmental and Intellectual Disabilities



## ATTACHMENT A

### Service Documentation Requirements

#### Documentation Required per Waiver and Service

For those services not specifically mentioned herein, please refer to the regulations for service provision requirements.

#### Supports for Community Living (SCL) Requirements:

- a. **The following services in SCL will require Monthly Summaries:**
  - Case Management
  - Day Training
  - Residential
  - *All other monthly summary notes are no longer required.*
  
- b. **The following services in SCL will require an In/Out Log**
  - Day Training
  - Residential
  
- c. **Positive Behavior Supports will require a positive behavior support plan**
  
- d. **The following services in SCL will require “per contact” notes**  
**Monthly summaries are not required:**
  - Clinical, Consultative and Therapeutic Services
  - Community Access
  - Community Guide
  - Occupational Therapy
  - Person Centered Coach
  - Personal Assistance
  - Physical Therapy
  - Respite
  - Speech Therapy
  - Supported Employment

**Michelle P. Waiver (MPW) Requirements:**

**A. The following Services in MPW will require Monthly Summaries:**

- Day Training
- Case Management (must include all contacts, location and time in and time out to support billing)

**B. The following services in MPW will require In/Out Logs**

- Day Training

**C. The following services in MPW will require "per contact" notes  
Monthly summaries are not required:**

- Attendant Care
- Behavior Support Service
- Community Living Supports
- Homemaker
- Occupational Therapy
- Personal Care
- Physical Therapy
- Respite
- Speech Therapy
- Supported Employment

**Note: Adult Day Health Centers are regulated by 902 KAR 20:066, a regulations maintained by the Commonwealth of Kentucky's Office of the Inspector General.**

## **Documentation Requirements**

### **Supports for Community Living Waiver and the Michelle P. Waiver**

#### **1. In/Out Log:**

- Beginning and Ending Time
- Date of Service
- Location of Service (not specific address)
- Name, title, signature and signature date of the individual attesting to the attendance

#### **2. Contact Note:**

- Beginning and Ending Time of the services
- Date of Service
- Location where the service was provided (not specific address)
- Description of the service provided including effort toward meeting outcomes
- Name, title, date and signature of person writing the note

#### **3. Monthly Summary:**

- The monthly summary for direct service providers follows the calendar month, must be inclusive of all service dates within the calendar month, and must be written and available to audit/review teams within 10 business days following the last day of the month. Case management monthly summaries must be written and available to audit/review teams no later than 15 business days following the last day of the month. All summaries must be filed by the last day of the calendar month in which the summary was written.
- The monthly summary must contain a description of progress toward the participant's outcome(s) as noted by the pertinent waiver requirements.
  - Provide information including; but not limited, to daily events/involvement in the community, concerns, patterns, trends, and unusual occurrences during the month that had an impact on the participant's quality of life.
- Month and year for the time period the note covers
- Name, date, title and signature of the person completing the summary
- Desk audits will be completed for one or more periods between March 15 and December 31, 2017 for those providers following the monthly summary methodology. These audits will be completed by DMS and will result in

**technical assistance, if needed. This does not eliminate the possibility of recoupment when billing audits are completed.**

## **ATTACHMENT B**

### **Exceptional Support Purpose and Process**

#### **PURPOSE**

Exceptional supports are for the sole purpose of ensuring the health, safety and welfare of the waiver recipient. Under no circumstances shall a support be approved because a waiver recipient chooses not to attend day services or for the staffing ease of the direct service provider.

#### **PROCESS**

##### **1. Person-Centered Team Approval**

All exceptional supports requests must be approved by consensus vote of the person-centered team via a person centered team meeting. In order to ensure a timely process, a team meeting may be conducted via telephone. Under no circumstances should a case manager, acting on his/her own and without person-centered team approval, direct a provider to provide an exceptional support. Effective March 15, 2017 there are **no** exceptions to the person-centered team approval. Other than emergency situations, as defined below, services shall not begin until the Exceptional Support Packet has been submitted and approved.

