Iowa Medicaid
IOWA HHS

Frequently Asked Questions (FAQ)

CONSUMER CHOICE OPTIONS
SERVICE DOCUMENTATION

This FAQ was created to assist providers in understanding expectations in addition to the recorded training available to LTSS providers. This aid was prepared as a service to the public and is not intended to grant rights or impose obligations. This aid may contain references or links to statutes, regulations, or other policy materials outside of Iowa Medicaid. The information provided is only intended to be a general summary. Use of this aid is voluntary. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Contents

FAQ CREATED: 4/4/2023 | LAST UPDATED: 04/11/2023

Formatting Documentation

QUESTION	ANSWER
How can checklists be used within the Veridian format? How would an employee upload a checklist in veridian?	The example documentation from the power point is not intended for the comment section on the Veridian timecard. Checklists are not intended to be used within the Veridian format but are separate processes.
Veridian only allows a comment section what is supposed to be written there?	No information is required for Iowa Medicaid in this comment field. If something is required to submit your time an employee can input whatever information assists them or the member, "N/A" for not applicable, or "none." The comment section will likely be removed in the future.

QUESTION	ANSWER
Will there need to be a separate form from the Veridian timecard and comment?	Service documentation is a separate document from the timecard.
Does anything need to be scanned in to the Veridian timecard?	Service documentation is a separate document from the timecard. No service documentation should be uploaded or stored with Veridian going forward.
Will we continue to turn notes into Veridian? Can you continue to use Veridian comments for the documentation of services?	No additional information or comments are required for Iowa Medicaid on the timecard. Veridian does not review documentation narrative or content. Going forward from this training, service documentation should be maintained separate from the timecard.
Can you keep documentation in a member's home and not on the Veridian time sheet?	Service documentation should be maintained by the employer (Medicaid member).
Can we stop commenting on Veridian now and start our own documentation?	Yes, this is an expectation of this training.
What do I tell my respite workers who haven't kept records for past hours worked. When I went to CCO my Case Worker who left only said CDAC workers needed to document. My new case worker is just learning everything.	Going forward from this training, service documentation should be maintained separate from the timecard.
If they keep documentation on the Veridian portal, can they continue to do that, and just provide the PDF to the case manager when requested?	No. Service documentation is a separate document from the timecard. No service documentation should be uploaded or stored with Veridian going forward. Case Managers will be able to see the comments on any previous timecards until there are no comments available. If you continue to use the Veridian comment section for documentation, you will need to print, sign, and maintain documentation with the employer.
What is the timeline for the updated timecards you are referencing? When will the comment section on the Veridian timecard be eliminated?	Going forward from this training, service documentation should be maintained separate from the timecard.
While using the Narrative Example, the Veridian system does not allow to retain comments once submitted. Is this what is meant by retaining documentation up to 5 years?	Veridian comments will continue to be saved for past comments, but Service documentation is a separate document from the timecard.

QUESTION	ANSWER
Is there a specific checklist to use? Or does the member need to create their own?	There is no specific form or checklist that you must use. The member/employer can create their own. See slides 6, 7, and 8 from the training Power Point for some examples.
What is the respite documentation supposed to look like?	All services have the same general expectations for documentation (Slide 5). Supports and services provided, goals addressed, interventions, and frequency of intervention/support/monitoring (how often / how many) are all required elements. Documentation should be individualized to member need. There is no specific form, format, or checklist that you must use. The member/employer can create their own. See slides 6, 7, and 8 from the training Power Point for some examples.
Are we supposed to establish goals for respite services and use them in documentation? Is this level of documentation required for someone who is in a host home?	Yes respite goals need to be in the service plan and you are required to document on all services in the plan. If you are providing a HCBS waiver service in the Host Home then you are required to document on the service being provided.
Are the MCOs aware of this training and this change?	Yes. There was an informational letter issued for the training. Representation from each MCO was present.
Should narrative documentation include the full goal verbiage, or can I shorten the goals we worked on that day to 1-2 word categories such as those on the example checklist?	Examples given are appropriate for use as long as they are complete, accurate, and created with individual member needs and supports in mind.

Maintaining and Monitoring Documentation

QUESTION	ANSWER
Since we have never been required to have anything other than Veridian notes, will HHS be able to monitor anything prior to today's date?	Iowa Medicaid can monitor using Veridian records and the member file if needed for review of the integrity of services provided (fraud, waste, and abuse). Iowa Medicaid will not be auditing specific to the comment section on Veridian notes at this time. These may be reviewed by case managers or the program integrity unit.
Do I have to show medical necessity on service documentation?	No. Medical necessity is an expectation of the medical (clinical) record as a whole and not specifically required in the component of service documentation.
For handwritten notes, who keeps (maintains) the documentation? Who turns it in to the employee/member?	The direct support staff completes the documentation, turns it in to the employee/member, and the employee/member

