

*The New York State
Office of Mental Retardation
and Developmental Disabilities*

FISCAL AUDIT
PROVIDER
RESOURCE MANUAL
(Volume II of II)
Billing and Claiming Reviews

The Division of Administration and Revenue Support

November 15, 2006

**FISCAL AUDIT PROVIDER RESOURCE MANUAL
TABLE OF CONTENTS**

	<u>Page</u>
I. PREFACE	1
II. BILLING AND CLAIMING REVIEWS	
• Background	3
• General Tips for Ensuring Appropriate “Case Record” Documentation by your Agency	4
• Services Included in Billing and Claiming Reviews	7
➤ Time Period Covered by the Reviews	7
• Review Process	8
• Documentation Reviewed to Support Service Billings	9
➤ Medicaid Service Coordination	10
➤ Supportive Employment	11
➤ IRA Residential Habilitation	13
➤ Article 16 Clinic Services	15
➤ Group Day Habilitation	17
➤ Supplemental Group Day Habilitation	19
➤ Prevocational Services	21
➤ Respite	23
APPENDIX A BILLING AND CLAIMING DIRECTIVES	25

I. PREFACE

The Office of Mental Retardation and Developmental Disabilities (OMRDD) Bureau of Fiscal Audit (BFA) is a unit within the Division of Administration and Revenue Support. BFA's primary mission is to ensure the fiscal integrity and accountability of voluntary provider agencies (not-for-profit agencies) which operate programs and services under the auspices of OMRDD. To carry out this mission, BFA conducts Limited Fiscal Reviews (LFRs) of voluntary service providers. The reviews focus on agency fiscal viability; governance and the board of directors' oversight of the agency; agency fiscal operating procedures; and internal controls. A review of "case record" documentation supporting Medicaid paid claims and other 100% State-funded claims is also carried out. This component of the LFR is called a "Billing and Claiming Review".

The purpose of this Fiscal Audit Provider Resource Manual-Volume II is to provide agencies with reference material on the Billing and Claiming Review. A companion Fiscal Audit Provider Resource Manual-Volume I, provides general information on the other parts of the Limited Fiscal Review (LFR).

If you would like a copy of Provider Resource Manual - Volume I, or if you have any questions related to Billing and Claiming Reviews, please contact David Picker, Director, Bureau of Fiscal Audit, at 44 Holland Avenue, Albany, NY 12229 (518) 473-6156 or by e-mail at David.Picker@omr.state.ny.us.

II. BILLING AND CLAIMING REVIEWS

Background

The purpose of this manual is to provide important information about OMRDD's Billing and Claiming Review, which is part of the broader Limited Fiscal Review (LFR). The Bureau of Fiscal Audit (BFA) conducts Billing and Claiming Reviews of provider agencies to ensure that services claimed for reimbursement to Medicaid or OMRDD are supported by verifiable documentation. The reviews address Medicaid State Plan Services (e.g., Medicaid Service Coordination and Article 16 Clinics) and Home and Community Based Waiver Services (HCBS) (e.g., residential habilitation and day habilitation). This manual includes the questions that OMRDD's auditors use in the reviews and also shares the review scoring methodology.

Expanded Reviews/Reviews by Other Entities

Provider agencies should be aware that OMRDD reserves the right to modify review methods and procedures, to add additional services for review, and to add review questions, with or without notice to provider agencies. Provider agencies should also be aware that services may be audited by entities other than OMRDD and that these entities may employ their own audit questions and scoring methodology.

Role of Agency Executive Director in a Review

During a Billing and Claiming Review, it is recommended that the Executive Director of the agency personally pay careful attention to the review, given the serious fiscal repercussions that can result from review findings. **It is particularly important for the Executive Director to ensure that staff respond promptly to documentation requests, and to ensure that staff are instructed to provide records as they originally existed. The creation of any new document or alteration of any existing document in support of Medicaid billings may be considered Medicaid fraud.**

General Tips for Ensuring Appropriate “Case Record” Documentation by Your Agency

The following are general tips related to service documentation. We recommend that you share the review tips with all personnel involved in the documentation and billing of Medicaid/OMRDD-funded services:

1. Documentation = Dollars

All documentation that supports the delivery of Medicaid/OMRDD services must be safeguarded and retained for a period of six years from the date of the service billed. During a Billing and Claiming Review, failure to produce required documentation evidencing the delivery of services may result in serious financial and legal repercussions for an agency.

2. Make sure your billing department is not on “automatic pilot”.

“Automatic pilot” billing occurs when your billing office bills services based solely on a program roster. Rather, your billing must always be based on actual program attendance and a determination that service has been delivered in accordance with billing standards. For example: your billing department should bill a full month of Supervised IRA for a resident only where it has received information from the IRA site staff indicating that the resident was present at the IRA for 22 days during the month and received at least one documented IRA Residential Habilitation service for each of the 22 days.

Billing Medicaid for a service that was not provided or not documented may be considered Medicaid fraud. For this reason, it is vitally important that your agency establish and maintain controls that ensure that Medicaid is billed only when services have been provided and documented in accordance with OMRDD billing standards.

3. Never create or alter Medicaid documentation after the fact.

During a Billing and Claiming Review, staff must be instructed to provide auditors with records as they originally existed. The creation of new documentation or alteration of existing documentation to support Medicaid billings is a major problem and may be considered Medicaid fraud.

4. Ensure the Individualized Service Plan (ISP) identifies your agency as service provider and is signed by all necessary parties.

If you provide HCBS waiver services, make sure your agency receives a copy of the Individualized Service Plan (ISP) for the person served from their Medicaid Service Coordinator in a timely fashion and that the ISP identifies your agency as the service provider and is signed by all necessary parties. Contact the Medicaid Service Coordination (MSC) agency Executive Director if there is a delay. If the MSC agency does not comply with your request, seek assistance from OMRDD's New York City Regional Office (NYCRO) or, for agencies outside the city, your local Developmental Disabilities Services Office (DDSO).

5. Keep all Medicaid documentation (including ISPs and Habilitation Plans) for a minimum of six years, even for people you no longer serve. Retain records even if your agency stops providing the service.

Retain ISPs for at least six years from the date of the service billed as Medicaid audits can look back six years. This rule applies even when you no longer serve the person or the person is deceased. At all times, ensure that the original ISP and other Medicaid documentation are retrievable quickly and easily.

6. Sign and date all ISPs, Habilitation and Treatment Plans, and service documentation; signature dates must be contemporaneous with service delivery.

Sign and Date! Sign and Date! Sign and Date! Ensure that billing documentation is prepared contemporaneously with service provision and is signed and dated by the staff person who provides the service. Instruct staff to prepare and sign service documentation as soon as possible after the provision of the service.

7. *Service documentation must clearly indicate face-to-face staff service to the person served.*

8. *Conduct your own internal reviews by sampling paid Medicaid claims.*

Use the materials provided in this manual to sample your agency's paid Medicaid claims. Such reviews should be done frequently and across a broad sample of records created by different staff and at different program sites.

9. *Guard against overlapping Medicaid claims.*

Where multiple Medicaid services are delivered on the same day, make sure the service times do not overlap. For example, if the person served attends Day Habilitation and receives an Article 16 clinic service on the same day, make sure the four hour service minimum for billing a full unit of Day Habilitation service does not overlap with the time the person spends receiving an Article 16 clinic service. In other words, "back out" or subtract the time the person spends receiving the clinic service from the Day Habilitation clock time.

10. *Bill at the correct payment level!*

Where there is a choice of payment level, make sure the level billed matches the duration of the service. For example, bill a full unit of Group Day Habilitation only where you have provided a minimum of four hours of service. If you provide at least two hours but less than four hours, bill only half a unit of Group Day Habilitation.

Services Included in OMRDD Billing and Claiming Reviews

The following is a list of the Medicaid State Plan and HCBS Waiver services that are or will be included in OMRDD Billing and Claiming Reviews. “Mirrored” or “Non-Waiver Enrolled” (NWE) services are also reviewed. This list is subject to change at any time.

- Medicaid Service Coordination (MSC);
- Supported Employment (SEMP);
- IRA Residential Habilitation (IRA Res Hab);
- Article 16 Clinic Services;
- Group Day Habilitation (GDH);
- Supplemental Group Day Habilitation (SDH);
- Prevocational Services (PVS); and
- Respite (Reviews will start on 1/1/07)

Time Period Covered by the Reviews (i.e., “the review period”)

The following chart outlines the “review period” for each service. The “review period” is based on dates of service delivery. In a Billing and Claiming Review, a sample of paid claims from the “review period” is selected for review. In general, the review period for each service will be approximately two years based on the prior audit history of the service for the agency under review.

Service	Review Period
Medicaid Service Coordination	Approximately two years based on prior audit history (1/1/04 forward)
Supported Employment	Approximately two years based on prior audit history (1/1/04 forward)
IRA Residential Habilitation	Approximately two years based on prior audit history (1/1/04 forward)
Article 16 Clinic	Approximately two years based on prior audit history (1/1/05 forward)
Group Day Habilitation	1/1/06-forward
Supplemental Group Day Habilitation	1/1/06-forward
Prevocational Services	1/1/06-forward
Respite	7/1/06-forward

Review Process

BFA's Billing and Claiming Reviews are conducted using a two step review process.

1. **Step I (i.e., "Probe"):** The first step of the Billing and Claiming Review process is considered a probe.
 - a. **Examination of 50 Random Claims:** For each type of service (e.g., IRA Residential Habilitation), a random sample of 50 claims is selected from the review period. For each claim, the supporting service documentation is examined using standard review questions, which are described in subsequent sections of this manual.
 - b. **Review Scoring:** For each claim selected from the review period, the auditor uses a set of ten questions to determine whether there is sufficient documentation for the claim. A value of one is assigned to each of the ten questions. Thus a perfect score for a claim is ten. If all 50 claims have appropriate documentation, a provider achieves a 500 (50 claims times 10 points) for the service under review. There are exceptions to this scoring system. Given the importance of the ISP to HCBS Waiver service delivery, questions related to the ISP are considered "threshold" questions. This means that a zero score on an ISP question results in an automatic score of zero for the sampled claim.
 - c. **Passing Score for Each Service:** A passing score for each service type is 450 (90%) or higher. Services that "pass" the Billing and Claiming Review do not progress to a Step II review. However, individual claims may be subject to recovery/voiding by OMRDD
 - d. **Failing Score for Each Service:** A score of 449 or less for a particular service type is a failing score. A failing score will trigger an expanded Billing and Claiming Review (i.e., Step II) for the failing service.

2. **Step II, Full Review Process (i.e., Expanded Review):**

As described above, a failing score (449 or less) on any service reviewed by BFA during a Billing and Claiming Review will trigger an expanded review.

 - a. **Examination of 200 Random Claims:** For each service that fails the probe (i.e., Step I), a statistically valid sample of 200 claims will be reviewed using the same protocol (review questions) that is used during the Step I Review.

- b. **Expanded Review Fiscal Recovery:** Each claim that scores eight (8) or less will be considered a “review exception”. The value of all review exceptions will be extrapolated to the total universe of paid claims during the review period for that service. For example, if 20% of the claims reviewed in the 200 claim sample for IRA Residential Habilitation score eight points or less, the provider is required to pay back approximately 20% of all IRA Residential Habilitation billings during the review period. The precise amount is expressed as a “disallowance range” with a certain statistical confidence level.

Documentation Reviewed to Support Service Billings

The following provides additional information on documentation that will be requested during a Billing and Claiming Review. As you review this information, please note that OMRDD retains the right to modify review methods and procedures, to add additional services to be reviewed, or to request additional documentation as circumstances dictate.

It is also important to note that the material that follows pertains only to the fiscal review process used by OMRDD’s Bureau of Fiscal Audit. OMRDD’s Division of Quality Assurance conducts reviews (surveys) against broader regulatory and programmatic requirements. In addition, as previously noted, entities other than OMRDD may audit providers for Medicaid compliance.

Appendix A contains documents related to Billing and Claiming Reviews for each service (i.e., Administrative Memoranda and the MSC Manual). Claims submitted for reimbursement must meet all of the criteria set forth in these directives.

Medicaid Service Coordination (MSC)

The primary element examined in the MSC Billing and Claiming Review is the presence of a valid Individualized Service Plan (ISP). The review questions also address documentation of the required monthly face-to-face visit by the MSC Service Coordinator. The following questions are used to review a paid MSC claim:

MSC Billing and Claiming Review Questions	YES	NO
1. Individualized Service Plan (ISP) for the person served which is effective on the date of service claim*		
2. An ISP which identifies the claimant as the MSC service provider*		
3. An ISP which identifies the type of service to be provided (i.e., MSC)*		
4. An ISP which includes all of the elements above which is signed by at least one MSC agency staff person*		
5. Name of person served on service documentation record/ service coordination notes		
6. Documentation of required monthly face-to-face service meeting		
7. Location of required face-to-face service meeting		
8. The MSC Service Coordinator’s signature on the monthly face-to-face service meeting note/ documentation		
9. The date of the Service Coordinator’s signature is contemporaneous with the monthly face-to-face service meeting		
10. Verification that the correct MSC rate code was billed		

* For OMRDD Billing and Claiming Review purposes only, an effective ISP on the date of the claim means an ISP that is new, reviewed or revised within the 13 months preceding the month of the claim. The date of the MSC agency staff person’s signature on the newly created, reviewed, or revised ISP is used to make this determination. For example, if the claim/service date is in June 2006, the ISP should have been created, reviewed, or revised in May 2005 or after to be considered effective.

* Questions 1-4 above pertaining to the ISP are considered “threshold” questions. This means that if the answer to questions 1, 2, 3 or 4 is “no”, the claim examined will automatically score a zero.

Supported Employment (SEMP)

This program is funded through Medicaid or State payment based upon the eligibility of the person served. In the case of Medicaid-funded services, the existence of a valid ISP specifying that the SEMP service will be provided is required. In addition, there must be a SEMP Plan. In cases where SEMP is provided through State funding, an ISP is not required, but the SEMP Plan is. For both Medicaid and non-Medicaid funded SEMP services, the documentation related to the provision of required face-to-face service is examined to determine if it provides adequate documentation for the services claimed. The following are the ten SEMP questions:

SEMP BILLING AND CLAIMING REVIEW QUESTIONS	YES	NO
<p>1. A. An Individualized Service Plan (ISP) which identifies the claimant as the service provider. The ISP must have at least one MSC agency signature. In addition, the agency/ case record includes a Supported Employment Plan for the date of service tested with at least one supported employment agency staff signature. (This applies to Medicaid SEMP claims only) *</p> <p style="text-align: center;">OR</p> <p>B. A Supported Employment Plan for the date of service tested with at least one supported employment agency staff signature. (This applies to Non-Medicaid SEMP claims only)*</p>		
<p>2. A Supported Employment Plan which identifies the specific services to be provided to the person served</p>		
<p>3. For the date of service, documentation that identifies Supported Employment as the category of waiver service provided</p>		
<p>4. Documentation of services provided during the service month (4 services per month if the person served is not employed; 2 services per month if employed)</p>		
<p>5. Dates of service in Question 4 (above)</p>		
<p>6. Evidence presented in Question 4 (above) which is signed by the supported employment staff person who provided the service</p>		
<p>7. Evidence presented in Question 4 (above) includes a staff signature date which is contemporaneous to the date of service</p>		
<p>8. Documentation of required face-to-face service meetings (2 per month)</p>		
<p>9. Locations of services specified (if employed, 2 face-to-face services must be delivered at the job site)</p>		
<p>10. Documentation of the response of the person served to Supported Employment services by the end of the month following the date of service</p>		

- * For OMRDD Billing and Claiming purposes only, an effective ISP and/or SEMP Plan on the date of the claim means an ISP/SEMP Plan that is new, reviewed or revised within the 13 months preceding the month of the claim. The date of the staff person's signature on the newly created, reviewed, or revised document is used to make this determination. For example, if the claim/service date is in June 2006, the ISP and/or SEMP Plan should have been created, reviewed, or revised in May 2005 or after to be considered effective.

- * Question 1 above pertaining to the ISP and/or the SEMP Plan is considered a "threshold" question. This means that if the answer to question 1 is "no", the claim will automatically score a zero.

