pennsylvania
DEPARTMENT OF HUMAN SERVICES

OFFICE OF DEVELOPMENTAL PROGRAMS BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
September 3, 2026	January 1, 2027	00-26-04

SUBJECT	BY
Handbook for Claim and Service Documentation	Kristin Ahrens, Deputy Secretary for Developmental Programs

SCOPE:

Administrative Entity Administrators or Directors
Agency With Choice Financial Management Services
Common-Law Employers in the Vendor/Fiscal Employer Agent Financial Management Services Model
County Mental Health and Intellectual Disability Administrators
Supports Coordination Organizations (SCOs), including SCOs that provide Targeted Support Management
Base-Funded Supports Coordination Providers
Providers of Consolidated, Community Living, Person/Family Directed Support (P/FDS), and Adult Autism Waiver Services
Providers of Base-Funded Services

PURPOSE:

The purpose of this bulletin is to provide guidance on documentation needed to substantiate a claim and guidance on the service documentation processes.

BACKGROUND:

The Department of Human Services (DHS) uses claim and service documentation to verify that the services billed to DHS are delivered to the individuals approved to receive the services in accordance with state and federal requirements. There are also federal and state requirements regarding the type of documentation that must be available at the time of claim submission. To ensure that all federal and state requirements are met, providers must maintain the documentation used to generate a claim. If the provider does not have this documentation, the claim is not eligible for Federal Financial Participation (FFP).

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate Regional Office of Developmental Programs

Visit the Office of Developmental Programs website at
https://www.pa.gov/agencies/dhs/departments-offices/odp-info/odp-bureau-community-services

Federal and state requirements include:

- Section 2497.2 of the Centers for Medicare and Medicaid Services' (CMS) State Medicaid Manual requires accounting records to be supported by appropriate source documentation and be readily available for audit.

- Chapter 1101 of 55 Pa. Code (relating to general provisions) specifies what must be included in a patient record. Payment will only be made for services if the required information is included in the record. Providers of home and community-based services are required to comply with Chapter 1101.

- Section 6100.226 of 55 Pa. Code (relating to documentation of claims) includes the minimum standards for documentation that are needed to substantiate a claim. Some services require additional documentation to support a claim based on the service definitions within each of the approved waivers.

- Section 6100.227 of 55 Pa. Code (relating to progress notes) includes the minimum requirements for the completion of progress notes.

DISCUSSION:

A record of services delivered to an individual must be prepared and kept by the provider, SCO, Agency with Choice (AWC) organization, or common-law employer for the purposes of substantiating a claim and documenting service delivery. The Office of Developmental Programs (ODP) has developed Technical Guidance for Claim and Service Documentation (Attachments 1 and 2), which provides specific guidance on the documentation that must be kept for each service to support a claim and document service delivery. These attachments apply to services rendered by providers and SCOs that have enrolled directly with ODP, organized health care delivery systems (OHCDS), and services delivered through both self-directed services models, AWC and Vendor Fiscal/Employer Agent (VF/EA).

I. Service Notes

Service notes are important because they:

- Provide a record of the service(s) delivered. Providers, SCOs, OHCDS, AWC organizations and the VF/EA cannot bill for services when there is no record that the service was delivered.
- Demonstrate whether service delivery meets the individual's unique needs and supports the individual's preferences, outcomes, and goals as outlined in the Individual Support Plan (ISP) (55 Pa. Code § 6100.224 and §6100.226).
- Support the delivery of quality services.
    - Providers can use service notes to determine what works well and avoid what does not work well for the individual and providers can share this information with the individual's support team.

- Service notes allow the provider to identify changes needed to the ISP and advocate for those changes.
- Supervisors, program specialists, common law employers, managing employers, and other team members can use service notes to track progress over time, which can then be reflected in the progress notes when applicable Progress notes are discussed beginning on page 9 of this bulletin.

