

## **OPWDD Guidance Documents with Payment Standards**

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**ADMINISTRATIVE MEMORANDUM - #2008-02**

**TO:** Executive Directors of Agencies Providing Day Treatment Services

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**DATE:** October 1, 2008

**SUBJECT: DAY TREATMENT BILLING STANDARDS**

**Suggested Distribution:**

Program/Service Staff  
Quality/Compliance Staff  
Billing Department Staff

**Purpose:**

This is to review existing day treatment documentation requirements. The requirements are based on the service documentation rules established by the Centers for Medicare and Medicaid Services (CMS) and Part 690 of Title 14 of the Official Compilation of Codes, Rules and Regulations of the State of New York.



## **Background:**

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 the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish 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.” Currently in New York State the Office of the Medicaid Inspector General has primary responsibility for Medicaid audit. It should be noted that there are other entities with rights to audit Medicaid claims as well, including OMRDD.

## **Day Treatment Services:**

This memorandum describes the service documentation requirements to bill Medicaid or OMRDD for day treatment services. Day treatment is intended to be a planned combination of diagnostic, treatment and habilitative services provided to persons with developmental disabilities in need of a broad range of clinically supported and structured habilitation services. These services are provided in a free-standing certified site or approved satellite (Sec. 690.1(d)).

## **Day Treatment Billing Standards:**

The unit of service for Day Treatment is a day claimed as a full day, a half day, or a partial day (Sec. 6901(d)(1)). Only co-located Day Treatment programs may submit claims for partial days. A day treatment site is certified as “co-located day treatment” if it is located at the same site as a day training program or a sheltered workshop (Sec. 690.1(d)(2)).

Claims for day treatment services may be submitted to eMedNY once the following conditions are met:

- A full day claim may be submitted when the day treatment provider delivers and documents five hours or more of service to a person on a given day.
- A half day claim may be submitted when the day treatment provider delivers and documents from three to five hours of service to a person on a given day.
- A partial day claim may be submitted when the provider delivers and documents at least one and one-half hours of service to a person at a co-located Day Treatment site.

### **Non-Billable Time:**

Time associated with any other Medicaid service, for example, the time a person spends at a clinic medical service, may not be counted toward the billable service time for day treatment (Sec. 690.3(a)(5)(i)). Further, time the person spends traveling from home (or elsewhere) to the day treatment program at the beginning of the day and from the day treatment program back home (or elsewhere) at the end of the day does not count toward billable service time.

### **Vocational Billing Restriction:**

Day treatment services may not be claimed if they are purely vocational in nature (i.e., works for pay) (Sec. 690.3(a)(2)) or if they are performed in an activity that generates outside revenue for the facility (Sec. 690.3(a)(2)(iv)).

### **Documentation of a Developmental Disability:**

The day treatment provider must have on file for each individual served, a clinical assessment substantiating a specific diagnosis of developmental disability. On an annual basis, the clinical assessment must be reviewed by an interdisciplinary team for relevancy and appropriateness, and updated as necessary (Sec. 690.6(1)(3)).

### **Individual Program Plan:**

Each day treatment participant must have an Individual Program Plan which consists of treatment plans and a comprehensive functional assessment (Sec. 690.5(d)(6)(ii)). The Individual Program Plan must be reviewed at least annually by the interdisciplinary team (Sec. 690.5(d)(9)(ii)). The physician review is to ensure that the services are medically appropriate.

In addition, there must be a written prescription from a physician for occupational therapy and/or physical therapy services if these services are provided as part of the day treatment program (Sec. 690.3(a)(3)). The Individual Program Plan should also include (but is not limited to) progress notes describing the person's response to treatment and an activity and attendance schedule along with staff members responsible for providing each service (Sec. 690.6(s)(1-6)).

### **Documenting Daily Service Provision:**

As for all Medicaid services, the Centers for Medicare and Medicaid Services (CMS) requires that, for each day a day treatment service is billed, the provider must have a contemporaneous record of service delivery that is signed and dated by the day treatment staff person providing the service. Progress notes, treatment notes, data or other written documentation that are signed and dated can be used to fulfill this requirement of contemporaneous record of service delivery (Sec. 690.6(r)(6)).

### **Documenting Service Duration:**

In accordance with regulation (Sec.690.5(b)(2)(xv)(b)), the day treatment provider must maintain a daily census record. The census record or other day treatment documentation must identify whether the length of time the person participated in day treatment met the standard for submitting a full day or a half day, or for co-located day treatment sites, a partial day claim. While the regulation does not mandate that the census record include the start time and stop time of the day treatment service on a given day, in an audit a day treatment provider will be expected to provide documentation that substantiates the choice of the full day, half day, or partial day unit of service billed. For example, if the day treatment provider submits a full day claim for April 2<sup>nd</sup> service to an individual, the auditor will ask for documentation that substantiates the April 2<sup>nd</sup> billing of a full day rather than a half day unit of day treatment.

Since the time receiving another Medicaid service during the hours of participation in day treatment is not billable time for day treatment, the day treatment provider must specifically “back out” this time when determining the consumer’s day treatment service duration on any date claimed.

### **Service Documentation Audits:**

In a billing and claiming review of day treatment services completed by OMRDD staff, an auditor will select a particular date for a person which was claimed (i.e., billed) by the day treatment provider. The day treatment provider will be asked to furnish:

1. The person’s Individual Program Plan that “covers” the selected date of service.
2. Contemporaneously documented evidence of delivery of a day treatment service on the date of the claim. This evidence must include a progress note, a treatment note, or data or other written documentation signed and contemporaneously dated by the day treatment staff person who delivered the service.

3. The daily census record or other documentation which demonstrates that, on the selected claim date, the length of time the person participated in day treatment met the standard for claiming a full day or a half day or, in the case of services delivered at a co-located day treatment site, a partial day.
4. A written medical prescription for occupational and/or physical therapy services if these services are provided as part of the day treatment program.

**Documentation Retention:**

All documentation specified above must be retained for a period of at least six years from the date of the service billed. Diagnostic information and other clinical records are generally maintained for a longer period of time and are not the subject of this memorandum.

**For Additional Information:**

For additional information on billing documentation requirements or sample forms contact Ms. Eugenia Haneman of Medicaid Standards at (518) 408-2096. For additional programmatic information, contact Ms. Nimmi Sankaran, Technical Assistance and Consultation Group at (518) 474-8652.

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