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STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

44 HOLLAND AVENUE
ALBANY, NEW YORK 12229-0001
(518) 473-1997 • TDD (518) 474-3694
www.omr.state.ny.us

ADMINISTRATIVE MEMORANDUM - #2005-01

To: Executive Directors of Agencies Authorized to Operate Article 16 Clinics
Executive Directors of Agencies Authorized to Operate Joint Clinic
Operations
Executive Directors of Agencies Authorized to Provide Medicaid Service
Coordination (MSC)
DDSO Directors

From: Gary Lind, Director
Policy, Planning and Individualized Initiatives

Subject: Standards for Article 16 Clinics

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Suggested Distribution:

Clinic Administrators and Treatment Coordinators
Clinic Staff
Quality/Compliance Staff
MSC Service Coordinators and Service Coordinator Supervisors

Purpose

This is to review requirements for Article 16 clinics (clinic treatment facilities) certified by the NYS Office of Mental Retardation and Developmental Disabilities (OMRDD). The requirements contained in this administrative memorandum provide additional detail to the components and definitions of clinic visits, identify documentation guidelines and essential standards of practice, and add specificity to applicable principles of compliance found in 14 NYCRR Part 679 and Article 16 of the Mental Hygiene Law. Together, these requirements are the basis for OMRDD program and fiscal reviews of all Article 16 clinic operations, including DDSO joint clinic operations with voluntary agency providers.

Background

Title 18 NYCRR, Section 504.3(a) states that by enrolling in the Medicaid program, “the provider agrees...to prepare and to **maintain contemporaneous records** demonstrating its right to receive payment under the medical assistance program and to **keep for a period of six years from the date of care, services or supplies were furnished, all records** necessary to disclose the nature and extent of services furnished and such records and information, upon request, to...the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health.” It should be noted that there are other entities with rights to audit Medicaid clinic claims, including OMRDD.

The regulatory basis for requirements contained in this Administrative Memorandum is in 14 NYCRR Sections **679.1** (d) (2) & (4); **679.3** (b), (c) (6) & (8), (d), (g), (h), (m), (o), (q) & (t); **679.4** (h), (j) (3)-(6), (k) (2) & (m); **679.5** (c); **679.6** (i); and **679.99** (a), (f), (h) & (i).

Clinic Visits

Article 16 clinics may receive reimbursement for clinic visits based on the number of minutes of face-to-face service/encounter that is provided to an individual.

- Face-to-face service/encounter time is defined as the duration of time during which the authorized party directly provides individualized attention, care, and treatment to an admitted person, potential admittee, collateral or other specified party and may include such tasks as obtaining a history, conducting an assessment/evaluation and performing an examination or treatment. Face-to-face service/encounter time also includes observation time directly associated with the individualized clinical intervention.
- Face-to-face service/encounter time does **NOT** include the time the person or party spends getting ready to begin, resting, toileting, waiting for equipment, or independently using equipment, or the authorized party’s pre and post delivery services/encounter time.
- Pre and post delivery services/encounter time is the time spent by the authorized party before and/or after a face-to-face service/encounter performing the following tasks:
 1. Reviewing records and tests.
 2. Arranging for additional services.
 3. Communicating with other professionals or service providers in any manner, such as in person, through written reports or telephone or electronic contact.
 4. Communicating with the person, the collateral, or others through written reports or telephone contact.
 5. Documenting the face-to-face service/encounter in the clinical record.

- If an authorized party begins to provide a face-to-face service/encounter to an individual and the individual refuses to stay, becomes disruptive or a piece of equipment fails, etc., thus preventing the completion of the service delivery, the **ACTUAL** time spent providing the face-to-face service/encounter can be claimed for reimbursement. These situations should be clearly documented in the clinical record to prevent claiming disallowances.
- The following types of clinic visits with the specified duration of face-to-face service/encounter are authorized for reimbursement:
 1. Intake visit - 30 minutes or more of face-to-face service/encounter time with a potential admittee, his/her collateral and/or the referral source. If the potential admittee cannot be present, there must be documented clinical justification for the absence of the potential admittee.
 2. Full clinic visit - 30 minutes or more of face-to-face service/encounter time within a single day for an appropriately admitted person by one or more licensed/certified professional(s), and/or those authorized to provide services under Part 679. If the full clinic visit consists of more than one face-to-face service/encounter, the minimum duration of each service/encounter must conform to the standards for a brief clinic visit (see below).
 3. Brief clinic visit - fewer than 30 minutes of face-to-face service/encounter time. The minimum duration of face-to-face service/encounter time for a brief visit must be 15 minutes, except for:
 - Medical services, including specialty medical services and dental services delivered by a physician, physician assistant, nurse practitioner or dentist, or students-in-training in those disciplines;
 - Immunizations and TB screenings; and
 - Other services, if there is a documented clinical justification for the delivery of services of a shorter duration.
 4. Group clinic visit - 45 minutes or more of face-to-face service/encounter time for individuals over 18 years old and 30 minutes or more of face-to-face service/encounter time for individuals under 18 years old. Group clinic visits can be provided for a maximum of 12 persons.