In accordance with 55 Pa. Code § 6100.226(c), all service notes must include, at a minimum:

- **Identifying information for the individual.** One of the following must be used: Individual's full name (first and last), the individual's Master Client Index (MCI) number, or the individual's Medical Assistance (MA) number.
- **Identifying information for the provider.** One of the following must be used: The provider agency's full name or the provider agency's 9-digit Master Provider Index (MPI).
- **The date of service delivery.**
- **Identification of the service delivered.** Either the name of the service or 5-digit procedure code must be used.
- **The date the service note is completed.**
- **The name and signature of the person completing the service note.** The professional (direct support professional, support service professional, Supports Coordinator, or Targeted Support Manager) completing the service note must sign the service note. The professional cannot sign service notes weekly or solely put their initials on the service notes. If multiple service notes from the same professional for the same calendar day are captured on one document, the professional only needs to print their name and sign the document once. Electronic signatures are acceptable[1].
- **The name of the professional who delivered the service, if the professional who delivered the service is different than the person completing the service note.** For services delivered in a facility-based setting or if there is a staff ratio greater than 1:1, the names of all professionals who delivered services must be documented in the service note. Providers and common law employers are also encouraged to maintain supporting documentation of the professionals delivering the service such as time sheets, scheduling documents, attendance logs, etc.
- **The place(s) the service was delivered.** If the location where the service was delivered is inherently clear in the description of activities, there is no need to list the place(s) the service was delivered separately in the service note. Service notes must include the general names of locations in the community where services were delivered such as the name of a restaurant, park, or community activity. Documenting "community" or "other" does not satisfy this requirement.
- **The number of units of service delivered.** For services billed in hour units or 15-minute units and day unit Respite, the start time and end time of when

[1] A signature is not required for Supports Coordination services because information captured in HCSIS satisfies the signature requirement.

services were delivered must be documented in the service note to determine the number of units delivered and substantiate the claim. Start and end times substantiate the number of units as those are used to calculate minutes/ time spent for units of service delivery.[2] For Residential Habilitation, Supported Living, and Life Sharing services the provider is not required to document in a service note start and end times for the delivery of services or the number of units of services delivered.

- **The nature or description of the activities involved in the service.** The service note must identify the assistance, support, or guidance provided that is consistent with the individual's goals identified in the ISP and the waiver service definitions. The nature or description of the activities involved in the service must include enough detail to substantiate the amount of time billed for that service. It is recommended that the service note also include a description of any activities that were offered during service delivery but declined by the individual.

  For some services, providers and common law employers may choose to create and use a checklist to document the activities provided to or on behalf of the individual. Services that are allowed to use a checklist to meet this requirement and guidance about the use of checklists are outlined in Attachments 1 and 2.

Service notes are not required to be completed for every service. The claims for some services are satisfied by an invoice, receipt, or other documentation. Attachments 1 and 2 specify the requirements for each service.

When service notes are required, they must be completed as specified in this bulletin regardless of whether the service was a direct service delivered in-person, was delivered using technology when permitted, or an indirect billable activity completed on behalf of the individual. Service notes must be made available to the individual's Supports Coordinator, AE or ODP upon request.

Service Note Requirements for Providers (Not Including Supports Coordination and Targeted Support Management)

Service notes are used to document the provision of a service and the activities that occurred. Service notes may be reviewed by ODP, Administrative Entities (AEs), and SCOs to verify that services are being delivered as required in the ISP, regulations, and waivers. Each service note should include the goals, outcomes, or objectives identified in the ISP that were worked on during the provision of service.

In accordance with 55 Pa. Code § 6100.226(b), providers must comply with the following requirements for service notes for services billed in **hour or 15-minute units**:

- A service note must be completed for each continuous span of billing units. A continuous span of billing units is defined as the provision of a service by the

[2] There are different requirements for Supports Coordination services related to start and end times and units of service. Please see pages 6 through 8 for requirements specific to Supports Coordination services.

same staff person that is not stopped or discontinued. A new service note must be completed if there is an interruption in service and the service is reinitiated within that same calendar day or if there is a change of direct support professional (DSP) or support service professional (SSP) providing the service within the calendar day and the service is reinitiated within that same calendar day.[3]

- The service note must be completed by the DSP or SSP providing the service.[4]
- A service note must be completed on the day the service is delivered.[5] It is best practice to complete the service note during or immediately after the provision of a service. For example, the service note could be completed near the end of a DSP's or SSP's shift or after the DSP or SSP assists the individual with a community activity. Service notes can also be started at the beginning of a shift and worked on throughout the DSP's or SSP's shift, but DSPs and SSPs must complete the service note on the day the service is delivered.
- If an individual receives multiple services throughout the day and the services are rendered by the same DSP or SSP, service notes may be entered in the same document or form as long as all required information is included for each service/procedure code, including start and end times of each service and the name of each service or 5-digit procedure code for each service.

