



ADMINISTRATIVE MEMORANDUM - #2015-05

TO: Executive Directors of Voluntary Provider Agencies
Executive Directors of Agencies Authorized to Provide Fiscal Intermediary Services
Developmental Disabilities Regional Office and State Operations Office Directors
Medicaid Service Coordinators and MSC Supervisors

From: Katherine Marlay, Acting Deputy Commissioner
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Service Delivery and Integrative Solutions

DATE: April 10, 2015

SERVICE EFFECTIVE DATE: October 1, 2014

SUBJECT: Service Documentation for Individual Directed Goods and Services

SUGGESTED DISTRIBUTION:

Administrative Staff of Fiscal Intermediary Services Providers
Support Brokers
Quality Improvement Staff
Medicaid Service Coordinators (MSCs) and Supervisors who serve individuals receiving IDGS
Regional Office Front Door Staff

Purpose:

This Administrative Memorandum describes the payment standards and service documentation requirements to support a provider's claim for reimbursement for Individual Directed Goods and Services. New York State regulations require each Medicaid provider to prepare records to demonstrate its right to receive Medicaid payment for a service. These records must be "contemporaneous" and kept for six years from the date the services were provided. 18 NYCRR section 504.3(a).

Individual Directed Goods and Services are available only for Home and Community Based Services (HCBS) Waiver authorized participants who self-direct their services with a self-direction budget. When an individual chooses to receive IDGS, the individual must choose a Fiscal Intermediary (FI) to bill and administer the service.

Individual Directed Goods and Services:

Individual Directed Goods and Services (IDGS) are services, equipment or supplies not otherwise provided through OPWDD's HCBS Waiver or through the Medicaid State Plan that address an identified need in a participant's service plan, which includes improving and maintaining the participant's opportunities for full membership in the community. IDGS, as part of a person-centered plan, allow an individual to receive services in the most integrated setting possible. IDGS items and services decrease the need for other Medicaid services, promote inclusion in the community, and/or increase the individual's safety and independence in the home environment.

Participants self-directing their services receive an individualized budget that they direct pursuant to an approved plan.

Participants manage their IDGS services, as described in their Individualized Service Plan and Self-Direction Budget, to fully purchase or put funds towards their personal fiscal resources to purchase items or services which meet the following criteria:

- Are related to a need or goal identified in the Individualized Service Plan;
- Are for the purpose of increasing independence or substituting for human assistance, to the extent the expenditures would otherwise be made for that human assistance;
- Promote opportunities for community living and inclusion;
- Are able to be accommodated without compromising the participant's health or safety; and,
- Are provided to, or directed exclusively toward, the participant.

Qualifying expenses include, but are not limited to community classes, clinician services not otherwise funded through Medicaid, community membership dues, household appliances that assist a person to live independently, and staff management supports. Examples of expenses not allowed under IDGS include cell phones and telephones, leased vehicles, and experimental therapies. A full list of qualifying expenses are found in the "Individual Directed Goods and Services Definitions Chart."

Individual Directed Goods and Services Billing Standard and Service Documentation:

The billing unit for Individual Directed Goods and Services is a ten-dollar increment. Providers must bill in \$10 increments. Providers may not round up.

To bill IDGS, the FI agency must ensure that the services, equipment and supplies are described in the participant's Self-Direction budget.

A summary of expenses paid on behalf of the participant along with supporting receipts/documents must also be made maintained. This expense summary must include:

1. Individual's name and Medicaid number (CIN).
2. Name of the FI agency paying for IDGS supports and services.
3. Identification of the category of waiver service provided (e.g., Individual Directed Goods and Services or IDGS).
4. A list of expenses paid on behalf of the participant.
5. The date(s) the expenses were paid.
6. The amount paid for each expense.

FI Provider Billing Instructions:

IDGS is billed to Medicaid in \$10 increments, with one unit equal to at least \$10 in expenditures. Due to limitations within the eMedNY system, a maximum of 99 units may be billed to Medicaid on a given date of service. This system limit equates to \$990 per date of service toward the statewide fee for IDGS. In regard to the \$10 increment, each \$10 threshold must be met to bill a unit of IDGS service and there will be no rounding up.

In instances where the FI has receipts and documentation substantiating allowable expenditures beyond the daily billing limit of \$990, OPWDD suggests billing eMedNY using consecutive dates of service. For example, if receipts and documentation substantiate \$1,500 in qualified IDGS reimbursement, OPWDD suggests submitting one claim for 99 units totaling \$990 on a given date of service and submitting an additional claim for the remaining balance of 51 units totaling \$510 on the next date of service. If the FI has incurred the total statewide IDGS fee for an individual, OPWDD suggests billing the full amount to eMedNY by using four consecutive dates of service as follows: Day 1 = 99 Units/ \$990, Day 2 = 99 Units/ \$990, Day 3 = 99 Units/ \$990, and Day 4 = 3 Units/ \$30.

The monthly FI fee associated with IDGS is to be billed to eMedNY on the first of the calendar month following the final IDGS claim for an individual. If IDGS is the only service provided to an individual by the FI, the FI is entitled to a single monthly FI fee for that individual even if the FI submitted IDGS claims using dates of service in different months.

ISP Documentation Requirements

In addition to the documentation described above for IDGS claims, the agency billing for these services must maintain a copy of the participant's Individualized Service Plan (ISP), developed by the participant's Medicaid Service Coordinator (MSC).

For IDGS, the following elements must be included in the ISP:

- Identification of the IDGS category of waiver service (i.e., Individual Directed Goods and Services).
- Identification of the FI agency billing IDGS.
- Specification of an effective date for IDGS that is on or before the date of service for which the FI agency bills IDGS for the participant.
- Specification of the frequency for IDGS is “day.”
- Specification of the duration for IDGS is “ongoing.”

These services are not habilitative in nature, and therefore do not require a habilitation plan.

Documentation Retention

All documentation specified above, including the ISP and service documentation, must be retained for a period of at least six years from the date the service was delivered or when the service was billed, whichever is later.

For additional information on the documentation requirements contact the OPWDD Director of Waiver Management at (518) 474-5647.

Attachment

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