5. Collateral clinic visit - 30 minutes or more of face-to-face service/encounter time with the collateral of an appropriately admitted person. Services delivered during a collateral clinic visit are limited to those services that contribute to meeting the identified needs of the admitted person with developmental disabilities.
Collateral may only be:
 - A member of the family, defined as biological/adoptive family, guardian, foster care parent, or family care provider; or
 - A non-related party, who has a long-term care-giving relationship with the admitted person with developmental disabilities, provided they are not being paid to provide clinical or direct care-giving services to that person.

6. Comprehensive diagnostic and evaluation visits - 2 hours or more of face-to-face service/encounter time. An interdisciplinary or discipline specific comprehensive visit may be reimbursed when the visit consists of a comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, and if the cumulative face-to-face service/encounter time provided to a person and collateral (for purposes of completing an appropriately administered assessment protocol) on the same or different days is two hours or more. If the comprehensive diagnostic and evaluation visit is conducted over more than one day, the service date for billing purposes is the last day that the face-to-face service/encounter occurs.

Clinic Nursing Services

Article 16 clinic nursing services shall consist of professional services that require the skill or direction of a registered nurse (RN) to perform. A licensed practical nurse (LPN) may provide nursing tasks within his/her scope of practice as defined by the NYS Education Department, under the direction of an RN, licensed physician, dentist, physician assistant and/or nurse practitioner directly employed by the Article 16 clinic.

- Any treatment generally considered first aid; collection of a laboratory specimen (including phlebotomy), or routine medication administration is **NOT** a reimbursable Article 16 nursing service.

- Medication administration is a reimbursable service only when medication is administered in connection with directly observed therapy for treatment of tuberculosis or for HIV/AIDS.

- Nursing services required by Administrative Memorandum #2003-01, Registered Nursing Supervision of Unlicensed Direct Care Staff in Residential Facilities Certified by the Office of Mental Retardation and Developmental Disabilities, are **NOT** reimbursable Article 16 nursing services.

Clinic Service Documentation

Medicaid reimbursement rules require the inclusion of sufficient, supporting documentation in the person's clinical record to support the services delivered and claimed for reimbursement.

Required service documentation elements are:

- The service date (month/date/year).
- The location of service delivery (e.g. Maple Avenue IRA).
- The duration of the face-to-face service/encounter (e.g. 35 minutes).
- A treatment note (progress note) describing the face-to-face service/encounter, i.e. what happened during the session; the tasks, activities and/or procedures performed that are associated with the person's clinic treatment plan, and the progress, result and/or the person's response to the clinic service.
- The full signature and title of the clinic staff providing the clinic service. (Full countersignature and title must be provided if required by the NYS Education Department).
- The date the note was written. (Medicaid rules require that the note must be contemporaneous to the service provision.)

Clinic Treatment Plans

All clinic treatment plans shall be based on a current and written individualized, clinical examination, assessment and/or evaluation; be individually tailored, and shall contain the following elements:

- A description of the person's developmental disability, other documented diagnoses (medical and/or psychiatric), and the treatment diagnosis as well as symptoms, problems, complaints, or other need for the service(s). The treatment diagnosis must be related to the primary reason the service is provided.
- Identification of the therapy, therapies or specific type or modality of therapeutic intervention (e.g. physical therapy – gait training) that will be used to address the person's need(s), and the treatment goals.
- The frequency, type of clinic visit and location of service delivery. (Please note: If the service delivery is in an OMRDD-certified residence, the treatment plan must identify the specific clinic service and provide justification for the delivery of this service in the residence.).
- The clinic medical director (or designee) must review and approve all treatment plans at least annually, or when there are significant changes to the ongoing treatment plan, per §679.3 (q) & §679.4 (h).