In accordance with 55 Pa. Code § 6100.226(b), providers must comply with the following requirements for service notes for services billed **in day units**:

- A service note must be completed for each day unit that documents the provision of direct or indirect services (such as staff on-call or the use of remote supports as a method of residential service delivery) for the minimum number of hours required to bill for the day unit. A new service note is not needed if there is an interruption of the service within a calendar day and the service is reinitiated within that same calendar day.
- For residential services (Residential Habilitation, Life Sharing and Supported Living) or Respite services provided in licensed or unlicensed residential settings or other licensed settings (private Intermediate Care Facilities for Individuals with an Intellectual Disability [ICFs/ID] or nursing homes), a service note must be completed for each day unit that documents the provision of at least 8 hours of support.
- For Out-of-Home Respite services provided through the Adult Autism Waiver, a service note must be completed for each day unit that documents the provision of more than 16 hours of support.

[3] Exceptions to the completion of a new service note when there is a change in staff person exist for Community Participation Support and Day Habilitation services delivered in a facility-based setting. See Attachments 1 and 2 for guidance.

[4] In facility-based or residential settings, a supervisor or program specialist who is present for the entirety of the service provision on the day services were delivered can complete the service note based on their observations of service delivery and staff reports about the activities that were provided to or on behalf of the individual.

[5] Exceptions to the requirement that the service note be completed on the day the service was delivered will be made for extraordinary circumstances or emergencies when the provider documents the extraordinary circumstance or emergency and why it precluded a service note from being completed on the day the service was delivered.

- For Respite services provided in private homes that are billed as a day unit, a service note must be completed for each day unit that documents the provision of more than 16 hours of support.
- A service note must be completed on the day the service is delivered.[5]
- The service note must be completed by the DSP or SSP providing the service.[6]
- When there is a change in the DSP or SSP providing a service that is billed in day units, a new service note is not required. It is best practice when there is a change in the DSP or SSP during the provision of services that the DSPs or SSPs involved in service delivery communicate with each other so that the service note will have information from the entire time that services were rendered.
- Providers of Residential Habilitation, Life Sharing, and Supported Living[7] services in the Consolidated, Community Living or Adult Autism Waivers must include start and end times of when the individual is receiving services or unpaid support that are not included in the residential service in the service note. A description of what occurred during the provision of services or unpaid support that is not included in residential services is not required to be included in the residential service note.
- Multiple service notes for one individual may be entered in the same document or form if all required information is included. For example, if multiple DSPs deliver services to an individual during the day unit and the residential provider chooses to have each DSP write a description of activities the DSP completed with the individual, all those descriptions could be recorded in one document.

The service notes requirements also apply to participant-directed services delivered through either the VF/EA or the AWC model. In the VF/EA model, the common-law employer is responsible for ensuring that service notes are completed and maintained in the individual's record. In the AWC model, the managing employer is responsible for ensuring that service notes are completed and maintained in the individual's record, while the AWC organization is responsible for monitoring managing employers' adherence to service notes requirement and for agency-wide compliance with 55 Pa. Code § 6100.226(b).

Service Note Requirements for Supports Coordination Organizations That Deliver Targeted Support Management, Base-Funded Supports Coordination and Supports Coordination Funded through the Consolidated, Community Living, and Person/Family Directed Support Waivers

The Home and Community Services Information System (HCSIS) service note must include all information necessary to substantiate a claim. The service note must be written by the Supports Coordinator, Targeted Supports Manager, Supervisor, or Associate Supports Coordinator. SCOs that deliver Supports Coordination through the

[6] In facility-based or residential settings, a supervisor or program specialist who is present for the entirety of the service provision on the day services were delivered can complete the service note based on their observations of service delivery and staff reports about the activities that were provided to or on behalf of the individual.
[7] Supported Living is not covered by the Adult Autism Waiver.