IRA Residential Habilitation (IRA Res Hab)

The primary review elements include the presence of a valid Individualized Service Plan (ISP) for the date of the claim which specifies that the claimant will provide IRA Residential Habilitation services and a valid IRA Residential Habilitation Plan effective on the date of the claim. Additionally, the review determines if there is adequate documentation of countable service days and whether there is a monthly note documenting the response of the person served to the service. The ten IRA Residential Habilitation questions are:

IRA RES HAB BILLING AND CLAIMING REVIEW QUESTIONS	YES	NO
1. An Individualized Service Plan (ISP) for the person served which is effective on the date of service*		
2. An ISP which identifies the claimant as the IRA Res Hab service provider*		
3. An ISP which includes elements of Questions 1 and 2 (above) which is signed by at least one MSC agency staff*		
4. A Residential Habilitation Plan for the person served which is effective on the date of service		
5. A Residential Habilitation Plan which identifies the specific services to be provided to the person served		
6. A Residential Habilitation Plan which includes the elements required in Questions 4 and 5 (above) that is signed by at least one Residential Habilitation staff member		
7. Documented evidence of the required face-to-face services drawn from the Residential Habilitation Plan which meets the “countable service day” requirements: <i>Supervised IRA</i> (22 days with one service each day for a full month; 11 days with one service each day for a half month) <i>Supportive IRA</i> (4 days with one service each day for a full month-up to 2 per week; 2 days with one service each day for a half month-1 per week)		
8. Evidence presented in Question 7 (above) which is signed by the IRA staff providing the service		
9. The IRA staff signature (or initials) date is contemporaneous to the service provided		
10. Documentation of the response of the person served to the service by the end of the month following the date of service		

- * For OMRDD Billing and Claiming Review purposes only, an effective ISP on the date of the claim means an ISP that is new, reviewed or revised within the 13 months preceding the month of the claim. The date of the MSC agency staff person's signature on the newly created, reviewed, or revised ISP is used to make this determination. For example, if the claim/service date is in June 2006, the ISP should have been created, reviewed, or revised in May 2005 or after to be considered effective.

- * Questions 1-3 above pertaining to the ISP are considered "threshold" questions. This means that if the answer to questions 1, 2, or 3 is "no", the claim will automatically score a zero.

Article 16 Clinic Services

The review elements include the presence of a valid Clinic Treatment Plan for the date of the claim which specifies the clinical service(s) to be provided. Additionally, the review determines if adequate documentation, in the form of a valid Treatment/Progress note for each claim, is present. Documentation of the clinic service duration is also required. The ten Article 16 Clinic review questions are:

ARTICLE 16 CLINIC REVIEW QUESTIONS	YES	NO
1. Clinic Treatment Plan which is effective on the date of service*		
2. Plan specifies type of clinical service provided*		
3. Plan includes dated (contemporaneous) signature of the Medical Director or designated physician/dentist*		
4. Documentation that the Plan was reviewed within the prior seven months by either the treating practitioner or the clinic treatment coordinator		
5. Treatment/progress note that includes documentation of the specific clinical service delivered		
6. Treatment/progress note that includes documentation of date of service		
7. Treatment/progress note that includes location of service delivery For clinic services delivered at OMRDD certified residences: A. Clinic Treatment Plan includes the treating clinician's justification for providing the clinic service at the residence OR B. consent of Executive Director/Designee of the residence where the clinic services were delivered which includes justification for clinic service delivery at the residence		
8. Treatment/progress note that includes required duration of clinic service		
9. Treatment/progress note that is signed by the clinician or treatment coordinator		
10. Treatment/ progress note that has a staff signature date which is contemporaneous to the date of service		

* Questions 1-3 pertaining to the Clinic Treatment Plan are considered “threshold” questions. This means that if the answer to questions 1, 2, or 3 is “no”, the claim will automatically score a zero. In addition, if the answer is “no” to any question, the claim is voided.

In addition to the 50 random claim review, BFA will also focus on the following in the clinic review:

- A review of Comprehensive Diagnostic and Evaluation claims to determine if the required number of hours (two hours) of face-to-face service was provided.
- A review of Day service claims for persons who received clinic services and day program services on the same day is examined to check for overlapping service times. Clinic records will be examined to determine if clinic services were supported by documentation and meet minimum service duration times for the type of clinic service claimed. Day program service records will be examined to determine if the required number of hours of Day program service was provided.

Group Day Habilitation (GDH)

The primary review elements include the presence of a valid Individualized Service Plan (ISP) for the date of the claim that specifies that the claimant will provide Day Habilitation services and a valid Group Day Habilitation Plan effective on the date of the claim. Additionally, the review determines if there is adequate documentation to substantiate billing for a full unit or a half unit of service and documentation of the delivery of the required number of habilitation services from the Group Day Habilitation Plan. The ten Group Day Habilitation service questions are:

GROUP DAY HABILITATION REVIEW QUESTIONS	YES	NO
1. Individualized Service Plan (ISP) for the person served which is effective on the date of service*		
2. An ISP which identifies the claimant as the Day Habilitation service provider*		
3. An ISP which includes elements of Questions 1 and 2 (above) which is signed by at least one MSC agency staff*		
4. A Group Day Habilitation Plan which identifies services to be provided for the person served and which has been reviewed within the 7 months prior to the date of service		
5. A Group Day Habilitation Plan which includes the elements required in Question 4 that is signed by at least one Group Day Habilitation staff member.		
6. Documentation that substantiates the duration billed (i.e., full or half unit) with meals and "to and from transportation" excluded		
7. For the date of the service, documented evidence of the delivery of the required number of habilitation service(s) drawn from the Group Day Habilitation Plan. (2 services for a full unit, 1 for a half unit)		
8. Evidence presented in Question 7 (above) is signed by the Day Habilitation staff providing the service		
9. Evidence presented in Question 7 (above) includes a staff signature date which is contemporaneous to the date of service		
10. Documentation of the response of the person served to the day habilitation services provided by the end of the month following the date of service		

* For OMRDD Billing and Claiming Review purposes only, an effective ISP on the date of the claim means an ISP that is new, reviewed or revised within the 13 months preceding the month of the claim. The date of the MSC agency staff person's signature on the newly created, reviewed, or revised ISP is used to make this determination. For example, if the claim/service date is in June 2006, the ISP should have been created, reviewed, or revised in May 2005 or after to be considered effective.

* Questions 1-3 above pertaining to the ISP are considered “threshold” questions. This means that if the answer to questions 1, 2, or 3, is “no”, the claim will automatically score a zero.

Supplemental Group Day Habilitation (GDH)

The primary review elements include the presence of a valid Individualized Service Plan (ISP) for the date of the claim that specifies that the claimant will provide Day Habilitation services and a valid Group Day Habilitation Plan effective on the date of the claim. Additionally, the review determines if there is adequate documentation to substantiate billing for a full unit or a half unit of service (including start and stop times) and documentation of the delivery of the required number of habilitation services from the Group Day Habilitation Plan. The ten Supplemental Group Day Habilitation questions are:

SUPPLEMENTAL GROUP DAY HABILITATION REVIEW QUESTIONS	YES	NO
1. Individualized Service Plan (ISP) for the person served which is effective on the date of service*		
2. An ISP which identifies the claimant as the Day Habilitation service provider*		
3. An ISP which includes elements of Questions 1 and 2 (above) which is signed by at least one MSC agency staff*		
4. A Group Day Habilitation Plan which identifies services to be provided for the person served which has been reviewed within the 7 months prior to the date of service		
5. A Group Day Habilitation Plan which includes the elements required in Question 4 that is signed by at least one Group Day Habilitation staff member.		
6. Documentation of service start and stop time which substantiates the duration standard for the unit of service billed (i.e., full or half unit) with meals and “to and from transportation” excluded		
7. For the date of the service, documented evidence of the delivery of the required number of habilitation service(s) drawn from the Group Day Habilitation Plan. (2 services for a full unit, 1 for a half unit)		
8. Evidence presented in Question 7 (above) is signed by the Day Habilitation staff providing the service		
9. Evidence presented in Question 7 (above) includes a staff signature date which is contemporaneous to the date of service		
10. Documentation of the response of the person served to the Day Habilitation services by the end of the month following the date of service		

* For OMRDD Billing and Claiming Review purposes only, an effective ISP on the date of the claim means an ISP that is new, reviewed or revised within the 13 months preceding the month of the claim. The date of the MSC agency staff person’s signature on the newly created, reviewed, or revised ISP is used to make this determination. For example, if the claim/service date is in June 2006, the ISP should have been created, reviewed, or revised in May 2005 or after to be considered effective.

- * Questions 1-3 above pertaining to the ISP are considered “threshold” questions. This means that if the answer to questions 1, 2, or 3 is “no”, the claim will automatically score a zero.

Prevocational Services (PVS)

The primary review elements include the presence of a valid Individualized Service Plan (ISP) for the date of the claim that specifies that the claimant will provide Prevocational Services and a valid Prevocational Services Plan effective on the date of the claim. Additionally, the review determines if there is adequate documentation to substantiate billing for a full unit or a half unit of Prevocational Service and documentation of the delivery of the required number of Prevocational Services from the Prevocational Services Plan. The ten Prevocational Service questions are:

PREVOCATIONAL SERVICE REVIEW QUESTIONS	YES	NO
1. Individualized Service Plan (ISP) for the person served which is effective on the date of service*		
2. An ISP which identifies the claimant as the Prevocational Services provider*		
3. An ISP which includes elements of Questions 1 and 2 (above) which is signed by at least one MSC agency staff*		
4. A Prevocational Services Plan which identifies services to be provided to the person served and which has been reviewed within the 7 months prior to the date of service		
5. A Prevocational Services Plan which includes the elements required in question 4 that is signed by at least one Prevocational Services staff member.		
6. Documentation that substantiates the duration billed (i.e., a full or half unit) with meals and "to and from transportation" excluded		
7. For the date of the service, documented evidence of the delivery of the required number of service(s) drawn from the Prevocational Services Plan. (2 services for a full unit, 1 for a half unit)		
8. Evidence presented in Question 7 (above) is signed by the Prevocational Services staff providing the service		
9. Evidence presented in Question 7 (above) includes a staff signature date which is contemporaneous to the date of service		
10. Documentation of the response of the person served to Prevocational Services by the end of the month following the date of service		

* For OMRDD Billing and Claiming Review purposes only, an effective ISP on the date of the claim means an ISP that is new, reviewed or revised within the 13 months preceding the month of the claim. The date of the MSC agency staff person's signature on the newly created, reviewed, or revised ISP is used to make this determination. For example, if the claim/service date is in June 2006, the ISP should have been created, reviewed, or revised in May 2005 or after to be considered effective.

- * Questions 1-3 above pertaining to the ISP are considered “threshold” questions. This means that if the answer to questions 1, 2, or 3 is “no”, the claim will automatically score a zero.

Respite

The primary review element is the presence of a valid Individualized Service Plan (ISP) for the date of the claim that specifies that the claimant will provide Respite Services. Additionally, the review determines if there is adequate documentation to substantiate billing for Respite services including documentation of start and stop times. The ten Respite Service questions are:

RESPITE REVIEW QUESTIONS	YES	NO
1. Individualized Service Plan (ISP) for the person served which is effective on the date of service*		
2. An ISP which identifies the claimant as the Respite service provider*		
3. An ISP which includes elements of Questions 1 and 2 (above) which is signed by at least one MSC agency staff*		
4. For the date of the service, documentation that identifies Respite as the category of waiver service provided		
5. Documentation that includes the name of the person served		
6. Service delivery documentation that includes the name of the agency providing the Respite service		
7. Service delivery documentation that includes the date of service delivery		
8. Documentation of service delivery which is signed by the Respite service staff providing the service		
9. Documentation of service delivery presented in Question 7 (above) that has a date of signature contemporaneous with the date of service		
10. The quarter hour units billed correspond to the start and stop times recorded by Respite staff		

*If the person served is non-waiver, 1 point each is automatically granted for Items 1-3.

If the person served is waiver enrolled:

- For OMRDD Billing and Claiming Review purposes only, an effective ISP on the date of the claim means an ISP that is new, reviewed or revised within the 13 months preceding the month of the claim. The date of the MSC agency staff person's signature on the newly created, reviewed, or revised ISP is used to make this determination. For example, if the claim/service date is in June 2006, the ISP should have been created, reviewed, or revised in May 2005 or after to be considered effective.
- Questions 1-3 above pertaining to the ISP are considered threshold questions. This means that if the answer to questions 1, 2, or 3, is "no", the claim will automatically score a zero.

Appendix A

Billing and Claiming Directives

Note: Claims submitted for reimbursement must meet all of the criteria set forth in these directives as well as any Medicaid rules.

Administrative Memoranda can be accessed on OMRDD's website: <http://www.omr.state.ny.us>.

- 1. Click "Information for Providers"**
- 2. Click "Publications"**
- 3. Click "OMRDD Administrative Memoranda"**

**BILLING AND CLAIMING
DIRECTIVES**

Appendix

- Medicaid Service Coordination Vendor Manual September 2002 (This manual is not attached but it can be found on OMRDD's Web Site (<http://www.omr.state.ny.us>) in the Information for Providers section) NA

- Administrative Memorandum - #2002-01
IRA Residential Habilitation Service Documentation Requirements - September 3, 2002 A-1

- Administrative Memorandum - #2002-02
Supported Employment Service Delivery and Documentation Requirements- September 17, 2002 A-2

- Administrative Memorandum - #2003-03
Habilitation Plan Requirements - December 5, 2003 A-3

- Administrative Memorandum - #2005-01
Standards for Article 16 Clinics - February 18, 2005 A-4

- Administrative Memorandum - #2006-01
Group Day Habilitation Service Documentation Requirements- January 1, 2006 A-5

- Administrative Memorandum - #2006-02
Individual Day Habilitation Service Documentation Requirements
January 1, 2006 A-6

- Administrative Memorandum - #2006-03 Service Documentation
Requirements for Prevocational Services - January 1, 2006 A-7

- Administrative Memorandum - #2005-02 Service Documentation
Requirements for HCBS Respite/Non Waiver Enrolled Respite Service
June 15, 2005 A-8

A-1

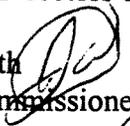


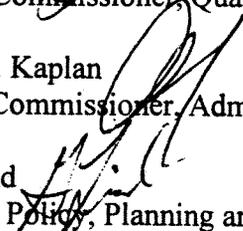
STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

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

Administrative Memorandum - #2002-01

To: Executive Directors of Agencies providing Individualized Residential
Alternative (IRA) Residential Habilitation Waiver Services
Executive Directors of Agencies providing Medicaid Service Coordination

From: Jan Abelseth 
Deputy Commissioner, Quality Assurance

Alden B. Kaplan 
Deputy Commissioner, Administration and Revenue Support

Gary Lind 
Director, Policy, Planning and Individualized Initiatives

Subject: IRA Residential Habilitation Service Documentation Requirements

Date: September 3, 2002

Suggested Distribution:

Program/Service Staff
Quality/Compliance Staff
Billing Department Staff
MSC Service Coordinators

Purpose: This is to advise you that documentation for IRA Residential Habilitation services delivered on or after July 1, 2002 must meet the criteria set forth below. These criteria apply to IRA Residential Habilitation services rendered to Home and Community Based Service (HCBS) waiver enrolled individuals, as well as to non-enrolled individuals. The service documentation requirements set forth in this Administrative Memorandum supersede fiscal audit service documentation requirements addressed in The Key to Individualized Services, OMRDD's HCBS Waiver Policy Manual. Quality service standards remain the same.

Background: Effective July 1, 2002 the unit of service for IRA Residential Habilitation was changed from a day to a month. Title 14 of the Official Compilation of Codes, Rules and



Regulations of the State of New York Part 635-10.5(b) states new reimbursement and payment provisions for residential habilitation services provided in IRAs that took effect July 1, 2002. On July 1, 2002 IRA sites were designated supervised or supportive. See Attachment A for the definitions for supervised and supportive IRAs.

