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ADMINISTRATIVE MEMORANDUM #2010-03

TO: Executive Directors of Voluntary Provider Agencies
Executive Directors of MSC Vendors
DDSO Directors

FROM: James Kiyonaga, Acting Deputy Commissioner
Division of Fiscal and Administrative Solutions

Suzanne Zafonte Sennett, Deputy Commissioner
Division of Policy and Enterprise Solutions

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**SUBJECT: Medicaid Service Coordination (MSC) Documentation
Requirements for Billing**

DATE: January 13, 2011

EFFECTIVE DATE: October 1, 2010

Suggested Distribution

DDSO Medicaid Service Coordination Service Coordinators and Supervisors
DDSO Home and Community Based Services (HCBS) Waiver Coordinators
MSC Service Coordinators and Supervisors

Purpose

Effective October 1, 2010, this memorandum describes the documentation requirements for MSC billing. The service documentation requirements set forth in this Administrative Memorandum supersede documentation requirements that were issued prior to October 1, 2010 including those documentation requirements found in the Key to Individualized Services, the MSC Vendor Manual, updates, and advisories. The criteria described in this document apply to Medicaid Service Coordination services rendered to Home and Community Based Services (HCBS) waiver enrolled individuals as well as to non-waiver enrolled individuals and do not apply to any other service including services authorized or described in an individual's ISP.

Background

MSC is an ongoing service requiring contact between the individual, qualified contacts and the service coordinator. Each MSC service provider must have a current contract with OPWDD to provide MSC services, must ensure that each service coordinator and service coordination supervisor meets minimum qualifications (i.e., education and experiential requirements) and that a service coordinator's maximum caseload is not exceeded. Each person enrolled in the HCBS waiver must have an Individualized Service Plan (ISP). Typically the ISP requirement is met as part of MSC, which is a Medicaid State Plan service, or Plan of Care Support Services (PCSS), which is an HCBS waiver service for individuals who do not need ongoing and comprehensive service coordination.

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." 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 with rights to audit Medicaid claims as well, including OPWDD.

Title 14 of the Official Compilation of Codes, Rules and Regulations of the State of New York, Section 635-5.3 states the service standards and requirements for MSC.

MSC Billing Standards

In addition, payment for MSC requires for each individual served, prior authorization and registration with the vendor in the OPWDD Tracking and Billing System (TABS). This authorization is received from the DDSO or Service Delivery and Integrated Solutions Region 2 (formerly NYCRO) where the individual resides.

The unit of service for MSC is a month. To bill for a month of service, an MSC service coordinator must deliver and document at least one activity from List A or at least two activities from List B. Activities that are documented must serve to develop, monitor, or implement the valued outcomes of the person's ISP. These lists are below:

List A: When the service coordinator delivers and documents the provision of at least one activity from the following list, the minimum billing standard is met:

1. Face-to-face service meeting with the individual.
2. ISP reviews (which may include the creation of the initial ISP, a face-to-face ISP review, and any non-face-to-face ISP review).
3. Updates (addendum) to the ISP (this does not have to be a face-to-face service meeting).
4. Completion of the ICF/MR level of care eligibility determination or redetermination (this does not have to be a face-to-face service meeting).

List B: When the service coordinator delivers and documents the provision of at least two activities from the following list, the minimum billing standard is met. The documentation must also demonstrate that the purpose of the activity is related to referral/linkage, or monitoring to ensure that the ISP is implemented and addresses the needs of the person. It is allowable for the two activities to fall into the same category as described below.

1. Non-face-to-face contacts with the individual (e.g., phone calls).
2. Direct contact with a qualified contact during which the service coordinator gathers information to assess or to monitor the status of the individual. This can include:
 - Phone call or personal contact;
 - Email exchange;
 - Letter/correspondence exchange.
3. Direct contact with other agencies to maintain benefits eligibility or to obtain referrals for services that might be appropriate for the individual. This can include:
 - Phone call or personal contact;
 - Email exchange;
 - Letter/correspondence exchange.

A qualified contact is someone directly related to the identification of the individual's needs and care and who can help the service coordinator with the assessment, care plan development, referral, monitoring, and follow-up activities for the individual. Examples of qualified contacts include family members, medical providers, social workers, educators, and service providers.