Consolidated, Community Living, and Person/Family Directed Support Waivers and Targeted Support Management are no longer required to document exact start and end times of the Supports Coordination or TSM service they provided. In addition, SCOs that deliver base-funded Supports Coordination are no longer required to document exact start and end times of the Supports Coordination they provided unless the AE chooses to continue to pay for base-funded Supports Coordination using a 15-minute unit. If an SCO chooses to continue documenting start and end times, the SCO may use any of the following ways to document the start and end times of each service provided:

- Inserting the information in the start and end time field in HCSIS;
- Documenting the start and end times in the body of the text of the service note in HCSIS; or
- Including the start and end times on the documentation that is completed within one business day of the activity.

AEs may choose to continue to pay for base-funded Supports Coordination using a 15-minute unit. The base-funded Supports Coordination provider is required to document the exact start and end times of the base-funded Supports Coordination service and may use any of the following ways to document the start and end times of each service provided:

- Inserting the information in the start and end time field in HCSIS;
- Documenting the start and end times in the body of the text of the service note in HCSIS; or
- Including the start and end times on the documentation that is completed within one business day of the activity.

SCOs and base-funded Supports Coordination providers do not need to maintain the documentation of service activities that occur with or on behalf of individuals that was completed within one business day of the activity if all elements required in a service note are included in the HCSIS service note. If a person other than the Supports Coordinator or Targeted Support Manager who rendered the service completes the HCSIS service note, the SCO or base-funded Supports Coordination provider must retain the documentation that verifies the service activities that occurred and who rendered the activities.

SCOs and base-funded Supports Coordination providers[8] must document the List A and/or B activities[9] in the “service note/billable claim details” screen in HCSIS for each service note.

SCOs and base-funded Supports Coordination providers may enter multiple service notes for List B activities as a single entry in HCSIS for services delivered to the same individual, by the same Supports Coordinator or Targeted Support Manager, on the

[8] Base-funded Supports Coordination providers must confirm with AEs how base-funded Supports Coordination is to be billed and verify billing requirements.
[9] List A and List B activities are outlined in Attachment 3. Attachment 3 does not apply to Supports Coordination provided through the Adult Autism Waiver.

same calendar day. When entering multiple service notes as a single entry, the staff completing the service note will utilize the “service type”, “category”, and “sub-category” drop downs to identify the List B service provided. The List B service provided must be documented in the text of the service note in HCSIS or on the documentation of activity that is completed within one business day of the activity occurring.

Service Note Requirements for Supports Coordination Organizations that Deliver Supports Coordination Through the Adult Autism Waiver

Due to the nature of the delivery of this service, Supports Coordinators must document service activities that occur with or on behalf of individuals within one business day of the activity. Documentation of service activities may be in any form (for example, logs, electronic notes, and other recorded documentation completed during provision of services) as long as there is sufficient information to complete HCSIS service notes.

SCOs have 7 calendar days from the date of contact with the individual to enter their service notes into HCSIS. Each HCSIS service note must include all information necessary to substantiate a claim, including the number of units and start and end times.

SCOs may use any of the following ways to document the start and end times of each service provided:

- Inserting the information in the start and end time field in HCSIS;
- Documenting the start and end times in the body of the text of the service note in HCSIS; or
- Including the start or end times on the documentation that is completed within one business day of the activity.

The documentation of service activities that occur with or on behalf of individuals that was completed within one business day of the activity does not need to be retained if all elements required in a service note, including start and end times for each service provided, are included in the HCSIS service note. If the start and end times are not included in HCSIS, the documentation that verifies the start and end times for the service must be maintained in accordance with 55 Pa. Code § 6100.54 (relating to recordkeeping) and must be available for review to substantiate a claim. If a person other than the Supports Coordinator who rendered the service completes the HCSIS service note, the SCO must retain the documentation that verifies the service activities that occurred and who rendered the activities.

In addition to start and end times, SCOs must document the number of units in the “service note/billable claim details” screen in HCSIS for each service note.

SCOs may enter multiple service notes as a single entry in HCSIS for services delivered to the same individual by the same Supports Coordinator on the same calendar day. When entering multiple service notes as a single entry, the start and end times of each service provided must be documented in the text of the service note in HCSIS or on the

documentation of activity completed within one business day. When choosing "location of service," "service type," "category," and "sub-category" on the Service Note screen in HCSIS, the SCO should choose the response that was most prominent during the time span of service delivery.