##### **2. Emergency Situations After Hours**

If a provider believes that an exceptional support is necessary to ensure the health, safety and welfare of a waiver recipient, but it is after normal business hours or occurs during a weekend or holiday, the provider shall contact the case manager utilizing the after-hours contact process for the agency. If the case manager agrees that the service is needed, the provider may put the service in place.

Following the phone approval, it is the responsibility of the service provider to submit an email to the case manager and executive director of the case management agency. The email will serve as a record of the approval and should include the date the service began, time and date of the phone approval with the case manager and the date of the first business day on which the person-centered team meeting must occur.

It is the responsibility of the case manager to conduct a person-centered team meeting on the first business day following the emergency. If the case manager is not available, the case management agency must ensure the meeting occurs.

If the team approves, via consensus vote, the support request during the person-centered team meeting, the case manager will submit the information and note the date the service began due to the stated emergency.

If the team does not approve the exceptional support request, a request packet will not be submitted and the support will be ended immediately. No reimbursement will be made for supports that have not been approved by the person-centered team.

### **3. Timeline**

Within one business day of the person-centered team meeting, the case manager shall submit the exceptional support packet to the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). Submission through the MWMA system is preferred as it provides a more efficient method to process the request. Further, the case manager shall send written notification of the date and time of submission to the service provider(s) who will be implementing the exceptional support.

The packet must contain the following:

- i. Name and identifying information of recipient
- ii. Description of the exceptional supports being requested
- iii. Specific description of challenges presented by the waiver recipient and interventions provided that have resulted in the request. Dates, times, location of occurrences must be included
- iv. Summary notes of the person centered team meeting held to determine if the request for exceptional support was appropriate. Notes should include signatures of the team members and date, time and location of the meeting. For emergency meetings held by conference call, a confirmation email from each team member shall be included
- v. Updated Plan of Care with exceptional service documented
- vi. If this is an on-going or repeat request, description of any interventions taken by the Person-Centered Team to stabilize the challenges. Please describe the results of the interventions
- vii. Detailed cost analysis using the approved Rate Determination Template for all requests for Unit Cost Increases

- viii. If emergency approval was granted, copy of the email from the provider to the case manager noting approval and date for the person centered team meeting

Within three business days, DBHDID shall review the packet for accuracy and completeness and will either deny or approve the request. Approved packets will be forwarded to the DMS fiscal intermediary who will then review for prior authorization. This process is routinely completed within three business days. The date of service will be authorized on the date of submission of a complete and accurate packet to the DBHDID unless the service began during an After Hours emergency, as illustrated above. In an emergency situation, the date of service will be authorized on the first day the emergency service was rendered. Services associated with data that was not submitted timely and in accordance to expectations will not be considered for reimbursement.

If approved, the prior authorization will be in effect for six months and can follow the recipient if a transition to another provider occurs through an amendment for a prior authorization.

Upon approval by the person-centered team, a new request can be submitted no later than 15 days prior to end of the previous prior authorization.



## EXCEPTIONAL SUPPORT PROCESS CHECKLIST

### Complete and Include with Packet

**Demographic Information:** \_\_\_\_\_

**Name of Recipient:** \_\_\_\_\_

**Medicaid Number:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Case Manager:** \_\_\_\_\_

**Agency:** \_\_\_\_\_

**Contact Information:** \_\_\_\_\_

### Attach documentation that illustrates the following:

1. Description of the exceptional supports requested.
2. Specific description of challenges and interventions presented by the waiver recipient that has resulted in the request. Please provide dates, times, location of occurrences.
3. Summary notes of the person centered team meeting held to determine if the request for exceptional rate was appropriate. Notes should include signatures of the team members and date, time and location of the meeting.
4. Updated Plan of Care with exceptional service documented.  
If this is a recurring request, describe any interventions taken by the Person Centered Team to stabilize the challenges. Please describe the results of the interventions.
5. Detailed cost analysis using the approved Rate Determination Template for residential and day training services. All other requests shall provide detailed cost analysis.
6. If the service was provided due to an emergency, a copy of the e-mail from the provider to the case manager and case management agency noting temporary approval and date the person centered team meeting must be conducted.

