Respite

- iBudget Handbook -

This service is generally used due to a brief planned or emergency absence, or when the primary caregiver is available, but temporarily physically unable to care for or supervise the person for a brief period of time.

Respite care is a service that provides supportive care and supervision to individuals under the age of 21 when the primary caregiver is unable to perform the duties of a caregiver.

Individuals living in licensed group homes or who are in supported or independent living are not eligible to receive Respite services.

Respite services are only available to individuals under the age of 21 and who live in the family home.

Respite care can be provided in the person's family home, while involved with activities in the community, or receive respite services in a licensed group home, foster home, or assisted living facility (ALF).

iBudget Handbook Effective Date: 6/10/18 (2-43)

Service Specific Record Review – Respite (under 21 only)

#	Performance Measure/Standard	Protocol	Not Met Reasons
1	The provider has complete Service Logs covering services provided and billed during the period under review.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Pages 1-10, A-4 COMPLIANCE Review Services Log(s) for the entire period of review. • Determine available Service Log (s) include all required components. ▪ Name of person receiving service ▪ Name of person providing the service ▪ Name of the service ▪ Date of service ▪ Time in/out ▪ Summary or list of services provided Review Service Log (s) against claims data to ensure accuracy in billing. • Compare each date of service in claims to documented date of service on each Service Log in the period of review. • Compare units paid in claims to units documented on each Service Log. • Billing can be done on a periodic basis combining documented units into one billable unit. In these instances, the single billed unit must equal total documented units since the last billing date. • In order to bill the day rate provider documentation must demonstrate 40 quarter hours or more of service per date. Instances of billing a day rate when documentation demonstrated **less than 40-quarter** hours per day should be documented as a discrepancy. **This standard is subject to identification of a potential billing discrepancy**	1) Service Log was not present for the date of service for which the claim was submitted. (B) 2) Service Log did not contain the name of the person receiving services. (B) 3) Service Log did not contain the date service was rendered. (B) 4) Service Log did not contain time in/out. (B) 5) Service Log did not contain a summary or list of services provided. (B) 6) Discrepancies were noted between units billed and services documented. (B)

Service Specific Record Review – Respite (under 21 only)

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2	The provider maintains accurate Service Authorization(s) covering services provided and billed during the period under review.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Pages 1-3, 1-10, 3-4, 3-5 COMPLIANCE Service Authorizations are provided quarterly or more frequently as changes dictate. Review the Service Authorizations for Respite to ensure: • The Service Authorizations are available to cover all services provided and billed during the period under review. • The Service Authorizations are in approved status. • The Service Authorizations indicate the correct rate (e.g. agency, solo, geographic, non-geographic, Monroe county rate, day and/or quarter hour rate, ratio). ❖ Refer to the current APD Provider Rate Table as needed. WSCs and service providers must verify the Service Authorizations are correct based on the amount, duration, frequency, intensity and scope authorized in the iBudget system. If corrections are needed, the service provider should immediately contact the WSC for resolution. • Consider provider's documented due diligence in securing corrected Service Authorizations when incorrect Service Authorizations are received or updates are in process.	1) Service Authorizations were not present in the record. 2) One or more Service Authorizations were not present in the record. 3) One or more Service Authorizations were not in approved status. 4) One or more Service Authorizations did not indicate the correct rate.
3	The provider is in compliance with billing procedures and the Medicaid Wavier Services Agreement.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Pages 1-2, 1-10, 2-43, 2-44, 3-4, 3-5, Current APD Rate Table COMPLIANCE Determine if services are provided in accordance with the Handbook.	1) Provider documentation demonstrated provider is a solo but billed the agency rate. (B) 2) Provider documentation demonstrated the provider is not considered an agency for rate purposes but billed the agency rate. (B)

