

NC Innovations Provider Quarterly Self-Review of Member Record

Instructions:

This NC Innovations Provider Self-Review Tool reflects provider requirements outlined in the Quarterly Innovations Waiver Monitoring Checklist tool. Innovations Waiver providers must complete this self-review tool for every quarter in which they deliver Innovations Waiver services to a member. Completion and execution of this self-review tool indicates that the undersigned provider verifies and attests to all applicable items listed below in the member's specific health record maintained by your agency. Providers are required to meet all Medicaid and Innovations Waiver documentation requirements applicable to the services provided.

Contemporaneously meeting documentation standards is an express condition of payment, and providers should not bill Vaya Health (Vaya) for services that are not supported by applicable documentation outlined herein. **The assigned care manager will continue to monitor the provision of services through observation of service provision, review of documentation, and verbal reports in the monthly or quarterly face-to-face meeting.** All providers continue to be subject to scheduled and unscheduled post-payment review and monitoring by Vaya. Completion of this Self-Review Tool is not a substitute for meeting the requirements listed below.

If you choose not to complete this Self-Review Tool, you are required to submit the member record via secure encrypted email to the assigned care coordinator no later than the 10th day of the third month in the calendar quarter for which you are reporting. The member record includes, but is not limited to, the Member Care Plan, Provider Plan/Short-Range Goals, service notes/service grids, Positive Behavior Support Plan (if applicable), Medication Administration Record (if applicable), all orders by medical doctors/doctors of osteopathy/nurse practitioners/physician's assistants (MD/DO/NP/PAs), all member/legally responsible person (LRP) consents, Health and Safety Checklist (if applicable), and any other additional documentation (such as seizure or sleep logs, progress/service notes recording any incidents affecting the member) and any other documentation related to the member that addresses the items in the Self-Review Tool (e.g., Client Rights Committee minutes).

Please contact the member's assigned care manager if you have questions about this Self-Review Tool.

To Be Completed by Authorized Provider Representative:

Member name: _____ Member DOB: _____

Member ID#: _____ Care manager name: _____

Provider name: _____ Provider contact email: _____

Innovations Waiver services delivered by provider: _____

Dates covered by Self-Review Tool: _____

Return to Vaya via secure email [at CCMProgramAssistants@vayahealth.com](mailto:CCMProgramAssistants@vayahealth.com) no later than the 10th day of the month following the calendar quarter for which you are reporting. By signing below on page 5, the provider attests to the following for the dates covered by this self-review as listed above:

1. Member Care Plan (plan of care) is current and in member record.	☐ Yes	☐ No
2. Provider plan is current and in member record, and dates on goals have not expired.	☐ Yes	☐ No
3. Provider Plan/Short-Range Goals and strategies meet long range outcomes in Member Care Plan.	☐ Yes	☐ No
4. Provider Plan/Short-Range Goals elements include measurable goal statement; strategies, interventions, or task analysis to meet the goal; and target date, including month, day, and year.	☐ Yes	☐ No
5. Provider Plan was signed by legally responsible person (LRP) prior to implementation of the Member Care Plan and Provider Plan and delivery of the services.	☐ Yes	☐ No
6. Direct support professional(s) (DSPs) have direct access to Provider Plan/Short-Range Goals while delivering services to member.	☐ Yes	☐ No
7. Service notes/service grid match the Short-Range Goals and documented interventions/task analysis/strategies.	☐ Yes	☐ No
8. Service notes/grids have a key that reflects type of criteria/data to be documented and can be cross-walked with task analysis/strategies (annually and as updates occur).	☐ Yes ☐ Not applicable	☐ No
9. Provider is monitoring member progress on Short-Range Goals at service delivery level as documented through service notes or other mechanism developed by the provider.	☐ Yes	☐ No

For any responses above checked “No,” provide a concise justification why the documentation does not meet requirements as of the date of this self-review and describe intended plan for correction:

Section Two: Service Authorization/Deviations in Service Delivery

10. Member is receiving services in the type, scope, amount, and frequency authorized by Vaya. ☐ Yes ☐ No
11. Any significant deviations in service delivery was reported to Vaya, either directly to the assigned care coordinator and/or via the Back-Up Staffing Report ("significant" means breaks in services due to staffing/illness/vacation that exceed one week and/or a billing increase/decrease for three consecutive weeks, which indicates a plan update may be necessary). ☐ Yes ☐ No
☐ Not applicable
12. The reason for any service deviation is documented in member record. ☐ Yes ☐ No
☐ Not applicable

Service	Authorized units	Units authorized per week	Units used this quarter	Total units used of current auth	Remaining units

In the above grid, if units are over- or under-utilized based on current authorization(s), explain why this occurred (e.g., hospitalization of member, staff out sick, member declined services).

