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ADMINISTRATIVE MEMORANDUM #2012-06

TO: Executive Directors of Voluntary Provider Agencies
Executive Directors of PCSS Agencies
State Operations and Regional Office Directors

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SUBJECT: Plan of Care Support Services (PCSS) Program Standards and
Documentation Requirements for Billing

DATE: **October 30, 2012**

EFFECTIVE DATE: 10/1/2012

Suggested Distribution

MSC Service Coordinators and Supervisors
PCSS Service Coordinators and Supervisors
Waiver Coordinators

Purpose

Effective October 1, 2012, this memorandum describes the program standards and payment standards for Plan of Care Support Services (PCSS). See Administrative Memorandum #2010-01 for the definition of "program standards" and "payment standards."

The program standards and service documentation requirements set forth in this Administrative Memorandum supersede Administrative Memorandum #2003-02.

The criteria described in this document apply to PCSS services both rendered to Home and Community Based Services (HCBS) waiver enrolled individuals and non-waiver enrolled individuals (i.e. those receiving state paid, non-waiver PCSS).

Background

PCSS provides activities and assistance necessary to conduct timely reviews and updates of a person's individualized service plan (ISP), and to maintain documentation supporting the person's HCBS waiver level of care eligibility determination. The service also assists to meet the needs of the individual as described in the ISP. Each person enrolled in the HCBS waiver must have an ISP. The ISP requirement can be met through PCSS, an HCBS Waiver Service, for individuals who do not need ongoing and comprehensive service coordination.

PCSS shall be provided during at least two months per year, and Medicaid will not pay for more than four months of PCSS per year. If service coordination activities are needed more frequently than four months per year, the individual should be assessed as to whether he/she should be enrolled into MSC.

For individuals who have not been enrolled in the HCBS waiver prior to receiving PCSS, PCSS may also include activities and assistance necessary for initial service plan development and implementation.

To provide PCSS services, each service provider must be currently authorized by OPWDD to provide MSC and must also be an authorized waiver provider of PCSS. PCSS providers must also ensure that each PCSS service coordinator is a qualified MSC and therefore meets minimum qualifications (i.e., education and experiential requirements).

18 NYCRR, Section 504.3(a) states that by enrolling in the Medicaid program, "the provider agrees ... to prepare and **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 (emphasis added)." In addition, 18 NYCRR, Section 517.3(b)(2) states that "All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later..." It should be noted that there are other entities, in addition to OPWDD, with rights to audit Medicaid claims.

Specific regulatory requirement applicable to PCSS are in 14 NYCRR, subdivision 635-10.5(a). PCSS, as an HCBS Waiver Service, must also comply with requirements found in 14 NYCRR, Parts 624, 633, and 635.

PCSS Program Standards

Individual's PCSS Record

The first section of an individual's PCSS record contains the eligibility and enrollment documentation for the individual with developmental disabilities and should include:

- Documentation that the individual has been determined to have a developmental disability.
- Documentation of Medicaid eligibility and enrollment in Medicaid (if Medicaid eligible).
- Notice of individual rights and responsibilities per 14 NYCRR section 633.4.

For people enrolled in the HCBS Waiver, the following HCBS Waiver enrollment information/documents should also be included in this section:

- Waiver Enrollment forms:
 - Application for Participation,
 - Preliminary ISP,
 - Documentation of Choices,
 - Initial Level of Care Eligibility Determination (LCED) and required documentation supporting the determination,
 - Notice of Decision (NOD).
- Current re-determination of ICF/DD Level of Care eligibility. It is recommended that vendors retain the initial LCED (the first determination), the current re-determination and if applicable, redeterminations for six years prior to the current one in the person's active service coordination record.
- Name of the person's advocate or statement that the person is self-advocating.

The written evaluations section of the individual's PCSS record contains written, professional evaluations regarding the person. It should include:

- Clinical assessments and recommendations, service provider reports, and medical information.
- The ICF/MR final summary and post discharge plan for people enrolled in the HCBS Waiver who moved directly from an ICF/MR to Waiver enrollment.
- Other service plans for non-HCBS Waiver services (e.g., day treatment plans).

The contents of the ISP section of the individual's PCSS record contain the ISP with appropriate attachments. The ISP, with its required attachments, constitutes the "plan of care" for purposes of the HCBS waiver. The attachments include:

- HCBS Waiver habilitation plans (residential habilitation, day habilitation, community habilitation, pre-vocational, supported employment, consolidated supports and services, etc.) for HCBS Waiver enrollees.
- The Individual Plan for Protective Oversight if the person lives in an Individualized Residential Alternative (IRA).

The ISP, which is written by the service coordinator, identifies all supports and services the individual receives. If the individual is enrolled in the HCBS Waiver, all of his or her Waiver habilitation plans should be with the ISP. The habilitation plan describes the habilitation activities that will be put in place to pursue the valued outcomes as described in the ISP. All waiver habilitation services are required to have a habilitation plan. Some examples of waiver habilitation services include: residential habilitation, community habilitation, prevocational, and supported employment.