QUESTION	ANSWER
	keeps the documentation and is expected to maintain these records for at least 5 years from the date of service.
Are there any recommendations for how to maintain documentation through potential natural disasters? And should Case Managers be discussing this when service planning?	There are no requirements on how documentation is entered or the format for maintenance such as electronic documentation, scans, files, paper, or other options. All documentation must stand alone to support the services provided. The employer should have a procedure for safe storage including in the event of natural disaster. This procedure is up to the employer to create and maintain. Case managers are not required to review this, but it may be helpful for the team to discuss.
Is it acceptable for employee to document while caring for client?	Yes, document during services or as soon as practical after. (Slide 12) You must be considerate of the needs of those you support and ensure documenting while providing services does not compromise the needs or safety of the employer.
If staff has been documenting on Veridian but has not printed that out to save another way, do that need to do that at this point? How far back do they need to go? I don't keep any paper documentation and have it stored with Veridian, are staff required to keep paper documentation of some sort?	Veridian comments will continue to be saved as entered for past dates of service, but service documentation is separate from the timecard and should be completed by the direct support staff. Veridian is not responsible for documentation, the review of documentation, or the maintenance of documentation. There are no requirements on how documentation is entered or the format for maintenance such as electronic documentation, scans, files, paper, or other options. The employer/member is expected to maintain the storage of documentation.
Can the member have their services reduced based on the poorly written documentation by the employee?	No, services are not based on this information.

Content of Documentation

QUESTION	ANSWER
Are you saying that we need to document each instance throughout the day that the member required assistance in toileting?	No, this is not required. You can summarize that you assisted with a task/intervention a certain number of times. You do not need to note these assists in real time or stop to document each time.
The power point and training states that providers should not cut and paste content from day to day or member to member: What about those individuals who have a specific routine and it needs to	Using a form that is consistent from day to day is not "cutting and pasting." Using a checklist every day may mean that some days look alike and this is acceptable. Services should be individualized to member needs. If you continue to use narrative, that cannot be cut and pasted. One way to ensure

QUESTION	ANSWER
be followed or there can be significant behaviors? Do you need to write the same thing over and over?	variance in the documentation is to note changes in services from day to day or changes in member response. This is not required. Routines will look similar and are understandable. Using a checklist or standard format can ensure that you are not writing them repetitively. Discuss this with the employer and check to see how they would like this to be documented.
When using narrative documentation, we are told to use first person for goals ("I will…"), and third person for the activities ("John and his staff…"). Is this required of CCO documentation?	Discuss this with the employer to see how they would like services and supports to be documented. First person language is the philosophy for person-centered plans and the planning process. HCBS services are to be person-centered. You will see service plans in this language which is why goals are documented this way. Service documentation notes services and supports provided to the member from the staff and should be written as such. See the sample documentation on slides 6-8 of the presentation.
I've been told that our employees need to keep track of mileage. How detailed does this need to be documented? Do they need to write down their odometer reading? Or just destinations and miles?	Mileage log. <u>The name, date, purpose of the trip, and total miles, including odometer reading, for transportation provided as part of the service.</u> ▪Tips: • Noting the location of services on documentation does not take the place of mileage logs • Contents listed above need to be accounted for in documentation somewhere. • You can use paper or electronic records • Fleet management software is accepted as well • If transportation is a component of service, this needs to be documented • May use existing records and add on these items One option for a milage form is found here: https://www.veridianfiscalsolutions.org/cco/docs/Mileage.pdf
Do respite workers get mileage reimbursement? Or just other service providers? Just to clarify	The case manager can authorize both services within the plan. The way to explain is that the respite rate pays for the wage of the direct care staff and the transportation rate basically reimburses for the costs associated with transportation during that time. The case manager will just need to ensure that they get a close approximation of the members transportation needs during services in each month as you cannot "save" CCO transportation dollars to use in future months.
Does the documentation need to be signed?	Yes.
Who needs to sign the documentation when it is completed?	The direct support staff who provided the services should write and sign the documentation.
Once starting notes that are not on Veridian timecards, if documentation	Yes.

QUESTION	ANSWER
is being done electronically is a typed signature acceptable?	
If a staff is using electronic visit verification (EVV) is that enough documentation?	If it contains the necessary components of the documentation (Slide 5). Supports and services provided, goals addressed, interventions, and frequency of intervention/support/monitoring (how often or how many) are all required elements. Documentation should be individualized to member need.
I have never been given goals for my son for respite? Should my case manager send me the respite goals?	Yes. Any waiver service in the plan should have a goal.
Do we need detailed notes along with the check list?	No. Narrative is not required (Slide 5). See also, general principals of documentation (Slide 12).

General Questions

QUESTION	ANSWER
When you refer to the 'team" who helps with the service plan, who is the 'team'.	Whomever the Medicaid Member would like to be a part of the planning, but at least the member, employee, and case manager. The case manager writes and maintains the person-centered service plan.
As CBCM's we do not do any training of documentation. Is that is up to the employer/ISB?	It is the employer's responsibility to ensure employees understand documentation requirements (Slide 9).
Are other vendors or other services such as horse therapy, dyslexia therapy, transportation to work, lawn and snow removal/chore required to document their services provided?	These example services have professional standards, billing, accrediting requirements, and other rules that dictate their services. If Iowa Medicaid needs access to the records, they will request these with the provider.