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		Provider bills the appropriate rate: • Solo vs. Agency • Geographic, non-geographic, Monroe County • 1:1, 1:2, 1:3 Ratio • An agency or group provider for rate purposes is a provider that has two or more employees to carry out the enrolled service(s). A provider that hires only subcontractors to perform waiver services is not considered an agency provider for rate purposes. ○ Determine if provider has at least two employees to carry out the enrolled service(s). If necessary, ask to see the W9 or W4 forms. Approval for use of a relative to provide Respite services must be granted by the APD Regional office. ○ Documentation of Regional APD's approval must be maintained in **both** the provider and WSC files. Review Claims data to determine rate billed ❖ Refer to the current APD Provider Rate Table as needed. • Review provider records for Service Authorizations. • Refer to Service Authorizations for approved ratios and frequency of service (ratio of 1:1, 1:2, or 1:3, Days per week/month, etc.). • If Service Authorizations and/or Service Logs are not present for some or all of the period under review, refer to other available provider documentation for information that may assist with determinations. If service is being routinely rendered at a frequency less than	3) Provider documentation demonstrated provider billed a geographic rate for services rendered in a non-geographic area. (B) 4) Provider documentation demonstrated provider billed the Monroe County rate for services not rendered in Monroe County. (B) 5) Provider documentation demonstrated services were rendered in groups larger than the authorized ratio. (B) 6) Provider documentation demonstrated services were rendered in a group larger than three individuals. (B) 7) Provider documentation did not contain specific APD Regional Office approval for use of a relative to provide Respite services. (B) 8) Service is not being rendered in accordance with the Handbook. (B)

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		or greater than the Service Authorization, score as Met and add a Discovery statement. **This standard is subject to identification of a potential billing discrepancy**	
4	Provider bills for services after service are rendered.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Page 3-2 COMPLIANCE Provider is not to bill for services prior to rendering. • Review Claims data for date billed. • Review service dates on Service Logs. • Compare service dates on Service Logs to the "claim billed date" in claims data. • Determine if services were rendered prior to billing for each date of service in the period of review. • Refer back to protocol in standard #1 regarding providers that bill on a periodic or regular basis rather than daily. Apply the same logic when applicable.	1) Provider documentation demonstrated provider billed for services prior to rendering on one or more dates during the period under review.
5	Provider renders service only to persons under age 21 who live in the family home.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Pages 2-43, 2-44 COMPLIANCE Respite services are only available to people under the age of 21 who live in the family home. Ask the provider where the person lives. • Review available provider documentation to determine the following: ○ The person remained under the age of 21 during the	1) Provider documentation demonstrated the person was 21 years of age or older on the date of service for which the claim was submitted. (B) 2) Provider documentation did not demonstrate the person was under the age of 21. (B) 3) Provider documentation demonstrated services were rendered to a person living in a licensed residential facility. (B) 4) Provider documentation demonstrated services were rendered to a person living

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		entire period of review. ○ The person lived in the family home during the entire period of review. • Refer to the Support Plan if necessary to assist in determination of age and primary residence. **This standard is subject to identification of a potential billing discrepancy**	in supported living. (B) 5) Provider documentation demonstrated services were rendered to a person in independent living. (B)
6	Services are rendered only in the person's family home, while involved with activities in the community, in a licensed group home, foster home, or assisted living facility (ALF).	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Page 2-44 COMPLIANCE • Review Service Log(s) to determine service location. • Look for indications the provider is rendering the service in the person's home, community or licensed facility. • Person may not receive this service in the provider's personal residence at any time. **This standard is subject to identification of a potential billing discrepancy**	1) Provider documentation demonstrated services were provided in the personal residence of the provider. (B) 2) Provider documentation demonstrated services were provided in the home of a friend or relative of the provider. (B)
7	The provider documents ongoing efforts to address the person's choices and preferences.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Pages 1-7, 2-4, 2-7, 2-8, B-7 PERSON CENTERED PRACTICE Ask the provider to describe method of soliciting and documenting the person's choices and preferences as related to this service. • Review record for documentation supporting stated method of soliciting and addressing the person's choices and preferences on an ongoing basis.	1) Provider documentation did not demonstrate efforts to learn about the person's choices and preferences. 2) Provider documentation did not demonstrate ongoing efforts to address the person's identified choices and preferences.

