RESPITE SERVICES

Effective January 1, 2020

Audit protocols assist the Medicaid provider community in developing programs to evaluate compliance with Medicaid requirements under federal and state statutory and regulatory law, and administrative procedures issued by the New York State Office for People with Developmental Disabilities (OPWDD). The protocols listed are intended solely as guidance in this effort. This guidance does not constitute rulemaking by OPWDD and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person. Furthermore, nothing in the protocols alters any statutory, regulatory or administrative requirement and the absence of any statutory, regulatory or administrative citation from a protocol does not preclude OPWDD from enforcing a statutory, regulatory or administrative requirement. In the event of a conflict between statements in the protocols and statutory, regulatory or administrative requirements; the requirements of the statutes, regulations and administrative procedures govern.

A Medicaid provider's legal obligations are determined by the applicable federal and state statutory and regulatory law. Audit protocols do not encompass all the current requirements for payment of Medicaid claims for a particular category of service or provider type and therefore are not a substitute for a review of the statutory and regulatory law or administrative procedures.

Audit protocols are applied to a specific provider or category of service(s) in the course of an audit and involve OPWDD's application of articulated Medicaid agency policy and the exercise of agency discretion. Audit protocols are used as a guide in the course of an audit to evaluate a provider's compliance with Medicaid requirements and to determine the propriety of Medicaid expended funds. In this effort, OPWDD will review and consider any relevant contemporaneous documentation maintained and available in the provider's records to substantiate a claim.

New York State, consistent with state and federal law, can pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the medical assistance program. Furthermore, audit protocols do not limit or diminish OPWDD's authority to recover improperly expended Medicaid funds and OPWDD may amend audit protocols as necessary to address identified issues of non-compliance. Additional reasons for amending protocols include, but are not limited to, responding to a hearing decision, litigation decision, or statutory or regulatory change.

Note:
Per ADM 2018-06R, As of July 1, 2018, individuals new to the OPWDD system (i.e., on or after July 1, 2018), will have Life plans developed and finalized in accordance with the CCO/HH Manual. Finalized Life Plans for newly enrolled CCO members (i.e., members enrolled after 10/1/2018) are due no later than 90 days after CCO enrollment or HCBS waiver enrollment, whichever comes first.

Per ADM 2018-06R, For Life Plans finalized on or before December 31, 2019 (i.e., the transition period), OPWDD is suspending service documentation requirements for documenting the Waiver service name, frequency, duration, and effective date in the Life Plan. Instead, only the name of the service provider and the service name must be identified in the Life Plan.

Service providers are responsible for reviewing the finalized, acknowledged and agreed to Life Plan. Providers may occasionally find inaccuracies in the finalized, acknowledged and agreed to Life Plan. Providers should demonstrate due diligence in working with the Care Manager, CCOs, OPWDD and/or others to correct the Life Plan as soon as possible. Service providers should document their timely efforts to correct any errors in the

Life Plan. Examples of this documentation may include notes in the individual's monthly summary, e-mails, phone calls, etc.

All Life Plans created or amended after the transition period must comply with all regulatory and policy standards.

Per ADM 2018-09R, As of March 1, 2020, At the time of transition to the Life Plan, Habilitation Plans must transition to Staff Action Plans. All individuals transitioning from an ISP to a Life Plan who receive habilitation services must have a staff Action Plan no later than March 1, 2020.

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1.	Missing Record
OPWDD Audit Criteria	If no record is available for review, claims for all dates of service associated with the individual will be disallowed.
Regulatory References	18 NYCRR Section 504.3(a) 18 NYCRR Section 540.7(a)(8)

2.	No Documentation of Service
OPWDD Audit Criteria	If the record does not document that a Respite service was provided, the claim will be disallowed.
Regulatory References	18 NYCRR Section 504.3(a) 18 NYCRR Section 517.3(b)

3.	No Determination of a Developmental Disability
OPWDD Audit Criteria	The claim for services provided in the absence of a clinical assessment substantiating a specific determination of developmental disability will be disallowed.
Regulatory References	14 NYCRR Section 635-10.3(a) and (b)(1) 14 NYCRR Section 671.4(b)(1)(i)

