HEALTH CARE
AUTHORITY

TECHNICAL ASSISTANCE GUIDE

Service Delivery Documentation

Developmental Disabilities Supports Division (DDSD)
New Mexico Health Care Authority (HCA)

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OVERVIEW

This guide summarizes documentation requirements for service delivery under the Developmental Disabilities Waiver (DDW), Medically Fragile Waiver (MFW), and Mi Via Self-Directed Waiver (Mi Via), consistent with applicable Medicaid regulations, including 8.302.1 NMAC.

As used in this document, "providers" includes all entities furnishing services to Medicaid eligible recipients, including service providers and vendors serving Mi Via participants pursuant to 8.314.6.12 NMAC.

This guide is intended as a reference for Developmental Disabilities Supports Division (DDSD) staff within the Health Care Authority (HCA) and service providers to clarify documentation expectations that support authorized service delivery and billing. This guide does not supersede federal or state law, NMAC provisions, or waiver service standards, which govern in all cases.

DDW providers, MFW providers, and Mi Via Waiver EORs and vendor agencies are subject to audits conducted by the Health Care Authority (HCA) and the Centers for Medicare and Medicaid Services (CMS). These audits are designed to verify that all services billed to Medicaid were authorized, delivered as documented, and supported by complete and accurate records.

DOCUMENTATION REQUIREMENTS

What are the guidelines that service providers need to follow for the documentation of service delivery?

Service delivery documentation must comply with applicable Medicaid regulations and waiver service standards. Providers are responsible for maintaining documentation that substantiates the delivery of authorized services and supports Medicaid billing.

The relevant New Mexico Administrative Code (NMAC) regulations regarding provider service delivery documentation are below.

Note: These are partial citations. Complete NMACs can be found through the links provided.

8.302.1 NMAC: MEDICAID GENERAL PROVIDER POLICIES

Record Keeping and Documentation Requirements
A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.
Citation: 8.302.1.17 NMAC - Rp, 8.302.1.17 NMAC, 7/1/2024

Detail Required in Records
Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed, diagnosis and medical necessity of any service. Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.
Citation: 8.302.1.17 NMAC - Rp, 8.302.1.17 NMAC, 7/1/2024

Records Retention
A provider who receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date: (1) treatment or care of any eligible recipient (2) services or goods provided to any eligible recipient (3) amounts paid by MAD on behalf of any eligible recipient; and (4) any records required by MAD for the administration of Medicaid.
Citation: 8.302.1.17 NMAC - Rp, 8.302.1.17 NMAC, 7/1/2024

Services Billed by Units of Time
Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.
Citation: 8.302.1.17 NMAC - Rp, 8.302.1.17 NMAC, 7/1/2024

This NMAC is incorporated by reference within each waiver's NMAC and applies across all waiver programs, as follows:

8.314.3 NMAC: MEDICALLY FRAGILE HOME AND COMMUNITY-BASED SERVICES WAIVER SERVICES

Provider Responsibilities
Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients.
Citation: 8.314.3.11 NMAC - Rp, 8 .314.3.11 NMAC, 3/1/2018

Reimbursement
Providers must follow all Medicaid billing instructions. See Section 8.302.2 NMAC.
Citation: 8.314.3.17 NMAC - Rp, 8 .314.3.17 NMAC, 3/1/2018

8.314.5 NMAC: DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER

Reimbursement
A DDW provider must follow 8.302.2 NMAC, MAD billing instructions, utilization review instructions, and supplements.
Citation: 8.314.5.19 NMAC - Rp, 8.314.5.19 NMAC, 12/1/2018

8.314.6 NMAC: MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER

Record Keeping and Documentation Requirements
Service providers and vendors who furnish goods and services to Mi Via eligible recipients are reimbursed by the FMA and must comply with all applicable NMAC MAD rules and service standards....including but not limited to... 8.302.1 NMAC.
Citation: 8.314.6.12 NMAC - Rp, 8.314.6.12 NMAC, 3/1/2016

REQUIRED DATA ELEMENTS

What information must be included to meet documentation requirements?

Direct service documentation must comply with 8.302.1 NMAC. Although providers may use different formats, documentation must include, at a minimum, the following elements:

1. Provider name
2. Name of recipient
3. Location of service
4. Date of service
5. Service title
6. Start time of service
7. End time of service
8. Name, title, and signature of the staff person providing the service. Each user account within an electronic health record (EHR) system is non-transferable. All actions taken while logged into a user account are attributed to that specific individual and are considered an electronic signature. For this reason, users must not share accounts or login credentials under any circumstances.
9. A description of the care, treatment, or support provided, including what occurred during the service period.
10. Outcomes of the services, including successes, barriers, or problems that occurred during service delivery.