II. Progress Notes

The requirements for progress notes are described in 55 Pa. Code § 6100.227 (relating to progress notes). A progress note must be completed at least every three months and is used to evaluate whether the activities occurring as part of the provision of home and community-based services are helping the individual achieve the individual's desired goals or outcomes as identified in the ISP. Progress notes are used by the ISP team to discuss progress towards an outcome or goal during the annual ISP meeting or more often, as needed. The completion of progress notes is also critical to the Quality Assessment and Improvement (QA&I) process as progress notes provide essential information for providers to review and use for self-monitoring to ensure services are rendered as authorized in the individual's ISP.

Progress notes[10] are typically written by a program specialist or other professional who conducts routine reviews or oversight of staff or during service monitoring. To formulate a progress note, the person preparing the progress notes must review service notes, observe service delivery, and speak with the individual, person(s) designated by the individual, and professionals involved with the individual as appropriate. Since a progress note is completed after the provision of services, it does not have to be completed prior to the submission of a claim. Progress notes must be maintained as part of the individual's record.

As required by 55 Pa. Code §§ 6100.42 (relating to monitoring compliance), 6100.54 (relating to recordkeeping), and 6100.227(a) (relating to progress notes), providers, common law employers, AWC organizations, or managing employers must make progress notes available to ODP, AEs, Supports Coordinators, or Targeted Support Managers, upon request. ODP, AEs, Supports Coordinators, Targeted Support Managers and other reviewers use information in progress notes to ensure services are meeting the individual's needs, goals and outcomes. Providers in the Adult Autism Waiver must continue to follow the previously outlined timelines and process for quarterly reporting including submission to the Supports Coordinator via QuestionPro.[11]

PROGRESS NOTE TIMEFRAMES

A. Consolidated, Community Living, and P/FDS Waivers and Base-Funded Services

[10] The Adult Autism Waiver previously referred to progress notes as Quarterly Summary Reports (QSR). QSRs are now referred to as Quarterly Progress Notes (QPNs).
[11] Additional resources for Adult Autism Waiver providers can be found on MyODP.org.

The provider must complete a progress note that covers a period of time that does not exceed three months. The provider has one month after the last date included in the timeframe under review to complete the progress note. For example, if the period of service delivery that will be included in the progress note is June 16th through September 16th, the provider has until October 16th to complete the progress note.

Progress notes must cover all dates of service delivery. When services are delivered during each three-month period of the year, there should be no gaps between the end date of the previous progress note and the start date of the subsequent progress note. For example, using the dates discussed above, because the last date covered by the progress note was September 16th, the period of service delivery for the next progress note must begin on September 17th, even if the service was not delivered on September 17th.

Providers may choose to complete progress notes more frequently than every three months (i.e. once a month or twice a month). A progress note cannot cover more than a three-month period. If the review dates are not convenient, a provider may choose to consider shortening one of the time periods under review so that the review dates are convenient for the provider. For example, if provider ABC begins to deliver services to an individual on March 15th, provider ABC may decide to complete a progress note that covers the period of March 15th through March 31st, and complete a progress note every three months thereafter. When determining a schedule for completing progress notes, providers should consider the number of individuals they serve and the number of professionals they have assigned to complete progress notes.

The progress note needs to cover the first date service was rendered and billed and the following three months, or more frequently if the provider chooses.

B. Adult Autism Waiver

Providers of Adult Autism Waiver services must continue to follow previously outlined timeframes for reporting quarterly progress. Providers should continue to refer to the Adult Autism Waiver QSR Due Dates chart found on MyODP. The chart specifies the quarter under review based on the individual's Plan Effective Date and the date by which quarterly progress note must be completed and submitted into QuestionPro. Providers will be compliant with 55 Pa. Code § 6100.227(a) as long as they are following the timeframes defined in the chart. A progress note must be submitted for every quarter in which services are authorized and delivered.

CONTENT OF PROGRESS NOTES

In accordance with 55 Pa. Code § 6100.227(c), progress notes must include the following:

(1) If the service was provided in accordance with the individual plan.

- Progress notes do not need to include every time services were not provided as specified in the ISP. If there is a discrepancy of more than 25% between utilization of services and authorization of services during the period of time covered by the progress note, there must be an explanation in the progress note that describes the reason for the discrepancy and whether adjustments in the back-up plan and/or service provision will be made to ensure needed and authorized services are provided at the duration and frequency noted in the ISP.