With the change in the unit of service, providers are required to meet new billing standards and comply with new service documentation requirements to substantiate monthly IRA Residential Habilitation billings. The federal Centers for Medicare and Medicaid Services' (CMS) HCBS Waiver Review Protocol lists elements that must be included in the documentation of HCBS Medicaid payment claims. Based on the federal listing, this OMRDD administrative memorandum provides clarifying information on the required components of acceptable service documentation for IRA Residential Habilitation Services.

Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York, Section 504.3 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." It should be noted that there are other entities with rights to audit Medicaid waiver claims as well.

IRA Residential Habilitation Billing Standards

Supervised IRA Billing Standards

The unit of service for supervised IRA residential habilitation services is a calendar month. The provider determines whether minimum services have been provided to bill a full month or a half-month for an individual resident based on the following:

To bill a **full month** for any resident:

1. The resident must be enrolled in the provider's supervised IRA program for a minimum of 22 days in a calendar month. "Enrollment" is defined as the time period commencing with the day of admission, up to and including the day of discharge.
2. The IRA staff must deliver and **document** a minimum of 22 separate days of face to face residential habilitation services, known as "countable service days", in accordance with the resident's ISP and Residential Habilitation Plan. A countable service day requires documentation of at least one residential habilitation staff service or action.

3. Days in a hospital, nursing home, ICF or other certified, licensed or government funded residential setting including overnight summer camps are **not** countable toward the 22-day minimum requirement.
4. Countable service days **may include**:
 - Day of admission and day of discharge to a hospital, nursing home, ICF or other certified, licensed or government funded residential setting in cases where on those days IRA staff deliver and document residential habilitation services to the resident at the IRA.
 - Days when IRA staff deliver and document residential habilitation services to a resident(s) who is away from the IRA for purposes such as vacations and visits with family or friends. Such days are countable only when staff regularly assigned to the resident's IRA deliver and document services that are similar in scope, frequency and duration to the residential habilitation services typically delivered to the resident at the IRA. Only 14 such days may be considered countable in a calendar month. Documentation must clearly state the location of this off-site service delivery.
 - Days when all residents of the IRA are relocated due to emergency conditions or other circumstances reported to and approved by the DDSO/NYCRO and DQA. (It must be necessary to relocate the residents to preserve their health and safety.) Such days are countable only when staff regularly assigned to the resident's IRA deliver and document services that are similar in scope, frequency and duration to the residential habilitation services typically delivered to the resident at the IRA. Documentation must clearly state the location of this off-site service delivery.

To bill a **half month** for any resident:

1. The resident must be enrolled in the provider's supervised IRA program for a minimum of 11 days in a calendar month. "Enrollment" is defined as the time period commencing with the day of admission, up to and including the day of discharge.
2. The IRA staff must deliver and **document** a minimum of 11 separate days of face to face residential habilitation services, known as "countable service days", in accordance with the resident's ISP and Residential Habilitation Plan. A countable service day requires documentation of at least one residential habilitation staff service or action.
3. Days in a hospital, nursing home, ICF or other certified, licensed or government funded residential settings including overnight summer camps are **not** countable toward the 11-day minimum requirement.

4. Countable service days may include:

- Day of admission and day of discharge to a hospital, nursing home, ICF or other certified, licensed or government funded residential setting in cases where on those days IRA staff deliver and document residential habilitation services to the resident at the IRA.
- Days when IRA staff deliver and document residential habilitation services to a resident(s) who is away from the IRA for purposes such as vacations and visits with family or friends. Such days are countable only when staff regularly assigned to the resident's IRA deliver and document services that are similar in scope, frequency and duration to the residential habilitation services typically delivered to the resident at the IRA. Only 7 such days may be considered countable in a calendar month. Documentation must clearly state the location of this off-site service delivery.
- Days when all residents of the IRA are relocated due to emergency conditions or other circumstances reported to and approved by the DDSO/NYCRO and DQA. (It must be necessary to relocate the residents to preserve their health and safety.) Such days are countable only when staff regularly assigned to the resident's IRA deliver and document services that are similar in scope, frequency and duration to the residential habilitation services typically delivered to the resident at the IRA. Documentation must clearly state the location of this off-site service delivery.

Supportive IRAs

The unit of service for supportive IRA residential habilitation services is a calendar month. The provider determines whether minimum standards have been provided to bill a full month or a half-month for an individual resident based on the following:

To bill a **full month** for any resident:

1. The resident must be enrolled in the provider's supportive IRA program for a minimum of 22 days in a calendar month. "Enrollment" is defined as the time period commencing with the day of admission, up to and including the day of discharge.
2. The IRA staff must deliver and **document** a minimum of 4 separate days of face to face residential habilitation services, known as "countable service days", in accordance with the resident's ISP and Residential Habilitation Plan. **These countable service days must be provided at the IRA or initiated or concluded there.** No more than 2 service

days within a week are countable toward the 4-day minimum. A countable service day requires documentation of at least one residential habilitation staff service or action.

3. Countable service days **may include:**

- Day of admission and day of discharge to a hospital, nursing home, ICF or other certified, licensed or government funded residential setting in cases where on those days IRA staff deliver and document residential habilitation services **to the resident at the IRA.**
- Days when all residents of the IRA are relocated due to emergency conditions or other circumstances reported to and approved by the DDSO/NYCRO and DQA. (It must be necessary to relocate the residents to preserve their health and safety.) Such days are countable only when staff regularly assigned to the resident's IRA deliver and document services that are similar in scope, frequency and duration to the residential habilitation services typically delivered to the resident at the IRA. Documentation must clearly state the location of this off-site service delivery.

To bill a **half month** for any resident:

1. The resident must be enrolled in the provider's supportive IRA program for a minimum of 11 days in a calendar month. "Enrollment" is defined as the time period commencing with the day of admission, up to and including the day of discharge.
2. The IRA staff must deliver and **document** a minimum of 2 separate days of face to face residential habilitation services, known as "countable service days", in accordance with the resident's ISP and Residential Habilitation Plan. **These countable service days must be provided at the IRA or initiated or concluded there.** No more than one service day within a week is countable toward the 2-day minimum. A countable service day requires documentation of at least one residential habilitation staff service or action.

3. Countable service days **may include:**

- Day of admission and day of discharge to a hospital, nursing home, ICF or other certified, licensed or government funded residential setting in cases where on those days IRA staff deliver and document residential habilitation services **to the resident at the IRA.**
- Days when all residents of the IRA are relocated due to emergency conditions or other circumstances reported to and approved by the DDSO/NYCRO and DQA. (It must be necessary to relocate the residents to preserve their health and safety.)

Such days are countable only when staff regularly assigned to the resident's IRA deliver and document services that are similar in scope, frequency and duration to the residential habilitation services typically delivered to the resident at the IRA. Documentation must clearly state the location of this off-site service delivery.

Required Actions:

IRA residential habilitation service note documentation must include the following:

Required Elements

1. Consumer's name and Medicaid number ("CIN"). (Note that the "CIN" need not be included in daily documentation; rather it can appear in the consumer's ISP or Residential Habilitation Plan).
2. Identification of category of waiver service provided (i.e. IRA residential habilitation).
3. **A description of the individualized service provided by staff**, which is based on the person's Residential Habilitation Plan (e.g. a staff person documents that she "taught the person how to shop independently").
4. The consumer's response to the service (e.g. "the consumer was able to make his own purchase at the store"). (At a minimum, the consumer response must be documented in a monthly summary note. A provider may choose to include the consumer response more frequently, e.g. daily.)
5. The date the service was provided.
6. The primary service location (e.g. North Main Street IRA).
7. Verification of service provision by **the staff person 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 signature and title of the staff person writing the note.
9. The date the note was written

Acceptable Formats for the Service Note Supporting a Provider's Billing Submittal:

Attached to this Administrative Memorandum are sample service note formats that conform to the required elements stated above. Attachment B is a sample daily narrative note and Attachment C is a daily checklist with a monthly summary note.

Attachment B – Daily Narrative Note Format

If the daily narrative note format is selected, the documentation can be completed in one of two ways. 1) Daily narrative note describes the staff service or action and the resident's response to

the service delivery or 2) Daily narrative note describes staff service or action only. If this second format is selected, a monthly summary note addressing the consumer's response to services is required. The daily narrative note must be written by the staff person who provides the service or, if written by another staff person, must include the verification of service delivery by staff who actually delivered the service (see #7 of Required Elements).

Attachment C – Daily Checklist with Monthly Summary Note Format

If the checklist format is chosen, a monthly summary note, which includes the resident's response to service, must be completed.

YOU MAY USE EITHER OF THESE FORMATS OR DEVELOP YOUR OWN SO LONG AS IT ENCOMPASSES ALL OF THE REQUIRED ELEMENTS LISTED ABOVE.

Other Documentation Required: In addition to the service note(s) supporting each monthly IRA residential habilitation claim, your agency must maintain the following documentation:

- A copy of the consumer's ISP covering the time period of the claim developed by the consumer's Medicaid Service Coordination (MSC) or Plan of Care Support Services (PCSS) service coordinator. The ISP must specify the category of waiver service that your agency is providing (i.e. residential habilitation) and must designate your agency as the provider of the service. Further, for the service you are providing, the ISP must specify a service effective date for IRA residential habilitation that is on or before the first date of service your agency bills.
- The Residential Habilitation Plan covering the time period of the claim developed by your agency. The Residential Habilitation Plan is attached to the person's ISP. For supportive IRAs, the Residential Habilitation Plan must state the number of service visits residential habilitation staff will provide to meet the consumer's individualized need. This service visit number can be expressed as a range.

Documentation Retention: All documentation specified above, including ISPs, Residential Habilitation Plans, and daily service documentation, must be retained for a period of at least six years from the date of the service billed.

Notification: Effective with services delivered on or after July 1, 2002, OMRDD will review IRA Residential Habilitation service claims utilizing the service documentation requirements set forth in this Administrative Memorandum.

For additional information on the documentation requirements, contact Ms. Carol Metevia, Director of Medicaid Standards and Control at (518) 408-2096 or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

cc: Provider Associations
DDSO Directors
Helene DeSanto
Kathy Broderick
Peter Pezzolla
Carol Metevia
Kevin O'Dell

Definition of Supervised & Supportive IRAs

686.99 Glossary

(l) *Community residence*. A facility providing housing, supplies and services for persons who are developmentally disabled and who, in addition to these basic requirements, need supportive interpersonal relationships, supervision, and training assistance in activities of daily living. Community residences are designed to accomplish two major goals:

- (1) provide a home environment; and
- (2) provide a setting where persons can acquire the skills necessary to live as independently as possible. For the purpose of this regulation, the following types of community residences are defined:

- (i) *supervised community residence* – a facility with staff onsite or proximately available at all times when the persons are present;
- (ii) *supportive community residence* – a facility providing practice in independent living under variable amounts of oversight delivered in accordance with the person's needs for such supervision;
- (iii) *individualized residential alternative* – a facility providing room, board and individualized protective oversight.

(a) A supervised Individualized Residential Alternative is a facility that has staff onsite or proximately available at all times when the persons are present;

(b) A supportive Individualized Residential Alternative is a facility that is providing practice in independent living under variable amounts of oversight delivered in accordance with the person's needs for such supervision and staff typically are not onsite nor proximately available at all times when the persons are present.

This citation would also appear at 635.99.1 (bl) *residence, community*

INSTRUCTIONS FOR COMPLETING IRA RES HAB DAILY CHECKLIST

AGENCY = Enter the name of the Agency providing the IRA Res Hab service.

CONSUMER NAME = Enter the name of the consumer who is receiving the IRA Res Hab service.

MEDICAID CIN NUMBER = Enter the consumers Medicaid client identification number (CIN). (e.g., AA12345B)

MONTH / YEAR OF SERVICE DELIVERY = Enter the month and year in which the IRA Res Hab service(s) was provided. (e.g., 10/02)

IRA ADDRESS = Enter the address of the IRA residence where the service was provided.

STAFF SERVICE OR ACTION = List key individualized services or actions by staff drawn from the Residential Habilitation Plan.

STAFF INITIALS ON THE DATE = For each day the described service or action is provided, the staff person providing the service or action should place his/her initials in the box corresponding to the day of the month the service was provided. (e.g., the service is provided on the 4th, 5th, 6th, 12th, 13th, 21st, 25th and 28th day of a given month. In the box for each one of those days, the staff member providing the service should place his/her initials to verify that the service or action was provided.)

KEY FOR INITIALS CODE = Each staff person who provided and initialed a service or action to the consumer during the month *must* be identified in the Initials' Key.

- **Initials** = The *initials* of the staff member providing a service or action during the month
- **Staff name** = The corresponding *name* of the staff member providing a service or action during the month
- **Title** = The *title* of the staff member providing a service or action
- **Signature** = The staff member providing a service or action should sign his or her name

INFORMATION FOR BILLING DEPARTMENT DATA:

- ✓ Check the appropriate unit of service box that corresponds to the consumer's "countable service days" during the month. *Countable service days are days on which at least one face-to-face Res Hab service/activity was provided and initialed by staff. For supportive IRA sites, the service/activity must be provided at the site or initiated or concluded there.*

When the individual resides in a supervised IRA, the monthly billing codes are to be used as follows:

FULL MONTH BILLING - Check this box when the individual has been enrolled in a supervised IRA for 22 or more days AND has received 22 or more countable service days during the month.

SEMI MONTHLY BILLING - You should bill for a half month of service when the individual has been enrolled in a supervised IRA for 11 or more days, but less than 22 days, AND has received at least 11 countable service days during the month. You should also bill for a half month of service when the individual has been enrolled in a supervised IRA for 22 or more days, and has received at least 11, but less than 22 countable service days during the month.

The guidelines for billing 1st half or 2nd half month are as follows:

- SEMI MONTHLY (1st half) - Check this box if the consumer meets the enrollment and service provision criteria for half month billing **AND** after the last day you provided services to the consumer, there were 11 or more days left in a month.

[Note: Should a consumer change providers during the month, this would enable another service provider to bill for services they provided to the consumer during the remainder of the month]

- SEMI MONTHLY (2nd half) - Check this box if the consumer meets the enrollment and service provision criteria **AND** after the last day you provided services to the consumer, there were less than 11 days remaining in the month.

[Note: Should a consumer change providers during the month, this would enable another service provider to bill for services they provided to the consumer during the beginning of the month]

NO BILLING - Check this box when the individual has been enrolled in a **supervised IRA** less than 11 days AND/OR has received less than 11 countable services days during the month.

When the individual resides in a supportive IRA, the monthly billing codes to be used are:

FULL MONTH BILLING - Check this box when the individual has been enrolled in a **supportive IRA** 22 or more days AND has received 4 countable service days during the month. There may be no more than 2 countable service days in any week.

[note: countable service days in a supportive IRA are days on which the IRA staff provided at least one residential habilitation service or action at the IRA site. This includes services or actions initiated or concluded at the IRA site.]

SEMI MONTHLY BILLING - You should bill for a half month of service when the individual has been enrolled in a **supportive IRA** for 11 or more days, but less than 22 days, AND has received a minimum of 2 countable service days during the month. You should also bill for a half month of service when the individual has been enrolled in a supervised IRA for 22 or more days, and has received at least 2, but less than 4 countable service days during the month.

The guidelines for billing 1st half or 2nd half month are as follows:

- **SEMI MONTHLY (1ST half)** - Check this box if the consumer meets the enrollment and service provision criteria for half month billing **AND** after the last day you provided services to the consumer, there were **11 or more** days left in a month.

[Note: Should a consumer change providers during the month, this would enable another service provider to bill for services they provided to the consumer during the remainder of the month]

- **SEMI MONTHLY (2ND half)** - Check this box if the consumer meets the enrollment and service provision criteria **AND** after the last day you provided services to the consumer, there were **less than 11** days remaining in the month.

[Note: Should a consumer change providers during the month, this would enable another service provider to bill for services they provided to the consumer during the beginning of the month]

NO BILLING - Check this box when the individual has been enrolled in a **supportive IRA** less than 11 days AND/OR has received less than 2 countable service days during the month.

[note: countable service days in a supportive IRA are days on which the IRA staff provided at least one residential habilitation service or action at the IRA site. This includes services or actions initiated or concluded at the IRA site.]

