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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.

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.

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
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