

Policy Transmittal Developmental Disabilities Services



Lilia Teninty
Authorized signature

Number: APD-PT-19-003
Issue date: 1/28/2019

Topic: Developmental Disabilities

Due date:

Transmitting (check the box that best applies):

- New policy
 Policy change
 Policy clarification
 Executive letter
 Administrative Rule
 Manual update
 Other:

Applies to (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging: {Select type} | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Aging and People with Disabilities | <input checked="" type="checkbox"/> Office of Developmental Disabilities Services (ODDS) |
| <input type="checkbox"/> Self Sufficiency Programs | <input checked="" type="checkbox"/> ODDS Children's Intensive In Home Services |
| <input checked="" type="checkbox"/> County DD program managers | <input type="checkbox"/> Stabilization and Crisis Unit (SACU) |
| <input type="checkbox"/> ODDS Children's Residential Services | <input checked="" type="checkbox"/> Other (please specify): Support Services Brokerages Directors |
| <input type="checkbox"/> Child Welfare Programs | |

Policy/rule title:	Agency Billing Activities		
Policy/rule number(s):	n/a	Release number:	
Effective date:	2/1/19	Expiration date:	
References:			
Web address:	n/a		

Discussion/interpretation: ODDS requires CMEs to monitor services and verify that services delivered align with those authorized. There is a need to streamline this process for consistency and ease of use.

Implementation/transition instructions:

Effective February 1, 2019, the review flags for agency providers will be set to default to NO for review. This review will no longer take effect in the field but will instead be conducted at ODDS as a provider claim QA process. This change is to agencies only

and does not affect the review of PSW timesheet entries. Review flags may only be turned on for agency providers when using the specific proc codes: OR539, OR570 or OR310.

If now or in the future you experience ongoing problems, suspect fraudulent billing or service issues with an agency that you are unable to resolve, please do the following:

- Communicate with ODDS at ODDS.Operations@state.or.us
- If there is a current agency you have specific concerns around removing the flag, please communicate with ODDS using the email above. We may flag for ODDS review.

A Case Management Entity (CME) must not void claims but should report to ODDS that claims may need to be voided and why. ODDS will void claims or have provider void claims.

This action will make IM-15-054 and the worker guide Agency/Independent Provider Invoice requirements for billing in Plan of Care obsolete. However, agencies and non-PSW independent providers will continue to be required to submit supporting documentation to the CME, within 30 calendar days of a request by the CME or consistent with local agreement between the CME and agency (OAR 411-370-0030(11)(b)), showing:

- The name of the individual to whom services were provided
- The dates of services provided
- Length of time (units of service) required for the service
- A description of the services provided (adequate to demonstrate the service was consistent with, and within the scope of, the service authorized for the provider in the Individual Support Plan (ISP) or Service Agreement (SA))
- Any additional documentation required by the CDDP or Brokerage for the purposes of monitoring and reviewing services delivered

Claims for Professional Behavior Services and Discovery must continue to pend until the provider supplies the agreed upon deliverables as described in the relevant program rules.

Payment to an agency for a service delivery claim, other than those mentioned above, will not be held pending receipt of the supporting documentation unless flagged by ODDS. Payment to an agency may not be held pending an individual's signature acknowledging receipt of the service.

If an individual or their designated representative wants to verify the information

contained in the supporting documentation through a signature, the individual's ISP or service agreement may be updated to reflect this if necessary to assure that it occurs. An agreement may also be reached between the individual, the agency provider and the CME outside of the ISP. ODDS recommends adding the expectation for signatures on the provider's supporting documentation to the "Person's preference on how this service is delivered" portion of the ISP for the service, as ISPs renew.

Training/communication plan: Monthly transmittal call in (third Thursday every month, 2pm, 877-873-8017, guest code #772325, please try to send questions in advance to ODDS.INFO@state.or.us)

Local/branch action required: Review with impacted eXPRS users

Central office action required: n/a

Field/stakeholder review: Yes No

If yes, reviewed by: Posted to the Engagement and Innovation website for feedback.

Filing instructions:

If you have any questions about this policy, contact:

Contact(s): Lea Ann Stutheit; Mike Parr	
Phone: 503-945-6675; 503-945-6109	Fax:
Email: Leaann.STUTHEIT@dhsosha.state.or.us; mike.r.parr@state.or.us	

Topic:	Indirect Case Management Monitoring v.3
Date Issued/Updated:	9/24/16 2/1/19

Overview

Description: Indirect monitoring of services is the case manager's use of documentation to ensure that the Individual Support Plan is effectively implemented and adequately addresses the needs of the person in services. This guide offers information about indirect monitoring.