CONSUMER ENROLLMENT DATA:

Check the box for the appropriate residential program type:

- ✓ **Supervised IRA** - staff onsite or proximately available at all times when the persons are present
- ✓ **Supportive IRA** - staff typically are not on site nor proximately available at all times when the persons are present

Check the box that indicates the appropriate enrollment status of consumer during the month:

- ✓ **Enrolled in program full month** - check this box if the consumer has been enrolled in the residential program for 22 or more days during the month.
- ✓ **Enrolled in program less than full month** - check this box if the consumer has been enrolled in the residential program for *less than 22 days of the month*. Enter the date the consumer was enrolled during the month OR enter the date the consumer was discharged during the month.

**INSTRUCTIONS FOR COMPLETING THE
IRA RES HAB MONTHLY SUMMARY NOTE**

AGENCY NAME = Enter the name of the Agency providing the IRA Res Hab service.

CONSUMER NAME = Enter the name of the consumer who is receiving the IRA Res Hab service.

MEDICAID CIN NUMBER = Enter the consumer's Medicaid client identification number (CIN). (e.g., AA12345B)

MONTH / YEAR OF SERVICE DELIVERY = Enter the month and year in which the IRA Res Hab service(s) was provided.
(e.g., 10/02)

IRA ADDRESS = Enter the address of the IRA residence where the service was provided. [*note: if the consumer resided at more than one IRA site during the month, enter the address of the site where the consumer last resided during the month*]

SUMMARY NOTE = Provide a narrative that summarizes the implementation of the individual's Residential Habilitation plan, and addresses the consumer's response to the services provided and any issues or concerns.

STAFF SIGNATURE = This is the signature of the staff person who wrote the summary note.

TITLE = This is the title of the staff person who wrote the summary note.

DATE = Enter the date, in month-day-year format, that the summary note was written.

A-2



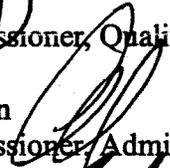
STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

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

Administrative Memorandum - #2002-02

To: Executive Directors of Agencies providing Supported Employment Services
Executive Directors of Agencies providing Medicaid Service Coordination

From: Jan Abelseth 
Deputy Commissioner, Quality Assurance

Alden B. Kaplan 
Deputy Commissioner, Administration and Revenue Support

Gary Lind 
Director, Policy, Planning and Individualized Initiatives

Subject: Supported Employment Service Delivery and Documentation Requirements

Date: September 17, 2002

Suggested Distribution:

Program/Service Staff
Quality/Compliance Staff
Billing Department Staff
MSC Service Coordinators

Purpose: This is to review the service delivery and documentation requirements for Supported Employment services delivered on or after October 1, 2001. These criteria apply to Supported Employment services rendered to Home and Community Based Service (HCBS) waiver enrolled individuals as well as to non-enrolled individuals. In addition to the requirements that became effective October 1, 2001, **a policy change on the location of service visits to employed individuals will go into effect on October 1, 2002.** This change is addressed in the New Policy on Service Delivery Location and Supported Employment Standards sections below. The service documentation requirements set forth in this Administrative Memorandum supersede fiscal audit service documentation requirements addressed in The Key to Individualized Services (1997), OMRDD's HCBS waiver policy manual. Quality service standards remain the same.

Background: Title 14 of the Official Compilation of Codes, Rules and Regulations of the State of New York Part 635-10.5 includes requirements applicable to supported employment services. Effective October 1, 2001, the regulation was changed so that reimbursement would be based on a monthly fee. Prior to the new regulation, reimbursement was based on an hourly fee.

The federal Centers for Medicare and Medicaid Services' (CMS) HCBS Waiver Review Protocol lists elements that must be included in the documentation of HCBS Medicaid payment claims. Based on the federal listing, this OMRDD administrative memorandum provides clarifying information on the required components of acceptable service documentation for Supported Employment Services.

Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York, Section 504.3 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." It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, such as OMRDD.

New Policy on Service Delivery Location:

On October 1, 2002, a new policy will take effect that requires that supported employment staff provide a minimum of two face-to-face documented services per month at the consumer's work site. Current policy requires that employed consumers receive a minimum of two face-to-face services per month from supported employment staff, but only one of these services must be provided at the consumer's work site. This policy change has been instituted for the following reasons: (1) to maintain consistency with requirements of other New York state agencies that provide supported employment funding; (2) to maintain consistency with the federal regulations pertaining to supported employment; (3) to reduce confusion in the field; and (4) to focus the supported employment service on job site issues. This change in policy is also consistent with OMRDD requirements prior to the October 1, 2001 supported employment conversion.

In rare situations, if the employed individual does not want the job coach to visit him/her at the work site, the supported employment agency can request a waiver from the work-site visit. The agency must send the request to the DDSO Supported Employment Coordinator stating the reason the consumer does not want the job coach at the work site, as well as identifying the supports and services that will be provided to assist the consumer in achieving his/her valued outcomes. The DDSO will determine if the waiver will be granted. If a waiver is granted, the supported employment provider must maintain a copy of the waiver in the consumer's record.

Supported Employment Standards:

The unit of service for Supported Employment Services is a calendar month.

Requirements for reimbursement depend on the employment status of the consumer:

- 1) To bill a month for an eligible **employed** consumer, the supported employment staff must render at least **two services provided face-to-face** with the consumer on separate days as specified in the consumer's Supported Employment Plan, and if required, the ISP. These face-to-face services must be documented and must be provided at the consumer's job site unless a written waiver has been granted by the DDSO.
- 2) To bill a month for an eligible consumer who doesn't have a job anytime during the month, the provider must actively engage in preparatory and placement activities leading to competitive employment or reemployment. The supported employment staff must render, on separate days, at least **four** such documented supported employment services, as specified in the Supported Employment Plan and if required, the ISP. At least **two** of these services by supported employment staff must be delivered in **face-to-face** contacts with the consumer.

Special Notes:

- A) Only **one** provider of supported employment services may claim for a service fee for an eligible person in a given calendar month.
- B) Reimbursement is contingent upon OMRDD's prior approval of HCBS waiver supported employment service to the person and documentation that the service is provided in accordance with the consumer's ISP and Supported Employment Plan.

Service Documentation Requirements:

Service documentation is necessary, at a minimum, for each of the services required for monthly billing. Documentation of services delivered must include the following required elements:

1. Consumer's name and Medicaid number (CIN). (Note that the CIN need not be included in daily documentation, rather it can appear in the consumer's Supported Employment Plan).
2. Identification of category of waiver service provided (i.e. Supported Employment).
3. **A description of the individualized service provided by supported employment staff**, which is based on the person's Supported Employment Plan (e.g. a staff person documents that she "instructed the person how to answer common job interview questions").

4. A statement regarding whether the service was delivered in a “**face-to-face**” contact with the consumer.
5. The consumer’s response to the service (e.g. “The staff person documents that based on the staff person’s instructions on answering common interview questions, the consumer was successful in her job interview.”). At a minimum, the consumer response must be documented in a monthly summary note. However, a provider may choose to include the consumer response each time a supported employment service is rendered.
6. The date the service was provided.
7. The primary service location (e.g. Madison Avenue Price Chopper).
8. **Verification of service provision by the supported employment staff person delivering the service.**
9. The signature and title of the staff person writing the note.
10. The date the note was written. (Medicaid rules require that the note must be contemporaneous to the service provision.)

Note: If the consumer experiences a significant life change, there should also be a note in the record assessing the impact of this change, any changes to valued outcomes, etc.

General Documentation Requirements: In addition to the service notes supporting each monthly Supported Employment claim, the supported employment agency must maintain the following documentation:

- For consumers receiving MSC and/or enrolled in the HCBS waiver, a copy of the consumer’s ISP, covering the time period of the payment claim, developed by the consumer’s Medicaid Service Coordination (MSC) or Plan of Care Support Services (PCSS) service coordinator. The ISP must include the following elements:
 1. The category of waiver service provided (i.e. Supported Employment Service) and identification of the supported employment agency delivering the service as provider of the service.
 2. Valued Outcome of the person receiving services (i.e. the person’s objective).
 3. Frequency and duration. The ISP should specify that the frequency of supported employment is “monthly” and the duration is “ongoing.”
 4. The effective date for Supported Employment Services (i.e. the date the consumer was enrolled in Supported Employment Services). This date must be on or before the first date of service that the supported employment agency bills for supported employment services.
- **The Supported Employment Plan** developed by the supported employment agency. The plan must cover the time period of the payment claim. For consumers requiring an ISP, the Supported Employment Plan is attached to the person’s ISP. The following elements must be included:

1. The category of waiver service provided (i.e. Supported Employment Service) and designation of the agency providing the supported employment service as provider of the service.
2. Valued Outcome of person receiving services (same as in ISP).
3. Frequency, duration, and effective date (same as in ISP).
4. Review Date. (The Supported Employment Plan must be reviewed every six months.)
5. Individualized Range of Service Frequency (e.g., for an employed consumer supported employment staff will provide from 2 to 8 services during the month.)
6. Locations where the service will be provided.
7. Description of the individualized supported employment services.
8. Safeguards to be taken by the provider to ensure person's health and safety if necessary.
9. Signature and title of the supported employment staff person writing the plan and the date the plan was written or updated

Documentation Retention: All documentation specified above, including ISPs, Supported Employment Plans, and daily service documentation, must be retained for a period of at least six years from the date of the service billed.

Notification: For those services delivered on or after October 1, 2001, OMRDD is reviewing supported employment service claims utilizing the service delivery and documentation requirements contained in this administrative memorandum. For services delivered on or after October 1, 2002, the location of service provision for employed consumers must be in compliance with the new policy discussed in the New Policy on Service Delivery Location and Supported Employment Standards sections.

For additional information, contact Ms. Carol Metevia, Director of Medicaid Standards and Control at (518) 408-2096 or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

Cc: DDSO Directors
DDSO Supported Employment Coordinators
Provider Associations
Helene DeSanto
Kathy Broderick
Peter Pezzolla
Jim Moran
Carol Metevia
Kevin O'Dell
Eugenia Haneman

A-3



STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

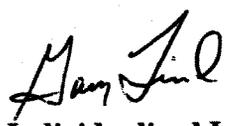
44 HOLLAND AVENUE
ALBANY, NEW YORK 12229-0001
(518) 473-1997 • TDD (518) 474-3694
www.omr.state.ny.us

ADMINISTRATIVE MEMORANDUM - #2003-03

TO: Executive Directors of Agencies Authorized to Provide:

- X Residential Habilitation Services**
- X Day Habilitation Services**
- X Prevocational Services**
- X Supported Employment Services**
- X Medicaid Service Coordination**

DDSO Directors

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

Jan Abelseth, Deputy Commissioner 
Division of Quality Assurance

SUBJECT: HABILITATION PLAN REQUIREMENTS

DATE: December 5, 2003

Suggested Distribution:

Habilitation Services Staff
Agency Managers
Billing Department Staff
Medicaid Service Coordinators and Supervisors

Purpose:

This Administrative Memorandum will define the Habilitation Plan and state the elements that must be in all Habilitation Plans for both Home and Community-Based Services (HCBS) Waiver enrollees and non-enrollees that receive a Habilitation Service funded by OMRDD.

Habilitation Services are:

- (a) Residential Habilitation in approved sites: Individualized Residential Alternative (IRA), Community Residence (CR), At-home, and Family Care;
- (b) Day Habilitation;
- (c) Prevocational Services; and
- (d) Supported Employment (SEMP).

ADMINISTRATIVE MEMORANDUM #2003-03
Habilitation Plan Requirements
December 5, 2003

The memorandum will also provide guidelines about the monthly summary note documentation and quality features of the Habilitation Plan.

There are standards for service quality and standards for service billing. Habilitation service providers must meet the documentation requirements in this administrative memorandum to justify habilitation service billing. Service quality standards are based on the requirements in this memorandum plus OMRDD Division of Quality Assurance Provider's Guide To the Non-ICF Survey Process (October, 2002) and The Key to Individualized Services - The Home and Community Based Services Waiver Provider Guide (OMRDD, 1997).

Defining the Habilitation Service and Habilitation Plan:

Habilitation Services are those supports and services that assist people to live successfully in their home, work at their jobs and participate in the community. Habilitation Plans describe what staff (the word "staff" in this memo includes family care providers) will do to help the person reach his or her valued outcome(s) that have been identified in the Individualized Service Plan (ISP). The ISP provides the authorization for delivering a particular Habilitation Service (e.g. Day Habilitation). Habilitation Services involve staff teaching a skill and/or helping the person, i.e., providing a support, and new experiences. The regulations that govern Habilitation Services are 14 NYCRR Parts 624, 633, 671, 686, and subpart 635-10.

Habilitation Plan Requirements:

The Habilitation Service Provider writes the Habilitation Plan. The ISP is written by the person's service coordinator as required under either Medicaid Service Coordination or Plan of Care Support Services. The Habilitation Plan describes the services and supports that will enable the person to pursue his/her valued outcome(s) stated in the ISP. The initial Habilitation Plan is written by the Habilitation Service Provider in collaboration with the person, their advocate and service coordinator, within 60 days of the start of the Habilitation Service and is forwarded to the service coordinator. Subsequent revised Habilitation Plans, which are also written by the Habilitation Service Provider, are given to the person's service coordinator no more than 30 days after either: (a) the six-month ISP review date, or (b) the Habilitation Service Provider makes a significant change in the Habilitation Plan as agreed upon by the person, their advocate and service coordinator.

ADMINISTRATIVE MEMORANDUM #2003-03

Habilitation Plan Requirements

December 5, 2003

The Habilitation Plan Must Contain the Following Seven Elements:

1. The person's (a) **Name** and (b) **Medicaid Identification Number (CIN)**, if the person is a Medicaid enrollee.
2. The **Habilitation Service Provider agency name and type of Habilitation Service provided** (e.g., Day Habilitation). The Habilitation Service Provider may use a pre-printed format for this information. Absent pre-printed information, the Provider name and type of Habilitation service must be entered on the plan.
3. The **date on which the Habilitation Plan was last reviewed**. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the Habilitation Service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least once every six months. It is recommended that the six-month review be conducted at the time of the ISP meeting arranged by the person's service coordinator. When the Habilitation Plan is reviewed at the ISP meeting, the Habilitation Plan review date will correspond to the ISP review meeting date. At least annually, the Habilitation Plan must be reviewed at the ISP meeting with the service coordinator, consumer, advocate, and with all other major service providers in attendance.
4. The person's **valued outcome(s)** that will be addressed through the Habilitation Service. The person's valued outcome(s) are specified in the ISP. The Habilitation Service is "authorized" only where the service relates to at least one of a person's valued outcomes. The Habilitation Plan writer uses these valued outcomes as a starting point for writing the Habilitation Plan and then goes on to describe the combination of skill acquisition, staff supports and exploration of new experiences that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes.
5. A description of the **services and supports** the Habilitation Service Provider staff will provide to the person. The services and supports that will be provided by the Habilitation staff are further described in the section of this memorandum titled "Quality Features of the Habilitation Plan."
6. The **safeguards** (health and welfare) that will be provided by the Habilitation Service Provider. The safeguards delineated in Section 1 of the ISP are used as the starting point for the Habilitation Service Provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff, as appropriate, must have knowledge of the person's safeguards.
 - a. Safeguards for persons receiving IRA Residential Habilitation are addressed in the individual's Plan of Protective Oversight in accord with 14 NYCRR Section 686.16. The individual's Plan of Protective Oversight is *attached* to the IRA Residential Habilitation Plan.

ADMINISTRATIVE MEMORANDUM #2003-03
Habilitation Plan Requirements
December 5, 2003

- b. For all other Habilitation Services (Residential Habilitation in Family Care, CRs and At Home; Day Habilitation; Prevocational Services; and Supported Employment) safeguards are *included* in the Habilitation Plan or the plan must reference other documentation that specifies the safeguards. *Information on the safeguards must be readily available to the Habilitation Service Provider staff.*

For example:

- i. A safeguard *included* in the Habilitation Plan for a person with exercise-induced asthma might state that he or she must use an inhaler prior to any physical activity.
- ii. The Habilitation Plan might reference the nutritional plan notebook located in the program office, which contains information on the individual's food allergies.