By documenting the above information, the provider maintains evidence to support Medicaid billing, provided that the service delivered is authorized and supported by person-centered plans, when applicable, relevant treatment or service plans. The level and type of service provided must be approved and documented in the person-centered plan prior to service delivery and billing.

ALL WAIVERS: DOCUMENTATION GUIDANCE

What form of documentation applies across all waivers to substantiate, support, and verify service delivery for Medicaid reimbursement?

- **Daily Log or Progress Notes**

  Service delivery documentation must be completed daily, or no later than 48 hours after the service for all billable time. Documentation must align with applicable waiver service standards, person-centered plans, plans of care, and authorized individual budgets. Requirements apply to both routine (e.g., residential/day) and intermittent services (e.g., therapies, nursing, case management).

  Progress Notes must:

  - Be legible and clearly documented, preferably electronically.
  - Describe the specific services delivered, including activities performed, supports provided, and the role of the staff person delivering the service.
  - Include the individual's name, date of service, and actual start and end time. Time intervals alone (e.g., "one hour") are not sufficient.
  - Reflect implementation of the person-centered plan, clinical goals, or medically necessary supports, including refusals or minimal participation when applicable.
  - Identify the staff person(s) delivering the service by name, signature, and title. Electronic signatures typically prepopulate through systems, are uniquely attributable to the individual, and incorporate a timestamp. Although more manual electronic formats are not typical, typed names, cursive-style fonts, or initials alone do not meet this requirement. In hard copy cases, a wet signature with a time and date would technically meet this requirement, as well.
  - Clearly identify the service provided and support that the service aligns with the approved plan and, where applicable, the authorized budget.
  - Be completed prior to billing and available upon request.
  - Be maintained separately for each service billed. If multiple services are delivered on the same day, each service must have its own documentation.
  - For Mi Via, these requirements apply to vendor agencies (including employees and subcontractors) and direct hire employees. Employers of Record (EORs) must ensure all documentation is complete, accurate, and compliant prior to approving timesheets and Vendor Payment Request (VPR) forms. This includes maintaining progress notes, invoices, and receipts (e.g., for purchases made with the Money Network Card (MNC)) sufficient to substantiate services billed.

  All required documentation must be complete and available upon request by HCA, MAD, CMS or other authorized agencies.

DDW & MFW ONLY: DOCUMENTATION GUIDANCE

What are the documentation formats that apply to DDW and MFW, exclusively?

- **Individual Service Plan (ISP)**

  The Individual Service Plan (ISP) for each individual should indicate how service implementation and progress will be documented. For DD Waiver services, this may include documentation column of Desired Outcomes and Action Steps as identified in the ISP. For Medically Fragile Waiver services, documentation must reflect the goals, services, and medical or clinical supports identified in the ISP and approved budget.

  Service providers are responsible for collecting and maintaining documentation consistent with the ISP and any applicable service plans. If regular written documentation of Desired Outcomes and Action Steps necessary to document DDW ISP implementation, the Daily Logs/Progress Notes can also be used to collect this information.

  The ISP may also identify alternate methods to document implementation, such as photographs, receipts, or other tangible evidence of service delivery. Some examples of this alternate documentation include the collection of pictures, receipts, bank statements, or other tangible evidence of implementation. It is necessary for the service provider to collect data as stated in the ISP or other types of support plans.

  It is important to note that while a provider may use an alternate methodology to provide evidence of ISP implementation, alternate documentation methods do not replace the requirement to maintain service delivery documentation sufficient to substantiate services billed.

  Providers may not bill for services unless documentation supports that the service was delivered as authorized. Failure to maintain this evidence or provide upon request may result in recoupment of funds or other administrative action.

- **Semi-Annual & Annual Reports**

  Under the DD Waiver, semi-annual reports provide updates on the individual's life circumstances, health status, and progress toward ISP Desired Outcomes, Action Plans, and applicable clinical or professional goals. Most DD Waiver provider agencies must complete semi-annual reports, except for Assistive Technology (AT), Environmental Modifications and Specialized Equipment (EMSP), Private Duty Nursing Respite (PRSC), Supported Self-Employment (SSE), and Crisis Supports. Respite providers must submit a semi-annual report when Respite is the only service in the ISP, other than Case Management, for an adult age 21 or older.

  The first semi-annual report covers the first six months of the ISP year and is due ten calendar days after the six-month period ends. The second semi-annual report is incorporated into the annual report or professional reassessment and is due fourteen calendar days prior to the annual ISP meeting. At a minimum, semi-annual reports must include the individual's name and date on each page, the reporting timeframe, progress toward ISP outcomes and service-specific goals, significant changes or life events, and the signature of the staff preparing the report. Reports must be distributed to IDT members and may be stored electronically.