4.	Missing or Inadequate Life Plan (LP)
OPWDD Audit Criteria	A copy of the individual's Life Plan (LP), covering the time period of the claim, must be maintained by the agency. The claim will be disallowed in the absence of a Life Plan (LP). If the Life Plan (LP) is not in place prior to the service date and in effect for the service date, the claim will be disallowed.
Regulatory References	14 NYCRR 635-10.2(a) OPWDD ADM #2017-01R, pp. 7-8 OPWDD ADM #2018-06R, pp. 1-2

5.	Unauthorized Respite Services Provider
OPWDD Audit Criteria	The claim will be disallowed if the Life Plan (LP) does not: • Identify Respite as the service to be provided. • List the provider as the authorized provider for a specific service. • Have an effective date for Respite services that is on or before the first day of service for which the agency bills for services.
Regulatory References	14 NYCRR Section 635-10.2(a) OPWDD ADM #2017-01R, pp. 7-8 OPWDD ADM #2018-06R, pp. 3-4,7

6.	Identification of Frequency and Duration of Service
OPWDD Audit Criteria	The claim will be disallowed if the Life Plan (LP) does not: • Specify that the frequency for Respite is “hour or hourly”. • Specify the duration for Respite is “ongoing”.
Regulatory References	OPWDD ADM #2017-01R, pp. 7-8 OPWDD ADM #2018-06R, pp. 3-4,7

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7.	Missing Required Elements for Respite Service Documentation
OPWDD Audit Criteria	The claim will be disallowed in the absence of one or more of the following required service documentation elements: 1. individual's name, and if applicable, the Medicaid ID (CIN); 2. identification of the category of Waiver service provided, in this case, "Respite;" 3. identification of the category of Respite service, i.e. In-Home, Camp, SiteBased, Recreational, or Intensive Respite; 4. name of the agency providing the Respite service; 5. the date the service was provided; 6. the start time and stop time for each continuous period of Respite service; 7. verification of provision by the Respite staff person who delivered the service (this is accomplished with a staff signature and title). Initials are permitted if a "key" is provided which identifies the title, signature, and full name associated with the staff initials; and 8. the date the service was documented (the date must be "contemporaneous" with service provision).
Regulatory References	14 NYCRR Sections 635-10.5(h)(9) 18 NYCRR 504.3 OPWDD ADM #2017-01R, p. 7

8.	Units of Service Billed Exceed Units of Service Documented
OPWDD Audit Criteria	All categories of Respite services are billed in 15-minute increments (billing units), with a full 15 minutes of service required to bill a single unit (i.e., there is no "rounding up"). If the number of 15-minute increments billed exceeded the number of 15-minute increments documented for Respite services, the undocumented 15-minute increments will be disallowed.
Regulatory References	OPWDD ADM #2017-01R, pp. 4-7

9.	Billing for Non-Reimbursable Service Time
OPWDD Audit Criteria	If non-reimbursable activities were included in the Respite billable service time, a portion of the claim will be disallowed.
Regulatory References	14 NYCRR Sections 635-10.5 (h)(5) and (8) OPWDD ADM #2017-01R, pp. 5-7

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10.	Incorrect Rate Code Billed
OPWDD Audit Criteria	Respite services may be delivered and billed under the following categories: 1. In-Home Respite Services; 2. Site-Based Respite Services; 3. Recreational Respite Services; 4. Camp Respite Services; 5. Intensive Respite; or, 6. Per Diem Rate. (Overnight Respite for In-Home and Site-Based Respite settings including Overnight Respite provided in a temporary use bed may be provided for no more than 42 days in a 180-day period. After the 42 days, any continued overnight billing will be limited to the regional average daily rate paid for Supervised IRA services.) It is the responsibility of the provider to ensure that the appropriate fee is billed for the category of Respite delivered. The claim will be reduced if the agency billed a rate code that is higher than that applicable for the service that was documented.
Regulatory References	14 NYCRR Sections 635-10.5(h)(4) and (5) 14 NYCRR Sections 686.15 OPWDD ADM #2017-01R, pp. 2-3, 5-6