Either including the safeguards or referencing the safeguards is acceptable.

- c. As required in 14 NYCRR Part 633, the medication records stand-alone from the Habilitation Plan. The Habilitation Plan references the medication records as containing important health related information when applicable. If the Habilitation Service Provider is teaching the person to self-administer medication, that goal and methodology should appear in the Habilitation Plan.
- d. Providers of residential habilitation, including at-home services or services provided in IRAs, must have written procedures for providing back-up supports to consumers when the absence of the provider's regularly scheduled staff would pose a serious threat to the person's health or safety.

For certified IRAs, this information must be included in site-specific plans for protective oversight, and in individual plans for protective oversight as appropriate. For individuals receiving at-home residential habilitation, the information could be included in individual residential habilitation plans if appropriate, but minimally must be available in writing as part of the agency's policies and procedures.

7. The **printed name, signature and title** of the person who wrote the Habilitation Plan and the **date** it was written or revised.

The Monthly Note:

To support service claim documentation and quality services, the service provider must assure that at least monthly, or more frequently if the provider so chooses, a narrative note is written that: a) summarizes the implementation of person's Habilitation Plan, b) addresses the person's response to the services provided, and c) states any issues or concerns about the plan or the person.

ADMINISTRATIVE MEMORANDUM #2003-03
Habilitation Plan Requirements
December 5, 2003

Service Claim Documentation:

ADM-2002-01, ADM 2002-02, ADM 2003-04 and ADM 2003-05 describe service documentation requirements for billing. For all Habilitation Services, there must be documentation of individualized services that are drawn from the person's Habilitation Plan.

Quality Features of the Habilitation Plan:

A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan should address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, and exploration of new experiences. The strategies are discussed below. The Habilitation Service Provider, using professional judgment and in collaboration with the person and his/her service coordinator, decides which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new Habilitation Service staff to know what they must do to implement the person's Habilitation Plan. It should be noted that the Habilitation Plan provides strategies for habilitation service delivery and is not meant to identify each and every activity that occurs throughout the day.

1. **Skill Acquisition/retention** describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by either observation, interviewing staff or others that know the person well and/or by data collection.

Skill acquisition/retention goals should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, the Habilitation Service can be directed to skill retention.

2. **Staff Supports** are those actions provided by the habilitation staff when the person is not expected to independently perform a task without supervision that is essential to preserve the person's health or welfare, or to reach a valued outcome. Examples are assistance with personal hygiene or activities of daily living. Staff oversight of the person's health and welfare is also a part of the Habilitation Service (e.g., when staff accompany people in the community or provide first aid).
3. **Exploration of new experiences** is an acceptable component of the Habilitation Plan when based on an appropriate review by the Habilitation Service Provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. This trial and error process eventually enables the person to make informed choices and, consequently, to identify new valued outcomes that then become part of the ISP and the Habilitation Plan.

ADMINISTRATIVE MEMORANDUM #2003-03
Habilitation Plan Requirements
December 5, 2003

For additional information about the Habilitation Plan, please contact Mr. Kevin O'Dell, Director of Waiver Management, at (518) 474-5647 or via e-mail at kevin.odell@omr.state.ny.us.

cc: **Provider Associations**
Lisa Kagan
Helene DeSanto
Kathy Broderick

Jim Moran
Barbara Brundage
Peter Pezzolla
Carol Metevia

Allen Schwartz
Barbara Brundage
Kevin O'Dell

A-4

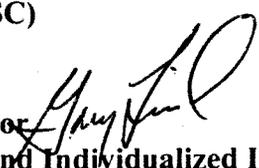


STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

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

Date: February 18, 2005

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

A-5



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 - #2006-01

TO: Executive Directors of Agencies Authorized to Provide Group Day Habilitation Services
Executive Directors of Agencies Authorized to Provide Medicaid Service Coordination
DDSO Directors

FROM: Helene DeSanto, Executive Deputy Commissioner
and Interim Director, Quality Assurance *Helene DeSanto*

Gary Lind, Director
Policy, Planning and Individualized Initiatives *Gary Lind*

James R. Moran, Deputy Commissioner
Administration and Revenue Support *JRM*

SUBJECT: GROUP DAY HABILITATION SERVICE DOCUMENTATION REQUIREMENTS

DATE: January 1, 2006

Suggested Distribution:

Group Day Habilitation Program/Service Staff
Quality/Compliance Staff
Billing Department Staff
MSC Service Coordinators and Service Coordinator Supervisors

Purpose:

This is to review the Group Day Habilitation service documentation requirements that support a provider's claim for reimbursement. These service documentation criteria apply to Group Day Habilitation services rendered to Home and Community Based Services (HCBS) waiver-enrolled individuals as well as to non-waiver enrolled individuals effective January 1, 2006. Requirements set forth in this Administrative Memorandum supersede Administrative Memorandum 2003-04 and fiscal audit service documentation requirements addressed in The Key to Individualized Services, The Home and Community Based Services Waiver (OMRDD, 1997). Quality service standards in The Key remain the same.

ADMINISTRATIVE MEMORANDUM #2006-01
Group Day Habilitation Service Documentation Requirements
January 1, 2006

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.” (emphasis added) It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, including OMRDD.

The regulatory basis for HCBS Waiver Group Day Habilitation is in 14 NYCRR section 635-10.4 (b)(2) and 635-10.5 (c)

Group Day Habilitation Services:

Effective January 1, 2006, for billing purposes, Day Habilitation will be categorized as Group Day Habilitation, Supplemental Group Day Habilitation, Individual Day Habilitation or Supplemental Individual Day Habilitation services. All four forms of Day Habilitation conform to the existing service definitions in 14 NYCRR section 635-10.4 (b)(2).

This memorandum describes the service documentation requirements for Group Day Habilitation and Supplemental Group Day Habilitation. Group Day Habilitation services are services that are generally provided to two or more consumers, although one-to-one services may also be provided. Group Day Habilitation services are provided on weekdays with a service start time prior to 3:00 p.m. Supplemental Group Day Habilitation are services that are delivered anytime on Saturday or Sunday, or on weekdays with a service start time of 3:00p.m. or later

Supplemental services billed separately to Medicaid or OMRDD are designed for consumers who live at home, in Supportive IRAs, in Supportive CRs or Family Care Homes. Supplemental Group Day Habilitation services may not be separately billed to Medicaid or OMRDD for consumers who live in residences with 24-hour staffing (e.g., Supervised IRAs or Supervised CRs). It is the responsibility of a residence with 24-hour staffing to provide residential habilitation services on weekday evenings and weekends.

Billing Standard:

Payment for Group Day Habilitation and Supplemental Group Day Habilitation requires for each consumer served, prior authorization from the DDSO/NYCRO. Service providers which have been authorized to provide Supplemental Group Day Habilitation must correctly categorize their services as “Supplemental Group Day Habilitation” vs. “Group Day Habilitation” based on these time parameters and must use the appropriate billing rate code for each.

ADMINISTRATIVE MEMORANDUM #2006-01
Group Day Habilitation Service Documentation Requirements
January 1, 2006

Group Day Habilitation and Supplemental Group Day Habilitation services are billed as either a Full Unit or a Half Unit. A Full Unit may be billed when staff deliver and document at least two individualized face-to-face Group Day Habilitation services to a consumer during the program day, and the program day duration is four to six hours in duration. A Half Unit of Group Day Habilitation or Supplemental Group Day Habilitation may be billed when staff deliver and document at least one individualized face-to-face Group Day Habilitation service to a consumer during the program day, and the program day duration is at least two hours.

For both Group Day Habilitation and Supplemental Group Day Habilitation the *program day duration* is defined as the length of time the provider delivers face-to-face Group Day Habilitation services to the person. Time spent in the following activities cannot be counted toward the program day duration:

- Time the consumer spends being transported to the first Group Day Habilitation activity of the day and time being transported home or to the next activity after the conclusion of Group Day Habilitation services.
- Time the consumer spends at a separate service (e.g., a clinic service) and the time being transported to and from the separate service.

Note: The provision of Medicaid Service Coordination (MSC) is the only exception to the rule regarding "backing out" time at another Medicaid service from the Day Habilitation program day. Time the consumer spends with his/her MSC Service Coordinator can be counted toward the Group Day Habilitation or Supplemental Group Day Habilitation program day as long as the visit occurs at a Day Habilitation service location. Also, the consumer's time at the ISP review conducted by the MSC Service Coordinator may count toward the Day Habilitation program day duration as long as the Day Habilitation staff accompany the consumer to the meeting.

- Mealtime.

Day Habilitation services delivered during mealtimes, while at a clinic or during travel specified above, cannot be used to meet the billing requirements for a Full or Half Unit. While services provided at these times are important to service quality, they cannot be used to fulfill the billing requirement of two services for a Full Unit or one service for a Half Unit.

Service Documentation:

Medicaid rules require that service documentation be contemporaneous with the service provision. Required service documentation elements are:

1. **Consumer's name and Medicaid number (CIN).** Note that the CIN need not be included in daily documentation; rather, it can appear in the consumer's Group Day Habilitation Plan.

ADMINISTRATIVE MEMORANDUM #2006-01
Group Day Habilitation Service Documentation Requirements
January 1, 2006

2. **Identification of category of waiver service provided.** Although the waiver service is identified as "Group Day Habilitation" or "Supplemental Group Day Habilitation" for billing and service documentation purposes, the consumer's Individualized Service Plan (ISP) should identify the category of waiver service as "Day Habilitation."
3. **A daily description of the required minimum number of face-to-face services provided by staff.** Face-to-face services are individualized services based on the person's Group Day Habilitation Plan, e.g., the staff person documents that he/she "taught the person how to count change up to one dollar." The number of face-to-face services required to support billing depends on the unit billed and is described in the above section titled "Billing Standards."
4. **Documentation that the minimum service duration requirement was met.**
 - **For Group Day Habilitation,** the provider may document the *program day duration* by indicating the service start time and service stop time. Alternatively, the provider may elect to document the program day duration with a daily affirmation, stating that the minimum duration was met in either a narrative note or checklist format, e.g., "*I attest that a 4-hour program day was provided today to John Smith. Sally Jones, Group Day Habilitation Worker, January 12, 2006.*" Note that where a provider does not document service start and service stop time, an outside reviewer may require other documentation that supports the service duration, for example, a bus log that demonstrates the consumer was at a Group Day Habilitation site for at least 4 hours.
 - **For Supplemental Group Day Habilitation,** the provider must document the service start time and the service stop time.

In addition to documenting the program day duration, when a consumer attends another service during the Group Day Habilitation or Supplemental Group Day Habilitation program day, such as a clinic service or doctor's appointment, the provider must document the "clock" time of the consumer's departure from the Group Day Habilitation program and the time the consumer returned.

5. **The consumer's response to the service.** For example, the staff person documents that "after several practice sessions the consumer was able to count the change he received after purchasing a magazine." Note that at a minimum, the consumer response must be documented in a monthly summary note, although a provider may choose to include the consumer response more frequently, e.g. daily.
6. **The date the service was provided.**
7. **The primary service location,** e.g., "Maple Avenue Group Day Habilitation" or "without walls," if services are provided at changing locations in the community and there is no primary service location.
8. **Verification of service provision by the Group Day Habilitation staff person delivering the service.** Initials are permitted if a "key" is provided, which identifies the title, signature and full name associated with the staff initials.

ADMINISTRATIVE MEMORANDUM #2006-01
Group Day Habilitation Service Documentation Requirements
January 1, 2006

9. **The signature and title of the Group Day Habilitation staff person documenting the service.**
10. **The date the service was documented.** Note that this date must be concurrent with service provision.

The acceptable format for the service documentation supporting a provider's billing submittal is either a narrative note or a checklist/chart with an entry made at the same time each Group Day Habilitation service is delivered and billed.

Narrative Note Format

If the narrative note format is selected, the documentation can be completed in one of two ways:

1. A daily service note describing at least two face-to-face individualized services delivered by Group Day Habilitation staff on each day the provider bills a Full Unit of either Group Day Habilitation or Supplemental Group Day Habilitation. At least one face-to-face individualized service delivered by Group Day Habilitation staff must be documented on each day the provider bills a Half Unit of either Group Day Habilitation or Supplemental Group Day Habilitation. Since the daily note does not include the consumer's response to the service, a monthly summary note is required. This monthly note must summarize the implementation of the individual's Group Day Habilitation Plan, address the consumer's response to the services provided and any issues or concerns; **OR**
2. On each day the provider bills a Full Unit of either Group Day Habilitation or Supplemental Group Day Habilitation, a daily service note describing at least two face-to-face individualized services delivered by Day Habilitation staff and the consumer's response to the service. On each day the provider bills a Half Unit of either Group Day Habilitation or Supplemental Group Day Habilitation, a daily service note describing at least one face-to-face individualized service delivered by Group Day Habilitation staff and the consumer's response to the service delivery. Additionally, at least one of the daily notes written during the month must summarize the implementation of the individual's Group Day Habilitation Plan and address any issues or concerns.

Checklist / Chart Format

For each day service is delivered, a provider may elect to document the required face-to-face individualized Group Day Habilitation and Supplemental Group Day Habilitation service delivered by Group Day Habilitation staff using a checklist or chart. If this format is selected, a monthly summary note is also required. The monthly summary note must summarize the implementation of the individual's Group Day Habilitation Plan; address the consumer's response to services provided and any issues or concerns.

Both the Narrative Note format and the Checklist/Chart format must include all the Service Documentation elements listed above, including a description of the required minimum number of face-to-face individualized services provided by Day Habilitation staff each day the provider bills either Group Day Habilitation or Supplemental Group Day Habilitation.

ADMINISTRATIVE MEMORANDUM #2006-01
Group Day Habilitation Service Documentation Requirements
January 1, 2006

Other Documentation Requirements:

In addition to the service note(s) supporting Group Day Habilitation or Supplemental Group Day Habilitation billing claims, your agency must maintain the following documentation:

- ✓ A copy of the consumer's Individualized Service Plan (ISP), covering the time period of the claim, developed by the consumer's Medicaid Service Coordinator (MSC) or Plan of Care Support Services (PCSS) service coordinator. Although for billing and service documentation purposes we distinguish between the four types of Day Habilitation (i.e., Individual Day Habilitation, Supplemental Individual Day Habilitation, Group Day Habilitation or Supplemental Group Day Habilitation), the ISP should identify the category of waiver service as "Day Habilitation." The ISP, which is the "authorization" for waiver services, must also identify your agency as the provider of the service. Further, the ISP must specify an effective date for Day Habilitation that is on or before the first date of service for which your agency bills Day Habilitation for the consumer. The ISPs should identify the frequency for Group Day Habilitation and Supplemental Group Day Habilitation as "a day".
- ✓ The **Group Day Habilitation Plan** developed by your agency that conforms to the Habilitation Plan requirements found in ADM 2003-03. For both Group Day Habilitation and Supplemental Group Day Habilitation the Habilitation Plan is entitled "Group Day Habilitation Plan". The Group Day Habilitation Plan must "cover" the time period of the Group Day Habilitation service claim. Note that the consumer's Group Day Habilitation Plan is attached to his/her ISP. If a consumer attends both Group and Supplemental Group Day Habilitation Services, you may maintain one Group Day Habilitation Plan. This plan must, however, have a separate section that clearly identifies the supports and services associated with Group Day Habilitation and a separate section that clearly identifies the supports and services associated with Supplemental Group Day Habilitation.

Documentation Retention:

All documentation specified above, including the ISP, Group Day Habilitation Plan and service documentation, 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.

Fiscal Audit:

In a fiscal audit a Day Habilitation claim for a sampled consumer will be selected and the auditor will typically ask for the ISP and Group Day Habilitation Plan in effect for the claim date. The auditor will also require, for the claim dates, the service documentation specified above.

