NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

ADMINISTRATIVE DIRECTIVE MEMORANDUM

Transmittal:	23-ADM-08
To:	Developmental Disabilities Regional Field Office (DDRFO) Directors Developmental Disabilities State Operations Office (DDSOO) Directors Executive Directors of Voluntary Agencies Care Coordination Organization (CCO) Administrators
Issuing OPWDD Office:	Division of Policy and Program Development
Date:	November 9, 2023 Effective November 11, 2023
Subject:	Service Documentation for Community Habilitation Services Provided to Persons Residing in Certified, Non-Certified Locations and In-residence Community Habilitation-Residential Services for Qualified Individuals
Suggested Distribution:	Habilitation Program/Service Staff Quality/Compliance Staff Billing Department Staff CCO and Basic HCBS Plan Support Care Managers and Care Manager Supervisors
Contact:	People First Waiver mailbox at peoplefirstwaiver@opwdd.ny.gov
Attachments:	

Related ADMs/INFs	Releases Cancelled	Regulatory Authority	MHL & Other Statutory Authority	Records Retention
ADM #2018-09R ADM #2021-02R ADM #2021-03	ADM #2015-01	14 NYCRR §635-10.4, §635-10.5 42 CFR §441.301	MHL§13.07, §13.09(b), §33.13, §43.02 OPWDD's Comprehensive HCBS Waiver §1915(c) of Social Security Act, 42 USC §1396n(c)	18 NYCRR §504.3(a) 18 NYCRR §517.3 14 NYCRR §635-4.5 New York False Claims Act – State Finance Law §192

PURPOSE

This Administrative Directive Memorandum (ADM) outlines requirements about Community Habilitation (CH) services. For example, it includes information like where CH may be delivered, how it is authorized, and how to document the service delivered for reimbursement. Requirements set forth in this ADM supersede ADM #2015-01.

This ADM is updated to include Community Habilitation-Residential (CH-R) services delivered in a certified residence (outlined in ADM #2021-02R).

APPLICABILITY

This ADM applies to providers of CH services delivered to individuals who are enrolled in the OPWDD Home and Community Based Services (HCBS) 1915(c) Waiver or to non-waiver enrolled individuals.

In this ADM, Community Habilitation ("CH") refers to all CH services delivered to a person in any setting. Community Habilitation delivered to a person who lives in a OPWDD certified residential setting is called "community habilitation-residential" ("CH-R"). If the person who lives in a certified residence receives CH-R services in the residence, this is called "in-residence CH-R." Specific references to the differences between CH and CH-R will be identified where applicable.

The requirements related to in-residence CH-R in this ADM are effective on November 11, 2023 (i.e., when the COVID-19 Appendix K authority ends). Additionally, the requirements described in this ADM apply to in-residence CH-R services that are intended to be a long-term service delivery option for a person. For the purposes of this ADM, a long-term delivery option is defined as the need for services, on a non-emergent basis for more than thirty (30) days.

BACKGROUND

Community Habilitation is a service designed to help people enhance the skills needed to live more independently in their homes and their community. CH supports may include, but are not limited to:

- Adaptive skill development;
- Assistance with activity of daily living;
- Community inclusion and relationship building;
- Training and support for independence with travel;
- Transportation;
- Adult educational supports;
- Development of social skills, leisure skills, self-advocacy and informed-choice skills; and
- Appropriate behavior development to help people access their community.

Community Habilitation can be delivered to people who live in non-OPWDD-certified residences (e.g., an apartment, their family home). This is called "Community Habilitation" or "CH."

DISCUSSION

1. Where Community Habilitation May Be Provided

With few exceptions, CH services must not be billed when delivered at a site certified by OPWDD or at a site operated by OPWDD which would be required to be certified if it were operated by another provider. The exceptions that allow for billing in OPWDD certified settings include when:

- The CH staff person accompanies the person to a clinic treatment facility certified in accordance with Part 679 regulations (also known as "Article 16 Clinics");
- The CH staff person accompanies the person to a Life Plan review meeting that occurs in a certified location; or
- The person is eligible for in-residence Community Habilitation-Residential (CH-R) per the criteria in ADM #2021-02R.

2. Prior Authorization

Providers cannot bill for CH services unless the person has prior service authorization from their OPWDD Developmental Disabilities Regional Field Office (DDRFO).

3. Fee Structure

Community Habilitation has ~~six~~ five different fee structures based on (a) the staff-to-individual ratio at the time of service delivery; and (b) the residential setting of the person(s) receiving CH.

- For CH delivered to a person residing in a non-OPWDD-certified setting, (except that which is self-directed with budget and/or employer authority) there are three fee structures:
  - one staff to one individual;
  - one staff to two individuals; and
  - one staff to three or four individuals.

- For CH-R delivered to a person residing in an OPWDD-certified setting and CH that is self-directed (with agency supported or self-hired staff), there are two fee structures:
  - one staff to one individual; or
  - one staff to group (group at least two but no more than four individuals).

Agencies must maintain documentation that validates that services were billed based on the correct staff-to-individual ratio.

4. Billing Standard

The unit of service for CH 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”). For billing purposes, the service provider must combine the total minutes for each session provided that day for each specific fee structure. Different fee structures as listed above cannot be combined in a single claim.