- Determination of whether services were provided in accordance with the ISP includes consideration of the implementation of the communication strategies and progress made towards the communication goals or outcomes for individuals who have functional communication impairments. Specific guidance on progress note requirements when an individual has communication goals or outcomes in their ISP can be found in ODP Bulletin 00-25-05, *Communication or its successor*.

(2) If the service met the needs and preferences of the individual.

(3) How progress will be addressed, if there was lack of progress on a desired outcome.

- If it is determined that the individual is not making progress towards the individual's desired outcomes or goals, the provider must identify why there is a lack of progress and document in the progress note the action steps the provider will take to address the lack of progress. Actions may include, but are not limited to, changing the way the service is being delivered, retraining professionals on delivery of service, or requesting an ISP team meeting to discuss and address the reasons for lack of progress or whether outcomes or goals need to be revised or a different service considered.

(4) Impact of the services on the individual's health, safety, well-being, preferences, and routine.

In accordance with approved waivers, ODP also requires documentation of restrictive procedures usage as part of the progress notes when restrictive procedures are included in an individual's ISP and Behavioral Support Plan. Communication related to restrictive procedures between Supports Coordinators or Targeted Support Managers and providers is critical to ensure the health, safety and protection of rights of individuals being supported.

In addition to the above, and to verify that progress notes were completed timely as well as satisfy basic principles for documenting a service, each progress note must include:

- **Identifying information for the individual.** One of the following must be used: Individual's full name (first and last), the individual's MCI number, or the individual's MA number.

- **Identifying information for the provider.** One of the following must be used: The provider agency's full name or the provider agency's 9-digit MPI.
- **The service provided and date range of services under review;**
- **The name of the person completing the progress note; and**
- **The date the progress note is completed.**

The requirements for progress notes in this bulletin apply to participant-directed services delivered through either the VF/EA or the AWC model. In the VF/EA model, the common-law employer is responsible for ensuring that progress notes are completed and maintained in the individual's record. In the AWC model, the managing employer is responsible for ensuring that progress notes are completed and maintained in the individual's record, while the AWC organization is responsible for monitoring managing employers' adherence to this requirement and for agency-wide compliance with 55 Pa. Code § 6100.227(c).

Progress notes are not required for all services. When progress notes are not required, service notes or other documentation satisfies the progress notes requirements for 55 Pa. Code Chapter 6100. It is the provider's responsibility to determine whether service notes are required using Column 3 of Attachments 1 and 2.

III. Other Required Documentation

Providers must document information such as issues that impact the individual's health, safety, preferences, priorities, and routine because it is critical to the provision of services and will be reviewed by DHS or its designee when services are monitored or when claims are reviewed. In addition, licensed providers must maintain documentation in accordance with licensing regulations.

Providers must bill using the procedure codes that correspond with their Approved Program Capacity (APC). Providers need to maintain their Approved Program Capacity and Noncontiguous Clearance Form and provide it for review upon request. The Approved Program Capacity and Noncontiguous Clearance Form is needed for the following services in the Consolidated, Community Living, P/FDS or Adult Autism Waivers or base-funded: Licensed or Unlicensed Residential Habilitation, Licensed or Unlicensed Life Sharing, Supported Living[12] (for reserved capacity), Respite Only Homes and Licensed Community Participation Support Facilities.

When applicable, the Consolidated, Person/Family Directed Support and Community Living Waiver Variance Form (DP 1086) must be retained by the provider and must be provided for review upon request.[13]

Providers that receive the Enhanced Communication Rate must maintain the Enhanced Communication Rate Request Form and the formal notice of approval from ODP in the individual's file and must provide these documents for review upon request.

[12] Supported Living is not covered in the Adult Autism Waiver.
[13] In the Adult Autism Waiver, this form is called the Exception to Established Service Limits form.

In addition to the above, Attachments 1 and 2 specify for each service the other documentation that must be maintained in the record to support a claim and meet standards for service delivery.

IV. Review of Claim and Service Documentation

Providers and SCOs are responsible for reviewing and ensuring the accuracy of their own claims for waiver and base-funded services, as applicable. Further, licensed and unlicensed providers must develop policies and procedures that include safeguards to demonstrate compliance with CMS assurances, including CMS expectations regarding state efforts to prevent fraud, waste, and abuse.