For additional information on the documentation requirements or to request samples of documentation checklist formats, contact Ms. Carol Metevia, Director of Training and Medicaid Standards at (518) 408-2096, or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

ADMINISTRATIVE MEMORANDUM #2006-01
Group Day Habilitation Service Documentation Requirements
January 1, 2006

cc: Provider Associations
Kathy Broderick
Michele Gatens
Carol Metevia
Kevin O'Dell
David Picker

**INSTRUCTIONS FOR COMPLETING
GROUP DAY HABILITATION DAILY SUMMARY SHEET**

AGENCY = Enter the name of your agency that is providing the Group Day Habilitation service.

MONTH/YEAR OF SERVICE = Enter the month and year in which the Group Day Habilitation service(s) was provided (e.g., 05/06).

CONSUMER NAME = Enter the name of the consumer who is receiving the Group Day Habilitation service.

TABS ID = Enter the Tracking and Billing System (TABS) identification number assigned to the consumer (e.g., 23456). [note: this number is automatically assigned when the consumer is registered in TABS. For assistance in obtaining the TABS ID number please contact your DDSO TABS Coordinator].

MEDICAID # = The consumer's Medicaid Number or CIN (an 8-digit number in the following format, AA12345A).

SITE ADDRESS = Enter the address of the Day Hab site where the service was provided or "without walls," if appropriate.

PRGM DAY/NOT PRGM DAY = Enter "P" if the service/staff action is delivered during the "program day duration" and "N" if the service is delivered during time that does not qualify as part of the "program day duration" (e.g., mealtime, to/from transportation and time at another Medicaid service).

DESCRIPTION OF THE INDIVIDUALIZED STAFF SERVICE/ ACTION PROVIDED = List key individualized services or actions by staff drawn from the Group Day Habilitation Plan.

STAFF PROVIDING SERVICE/ACTION MUST INITIAL THE DATE THE SERVICE/ACTION WAS PROVIDED = For each day the described service or action is provided, the staff person providing the service or action should place his/her initials in the box corresponding to the day of the month the service was provided (e.g., the service is provided on the 4th, 5th, 6th, 12th, 13th, 21st, 25th and 28th day of a given month. In the box for each one of those days, the staff member providing the service should place his/her initials to verify that the service or action was provided.).

TOTAL # OF SERVICES = Enter the total number of "P-program day" services delivered for the day.

IF CONSUMER RECEIVED OTHER MA SERVICE = If the consumer receives another Medicaid service during the Group Day Habilitation program day (e.g., a clinic service), staff must record the time the consumer leaves the Group Day Habilitation program (Time left Day Hab) and the time the consumer returns to the Group Day Habilitation program (Time Rtrn Day Hab).

TOTAL PRGM DAY DURATION = Circle "F" for full if the consumer received four or more hours of service provision for the day. Circle "H" for half if the consumer received more than two hours of service but less than four hours of service provision for the day. Circle "L2" if the consumer received less than two hours of service provision for the day. (note: mealtime, time at another Medicaid service and the transportation to and from the other Medicaid service, and time spent transporting the consumer to and from the day habilitation site does not count toward the program day duration).

Signature = The staff member providing a service or action should sign his or her name.

Print name = Print the corresponding name of the staff member providing a service or action during the month.

Initials = The *initials* of the staff member providing a service or action during the month.

Title = The *title* of the staff member providing a service or action.

BY SIGNING BELOW STAFF ARE VERIFYING THAT ON EACH SERVICE DATE RECORDED ON THIS FORM, THE PROGRAM DAY DURATION IS ACCURATELY DOCUMENTED = The total program day duration entries recorded on the individual Summary Sheet for the month must be verified. The staff person verifying the individual summary sheet should sign their name on the *signature* line, print their name on the *Print Name* line, and put their title on the *title* line.

GROUP DAY HABILITATION MONTHLY SUMMARY NOTE

AGENCY NAME = Enter the name of your agency that is providing the Group Day Habilitation service.

MONTH/YEAR OF SERVICE DELIVERY = Enter the month and year in which the Group Day Habilitation service(s) was provided (e.g., 10/06).

CONSUMER NAME = Enter the name of the consumer who is receiving the Group Day Habilitation service.

TABS ID = Enter the Tracking & Billing (TABS) identification number assigned to the consumer (e.g., 23456). *[note: this is the number automatically assigned when the consumer is registered in TABS. For assistance in obtaining the TABS ID number please contact your DDSO TABS Coordinator].*

MEDICAID # = The consumer's Medicaid Number or CIN (an 8-digit number in the following format, AA12345A).

GROUP DAY SITE LOCATION = Enter the address of the Day Hab site where the service was provided or "without walls," if appropriate.

SUMMARY NOTE = Provide a narrative that summarizes the implementation of the individual's Group Day Habilitation plan, and addresses the consumer's response to the services provided and any issues or concerns.

SIGNATURE OF STAFF PERSON WRITING THE NOTE = This is the signature of the staff person who wrote the summary note.

TITLE = This is the title of the staff person who wrote the summary note.

DATE = Enter the date, in month, day, year format, that the summary note was written.

**INSTRUCTIONS FOR COMPLETING
SUPPLEMENTAL GROUP DAY HABILITATION DAILY SUMMARY SHEET**

AGENCY = Enter the name of your agency that is providing the Supplemental Group Day Habilitation service.

MONTH/YEAR OF SERVICE = Enter the month and year in which the Supplemental Group Day Habilitation service(s) was provided (e.g., 02/06).

CONSUMER NAME = Enter the name of the consumer who is receiving the Supplemental Group Day Habilitation service.

TABS ID = Enter the Tracking and Billing System (TABS) identification number assigned to the consumer (e.g., 23456). [*note: this number is automatically assigned when the consumer is registered in TABS. For assistance in obtaining the TABS ID number please contact your DDSO TABS Coordinator*].

MEDICAID # = The consumer's Medicaid Number or CIN (an 8-digit number in the following format, AA12345A).

SITE ADDRESS = Enter the address of the Day Hab site where the service was provided or "without walls," if appropriate.

PRGM DAY/NOT PRGM DAY = Enter "P" if the service/staff action is delivered during the "program day duration" and "N" if the service is delivered during time that does not qualify as part of the "program day duration" (e.g., mealtime, to/from transportation and time at another Medicaid service).

DESCRIPTION OF THE INDIVIDUALIZED STAFF SERVICE/ ACTION PROVIDED = List key individualized services or actions by staff drawn from the Group Day Habilitation Plan.

STAFF PROVIDING SERVICE/ACTION MUST INITIAL THE DATE THE SERVICE/ACTION WAS PROVIDED = For each day the described service or action is provided, the staff person providing the service or action should place his/her initials in the box corresponding to the day of the month the service was provided (e.g., the service is provided on the 4th, 5th, 6th, 12th, 13th, 21st, 25th and 28th day of a given month. In the box for each one of those days, the staff member providing the service should place his/her initials to verify that the service or action was provided.).

TOTAL # OF SERVICES = Enter the total number of "P-program day" services delivered for the day.

TOTAL PRGM DAY DURATION = Circle "F" for full if the consumer received four or more hours of service provision for the day. Circle "H" for half if the consumer received more than two hours of service but less than four hours of service provision for the day. Circle "L2" if the consumer received less than two hours of service provision for the day. (*note: mealtime, time at another Medicaid service and the*

transportation to and from the other Medicaid service, and time spent transporting the consumer to and from the day habilitation site does not count toward the program day duration).

SERVICE START TIME = Enter the time Supplemental Group Day Habilitation services start.

SERVICE END TIME = Enter the time Supplemental Group Day Habilitation services end.

IF CONSUMER RECEIVED OTHER MA SERVICE = If the consumer receives another Medicaid service during the Supplemental Group Day Habilitation program day (e.g., a clinic service), staff must record the time the consumer leaves the Supplemental Group Day Habilitation program (Time left Day Hab) and the time the consumer returns to the Supplemental Group Day Habilitation program (Time Rtrn Day Hab).

Signature = The staff member providing a service or action should sign his or her name.

Print name = Print the corresponding name of the staff member providing a service or action during the month.

Initials = The *initials* of the staff member providing a service or action during the month.

Title = The *title* of the staff member providing a service or action.

BY SIGNING BELOW STAFF ARE VERIFYING THAT ON EACH SERVICE DATE RECORDED ON THIS FORM, THE PROGRAM DAY DURATION IS ACCURATELY DOCUMENTED = The total Program day duration entries recorded on the individual Summary Sheet for the month must be verified. The staff person verifying the individual summary sheet should sign their name on the *signature* line, print their name on the *Print Name* line, and put their title on the *title* line.

AGENCY: _____ **MONTH/YEAR OF SERVICE:** _____
CONSUMER NAME: _____ **TABS ID:** _____ **MEDICAID #:** _____
SITE ADDRESS: _____

STAFF PROVIDING SERVICE / ACTION MUST INITIAL THE DATE THE SERVICE / ACTION WAS PROVIDED.
 (NOTE : by entering initials, staff are attesting that the service/action was provided on that day. Initialing must occur at the same time as service delivery.)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
DESCRIPTION OF THE INDIVIDUALIZED STAFF SERVICE / ACTION PROVIDED (based on the consumer's Group Day Habilitation Plan)															
TOTAL # of SERVICES															
SERVICE START TIME															
SERVICE END TIME															
TOTAL PRGM DAY DURATION (circle one) F=Full: 4 or more hours / H=Half: 2 hours up to 4 hours / L2=less than 2 hours	F H L2														
If Consumer Received															
Other Service															

Signature _____ **Print Name** _____ **Initials** _____ **Title** _____
Signature _____ **Print Name** _____ **Initials** _____ **Title** _____
Signature _____ **Print Name** _____ **Initials** _____ **Title** _____

By signing below staff are verifying that on each service date recorded on this form, the program day duration is accurately documented.

SUPPLEMENTAL GROUP DAY HABILITATION MONTHLY SUMMARY NOTE

AGENCY NAME = Enter the name of your agency that is providing the Supplemental Group Day Habilitation service.

MONTH/YEAR OF SERVICE DELIVERY = Enter the month and year in which the Supplemental Group Day Habilitation service(s) was provided (e.g., 10/06).

CONSUMER NAME = Enter the name of the consumer who is receiving the Supplemental Group Day Habilitation service.

TABS ID = Enter the Tracking & Billing (TABS) identification number assigned to the consumer (e.g., 23456). [note: this is the number automatically assigned when the consumer is registered in TABS. For assistance in obtaining the TABS ID number please contact your DDSO TABS Coordinator].

MEDICAID # = The consumer's Medicaid Number or CIN (an 8-digit number in the following format, AA12345A).

SUPPLEMENTAL GROUP DAY SITE LOCATION = Enter the address of the Day Hab site where the service was provided or "without walls," if appropriate.

SUMMARY NOTE = Provide a narrative that summarizes the implementation of the individual's Group Day Habilitation plan, and addresses the consumer's response to the services provided and any issues or concerns.

SIGNATURE OF STAFF PERSON WRITING THE NOTE = This is the signature of the staff person who wrote the summary note.

TITLE = This is the title of the staff person who wrote the summary note.

DATE = Enter the date, in month, day, year format, that the summary note was written.

A-6



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 - #2006-02

**TO: Executive Directors of Agencies Authorized to Provide Individual Day Habilitation Services
Executive Directors of Agencies Authorized to Provide Medicaid Service Coordination
DDSO Directors**

**FROM: Helene DeSanto, Executive Deputy Commissioner
and Interim Director Quality Assurance**

**Gary Lind, Director
Policy, Planning and Individualized Initiatives**

**James T. Moran, Deputy Commissioner
Administration and Revenue Support**

**SUBJECT: INDIVIDUAL DAY HABILITATION SERVICE
DOCUMENTATION REQUIREMENTS**

DATE: January 1, 2006

Suggested Distribution:

Individual Day Habilitation Program/Service Staff
Quality/Compliance Staff
Billing Department Staff
MSC Service Coordinators and Service Coordinator Supervisors

Purpose:

This is to review the Day Habilitation service documentation requirements that support a provider's claim for reimbursement. These service documentation criteria apply to *Individual* Day Habilitation services rendered to Home and Community Based Services (HCBS) waiver-enrolled individuals as well as to non-waiver enrolled individuals effective January 1, 2006. Requirements set forth in this Administrative Memorandum

ADMINISTRATIVE MEMORANDUM #2006-02
Individual Day Habilitation Service Documentation Requirements
January 1, 2006

supersede Administrative Memorandum 2003-04 and fiscal audit service documentation requirements addressed in The Key to Individualized Services, The Home and Community Based Services Waiver (OMRDD, 1997). Quality service standards in The Key remain the same.

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.” (emphasis added) It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, including OMRDD.

The regulatory basis for HCBS Waiver Individual Day Habilitation is in 14 NYCRR section 635-10.4 (b)(2) and 635-10.5 (c)

Individual Day Habilitation Services:

Effective January 1, 2006, for billing purposes, Day Habilitation will be categorized as Group Day Habilitation, Supplemental Group Day Habilitation, Individual Day Habilitation or Supplemental Individual Day Habilitation services. All four forms of Day Habilitation conform to the existing service definitions in 14 NYCRR section 635-10.4 (b)(2).

This memorandum describes the service documentation requirements for Individual and Supplemental Individual Day Habilitation. **Individual Day Habilitation services are provided to a single enrolled consumer with at least one staff person providing services to no more than one consumer for the duration of the service.** Individual Day Habilitation services are delivered on weekdays with a service start time prior to 3:00 p.m.

Supplemental Individual Day Habilitation are services that are delivered anytime on Saturday or Sunday, or on weekdays with a service start time of 3:00 p.m. or later. Supplemental Individual Day Habilitation service may not be separately billed to Medicaid or OMRDD for consumers who live in residences with 24-hour staffing (e.g., Supervised IRAs or Supervised CRs). It is the responsibility of a residence with 24-hour staffing to provide residential habilitation services on weekday evenings and weekends.

ADMINISTRATIVE MEMORANDUM #2006-02
Individual Day Habilitation Service Documentation Requirements
January 1, 2006

Billing Standard:

The unit of service for Individual Day Habilitation and Supplemental Individual Day Habilitation services is an hour. Services are billed in 15-minute increments, with a full 15 minutes of service required to bill a single increment (i.e., there is no "rounding up"). Payment for Individual Day Habilitation or Supplemental Individual Day Habilitation requires, for each consumer served, prior authorization from the DDSO/NYCRO.

For each continuous period of service delivery (or "session"), the provider must document the delivery of at least one individualized, face-to-face service provided by Individual Day Habilitation staff that is based on the consumer's Individual Day Habilitation Plan. The provider must also document the service start time and service stop time for each Individual Day Habilitation or Supplemental Individual Day Habilitation "session."

The *billable service time* for Individual Day Habilitation and Supplemental Individual Day Habilitation is the time when Individual Day Habilitation staff are providing one-on-one, face-to-face Individual Day Habilitation services to a consumer. Time spent in the following activities cannot be counted toward the billable service time:

- **Time the consumer spends in group activities must be excluded when determining the number of quarter hours billed.** Group activities are activities that include two or more consumers. For example, if a staff person accompanies two consumers to the local mall to work on money management skills, this time is not "countable" as billable service time for Individual Day Habilitation.
- **Time at another service** (e.g., a clinic service or a medical appointment) and time being transported to and from the other service does not count in determining the number of quarter-hours to be billed toward the Individual Day Habilitation billable service time.

Note: Medicaid Service Coordination (MSC) is the only exception to the rule regarding other services being "backed out" of the Individual Day Habilitation billable service time. Time the consumer spends with his/her MSC Service Coordinator during the MSC monthly visit and at ISP reviews may be included as Individual Day Habilitation billable service time as long as Day Habilitation staff accompany the consumer to the meetings.

- **Transportation** to the first "out-of-home" activity of the day and transportation after the last "out-of-home" Individual Day Habilitation activity of the day does not count in determining the time that is to be billed. For example, an Individual Day Habilitation staff person picks up the consumer at his or her home at 9 a.m.

