

Improving the Services Rendered Form

The purpose of the Services Rendered Form is to document *what services were rendered*. The primary audiences for the SRF are: the family (to be able to recall/share what was discussed, learned, tried, etc.); the state (for purposes of compliance/record review); and Medicaid/private insurance plans (for billing accountability). It is easy to think of the SRF as a place to record the child's new skills but the SRF is not a progress note. In order to protect programs from the risks associated with insurance audit, the following practices should be followed:

- The SRF must be filled out completely. Follow all prompts.
- The SRF must be clear, legible, and jargon-free.
- Because the primary consumer of EI services is the parent, the body of the note should summarize how the parent was involved and coached as the learner, and how they were able to practice new strategies.
- The description of the service provided must support the billing code, the elapsed time, and the personnel involved.
- For a co-treat, the purpose of the *co-treat* must be clear. Why were 2 providers needed at the same time? (e.g., so one could demonstrate an intervention to the parent and another provider for carryover; to problem solve an issue across disciplines with the parent; etc). The note should document what role each staff person was providing simultaneously during the visit. Both staff could contribute to the writing of the SRF or one person could write it, describing both roles.
- The SRF includes a section for what will happen between visits. It reflects joint planning with the parent about which strategies the parent feels they can incorporate from your visit into their week. It is specific about what to do and how to do it.

SRF Quality Review

SRFs are reviewed for quality using a rating scale of 0-3 in four primary areas:

1. Documentation which supports the billing code, elapsed time and personnel
2. Documentation of the parent's participation in the visit
3. Documentation of the intervention(s) occurring in a natural routine/family activity
4. Documentation of joint plan, intervention (i.e. problem solving, modeling, practice), feedback and joint plan (i.e. what parent(s) will do between visits and a plan for next visit)

Improving the Services Rendered Form

Services Rendered Form Rating Criteria				
Rating	SRF requirements	Parent participation	Intervention occurs in a natural routine/family activity	Plan for between visits
0- No documentation-risk for audit	<ul style="list-style-type: none"> • Documentation does not support billing code • The note does not document the service that was provided to the parent; the note describes the child's progress or reads as an observation of the child • The documentation does not match the code utilized (a discipline code is used but write up reflects service coordination, or an activity unrelated to the discipline); • Billing code does not match the category of service listed on the IFSP (Nursing is billed yet the IFSP lists FTC as the service) • Documentation of a co treat does not support 2 people (reads as if 2nd person not there). 	Parent not referenced in body of SRF (as if not there)	Evidence that materials are brought and taken away. Evidence of EI as a "session" not tied to typical activities or activities that are not age appropriate	No plan
1-Minimum documentation-Evidence is there but poor quality	<ul style="list-style-type: none"> • Documentation minimally supports the code billed. • Although there is reference to more than one person in a co-treat the purpose of the co-treat is unclear. 	Minimal evidence of parent participation	An activity loosely linked to outcomes; might be generalized to daily routine	Plan very general
2-Fair documentation-does not meet all criteria for #3 but more than minimal	Documentation supports the code but is not clear picture of who was involved, role vaguely defined, description lacks detail to fully understand what occurred.	Parent involved in some of the visit; evidence parent was participating	Some evidence of use of child's /family materials; the visit is based somewhat on the child or parents interest or outcomes; during a routine or could become a routine	Plan with an example; Fairly specific
3-Good documentation-Useable as a training example	Documentation fully supports the code billed, time elapsed and the personnel involved. Roles of each person on a co-treat are clearly defined. Reader can visualize what visit looked like	Evidence of coaching (joint plan, observation/ intervention, feedback/reflection and joint plan); parent/caregiver participation	Clear use of child/ family materials or explanation otherwise; in a routine or typical activity (unless concern of safety or maladaptive behaviors that must be addressed throughout the day) can be carried out by all caregivers	Plan with examples, linked to a routine; Very specific.