  The annual report is provided to the full IDT at least two weeks prior to the annual ISP meeting. It must include justification for continuation of services and a summary of service delivery for the prior year, along with analysis of what worked, barriers encountered, and implications for future planning. All DD Waiver service providers, except respite and case management, must complete an annual report in accordance with DD Waiver Service Standards.

  All required documentation must be complete and available upon request by HCA, MAD, CMS or other authorized agencies.

MI VIA ONLY: DOCUMENTATION GUIDANCE

What are the documentation formats that apply to Mi Via, exclusively?

- **Service & Support Plan (SSP)**

  Under the Mi Via Self-Directed Waiver, services are authorized through the approved Service and Support Plan (SSP) and individual budget. The SSP identifies the participant's goals, supports, risk factors, backup plans, and the services and goods to be purchased within the approved budget.

  Documentation must demonstrate that services or goods were delivered as authorized in the approved SSP and budget. For employees and vendors, documentation must substantiate the date of service, time when applicable, description of services or goods provided, and the individual receiving the service. Documentation must also support that services align with the participant's identified needs, outcomes, and approved spending plan.

  Unlike the DD and Medically Fragile Waivers, Mi Via does not require traditional semi-annual or annual provider progress reports. However, documentation must reflect ongoing implementation of the SSP and be sufficient to support billing, monitoring, and compliance oversight as described in Mi Via Service Standards and 8.302.1 NMAC. Depending on the service type, documentation may include progress notes, vendor payment request forms, invoices, timesheets, or other records that substantiate the date, time when applicable, description of services or goods provided, and alignment with the approved SSP and budget. All documentation must be sufficient to support payment and demonstrate that services were delivered as authorized.

  Participants, Employees of Record, vendors, and Fiscal Management Agents must maintain documentation consistent with Mi Via standards, payment schedules, and Medicaid record-keeping requirements. All documentation must be retained in accordance with Medicaid record retention requirements and be made available upon request by HCA, MAD, CMS or other authorized state agencies.

  Failure to maintain documentation sufficient to substantiate services billed may result in recoupment of Medicaid funds or other administrative action.

ALL WAIVERS: ADDITIONAL VERIFICATION REQUIREMENT

What additional service verification requirement applies across all waivers?

- **Electronic Visit Verification (EVV)**

  Electronic Visit Verification (EVV) is required for applicable personal care and home and community-based services across all New Mexico waivers in accordance with federal Medicaid requirements and state policy. EVV is used to verify the date of service, location of service, individual receiving the service, staff providing the service, and the start and end time of the visit.

  While EVV requirements apply across waivers, oversight, monitoring processes, and operational expectations may vary by waiver and service type. For technical guidance, system support, or billing-related questions regarding EVV, refer to the Contact Information section provided in this document.

  Use of the EVV system alone does not meet all Medicaid documentation requirements. Providers must maintain additional service delivery documentation sufficient to substantiate services billed, consistent with 8.302.1 NMAC and applicable waiver service standards.

COMMON DOCUMENTATION MISTAKES TO AVOID

What are some common mistakes do providers make with documenting service documentation?

- **Mistake 1: Failure to state 'Time in' and 'Time out' for each period of service by each provider**

  8.302.1.17.A NMAC states, "Provider Records must be sufficiently detailed to substantiate the date,… time … [and] length of a session of service billed."".

  To substantiate the exact time and length of the session billed, providers must clearly document the start and end time of the service. Recording only a duration, such as "one hour" or "forty-five minutes," does not meet this requirement.

  Failure to document the start and end time of the service results in inadequate documentation that does not sufficiently substantiate the time billed. During review by an authorized HCA state agency, insufficient time documentation may result in recoupment of funds and corrective action.

- **Mistake 2: Failure to have a Signature/Title for each uninterrupted period of service**

  8.302.1.17.A NMAC states, "Provider Records must be sufficiently detailed to substantiate the …… rendering… provider."".
  Service documentation must be verified by the individual who provided the service. Verification must include the staff member's signature. This signature and title, either handwritten or electronically verified, for each documented for each period of time for which the service.

  It is not sufficient to sign at the end of the month or at the end of a page if multiple service periods are documented. Each note covering a continuous period of unbroken service must include the signature and title of the rendering provider.

  If documentation is reviewed by an authorized HCA state agency, failure to include a hand-written or electronic signature and title for each documented service period may result in recoupment of funds and corrective action.

- **Mistake 3: Blending of more than one service types in one progress note or billing record**

  8.302.1.17.C NMAC states, "Services billed on the basis of time units spent with an eligible recipient… must be sufficiently detailed to document… the services provided during that time unit."