Purpose/Rationale: Reliance on written documentation from a provider can be a useful method of monitoring when used appropriately. The case manager's progress note that supports the claim for a case management service has to describe how the case manager drew a conclusion about the services and the ISP.

Applicability: Case managers who receive and review documentation from providers and use it to assist in the monitoring of services.

Procedure(s) that apply:

In order to make a case management claim based on a review of documentation, a Personal Agent (PA) or Services Coordinator (SC) must apply professional judgment to determine whether the provider is meeting the support needs of the person. By comparing the individual's ISP and the SC/PA's knowledge of the individual and his or her support needs to the provider's written documentation a case management claim may be made.

Documentation that may serve as the basis for a monitoring service may come several ways, including provider progress notes and incident reports. A progress note or other written documentation may be part of a timesheet or invoice, sent separately from a timesheet or invoice, or delivered through email. However it arrives, the provider's documentation must be maintained in a record at the case management entity, accessible by anyone who needs to see it to verify it supports the case management claim.

To make a claim for an indirect monitoring service, a Services Coordinator or Personal Agent must write their own progress note following a review of the provider's documentation. [Unless there is reason to suspect that the assessed needs have changed or were incorrectly identified, a supporting progress note needs to show, at least, that the services delivered were consistent with the ISP.](#) A supporting progress note needs to show the reasoning that led to the conclusion that the services delivered did or did not meet the support needs identified in the ISP for which the provider is responsible to meet. The case manager's progress note must be able to show how the provider's documentation allowed the case manager to conclude that

the services delivered were adequate and effective, or not. It must tie the support described in the provider's progress note back to the ISP, even if to say the ISP is in need of change.

Checking the math on a timesheet is not a case management service, nor is comparing the amount of services delivered to those authorized and attempting to draw conclusions from the result. For example, a timesheet from a Personal Support Worker (PSW) that records a number of hours that matches what is authorized on the ISP is not enough to demonstrate that the specific supports required from the PSW to meet identified support needs were delivered, adequate and effective.

If it is unclear after review of the provider's documentation that the services were adequate or effective, follow up with the individual, provider, employer or others may be appropriate. Through conversation with others, this follow up may be a qualifying encounter if documented adequately.

An indirect monitoring service is not a reciprocal case management contact. It cannot substitute for site or setting specific monitoring or financial monitoring.

Provider Agency Progress Notes

Any paid service must be supported by documentation that shows:

1. The individual who was provided with the service
2. The date(s) of service
3. The provider of the service (Agency's business name or Independent Provider's name)
4. The amount of service (units of service)
5. A description of the service adequate to demonstrate the service was consistent with, and within the scope of, the service authorized for the provider in the Individual Support Plan (ISP) or Service Agreement (SA)

Adequate provider agency progress notes focus on describing the supports a person received to achieve the desired outcome. These include the ADL, IADL, medical and behavioral supports identified on the ISP as being needed. The notes should focus on the specific activities (i.e. "visited a museum") only insofar as they are important to achieving the desired outcomes as described in the ISP. Simply stating the name of the service associated with the procedure code is not sufficient (i.e. "Provided Day Support Activities" is not an adequate progress note to support a claim by the agency or for the purposes of indirect monitoring.) An adequate note will allow a SC/PA to determine if the services are consistent with those authorized in the ISP.

Provider agency progress notes are also a place for the provider to convey observations about possible changes in support needs, challenging behaviors and a wide variety of topics. These reported observations should be reviewed by the SC/PA for their potential impact on risk identification, new person-centered information, and service planning. The SC/PA's supporting progress note should reflect their assessment of the observations and the actions they will take in response, if any.

For auditing and regulatory purposes, a provider must maintain one progress note per shift or

claim per individual. A summary of progress notes can be the basis for indirect monitoring when it can adequately account for the services.

ISP goals (or the content from the ISP included on a service agreement) should be written in such a way that the provider can clearly understand what they should be doing when delivering a service. The provider will then be able to report back how they supported the individual to achieve the desired outcome(s) during the delivery of the service. The Oregon ISP Instruction Manual has information that will help a SC/PA describe desired outcomes in a way that will be useful for:

- individuals to use to guide their services,
- providers to give support that will be beneficial, and
- the SC/PA to be able to recognize the support as consistent with, or contradictory to, the ISP or service agreement.

Frequently Asked Questions:

Contact(s):

Name: Mike Parr; **Phone:** 503-945-6109; **Email:** mike.r.parr@state.or.us