11.	Intensive Respite Service Not Authorized
OPWDD Audit Criteria	Individuals must be authorized to receive Intensive Respite services by OPWDD's Regional Offices. The claim will be disallowed if an Intensive Respite service was billed without proper authorization.
Regulatory References	14 NYCRR Sections 635-10.5(h)(4)(v) 14 NYCRR Sections 635-10.5(h)(7)(ii) OPWDD ADM #2017-01R, p. 4

12.	Missing Copy of Intensive Respite Service Plan for High Behavioral Needs
OPWDD Audit Criteria	An individual receiving Intensive Respite services for individuals with high behavioral needs must have a Plan that is developed by the licensed professional; Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD)/ Systemic, Therapeutic Assessment, Resources and Treatment (START) Team Member; or Behavioral Intervention Specialist (BIS) that instructs Respite staff on the implementation of Respite staff actions to address the individual's high behavioral needs. If the Plan for High Behavioral Needs is missing or not valid for the service date, the claim will be disallowed.
Regulatory References	14 NYCRR Sections 635-10.5(h)(4)(v)(a) OPWDD ADM #2017-01R, p. 3

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13.	Missing Copy of Intensive Respite Service Plan of Nursing Services (PONS) for High Medical Needs
OPWDD Audit Criteria	An individual authorized for Intensive Respite with high medical needs must have a Plan of Nursing Services (PONS) that is developed by a Registered Nurse (RN). The PONS instructs Respite staff on the implementation of Respite staff actions to address the individual's high medical needs. If the PONS is missing or not valid for the service date, the claim will be disallowed.
Regulatory References	14 NYCRR Sections 635-10.5(h)(4)(v)(b) OPWDD ADM #2017-01, pp. 3-4

14.	Missing Plan Review for Intensive Respite Service (High Behavioral Needs)
OPWDD Audit Criteria	An individual receiving Intensive Respite services for individuals with high behavioral needs must have a Plan that is developed by the licensed professional, CSIDD/START Team Member; or BIS that instructs Respite staff on the implementation of Respite staff actions to address the individual's high behavioral needs. The Plan must be reviewed by the licensed professional, CSIDD/START Team Member, or BIS every six (6) months at a minimum, or as needed based on the individual's changing needs or schedule for service use. The claim will be disallowed in the absence of a plan review or if the review was not timely.
Regulatory References	14 NYCRR Sections 635-10.5(h)(4)(v)(a)(ii) OPWDD ADM #2017-01R, p. 3

15.	Missing Plan Review for Intensive Respite Service (High Medical Needs)
OPWDD Audit Criteria	An individual authorized for Intensive Respite with high medical needs must have a PONS that is developed by an RN. The PONS instructs Respite staff on the implementation of Respite staff actions to address the individual's high medical needs. The PONS must be reviewed by the RN annually at a minimum, or as needed based on the individual's changing needs or schedule for service use. The claim will be disallowed in the absence of a plan review or if the review was not timely.
Regulatory References	14 NYCRR Sections 635-10.5(h)(4)(v)(b)(2) OPWDD ADM #2017-01R, pp. 3-4

16.	Untrained Respite Staff – Intensive Respite Service (High Behavioral Needs)
OPWDD Audit Criteria	Respite staff, providing Intensive Respite services for individuals with high behavioral needs, must be trained in the implementation of the Plan by the licensed professional, CSIDD/START Team Member, or BIS. If documentation of the training is missing, the claim will be disallowed.

Regulatory References	14 NYCRR Sections 635-10.5(h)(4)(v)(a)(iii) OPWDD ADM #2017-01R, p. 3

17.	**Untrained Respite Staff – Intensive Respite Service (High Medical Needs)**
OPWDD Audit Criteria	Respite staff, providing Intensive Respite services for individuals with high medical needs, must be trained in the implementation of the PONS by the RN. If documentation of the training is missing, the claim will be disallowed.
Regulatory References	14 NYCRR Sections 635-10.5(h)(4)(v)(b)(2) OPWDD ADM #2017-01R, pp. 3-4

18.	**Billing for Services Not Authorized by Operating Certificate**
OPWDD Audit Criteria	The claim will be disallowed if the agency does not have an operating certificate identifying certification for Respite services.
Regulatory References	New York State Mental Hygiene Law, Section 16.03(a)(4) 14 NYCRR Sections 619.2(d) 14 NYCRR Sections 619.3

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