ADMINISTRATIVE MEMORANDUM #2006-02
Individual Day Habilitation Service Documentation Requirements
January 1, 2006

The consumer and the staff person travel to the local library where Day Habilitation services begin at 9:30 a.m. The two are engaged in Individual Day Habilitation activities from 9:30 until 1:00 p.m., at which time they travel to the Gym and continue Individual Day Habilitation services. At 3:00 p.m. Individual Day Habilitation services conclude for the day when the Individual Day Habilitation staff person and the consumer leave the Gym to travel to the consumer's home. In this case, the billable service time for the day is 5 ½ hours (or 22 quarter hours). The 5 ½ hours begins at the time the consumer accompanied by Individual Day Habilitation Staff, arrived at the first "out-of-home" Individual Day Habilitation site (the Library) through the conclusion of services at the Gym. The time being transported from home to the Library and from the Gym to home is not "billable service time." The "internal" or Day Habilitation "site to site" transportation time (i.e., the time spent being transported from the Library to the Gym) is "countable" toward the billable service time.

Note: There is one exception to the prohibition on counting as billable service time, the time spent in transport to the first service location of the day and back from the last activity of the day. If Individual Day Habilitation staff provide travel training during these transportation times, this time may be counted as long as the travel training is **time limited** and is specified in the consumer's Individual Day Habilitation Plan.

Service Documentation:

Medicaid rules require that service documentation be contemporaneous with the service provision. Required service documentation elements are:

1. **Consumer's name and Medicaid number (CIN).** Note that the CIN need not be included in daily documentation; rather, it can appear in the consumer's Individual Day Habilitation Plan.
2. **Identification of category of waiver service provided.** Although the waiver service is identified as "Individual Day Habilitation" or "Supplemental Individual Day Habilitation" for billing and service documentation purposes, the consumer's Individualized Service Plan (ISP) should identify the category of waiver service as "Day Habilitation."
3. **A daily description of at least one face-to-face service provided by staff during each "session" (or continuous period of Individual Day Habilitation service provision).** Face-to-face services are individualized services based on the person's Individual Day Habilitation Plan, e.g., the staff person documents that he/she "taught the person to select reading material at the library."

ADMINISTRATIVE MEMORANDUM #2006-02
Individual Day Habilitation Service Documentation Requirements
January 1, 2006

4. **Documentation of start and stop times.** The provider must document the service start time and service stop time for each continuous period of Individual Day Habilitation service provision or "session."
5. **The consumer's response to the service.** For example, the staff person documents that "consumer was able to present his library card to check out periodicals." Note that at a minimum, the consumer response must be documented in a monthly summary note, although a provider may choose to include the consumer response more frequently, e.g. daily.
6. **The date the service was provided.**
7. **The primary service location, e.g., "Maple Avenue Library" or "Various Community Locations."**
8. **Verification of service provision by the Individual Day Habilitation staff person delivering the service.** Initials are permitted if a "key" is provided, which identifies the title, signature and full name associated with the staff initials.
9. **The signature and title of the Individual Day Habilitation staff person documenting the service.**
10. **The date the service was documented.** Note that this date must be concurrent with service provision.

The acceptable format for the service documentation supporting a provider's billing submittal is either a narrative note or a checklist/chart with an entry made at the same time each Individual Day Habilitation service is delivered and billed.

Narrative Note Format

If the narrative note format is selected, the documentation can be completed in one of two ways:

1. A daily service note describing at least one face-to-face individualized service delivered by Individual Day Habilitation staff for each Individual Day Habilitation or Supplemental Individual Day Habilitation "session." The note does not include the consumer's response to the service. If this format is selected, a monthly summary note is required. This monthly note must summarize the implementation of the consumer's Individual Day Habilitation Plan, address the consumer's response to the services provided and any issues or concerns; **OR**

ADMINISTRATIVE MEMORANDUM #2006-02
Individual Day Habilitation Service Documentation Requirements
January 1, 2006

2. A daily service note describing at least one face-to-face individualized service delivered by Individual Day Habilitation staff for each Individual Day Habilitation or Supplemental Individual Day Habilitation "session" and the consumer's response to the service delivery. Additionally, at least one of the daily notes written during the month must summarize the implementation of the person's Individual Day Habilitation Plan and address any issues or concerns.

Checklist / Chart Format

For each service session, a provider may elect to document the face-to-face Individual Day Habilitation or Supplemental Individual Day Habilitation service delivered by Individual Day Habilitation staff using a checklist or chart. If this format is selected, a monthly summary note is also required. The monthly summary note must summarize the implementation of the consumer's Individual Day Habilitation Plan; address the consumer's response to services provided and any issues or concerns.

Both the Narrative Note format and the Checklist/Chart format must include all the Service Documentation elements listed above, including a description of at least one face-to-face individualized service provided by Individual Day Habilitation staff for each Individual Day Habilitation session. The start and stop time for each Individual Day Habilitation "session" must also be documented.

Other Documentation Requirements:

In addition to the service note(s) supporting the Individual Day Habilitation billing claim, your agency must maintain the following documentation:

- ✓ A copy of the consumer's **Individualized Service Plan (ISP)**, covering the time period of the claim, developed by the consumer's Medicaid Service Coordinator (MSC) or Plan of Care Support Services (PCSS) service coordinator. Although for billing purposes we distinguish between the four types of Day Habilitation (i.e., Individual Group Day Habilitation, Supplemental Individual Day Habilitation, Group Day Habilitation or Supplemental Group Day Habilitation), the ISP identifies the category of waiver service as "Day Habilitation." The ISP must also identify your agency as the Day Habilitation provider. The ISP must specify an effective date for Day Habilitation that is on or before the first date of service for which your agency bills Individual Day Habilitation or Supplemental Individual Day Habilitation for the consumer. The frequency for Individual Day Habilitation and Supplemental Individual Day Habilitation is an *hour*.
- ✓ The **Individual Day Habilitation Plan** developed by your agency that conforms to the Habilitation Plan requirements found in ADM 2003-03. For both Individual Day Habilitation and Supplemental Individual Day Habilitation the Habilitation Plan is

ADMINISTRATIVE MEMORANDUM #2006-02
Individual Day Habilitation Service Documentation Requirements
January 1, 2006

entitled "Individual Day Habilitation Plan". The Individual Day Habilitation Plan must "cover" the time period of the Individual Day Habilitation service claim. Note that the consumer's Individual Day Habilitation Plan is attached to his/her ISP. If a consumer attends both Individual and Supplemental Individual Day Habilitation Services, you may maintain one Individual Day Habilitation Plan. This plan must, however, have a separate section that clearly identifies the supports and services associated with Individual Day Habilitation and a separate section that clearly identifies the supports and services associated with Supplemental Individual Day Habilitation.

Documentation Retention:

All documentation specified above, including the ISP, Individual Day Habilitation Plan and service documentation, 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.

Fiscal Audit:

In a fiscal audit a Day Habilitation claim for a sampled consumer will be selected and the auditor will typically ask for the ISP and Individual Day Habilitation Plan in effect for the claim date. The auditor will also require, for the claim dates, the service documentation specified above.

For additional information on the documentation requirements or to request samples of documentation checklist formats, contact Ms. Carol Metevia, Director of Training and Medicaid Standards at (518) 408-2096, or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

cc: Provider Associations
Kathy Broderick
Michele Gatens
Carol Metevia
Kevin O'Dell
David Picker

**INSTRUCTIONS FOR COMPLETING
INDIVIDUAL HABILITATION DAILY SUMMARY SHEET**

CONSUMER NAME = Enter the name of the consumer who is receiving the Individual Day Habilitation service.

CONSUMER MEDICAID ID = The consumer's Medicaid Number or CIN (an 8-digit number in the following format, AA12345A).

CONSUMER TABS ID = Enter the Tracking and Billing System (TABS) identification number assigned to the consumer (e.g., 23456). [note: this number is automatically assigned when the consumer is registered in TABS. For assistance in obtaining the TABS ID number please contact your DDSO TABS Coordinator].

AGENCY NAME = Enter the name of your agency that is providing the Individual Day Habilitation service.

SERVICES FOR CALENDAR MONTH/YEAR = Enter the month and year in which the Individual Day Habilitation service(s) was provided (e.g., 02/06).

PRIMARY SERVICE LOCATION = Enter the address of the Day Hab site where the majority of service was provided or "without walls," if appropriate.

SERVICE DELIVERY DATE = Enter the date of service (DD/MM/YY).

SERVICE START TIME = Enter the time at which face-to-face services begin (e.g., 10:00 a.m.).

SERVICE STOP TIME = Enter the time at which face-to-face services end (e.g., 2:15 p.m.).

TOTAL DURATION PER "SESSION" = Calculate the duration of time spent delivering face-to-face services (HH:MM). If services started at 10:00 a.m. and ended at 2:15 p.m., staff would enter a duration of "4:15." A "session" is a continuous service period on a given day. For example, if services are delivered from 9:00 a.m. to 11:00 a.m., and again later in the day from 1:00 p.m. to 3:00 p.m., two sessions are delivered during the day. Each "session" must be reported on a separate line of the checklist.

SERVICE DESCRIPTION = List key individualized services or actions by staff drawn from the Individual Day Habilitation Plan. Then initial in the space below a Service Description, documenting the provision of services (at least one service must be initialed per "session"). By entering initials, staff are attesting that the service or action was provided on that day. Initialing must occur at the time of service delivery.

STAFF SIGNATURE LOG = This section must be completed on each checklist (even when multiple checklists are submitted for a single month).

Signature = The staff member providing a service or action should sign his or her name.

Print name = *Print* the corresponding name of the staff member providing a service or action during the month.

Initials = The *initials* of the staff member providing a service or action during the month.

Title = The *title* of the staff member providing a service or action.

BILLING OFFICE TALLY: DOS, SVCS, & COUNTABLE DURATION = These columns can be used to sum the number of services initialed on a given day and the total duration of services. Note although there may be multiple sessions on a single day, the agency will "roll-up" the service information and report the total service information for the day.

INDIVIDUAL DAY HABILITATION MONTHLY SUMMARY NOTE

AGENCY = Enter the name of your agency that is providing the Individual Day Habilitation service.

MONTH/YR OF SERVICE DELIVERY = Enter the month and year in which the Individual Day Habilitation service(s) was provided (e.g., 10/06).

CONSUMER NAME = Enter the name of the consumer who is receiving the Individual Day Habilitation service.

TABS ID = Enter the Tracking & Billing (TABS) identification number assigned to the consumer (e.g., 23456). *[note: this is the number automatically assigned when the consumer is registered in TABS. For assistance in obtaining the TABS ID number please contact your DDSO TABS Coordinator].*

MEDICAID # = The consumer's Medicaid Number or CIN (an 8-digit number in the following format, AA12345A).

AGENCY LOCATION = Enter the address of the Day Hab site where the service was provided or "without walls," if appropriate.

SUMMARY NOTE = Provide a narrative that summarizes the implementation of the consumer's Individual Day Habilitation plan, and addresses the consumer's response to the services provided and any issues or concerns.

SIGNATURE OF STAFF PERSON WRITING THE NOTE = This is the signature of the staff person who wrote the summary note.

TITLE = This is the title of the staff person who wrote the summary note.

DATE = Enter the date, in month, day, year format, that the summary note was written.

A-7



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 - #2006-03

TO: Executive Directors of Agencies Authorized to Provide Prevocational Services
Services
Executive Directors of Agencies Authorized to Provide Medicaid Service
Coordination
DDSO Directors

FROM: Helene DeSanto, Executive Deputy Commissioner *Helene DeSanto*
and Interim Director, Quality Assurance

Gary Lind, Director *Gary Lind*
Policy, Planning and Individualized Initiatives

J. Moran
James P. Moran, Deputy Commissioner
Administration and Revenue Support

SUBJECT: SERVICE DOCUMENTATION REQUIREMENTS FOR PREVOCATIONAL
SERVICES

DATE: January 1, 2006

Suggested Distribution:

Prevocational Services Program/Service Staff
Quality/Compliance Staff
Billing Department Staff
MSC Service Coordinators and Service Coordinator Supervisors

Purpose:

This is to review the Prevocational Services service documentation requirements that support a provider's claim for reimbursement. These service documentation criteria apply to Prevocational Services rendered to Home and Community Based Services (HCBS) waiver-enrolled individuals as well as to non-waiver enrolled individuals effective January 1, 2006. Requirements set forth in this Administrative Memorandum supersede Administrative Memorandum 2003-05 and fiscal audit service documentation requirements addressed in The Key to Individualized Services, The Home and Community Based Services Waiver (OMRDD, 1997). Quality service standards in The Key remain the same.



ADMINISTRATIVE MEMORANDUM #2006-03
Service Documentation Requirements for Prevocational Services
January 1, 2006

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.” (emphasis added) It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, including OMRDD.

The regulatory basis for HCBS Waiver Prevocational Services is in 14 NYCRR section 635-10.4 (c) and 635-10.5 (e).

Prevocational Services Billing Standard:

Payment for Prevocational Services requires for each consumer served, prior authorization from the DDSO/NYCRO. Prevocational Services are billed as either a Full Unit or a Half Unit. A Full Unit may be billed when staff deliver and document at least two individualized face-to-face Prevocational Services to a consumer during the program day, and the program day duration is four to six hours in duration. A Half Unit of Prevocational Services may be billed when staff deliver and document at least one individualized face-to-face Prevocational Service to a consumer during the program day, and the program day duration is at least two hours.

For Prevocational Services the *program day duration* is defined as the length of time the consumer attends the provider’s “vocational/work program.” In cases where the provider’s Prevocational Services are delivered outside a “vocational/work program” setting, the *program day duration* is the length of time that staff provide face-to-face Prevocational Services to the consumer. Time spent in the following activities cannot be counted toward the program day duration:

- Time the consumer spends being transported to the first Prevocational Services activity of the day and time being transported home or to the next activity after the conclusion of Prevocational Services.
- Time the consumer spends at a separate service (e.g., a clinic service) and the time being transported to and from the separate service.

ADMINISTRATIVE MEMORANDUM #2006-03
Service Documentation Requirements for Prevocational Services
January 1, 2006

Note: The provision of Medicaid Service Coordination (MSC) is the only exception to the rule regarding other services being "backed out" of the Prevocational Services Program Day. Time the consumer spends meeting with his/her MSC Service Coordinator may be counted toward the Prevocational Services Program Day as long as the visit occurs at the Prevocational Services site. Also, the consumer's time at the ISP review conducted by the MSC Service Coordinator may be counted toward the Prevocational Program Day duration as long as the Prevocational Services staff accompany the consumer to the meeting.

- Mealtime.

Prevocational Services delivered during mealtimes, while at a clinic or during travel specified above, cannot be used to meet the billing requirements for a Full or Half Unit. While services provided at these times are important to service quality, they cannot be used to fulfill the billing requirement of two services for a Full Unit or one service for a Half Unit.

Service Documentation:

Medicaid rules require that service documentation be contemporaneous with the service provision. Required service documentation elements are:

1. **Consumer's name and Medicaid number (CIN).** Note that the CIN need not be included in daily documentation; rather, it can appear in the consumer's Prevocational Services Plan.
2. **Identification of category of waiver service provided.** The consumer's Individualized Service Plan (ISP) should identify the category of waiver service as "Prevocational Services."
3. **A daily description of the required minimum number of face-to-face services provided by staff.** Face-to-face services are individualized services based on the person's Prevocational Services Plan, e.g., the staff person documents that he/she "taught the consumer how to return from breaks by using his watch to keep track of time." The number of face-to-face services required to support billing depends on the unit billed and is described in the above section titled "Billing Standards."
4. **Documentation that the minimum service duration requirement was met.** For Prevocational Services, the provider may document the *program day duration* by indicating the service start time and service stop time. Alternatively, the provider may elect to document the program day duration with a daily affirmation, stating that the minimum duration was met in either a narrative note or checklist format, e.g., "I attest that a 4-hour program day was provided today to John Smith. Sally Jones, Prevocational Services Worker, January 12, 2006." Note that where a provider does not

ADMINISTRATIVE MEMORANDUM #2006-03
Service Documentation Requirements for Prevocational Services
January 1, 2006

document service start and service stop time, an outside reviewer may require other documentation that supports the service duration, for example, a bus log that demonstrates the consumer was at a Prevocational Services site for at least 4 hours. In addition to documenting the program day duration, when a consumer attends another service during the Prevocational Services program day, such as a clinic service or doctor's appointment, the provider must document the "clock" time of the consumer's departure from the Prevocational Services program and the time the consumer returned.