Caseload

Persons served by the service coordinator who receive PCSS are counted as .3 on the service coordinator's caseload regardless of residential setting. However, for Service Coordinators who serve a member of the Willowbrook Class, a person receiving PCSS counts as one (1) unit on the service coordinator's caseload.

PCSS Service Coordinator Activities

For individuals who are being enrolled in PCSS, but have never been enrolled in the HCBS Waiver and have never received MSC, the PCSS service coordinator is responsible for

1. Developing the Person's ISP

The service coordinator:

- a. Uses a person centered planning approach to develop the ISP. The service coordinator identifies the desired goals and valued outcomes of the person and the supports and services that person wants and needs to achieve those outcomes,
- b. Helps a person with developmental disabilities plan by promoting and supporting informed choices and developing a personal network of activities, supports, services, and community resources based on the person's needs and desires,

- c. Documents in the ISP the supports, services, community resources needed and chosen by the person with developmental disabilities and the entities that will supply them,
- d. Helps the person with developmental disabilities to identify the service coordination activities and interventions that the person wants and needs to meet his or her individualized goals and valued outcomes as described in the ISP, and
- e. Develops the Preliminary ISP (PISP) for people enrolling in the HCBS Waiver

2. Implementing the Person's ISP

The service coordinator:

- a. Uses knowledge of the community and available resources to support the person with developmental disabilities to make informed choices regarding how to achieve his or her valued outcomes,
- b. Coordinates access to and the delivery of supports and services identified in the ISP,
- c. Helps to locate and/or create natural supports and community resources,
- d. Locates funded services,
- e. Helps determine eligibility,
- f. Makes referrals,
- g. Facilitates visits and interviews with family members, service providers, housing options, etc. and
- h. Ensures essential information is made available to the person and providers and others with the consent of the individual with developmental disabilities.

Service coordinators providing PCSS must also perform the following tasks:

1. Maintaining a current ISP in consultation with the individual, and completing a review at least twice within a twelve month period. Both reviews must include a face-to-face contact with the individual at the individual's residence or at an alternate site mutually agreed to by the individual and the service coordinator. However it is recommended that at least one review per year take place in the residence. The individual is responsible for contacting the service coordinator to initiate any changes to the ISP should they be needed prior to the next review. ISPs will be based on individual choice, individual capabilities, appropriate professional consultation, and the professional judgment of the service coordinator.
2. Making whatever contacts with the individual's advocate, if any, and major service providers necessary to accurately review and update the ISP if needed. The individual, his/her family or advocate may request a review or voice an objection to the ISP, consistent with 14 NYCRR section 633.12.

3. Assuring that necessary safeguards have been identified to protect the health and welfare of the individual.
4. Assuring that the ICF/DD level of care eligibility determination is completed annually for all HCBS enrollees.
5. Maintaining a record that includes all required waiver enrollment documentation, clinical assessments, the ISP (and attachments) and PCSS notes. The ISP must be retained by the PCSS provider agency with copies provided to the individual, advocate and primary service providers.
6. Notifying the OPWDD Regional Office if the individual is no longer eligible for waiver services.
7. Initiating a re-enrollment in MSC if circumstances warrant, such as if the individual's health or safety are compromised or the ISP can not address the needs or outcomes.

PCSS Payment Standards

Payment for PCSS requires for each individual served prior authorization and registration with the agency in the OPWDD Tracking and Billing System (TABS). This authorization is received from the OPWDD Regional Office where the individual resides.

The unit of service for PCSS is a month. To bill for a month of PCSS, providers must meet either the first set of criteria or the second set of criteria described below.

Criteria Set One:

For two months within any twelve month period, PCSS should be provided for the purpose of reviewing and updating the person's individualized service plan, related records, and ensuring that the annually required HCBS waiver level of care eligibility determination is completed. During these two service months, PCSS service coordinators must meet and document all of the following first set of criteria:

1. Conduct a face-to-face service meeting with the individual.
2. Review (which may include the creation of the initial ISP) and/or update (addendum) the ISP.

Criteria Set Two:

For up to two additional months per twelve month period, PCSS may be provided if additional service coordination activities and assistance are provided during those months and are necessary to meet unexpected needs of the individual. Service coordination activities associated with an unexpected need must include at least one of the following:

1. Addressing a newly discovered health or safety issue,
2. Assisting and obtaining a needed service,

3. Negotiating and resolving conflict, or
4. Accessing entitlements and benefits for the individual.

In order to meet the billing requirement for the additional service months, the PCSS service coordinator must complete at least one face-to-face contact with the individual or two of the following contacts within a month: a non-face-to-face contact with the individual (e.g., phone calls), a direct contact with a qualified contact (see below), or a direct contact with other agencies. For each contact, PCSS service coordinators must document that the purpose of these contacts is related to at least one of the four items above.