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		• Review Service Log (s) and other available provider documentation to assist in determining if the person's choices and preferences are being identified, addressed and match provider activities on an ongoing basis. • If available refer to the Support Plan as a reference document to determine if person's choices and preferences are identified and match provider activities. • Take into consideration frequency/duration and purpose of service identified on the Support Plan.	
8	The provider documents ongoing efforts to ensure the person's physical health needs are addressed.	CMS Assurance – Health and Welfare iBudget Handbook – June 2018 Pages 1-2, 1-7, 1-10, 1-11, 2-7, 2-8 PERSON CENTERED PRACTICE Ask the provider to describe method used to gather and document knowledge of the person's physical health information relevant to the service provided. • Ask the provider how information related to physical health is maintained and updated on an ongoing basis. • Review record for documentation supporting stated method. • Supporting documentation may be found in Service Logs, intake forms, stand-alone forms, or other available provider documentation. • Take into consideration frequency/duration and purpose of service identified on the Support Plan. *Key/critical physical health information will vary by person, and could include, but not be limited to diagnosis, certain environmental factors, medication and related information, allergies, medical conditions and other key information critical to maintaining the person's physical health, and relevant to the service provided.	1) Provider documentation did not demonstrate efforts to gather information about the person's physical health needs. 2) Provider documentation demonstrated knowledge of the person's physical health needs but not ongoing efforts to address identified needs. 3) Key and critical physical health information was absent from the record.

Service Specific Record Review – Respite (under 21 only)

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9	The provider documents ongoing efforts to ensure the person's behavioral/emotional health needs are addressed.	CMS Assurance – Health and Welfare iBudget Handbook – June 2018 Pages 1-2, 1-7, 1-11, 2-7, 2-8 PERSON CENTERED PRACTICE Ask the provider to describe method used to gather and document knowledge of the person's behavioral/emotional health information relevant to the service provided. • Ask the provider how information related to behavioral/emotional health is maintained and updated on an ongoing basis. • Review record for documentation supporting stated method. • Supporting documentation may be found in Service Logs, intake forms, stand-alone forms, or other available provider documentation. • Take into consideration frequency/duration and purpose of service identified on the Support Plan. • If based on review of the current Support Plan and provider documentation there are no behavioral/emotional health concerns indicated, score N/A. *Key/critical behavioral/emotional health information will vary by person and frequency of service and could include, but not be limited to diagnosis, certain environmental factors, medication and related information, Behavior Plans, Safety Plans, emotional well-being (stress, anxiety, depression, grief, other emotional issues, or diagnosis) and any other information critical to maintaining the person's behavioral/emotional health and relevant to the service being provided.	1) Provider documentation did not demonstrate efforts to gather information about the person's behavioral/emotional health needs. 2) Provider documentation demonstrated knowledge of the person's behavioral/emotional health needs but not ongoing efforts to address identified needs. 3) Key and critical behavioral/emotional health information was absent from the record.
10	The provider submits documents to the Waiver Support Coordinator as required.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Pages A-2, A-4	1) Provider did not have documented evidence of submitting copies of Service Log(s).

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		COMPLIANCE
		
		Ask the provider to describe method used to submit required documents to the Support Coordinator.
		• Review provider documentation for proof of submission to the Support Coordinator.
		  ○ Examples could include fax transmittal reports with cover sheet indicating descriptions of what was faxed, submission tracking logs, date stamps, or indication of date of submission and method sent on the documentation.
		
		Items below must be provided to the WSC prior to billing or within 10 calendar days of billing at the latest.
		  ○ If billing more than once a month, information with an asterisk (*) and indicated as "(sent monthly)*" may be submitted to the WSC at the time of the last billing in the month.
		
		The following documentation is required to be provided to the WSC within the timeframes indicated:
		
		• Documents to be provided:
		  ○ Copy of service log (sent monthly)* within 10 days of billing
			2) Provider had documented evidence of submitting some but not all copies of Service Log(s).
			3) Provider had documented evidence of submitting copies of Service Log(s) but not within 10 days of billing each month.
			4) Provider had documented evidence of submitting copies of some but not all Service Log(s) within 10 days of billing each month.