For any responses above (10-12) checked “No,” provide a concise justification why the documentation does not meet requirements as of the date of this self-review and describe intended plan for correction:

Section Three: Positive Behavioral Support Plan (PBSP)

**** ☐ Entire section not applicable – skip to next section ****

- | | |
|---|---|
| 13. Copy of current PBSP is signed and accessible to DSP(s), documentation supports that PBSP is being followed and behavioral data is being collected. | ☐ Yes ☐ No
☐ Not applicable |
| 14. Copy of current PBSP includes any restrictive interventions (including protective devices used for behavioral support). | ☐ Yes ☐ No
☐ Not applicable |
| 15. Copy of current PBSP is signed/approved by a licensed psychologist and approved by the provider’s Clients Rights Committee. | ☐ Yes ☐ No
☐ Not applicable |

For any responses above checked “No,” provide a concise justification why the documentation does not meet requirements as of the date of this self-review and describe intended plan for correction:

**** ☐ Entire section not applicable – skip to next section ****

- | | | | |
|--|------------------------------|-----------------------------|---|
| 16. Signed consent from individual/LRP to conduct an approved intervention described in the Member Care Plan and PBSP (unless intervention unplanned) is in member record. | ☐ Yes | ☐ No | ☐ Not applicable |
| 17. Signed consent from individual/LRP to use protective devices for support described in Member Care Plan and PBSP is in member record, if applicable, is approved by the provider's Clients' Rights Committee. (Protective devices include, but are not limited to, seizure helmets, wheelchairs, AFOs, and standers.) | ☐ Yes | ☐ No | ☐ Not applicable |
| 18. If applicable, provider informs the member's care team of any changes to restrictive interventions (including protective devices used for support) described in the Member Care Plan. | ☐ Yes | ☐ No | ☐ Not applicable |

For any responses above checked “No,” provide a concise justification why the documentation does not meet requirements as of the date of this self-review and describe intended plan for correction:

Section Five: Medical and Medication Needs/Integrated Care

**** ☐ Entire section not applicable because the member has no medical or medication needs – skip to next section ****

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|--|--|
| 19. Member medical needs and/or changes in health status are documented in the member record. | ☐ Yes ☐ No ☐ Not applicable
☐ No changes in health status since last review
☐ No information provided by member/LRP |
| 20. All orders signed by a medical doctor/doctor of osteopathy/nurse practitioner/physician assistant (MD/DO/NP/PA) are followed by the provider. | ☐ Yes ☐ No
☐ Not applicable |
| 21. The provider QP and DSP who administer medication and/or are informed of the member's medication and understand why the member is taking any prescribed medication. | ☐ Yes ☐ No
☐ Not applicable |
| 22. Medication Administration Record (only for residential and day supports, if medication is administered) includes medication, times dispensed, refusals, and errors (including wrong or missed dosage, wrong medication, wrong time [more than one hour from prescribed time]) and is current. | ☐ Yes ☐ No
☐ Not applicable |
| 23. All healthcare and other appointments necessary for the member's wellbeing are attended and/or rescheduled as necessary (for residential only). | ☐ Yes ☐ No
☐ Not applicable |
| 24. All consents (for residential and day supports only, if medication is administered) needed to obtain medical records are in the member's record. | ☐ Yes ☐ No
☐ Not applicable |
| 25. Additional documentation such as seizure, sleep logs, or other documentation specific to the member are current (particularly for residential and day supports, but, if applicable, to other providers). | ☐ Yes ☐ No
☐ Not applicable |

For any responses above checked "No," provide a concise justification why the documentation does not meet requirements as of the date of this self-review and describe intended plan for correction:

Section Six: Health and Safety

26. Prior to the delivery of service in the DSP's home (and every six months afterward, as long as services continue to be provided in that home), Health and Safety Checklist is completed, signed by member/LRP, and in member record (only for CLS and Respite provided in DSP's home). ☐ Yes ☐ No ☐ Not applicable

27. All incidents affecting the member are recorded, and all Level II and Level III incident reports were timely filed in IRIS (generally within 72 hours of the incident). If technical assistance regarding incident reporting is needed, email IncidentReport@vayahealth.com. ☐ Yes ☐ No ☐ Not applicable

For any responses above checked "No," provide a concise justification why the documentation does not meet requirements as of the date of this self-review and describe intended plan for correction:

Provider Signature

I hereby attest on behalf of the provider that I have the authority to sign this Self-Review Tool regarding this member on behalf of the provider and that the information contained herein is true and accurate to the best of my and the provider's knowledge.

Provider name: _____ Provider representative/title: _____

Provider signature: _____ Signature date: _____