Non face-to-face contacts or direct contacts may include:

- Phone call or personal contact exchange;
- Email exchange;
- Letter/correspondence exchange.

A qualified contact is someone directly related to assisting or resolving the unexpected need of the individual. Examples of qualified contacts include family members, medical providers, social workers, educators, and service providers.

Hospitalization

Activities from either the first or second set of criteria that are conducted during an individual's first 30 days in the hospital can be counted toward the billing requirement. After the first 30 days of hospitalization, these activities can no longer be counted toward the billing requirement.

Service Documentation

Documentation of each service required for monthly billing must include the following monthly service note elements:

1. The individual's name.
2. Identification of the service provided (i.e., Plan of Care Support Services or PCSS).
3. Identification of the agency providing PCSS.
4. The month and year that the PCSS service was provided.
5. The location of the service meeting for the ISP review only.
6. A description of the activities that count toward the billing minimum that are described in the PCSS Payment Standards section. If the activity involves contact with a qualified contact then the identity of the qualified contact and the relationship to the person must also be included.
7. The full name, title and signature of the PCSS service coordinator delivering the service. Initials are permitted if a "key" is provided, which identifies the title, signature and full name associated with the staff initials.

8. The date the note was written (i.e., the signature date) which must include the day, the month, and the year.

The date the note was written must be contemporaneous, “at the time the service was delivered or shortly after” to the date the PCSS activity was provided. For PCSS, contemporaneous is defined as having a monthly service note, including the documentation of service coordination activities and a monthly summary, completed and signed by the 15th day of the month following the service month.

In addition to the service note supporting each monthly PCSS claim, the PCSS agency must maintain the following documentation to support claims for payment:

- Evidence that the PCSS service coordinator attended basic (i.e., core) training or received instruction using an approved OPWDD curriculum. Evidence may include, but is not limited to, a training certificate or an attestation from OPWDD that the service coordinator attended training.
- If the individual is enrolled in the HCBS waiver, a copy of the individual’s ICF/DD level of care eligibility determination (LCED) annual redetermination that has been completed and signed within 365 days from the effective date of the initial eligibility determination or from the signature date of the previous year’s review date.
- Any copy of the individual’s ISP that includes:
 1. Identification of the service provided (e.g., Plan of Care Support Services)
 2. Identification of the agency providing PCSS
 3. Frequency of the service (month or monthly)
 4. Identification of the effective date of PCSS. The effective date must be on or before the first date of service that your agency bills for PCSS.
- Evidence that the person’s ISP has been reviewed twice within a twelve month period. Evidence of a review may include, but is not limited to, a review sign-in sheet, a monthly service note indicating that the ISP was updated or revised, an ISP addendum, a revised ISP, or a review section on the ISP. All evidence of ISP reviews must include the following elements:
 1. The individual’s name.
 2. Name of the agency providing PCSS.
 3. The name, signature and title of a service coordinator or a supervisor who conducted the review. Initials are permitted if a “key” is provided, which identifies the title, signature and full name associated with the staff initials.
 4. The date of the review which must include the day, month and year.
 5. Description of any changes made to the ISP, if applicable.

An individual's first ISP must be written and signed by the service coordinator within 60 days of the HCBS Waiver enrollment date or of the PCSS enrollment date, whichever comes first.

Initial PCSS Payments

A PCSS agency may bill for a one-time initial PCSS payment for one month when the individual has never been enrolled in the HCBS Waiver prior to receiving PCSS, has never received MSC, and the service coordinator is assisting with developing and implementing the ISP. The amount of payment is three times the regular rate for PCSS. This initial payment is not available for children enrolled in Early Intervention.

The service coordinator must document information in the individual's record or maintain documentation that substantiates the eligibility for the one-time initial payment.

Early Intervention

Children participating in the Early Intervention (EI) Program receive an IFSP (Individual Family Service Plan) for their EI services, but they must also have an ISP if they are receiving an HCBS Waiver service at the same time. For these children, a provider may only bill a maximum of twice within a twelve month period.

The initial payment described above (three times the regular rate) is not available for children enrolled in Early Intervention. In addition, the documentation must meet the first set of criteria. If a Medicaid claim is denied due to the EI restriction code, the PCSS agency then bills OPWDD Payment Processing Unit with a transmittal letter identifying that EI edit caused Medicaid denial. OPWDD then reimburses the provider using 100% state funding. A copy of the remittance denial must accompany the billing claim to OPWDD, and claim to OPWDD must be submitted within 60 days of the Medicaid denial.

Documentation Formats

The PCSS agency may use the OPWDD-developed note that contains all of the required billing elements to document the provision of PCSS services. This is the same note used for MSC. Documentation that includes all of these elements is allowable in paper or electronic format.

Documentation Retention

All documentation specified above, including the ISP and service documentation, must be retained for a period of at least six years from the date the service was delivered or when the service was billed, whichever is later. 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 on program standards contact the OPWDD MSC Statewide Coordinator at (518) 474-5647.

cc: Provider Associations
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