Clinic Treatment Reviews

Clinic treatment reviews shall be conducted that incorporate a review of the type and frequency of the specific clinic services. Such reviews shall also take into consideration the treatment goal(s) the plan is intended to achieve, whether treatment goals have been met, and/or whether new goals need to be established. Clinic treatment goals should be established that incorporate expected achievements within specified time periods.

- The treating clinic practitioner or the clinic treatment coordinator, in consultation with the person receiving services and/or as appropriate, his/her collateral, must review clinic treatment outcomes and/or the course of clinic treatment at least semi-annually or as specified by the treating physician or dentist, or if there is significant change in the person's condition or service needs.
- The review of clinic treatment outcomes and/or the course of clinic treatment must be specific rather than general; quantifiable, if appropriate (i.e. percentage of goal achieved); and directly related to the person's clinic treatment plan.
- Documentation must indicate that the clinic treatment outcomes and/or the course of clinic treatment have been reviewed, and whether clinic treatment is to continue, be changed (next steps) or be discontinued.

Annual Physician (Re)assessment

The clinic medical director or designee (physician) shall assess all individuals annually as to the continuing need to be served by the clinic, per §679.3(t).

- The (re)assessment must include the review of the individual's treatment and evaluative and clinical/medical information.
- The review should take account of the type of clinic service provided, the frequency at which it is provided, the length of time it has been provided, the therapies or modalities employed in treatment, the intended treatment goals, and the clinical appropriateness of the treatment goals in relation to the individual's diagnosis(es), cognitive functioning, physical abilities and the provision of other clinical services to the person.
- Documentation must indicate the date of the (re)assessment and the physician's recommendations regarding continuing treatment and briefly, the rationale involved in the determination.

- The annual physician reassessment must be completed and dated no later than 31 days after a full calendar year has elapsed since the date of the last completed physician reassessment. For example: If the physician's reassessment is dated June 15, 2004, the date of the reassessment in 2005 must be on or before July 16, 2005.

Clinic Quality Assurance Plan

The clinic quality assurance plan shall include a planned and systematic process for monitoring and assessing the quality and appropriateness of treatment, the clinical performance of staff, a means to resolve identified problems to improve treatment, and the opportunity to incorporate input of consumers, collateral, referral sources and other pertinent parties. The quality assurance process must:

- Specify written operational procedures and the staff responsible for quality assurance activities that include both program and individual service evaluation.
- Include individual service evaluation that is representative of the population being served by the clinic and the type of services being provided to that population.
- Define methods for the identification and selection of clinical and administrative problems to be reviewed.
- Establish review criteria in accordance with current standards of professional community practice.
- Document findings, trends, recommendations, and actions taken to resolve problem areas.
- Demonstrate timely implementation of necessary corrective actions.
- Provide for periodic assessment or re-assessment of the corrective actions taken.

Coordination of Clinic Treatment Plans

The clinic treatment coordinator has primary coordination responsibility for all services, therapies and/or treatment provided to a person by the Article 16 clinic treatment program. The clinic treatment coordinator shall forward written treatment plan recommendations to the person's Medicaid Service Coordinator or other coordinator outside of the clinic program, and as appropriate, to other caregivers and referral sources. Written recommendations must be forwarded when the treatment plan is first developed; at least semi-annually when the review of clinic treatment outcomes and/or the course of treatment are completed; and whenever the clinic treatment plan is significantly changed.