Each service billed must be documented in a manner that clearly identifies the specific service delivered and the corresponding time billed. Documentation must allow the reviewer to distinguish which service was provided during each documented time period.

It is not acceptable to combine multiple separately billable services within the same documentation entry when billing those services separately. If multiple services are provided on the same day, separate documentation must be maintained for each service billed.

If documentation is reviewed by an authorized state agency, blending multiple services in a single entry without clearly distinguishing the services billed may result in recoupment of funds and corrective action.

- **Mistake 4: Failure to include sufficient detail**

8.302.1.17.C NMAC states, "Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document… the services provided during that time unit.""

Services billed by time unit must include documentation that describes what occurred during the service period. Documentation should reflect the nature of the service delivered, the level of support provided, and the individual's participation or response when applicable.

The regulation does not require a minute-by-minute account of every activity during the billing period. However, documentation must include more than a brief or conclusory statement. Entries must be detailed enough to substantiate the service provided and the time billed.

Adequate documentation allows a reviewer to understand the general course of the service period, including relevant routine or non-routine events and any implementation of the individual's plan.

If documentation is reviewed by an authorized HCA state agency, failure to include sufficient detail to substantiate the service billed may result in recoupment of funds and corrective action.

- **Mistake 5: Over-documenting services**

8.302.1.17 NMAC requires that provider records be sufficiently detailed to substantiate the services provided during the time billed. The regulation requires sufficient detail, not excessive or repetitive documentation.
Documentation does not need to describe activities in fixed intervals, such as every fifteen minutes, unless required by a specific service standard or individual support plan. Providers must document the start and end time of the service and include a

description of what occurred during that continuous period. For example, documenting services from 6:00 a.m. to 9:00 a.m. with an appropriate summary of supports provided meets the requirement. A minute-by-minute account of routine activities is not necessary unless clinically relevant.

Documentation should reflect meaningful information related to service delivery and planning. It is appropriate to note new, atypical, or clinically significant responses, as well as changes in level of support, health status, or other significant events. Routine repetition of established supports already reflected in the Individual Service Plan or required assessments is not required.

Documentation must substantiate billing and demonstrate implementation of the individual's plan. Insufficient detail may result in recoupment; however, documentation beyond what is required by regulation or waiver standards is not necessary for compliance.

- **Mistake 6: Failure to complete documentation timely**

8.302.1.17 NMAC requires that "Provider records must be sufficiently detailed to substantiate the date, time… [and] services provided." Documentation that is completed days or weeks after the service was delivered may not accurately substantiate the service billed.

Daily documentation should be completed contemporaneously. At the latest, it must be completed within 48 hours after the delivery of service. The requirement may be sooner as reflected by training requirements or professional license. Late entries increase the risk of incomplete or inaccurate documentation and may call into question the reliability of the record.

Backdating notes, pre-documenting services before they occur, or completing documentation in batches at the end of a pay period or month does not meet documentation expectations. Each entry must reflect the actual date the service was delivered and the actual date the documentation was completed, when different.

If documentation does not clearly support that services were delivered as billed, the claim is subject to recoupment. Repeated failure to complete documentation in a timely manner may result in corrective action, sanctions, or other administrative remedies as permitted under state and federal law.

CONTACT INFORMATION

- **For customer billing issues, contact:**
  - Phone: 1-800-283-4465
  - Automated service: 24/7
  - Live agent: Monday–Friday, 7:00 a.m.–6:30 p.m.
  - Email: NM.Customers@hsd.nm.gov

- **For provider billing issues, contact:**
  - Phone: 1-800-299-7304
  - Automated service: 24/7
  - Live agent: Monday–Friday, 7:00 a.m.–5:00 p.m.
  - Email: NM.Providers@hsd.nm.gov

- **For billing issues unresolved after 10 days, contact:**
  - Email: Rachel.Gonzales@hca.nm.gov
  - Text (General Information Only: Available 24/7 at 601-401-4995
  - Online Chat: Available 24/7 via the Medicaid Portal
  - TTY / Hearing Impaired: 711

- **For Developmental Disabilities Waiver (DDW) program questions, contact:**
  - Phone: 505-584-1687
  - Email: Steven.Fernandez@hca.nm.gov

- **For Medically Fragile Waiver (MFW) program questions, contact:**
  - Phone: 505-231-2304
  - Email: Melissa.Mcbride@hca.nm.gov

- **For Mi Via Self-Directed Waiver (MVW) program questions, contact:**
  - Phone: 505-506-6103
  - Email: Elaine.Hill@hca.nm.gov

- **For DD/Med Frag Waiver EVV support, contact:**
  - Phone: 1-800-299-7304

- **For Mi Via Waiver EVV support, contact:**
  - Phone: 1-800-283-4465