### SCL Exceptional Supports Rate Determination

Provider Name:					
Participant Name:		SSN:		MAID :	

*Please note: \*If a rate increase for residential services is approved through the Approved Exceptional Supports process - Rate increase will not be allowed for any other services.*

Additional 1:1 Residential Staffing Needs		Additional 1:1 Adult Day Training Staffing Needs	
Residential Hourly Gross Pay Rate		ADT Hourly Gross Pay Rate	
Total 1:1 Weekly Hours		Total 1:1 Weekly Hours	
Weekly Total Cost:		Weekly Total Cost:	
<b>Daily Residential Rate Requested:</b>		<b>ADT Unit Rate Requested:</b>	

**Additional Services:**  
**If there are requests for additional rates for other services, please submit detailed cost related information.**

## **ATTACHMENT C**

### **Recoupment and Technical Assistance Process**

For dates of service beginning March 15, 2017, all service documentation for billing audits must contain the following:

- 1) Beneficiary identified by Medicaid number or name on every page of documentation
- 2) Date and time service was provided
- 3) Location (not address) service was provided
- 4) Signature and signature date of individual providing the service when writing contact notes or when completing the monthly summary (where applicable)
- 5) Title and credentials of individual providing the service or completing the document (where applicable)

Billing for the incorrect number of units or other billing errors shall be eligible for recoupment. It is the responsibility of the provider to maintain all documentation, as required by regulation, with the exception of the specific changes and information noted herein. If all required documentation is not available at the time of the audit, services shall be eligible for recoupment.

**Note:** A complete, authorized person-centered plan of care is required to be followed for the reimbursement of any services. This requirement comports with the Centers for Medicare and Medicaid (CMS) guidance.

Other deficiencies not related to the above requirements may be identified during the billing audit and could result in corrective action plans. Identical deficiencies identified in corrective action plans for more than two consecutive billing audits shall result in recoupments.

DMS will assume responsibility for the Annual Billing Audits. This change will eliminate the need for second line reviews.

The Agencies, DMS, DAIL, and DBHDID, will increase technical assistance (TA) opportunities for providers. These will include annual courtesy reviews of a limited number of records. The reviewers will offer the provider agencies a verbal exit conference noting opportunities for improvement. The TA reviews are not meant to be comprehensive but are offered as a courtesy in preparation for the Billing Audit. It is the sole responsibility of the provider agency to ensure appropriate documentation is available for Billing Audits.

## **Documentation Requirements**

### **Supports for Community Living Waiver and the Michelle P. Waiver**

#### **1. In/Out Log:**

- **Beginning and Ending Time**
- **Date of Service**
- **Location of Service (not specific address)**
- **Signature, title and signature date of the individual attesting to the attendance**

#### **2. Contact Note:**

- **Beginning and Ending Time of the services**
- **Date of Service**
- **Location where the service was provided (not specific address)**
- **Description of the service provided including effort toward meeting outcomes**
- **Signature, title, signature date of person writing the note**

#### **3. Monthly Summary:**

- **The monthly summary for direct service providers follows the calendar month. It must be inclusive of all service dates within that calendar month and it must be written and available to audit/review teams within 10 business days following the last day of the month. Case management monthly summaries must be written and available to audit/review teams no later than 15 business days following the last day of the month. All summaries must be filed by the last day of the calendar month in which the summary was written.**
- **The monthly summary must contain a description of progress toward the participant's outcome(s) as noted by the pertinent waiver requirements.**

- Provide information including; but not limited, to events/involvement in the community, concerns, patterns, trends, and unusual occurrences during the month that had an impact on the participant's quality of life.
- Month and year for the time period the note covers
- Name, date, title and signature of the person completing the summary