- To avoid the duplication of clinical services, treatment plans must reflect and attempt to incorporate all of the person's other individualized written plans of services required by law or regulation. All plans should be generally consistent (i.e. not in conflict) and not duplicate the same clinical service or modality (e.g. gait training) from multiple sources. Plans can include: the Individualized Services Plan (ISP), the Individualized Education Program (IEP), the Individual Program Plan (IPP), and clinic treatment plans for services delivered by other clinics.
 1. If the person is enrolled in the OMRDD HCBS waiver, the clinic treatment coordinator should request that the Medicaid Service Coordinator provide a copy of the person's current ISP, so that this information can be considered when a clinic treatment plan is developed and can be included in the person's clinical record.
 2. If the person is a resident of an Intermediate Care Facility (ICF), the clinic treatment coordinator should request that the ICF administrator provide a copy of the person's IPP, so that this information can be considered when a clinic treatment plan is developed and can be included in the person's clinical record.
 3. If an OMRDD provider operates both a clinic certified pursuant to Article 16 of Mental Hygiene Law, and a clinic certified pursuant to Article 28 of Public Health Law, the clinic treatment plans for any person who is being served by both clinics must be coordinated.
- Treatment plans should be coordinated with clinical services delivered by other providers, including other clinics.
 1. If different clinic services are being provided to a person by two or more Article 16 clinics (e.g. clinic "A" is providing psychology services to the person while clinic "B" is providing occupational therapy to the same person), the clinical record and the clinic treatment plan for each clinic must include documentation that clearly indicates what service is being provided by each Article 16 clinic.
 2. If a particular clinic service (e.g. psychology) is being provided to a person by one Article 16 clinic, that service must not also be provided to the same person by another Article 16 clinic, unless there is a compelling clinical justification to do so (e.g. the person needs a specific treatment service that is only offered by a therapist from another clinic). The clinical record and the clinic treatment plan for each clinic must include documentation that the service is being provided by another Article 16 clinic, and include the clinical justification for the provision of the same service by two different clinics.

3. If a person residing in an ICF receives Article 16 clinic services (because the specific clinical service is not included in the reimbursement rate for the ICF), the clinic treatment coordinator should provide a copy of the person's clinic treatment plan to the ICF administrator when the clinic treatment plan is first developed; at least semi-annually when the review of clinic treatment outcomes and/or the course of clinic treatment are completed; and whenever the clinic treatment plan is significantly changed.

Contract Clinician Organizations

Clinical services provided by contract clinicians or contract clinician organizations for an Article 16 clinic shall be subject to control and oversight by the agency holding the Article 16 operating certificate. All referrals and recommendations for Article 16 clinic services must be reviewed and approved by the clinic medical director or other designated physician/dentist. Oversight of contract clinicians or contract clinician organizations shall be documented by the agency that holds the operating certificate for the Article 16 clinic.

- Contract clinicians or contract clinician organizations should not be the only mechanism used by an Article 16 clinic to obtain the services of clinicians. OMRDD expects that persons employed directly by the agency that holds the operating certificate for the Article 16 clinic will deliver a significant proportion of the clinical services.
- The agency which holds the operating certificate must describe in its clinic program policy and procedure manual or similar document, the plan to provide oversight of services delivered by contract clinicians or contract clinician organizations. The plan must specify how staff directly employed by the agency which holds the operating certificate will oversee the development of all clinic treatment plans and updates to the treatment plans.
- The agency which holds the operating certificate must document the oversight of contract clinicians or contract clinician organizations through monitoring reports that detail the type, frequency and location of clinical services provided, the review of "sign-in" and "sign-out" logs for clinicians, and visits to actual service delivery locations. Staff directly employed by the agency that holds the operating certificate must conduct the monitoring reports and reviews.
- The agency which holds the operating certificate must retain the final authority to decide what services will be delivered to each person, and the amount, frequency and length of time the services will be provided, and may not delegate final decision-making responsibility for such decisions.
- The agency which holds the operating certificate must retain the authority to adopt and enforce policies governing services delivered by the clinic, or by any party or organization hired or under contract to provide services.

- The agency which holds the operating certificate must retain access to and right of control of all books, records and supporting documents in connection with the operation of the clinic, and may not transfer ownership of, or relinquish control of such books, records and supporting documents except as otherwise required by law.
- The agency which holds the operating certificate must retain the authority to incur debts or liabilities and enter into contracts, and may not allow another party or organization to incur debts or liabilities or enter into contracts on their behalf.
- The agency which holds the operating certificate must not allow any part of an organization that is providing services on their behalf as an independent contractor, to do any marketing or advertising for or on behalf of the clinic program.

Clinic Administration

- The clinic administrator of an Article 16 clinic must be directly employed by the agency that holds the Article 16 clinic operating certificate.
- The clinic administrator, the medical director, and/or the medical director designee of an Article 16 must not have interests that could materially affect his/her objective judgment when making decisions about the provision of Article 16 clinic services.

Effective Date

June 1, 2005

Contact Information

For additional information, please contact Larry Zawisza at 518-473-9697 or e-mail larry.zawisza@omr.state.ny.us.

cc: Thomas Maul
Helene DeSanto
Jan Ablelseth
James Moran
Paul Kietzman
Kathleen Broderick
Peter Pezzolla
Gary Lind
Larry Zawisza
Karen DeRuyter