5. **The consumer's response to the service.** For example, the staff person documents that "the consumer is returning from breaks on time." Note that at a minimum, the consumer response must be documented in a monthly summary note, although a provider may choose to include the consumer response more frequently, e.g. daily.
6. **The date the service was provided.**
7. **The primary service location**, e.g., "Maple Avenue Prevocational Services" or "without walls," if services are provided at changing locations in the community and there is no primary service location.
8. **Verification of service provision by the Prevocational Services staff person delivering the service.** Initials are permitted if a "key" is provided, which identifies the title, signature and full name associated with the staff initials.
9. **The signature and title of the Prevocational Services staff person documenting the service.**
10. **The date the service was documented.** Note that this date must be concurrent with service provision.

The acceptable format for the service documentation supporting a provider's billing submittal is either a narrative note or a checklist/chart with an entry made at the same time each Prevocational Services service is delivered and billed.

Narrative Note Format

If the narrative note format is selected, the documentation can be completed in one of two ways:

1. A daily service note describing at least two face-to-face individualized services delivered by Prevocational Services staff on each day the provider bills a Full Unit of Prevocational Services. At least one face-to-face individualized service delivered by Prevocational Services staff must be documented on each day the provider bills a Half Unit of Prevocational Services. Since the daily note does not include the consumer's response to the service, a monthly summary note is required. This monthly note must summarize the implementation of the individual's Prevocational Services Plan, address the consumer's response to the services provided and any issues or concerns; **OR**
2. On each day the provider bills a Full Unit of Prevocational Services, a daily service note describing at least two face-to-face individualized services delivered by Prevocational Services staff and the

ADMINISTRATIVE MEMORANDUM #2006-03
Service Documentation Requirements for Prevocational Services
January 1, 2006

consumer's response to the service. On each day the provider bills a Half Unit of Prevocational Services, a daily service note describing at least one face-to-face individualized service delivered by Prevocational Services staff and the consumer's response to the service delivery. Additionally, at least one of the daily notes written during the month must summarize the implementation of the individual's Prevocational Services Plan and address any issues or concerns.

Checklist / Chart Format

For each day service is delivered, a provider may elect to document the required face-to-face individualized Prevocational Services delivered by Prevocational Services staff using a checklist or chart. If this format is selected, a monthly summary note is also required. The monthly summary note must summarize the implementation of the individual's Prevocational Services Plan; address the consumer's response to services provided and any issues or concerns.

Both the Narrative Note format and the Checklist/Chart format must include all the Service Documentation elements listed above, including a description of the required minimum number of face-to-face individualized services provided by Prevocational Services staff each day the provider bills Prevocational Services.

Other Documentation Requirements:

In addition to the service note(s) supporting Prevocational Services billing claims, your agency must maintain the following documentation:

- ✓ A copy of the consumer's Individualized Service Plan (ISP), covering the time period of the claim, developed by the consumer's Medicaid Service Coordinator (MSC) or Plan of Care Support Services (PCSS) service coordinator. The ISP should identify the category of waiver service as "Prevocational Services." The ISP, which is the "authorization" for waiver services, must also identify your agency as the provider of the service. Further, the ISP must specify an effective date for Prevocational Services that is on or before the first date of service for which your agency bills Prevocational Services for the consumer. The ISPs should identify the frequency for Prevocational Services as "a day".
- ✓ The **Prevocational Services Plan** developed by your agency that conforms to the Habilitation Plan requirements found in ADM 2003 -03. The Prevocational Services Plan must "cover" the time period of the Prevocational Services claim. Note that the consumer's Prevocational Services Plan is attached to his/her ISP.

Documentation Retention:

All documentation specified above, including the ISP, Prevocational Services Plan and service documentation, 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.

ADMINISTRATIVE MEMORANDUM #2006-03
Service Documentation Requirements for Prevocational Services
January 1, 2006

Fiscal Audit:

In a fiscal audit a Prevocational Services claim for a sampled consumer will be selected and the auditor will typically ask for the ISP and Prevocational Services Plan in effect for the claim date. The auditor will also require, for the claim dates, the service documentation specified above.

For additional information on the documentation requirements or to request samples of documentation checklist formats, contact Ms. Carol Metevia, Director of Training and Medicaid Standards at (518) 408-2096, or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

cc: Provider Associations
Kathy Broderick
Michele Gatens
Carol Metevia
Kevin O'Dell
David Picker

A-8



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 - #2005-02

TO: Executive Directors of Agencies Authorized to Provide Respite Services

Executive Directors of Agencies Authorized to Provide Medicaid Service Coordination

DDSO Directors

FROM: Jan Abelseth, Deputy Commissioner, Quality Assurance

Gary Lind, Director, Planning and Individualized Initiatives

James F. Moran, Deputy Commissioner, Administration and Revenue Support

SUBJECT: HCBS RESPITE/NON WAIVER ENROLLED (NWE) RESPITE SERVICE DOCUMENTATION REQUIREMENTS

DATE: June 15, 2005

Suggested Distribution

Respite Program/Service Staff
Quality Compliance Staff
Billing Department Staff
MSC Service Coordinators and Service Coordinator Supervisors

Purpose

This is to specify Respite service documentation requirements that support a provider's claim for reimbursement. These service documentation requirements apply to Home and Community Based Services (HCBS) Waiver Respite and "non-Waiver enrolled" (NWE) Respite Services provided in all settings. NWE Respite, also known as "mirrored" HCBS Respite, is provided to consumers not enrolled in the HCBS waiver.

ADMINISTRATIVE MEMORANDUM #2005-02
Respite Service Documentation Requirements
June 15, 2005
Page 2

In addition to the claim documentation requirements specified in this Administrative Memorandum (ADM), Respite providers must continue to comply with quality service standards set forth in The Key to Individualized Services, The Home and Community Based Services Waiver (OMRDD, 1997).

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" (emphasis added). It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, including OMRDD.

The regulatory basis for HCBS Respite is found in 14 NYCRR sections 635-10.4 (g) and 635-10.5 (h).

Billing Respite Services

Claims for payment of Respite services provided in Free-Standing Respite Centers and all other locations are submitted to EmedNY and OMRDD in 15-minute billing units. Respite service staff document the start and end time of a consumer's Respite services on a given day. The Respite provider's billing department uses the start and end time to determine the number of 15-minute billing units to be claimed. For example, where Respite service is provided to a consumer from 3:00 p.m. to 4:30 p.m., the billing department claims six 15-minute billing units. Respite services require in-person or "face-to-face" service provision by Respite staff.

Respite services are not always provided for a continuous time period on a given day. For example, a consumer may receive Respite service at a Free-Standing Respite Center from 9:00 a.m. to 10:00 a.m., and then leave to attend a Day Habilitation program. After the Day Habilitation service, the consumer may again receive Respite services at the center from 3:00 p.m. to 5:00 p.m. in the afternoon. In this case, the total billable duration for Respite services for the day is twelve 15-minute billing units (four billing units in the morning plus eight in the afternoon).

Service Documentation

Service documentation must be contemporaneous with Respite service provision. **Required service documentation elements are:**

1. Consumer's name, TABS ID and if applicable, the Medicaid ID (CIN)
2. Identification of the category of waiver service provided, which, in this case, is "Respite"
3. Name of the agency providing the Respite service (that is, your agency)
4. The date the service was provided
5. The start time and stop time for each continuous period of Respite service
6. Verification of service provision by the Respite staff person who delivered the service (this is accomplished with a staff signature and title)
7. The date the service was documented (that is, the date must be "contemporaneous" with service provision).

The **"Respite Documentation Record – Individual Summary"** attached to this Administrative Memorandum incorporates all the **"required service documentation elements"** specified above. Respite providers must use the attached record or one that incorporates all the above specified service documentation elements to document the Respite services provided to each consumer. A contemporaneous entry must be made on the Respite Documentation Record for each day a Respite service is delivered and billed for a consumer.

Special Billing Rules

Consumer travel time to receive Respite at the start of the Respite service does not count as billable time nor does travel home from a Respite program

Where Respite services are provided at various community sites, the time a consumer spends traveling with Respite staff to these sites may be counted as billable Respite time.

Time the consumer spends at his/her day program(s), does not count as billable Respite time.

Billable respite service time requires in-person or "face-to-face" service provision by Respite staff.

ADMINISTRATIVE MEMORANDUM #2005-02
Respite Service Documentation Requirements
June 15, 2005
Page 4

Other Documentation Requirements

In addition to the "Respite Documentation Record," the Respite provider must have a copy of the consumer's current Individualized Service Plan (ISP) on file.

For consumers enrolled in the HCBS waiver, the ISP, which is developed by the consumer's Medicaid Service Coordination (MSC) service coordinator or Plan of Care Support Services (PCSS) service coordinator, serves as the "authorization" for the Respite service. The ISP must include the following elements related to the Respite service:

1. Respite must be included as a waiver service the consumer receives and your agency must be identified as the provider of the Respite service.
2. For Frequency and Duration of the Respite service, specify that the Frequency is "an hour" since, for HCBS waiver purposes, the unit of service for Respite is an hour. In all cases, specify the Duration as "ongoing".
3. The Effective Date for Respite services. This date must be on or before the first day of service that your agency bills for Respite services.

Since Respite is not a habilitation service under the HCBS waiver, a Habilitation Plan is not required.

Documentation Retention

All documentation specified above, including the ISP and Respite service documentation, must be retained for a period of at least six years from the date of the Respite 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 on the documentation requirements or to request an example of a completed "Respite Documentation Record," contact Ms. Carol Metevia, Director of Training and Medicaid Standards at (518) 408-2096, or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

cc: Provider Associations
FSS Coordinators
HCBS Waiver Coordinators
Helene DeSanto
Kathy Broderick
Peter Pezzolla
Peter Brady
Lisa Kagan

Lori Lehmkuhl
Carol Metevia
Kevin O'Dell
David Picker
Wake Gardner
Linda Reinhardt

Instructions for Completing
Respite Documentation Record - Individual Summary

Items 1-14 to be completed by Respite Service Staff

Agency and Consumer Identifying Information

1. **Respite Service** = Indicate whether services recorded are "Hourly Respite" or "Free Standing Respite". "Free Standing Respite" is a program which provides respite services outside the individual's home. The program is "free standing" since it is operated in its own space which is separate and distinct from any certified facility. "Hourly Respite" is respite provided in all other settings, including a consumer's home.
2. **Agency Name** = Enter the name of your Agency, that is, the agency providing the Respite service.
3. **Consumer Name** = Enter the name of the consumer receiving the Respite service.
4. **Medicaid ID Number** = For a consumer enrolled in the HCBS Waiver, enter the Medicaid Client Identification Number (the "CIN").
5. **TABS ID** = For all consumers, enter the consumer's TABS ID number.
6. **Program Location** = Enter the address where the Respite service is provided.
7. **TABS Program Code** = Enter the code assigned to your Respite service in OMRDD's TABS system.
8. **Is Consumer HCBS Waiver Enrolled?** = Check **Yes** if the consumer is enrolled in the HCBS Waiver. Check **No** if the consumer is not enrolled in the HCBS Waiver. For a consumer enrolled in the HCBS Waiver, your agency will bill eMedNY (i.e. the Medicaid billing system) for Respite services. For a consumer not enrolled in the HCBS Waiver, your agency will report services using the internet web-based application.

Exception: Respite provided to any consumer enrolled in Family Care cannot be billed to Medicaid. Please contact your DDSO Family Care Coordinator for instructions on how to arrange for payment.

Documenting Respite Service Delivery

9. **Service Delivery Date** = Enter the date on which Respite services are provided. When the Respite stay continues over several days, services delivered on different days must be entered on separate lines. For example, if a consumer arrives at the respite program at 4:00 p.m. on March 2, 2006 and leaves on March 3, 2006, the March 2 and March 3 Service Delivery Dates are entered on separate lines.
10. **Start time** = Enter the time Respite services start.
11. **End Time** = Enter the time Respite services end.

For overnight Respite stays, the end time for the "Service Delivery Date" is always midnight. The hours after midnight are shown on the next service delivery date. For example: if a consumer arrives for an overnight Respite stay on 12/7/06 at 4:00 p.m. and leaves the next morning on 12/8/06 at 10:00 a.m., the "Start Time" for the 12/7/06 service delivery date is 4:00 p.m. and the "End Time" is 12:00 midnight. The "Start Time" for the 12/8/06 service delivery date is 12:00 midnight and the "End Time" is 10:00 a.m.

When a consumer has breaks in Respite service on a given day, each continuous period of service delivery (or session) is entered on a separate line on the Respite Documentation Record- Individual Summary document. For example, on 1/3/06, a consumer receives Respite services for a one hour session in the morning (from 9:00 a.m. to 10:00 a.m.), and then leaves to attend a Day Habilitation program. After the Day Habilitation service, the consumer again receives Respite services for a two hour session in the afternoon (from 3:00 p.m. to 5:00 p.m.). Two lines on the Respite Documentation Record-Individual Summary must be completed to document the Respite services delivered on 1/3/06. On one line, Respite staff document a "Start Time" of 9:00 a.m. and a "Stop Time" of 10:00 a.m. for the 1/3/06 "Service Delivery Date." On the next line on the Individual Summary Sheet, Respite staff again enter 1/3/06 under the "Service Delivery Date" column and document the afternoon session by entering the "Start Time" as 3:00 p.m. and the "Stop Time" as 5:00 p.m.

12. **Staff Signature** = A Respite staff person must sign on each "Service Delivery Date" line. By signing the staff person is verifying that Respite was provided for the hours shown.
13. **Staff Title** = The staff person must enter their work title.
14. **Date of Signature** = The staff person must enter the date (in month, day, year format) he/she signed.

Items 15 and 16 to be completed by the Respite Provider's Billing Department

15. **Service Delivery Time** = Based on the "Start Time and End Time" of service delivery on each line of the Respite Documentation Record-Individual Summary, enter the duration of Respite services the consumer received. For example, if on 1/7/06 the consumer arrived at 6:00 p.m. and left at 10:00 p.m., enter four hours for the Service Delivery Time.
16. **Billing Units** = The billing unit for this service is 15 minutes. For each line of the Respite Documentation Record-Individual Summary convert the "Service Delivery Time" into the appropriate number of 15 minute billing units and enter the number in this column.

Examples: "Service Delivery Time," and "Billing Units"

If on 9/1/06 a consumer's "Service Delivery Time" is 5 hours and 15 minutes, enter 21 billing units.

NOTE TO BILLING STAFF

All billing units provided on a single date of service are to be added together for billing purposes. Rounding up" is not allowed. For example, if the consumer receives Respite service for ten hours and ten minutes, only 40 15-minute billing units are entered and billed.

Special Rules for Calculating Billing Units

- **Consumer travel time to and from a Respite program is excluded.** Staff should be instructed to use the consumer's time of arrival at the program as the "Start Time" of the service. The "End Time" of the service is the time the consumer leaves the program.
- **Consumer travel time can be billed when a Respite staff member accompanies the consumer into the community as part of the Respite program.** For example: The consumer arrives at the Respite program at 10:00 a.m. on 12/5/2006. At 11:00 a.m., respite staff takes the consumer to a holiday show, returning at 1:00 p.m. The consumer leaves the respite program at 4:00 p.m. Since the travel time to and from the holiday show occurred as part of the Respite program and involved respite staff service provision, it is billable time. The Respite agency documents that service was delivered from 10:00 a.m. to 4:00 p.m. on 12/5/2006 and 24 15-minute billing units are billed.
- **Time the consumer spends at his/her day program or any other activity that is not part of the Respite service is excluded.** Staff should be instructed to record start and end times accordingly.

For additional information regarding the completion of the Respite Documentation Record - Individual Summary, please contact Mr. Earl Jefferson, Training and Medicaid Standards Bureau, OMRDD at (518) 408-2096.

For assistance with MMIS billing, please contact Mr. Wake Gardner, Central Operations, OMRDD at (518) 402-4333. For assistance with billing "non-waiver" Respite through the internet web-based application, please contact Ms. Linda Reinhardt, Central Operations, OMRDD at (518) 402-4333.