Activities from the lists above 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.

Note that to bill for a month of service for individuals who are members of the Willowbrook Class, service coordinators must continue to deliver and document a minimum of one face-to-face service meeting per month.

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 (e.g., Medicaid Service Coordination).
3. Identification of the vendor providing MSC.
4. The month and year that the MSC service was provided.
5. A description of the activity(s) provided by the service coordinator, which serves to develop, monitor, or implement the valued outcomes in the person's ISP. Activities that count toward the billing minimum are described in the MSC Billing Standards section.
 - If the activity involves a face-to-face service meeting with the individual then the purpose and outcome of the contact must be included. The location of the service meeting must also be included.
 - If the activity involves contact with a qualified contact then the purpose and outcome of the contact must be included. The identity of the qualified contact and the relationship to the person should also be included.
6. A monthly summary that includes the person's satisfaction with services along with any follow-up taken, changes in the person's life, and any issues or concerns identified over the month regarding the person's health and safety.
7. The full name, title and signature of the MSC 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 MSC activity was provided. For MSC, 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 MSC claim, the MSC Vendor must maintain the following documentation to support claims for payment:

- Evidence that the 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/MR level of care eligibility determination (LCED) annual redetermination that has been completed and signed within 365 days from the prior review and authorized signature date.
- Evidence that a Service Coordination Agreement was executed. Evidence may include, but is not limited to, a copy of the Service Coordination Agreement or a monthly service note indicating the agreement was reviewed.
- Any copy of the individual’s ISP that includes identification of the service provided (e.g., Medicaid Service Coordination) and identification of the agency providing MSC.
- Evidence that the person’s ISP has been reviewed twice annually. These two reviews must be completed within 12 months prior to or by the end of the service month under review. 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 vendor providing MSC.
 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.
 5. Description of any changes made to the ISP. If no changes were made, then this should be noted.

If a service coordinator writes a new ISP, re-writes the ISP or writes an addendum to the ISP, and the new or rewritten ISP or the addendum reflects a new service or a change in service provider, the service coordinator must show evidence that the new or rewritten ISP or addendum was distributed within 60 days from the date of the ISP review or addendum or later if the 60 day timeframe cannot be met. If distribution exceeds the 60 day limit, the service coordinator must document the reason for the delay, and then sign and distribute the ISP or addendum. Evidence of distribution may include, but is not limited to, a sheet stating when the document was distributed, a monthly service note indicating that the document was distributed, a page attached to the ISP indicating when it was distributed, or a notation on the ISP or addendum indicating when it was distributed. Regardless of method of distribution used, documentation must include the parties to which the ISP was sent and the date(s) on which it was sent.

If the ISP was reviewed and there were no changes made to the ISP, an agency does not have to show evidence that an ISP or addendum was distributed.

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 MSC enrollment date, whichever comes first.

For quality purposes, an MSC vendor should maintain evidence that the Service Coordination Agreement was reviewed within 365 days prior to the service month under review. Evidence of a review may include, but is not limited to, a monthly narrative note indicating the agreement was reviewed, a signed agreement by the service coordinator, or a dated agenda indicating the topics to be discussed at an ISP review.

Transition Payments

An MSC vendor may bill the transition payment level for one month under the following circumstances:

1. The individual is new to service coordination, that is, the individual has never received any type of service coordination/case management service through OPWDD's system; or
2. The individual moves from an OPWDD certified supervised or supportive IRA or CR to an independent uncertified living situation where the individual is responsible for his or her own living expenses.

The service coordinator must document information in the individual's record or maintain documentation that substantiates the eligibility for a transition payment.

Documentation Formats

The MSC vendor must use documentation that includes all of the elements of the OPWDD-developed note to document the provision of MSC services. Documentation that includes all of these elements is allowable in paper or electronic versions. A copy of this note and the directions for its completion are included with this Memorandum.

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 the billing standards contact the OPWDD Director of Medicaid Standards at (518) 408-2096 or for program standards contact the OPWDD MSC Statewide Coordinator at (518) 474-5647.

Attachments

cc: Provider Associations
Acting Commissioner Chmura
Mr. Moran
Ms. Gentile
Mr. Whitehead
Ms. Moeser
Ms. Haneman