If a provider or common-law employer discovers that any part of the required documentation is not present or does not include all required elements, the provider or common-law employer must act to remediate the situation to avoid recurrence. The type of remediation needed must be determined on a case-by-case basis and whether the finding of non-compliance was an isolated or systemic issue should be taken into consideration. Providers and common law employers are encouraged to reach out to AEs or ODP for technical assistance with appropriate remediation activities.

Review of claims and service documentation occur as part of the QA&I process as a result of a complaint or upon request. In addition, the Bureau of Financial Operations (BFO) may review claims and service documentation in accordance with their policies and procedures. During a review or audit, the provider must provide documentation that substantiates the claim in accordance with this bulletin and its attachments. If it is discovered that a provider is non-compliant with federal or state regulations or ODP waivers or policies during a review of claim and service documentation, the provider or common-law employer (through the common-law employer agreement) may be subject to sanction or remediation.

If a number of claims come into question, the review may be expanded. This may be done through a review of records obtained from the provider or an on-site visit. The scope and protocol will be determined based on the situation and data source.

V. Sanctions and Remediation[14]

In accordance with 55 Pa. Code §§ 6100.741 (relating to sanctions) and § 6100.742 (relating to enforcement), ODP has the authority to enforce compliance with 55 Pa. Code Chapter 6100 using an array of sanctions including recouping, suspending, or disallowing payment.

Regardless of how the problem with a claim is identified or by whom it is identified, claims must be voided by the provider when one of the following occurs:

[14] In accordance with 55 Pa. Code § 6100.804(b), this section of the bulletin does not apply to base-funded only services.

1) There are no time sheets for staff, records of attendance that demonstrate that an individual was present, or other documentation that substantiates that the individual received the service that was billed.
2) The activity was not eligible for payment. This could include, but is not limited to the following examples:
    - Residential Habilitation services were billed for the duration of an individual's stay in a nursing facility. Residential Habilitation services can only be billed on the day the individual is discharged from the nursing facility.
    - Two services which may not be provided at the same time were delivered or billed simultaneously (such as In-Home and Community Support and Companion services).
    - The service provided does not align with the service definition.
    - Services were provided more often than the frequency identified in the approved ISP.
    - A Community Participation Support provider bills consistently for the same number of units every week even though the provider was closed for a holiday or inclement weather.

3) The DSP or SSP providing the service is not qualified to provide the service on the date it was rendered.

4) The provider bills the wrong procedure code.

5) The provider combines units for different procedure codes or staffing ratios across an allowable span of time to fulfill the 15-minute unit billing standard.

Claims may need to be adjusted if the units documented are less than the units billed and paid. For example, time sheets and documentation indicate that the DSP or SSP was present for 4 hours (16 units) but 6 hours (24 units) were billed.

If issues with claims are discovered, the provider will be notified in writing. In addition to voiding or adjusting claims, the provider shall develop and implement a corrective action plan in accordance with 55 Pa. Code §§ 6100.42(e) and 42(h) (relating to monitoring compliance). In the development of this plan, the provider should conduct a review of agency policies, procedures and forms to determine if changes are needed in addition to considering other improvement strategies such as staff training. The completed corrective action plan shall be accompanied by a list of the affected claims internal control numbers (ICNs).

Please note that auditors and monitoring staff can use statistically valid random sampling and extrapolate the results of their testing over the universe of claims. When this is done, the individual claims will not be voided or adjusted, and the extrapolated amount will be considered for recovery purposes.

Providers are encouraged to review and consider using the Medical Assistance Provider Self Review Protocol to proactively identify and address any claim documentation related problems. The protocol can be found at: https://www.pa.gov/agencies/dhs/report-fraud/medicaid-provider-self-audit-protocol.

ATTACHMENTS:

Attachment 1, *Technical Guidance for Claim and Service Documentation for Supports Coordination Organizations and providers of Consolidated, Community Living, and Person/Family Directed Support Waiver services as well as Base-funded Services.*

Attachment 2, *Technical Guidance for Claim and Service Documentation for providers of services in the Adult Autism Waiver*

Attachment 3, *Minimum Activities for Billing Supports Coordination and Targeted Support Management*

OBSOLETE BULLETIN:

Bulletin 00-22-03, “Technical Guidance for Claim and Service Documentation”