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 CH staff that is based on the person’s CH Staff Action Plan. A face-to-face service may be delivered in-person or via remote technology as described in ADM #2021-03. The provider must also document the service start time and service stop time for each CH session. The *billable service time* for CH is the time when CH staff are providing face-to-face CH services to a person. For people receiving CH-R, whether services are delivered in the community or in the residence, services can only be provided on weekdays, the total billing must not exceed six (6) hours on a given day and the final continuous service session start time interval must begin prior to 3:00 pm. (See Section 2 for further billing limitations for people living in an allowable certified setting.)

For example, a person may receive Community Habilitation services for a one-hour session in the morning from 9:00 a.m. to 10:00 a.m. and again for a two-hour session in the afternoon from 2:00 p.m. to 4:00 p.m. For the morning session, the CH staff must contemporaneously document the service start time (9:00 a.m.) and the service stop time (10:00 a.m.) and document the provision of at least one face-to-face service which is drawn from the person’s CH Staff Action Plan. For the afternoon session, the Community Habilitation staff must contemporaneously document the service start time (2:00 p.m.) and service stop time (4:00 p.m.) and document the provision of at least one face-to-face service which is drawn from the person’s CH Staff Action Plan.

A. Billing CH While Receiving Other Medicaid Services

Time spent receiving another Medicaid service cannot be counted toward the CH billable service time, except:

i. For people residing outside of an OPWDD-certified setting, or for people residing in a Family Care Home (FCH):

- The person may receive Hospice at the same time as CH services.
- The person may receive Personal Care, Home Health Aide, or nursing services at the same time as CH services. This is only in cases where the Community Habilitation Plan describes supports and services that are distinct and separate from the supports and services being provided by the Personal Care, Home Health Aide, or nursing staff.
- Time that the person spends with their Care Manager during face-to-face visits may be included as CH billable service time if CH staff is present.

- Time that the person spends with their Support Broker during face-to-face visits may be included as CH billable service time only if CH staff is present. Time that the Support Broker is providing non-face-to-face services on behalf of the person is also allowed.

- Time that the person is at a medical appointment with a physician (including psychiatrists), a nurse practitioner, or physician assistant, or at a dental appointment may be included as CH billable service time if CH staff is with the person at these appointments. Transportation to and from the medical appointment may also be counted if staff accompany the person and Medicaid is not being charged separately for a transportation attendant for the trip.

- Time that the person is at an appointment for a clinical service of the type described below and staff is with the person to facilitate the implementation of therapeutic methods and treatments. The allowable types of clinical services are: occupational therapy, physical therapy, speech therapy, psychology, dietetics and nutrition, and social work. The time when a person is being transported to and from the appointment may also be counted if the staff accompanies the person and Medicaid is not being charged for a transportation attendant for the trip. Payment for CH services delivered concurrently with these clinical services is contingent upon the need for the CH staff's participation in the specified clinical service being described in the person's CH Staff Action Plan.

- For each calendar year, reimbursement is available for CH staff to participate in no more than twelve (12) clinical appointments per person, per clinical service type."

- Day of admission and day of discharge to a hospital, nursing home, rehabilitation facility, or Intermediate Care Facility for Individuals with Intellectual and/or Developmental Disabilities (ICF/IID) if CH Services are delivered prior to admission or after discharge and the services are not delivered in the hospital, nursing home, rehabilitation facility, or ICF/IID.

ii. For people living in an Individualized Residential Alternative (IRA), or Community Residence (CR):

- The person may receive hospice at the same time as CH services.

- Time when the Care Manager is conducting the face-to-face visit with the person may be counted toward the CH billing if the CH staff is present. This concurrent billing is allowed in order to promote the coordination of services.

- Time that the person spends with their Support Broker during face-to-face visits may be included as CH billable service time only if CH staff is present. Time that the Support Broker is providing non-face-to-face

services on behalf of the person is also allowed.

- Nursing services may be provided at the same time as CH services, but only in cases where the CH Staff Action Plan describes supports and services that are distinct and separate from the supports and services being provided by the nursing staff.

B. Billing Limitations for CH-R Generally

There are billing limitations specific to CH-R. These billing limitations apply whether the service is delivered in the residence (i.e., in-residence CH-R) or out in the community:

i. CH-R services may only be reimbursed if the services are delivered on weekdays and have a service start time prior to 3:00 p.m.

ii. CH-R services must not be reimbursed on a given day that the person receives:
   1) one full unit of group day habilitation services;
   2) one full unit of prevocational services; or
   3) any combination of two half units of group day habilitation, or prevocational services.

iii. On a given day, a maximum of the following may be reimbursed:
   4) six hours of CH-R services; or
   5) the combination of:
      a. one half unit of group day habilitation, or prevocational services; and
      b. four hours of CH-R services.

5. Service Documentation

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

A. *Person's name and Medicaid number (CIN).* Note that the CIN does not need to be included in daily documentation. However, it is required in the person's CH Staff Action Plan.

B. *Identification of the category of waiver service provided.* For billing and service documentation purposes, the person's Life Plan must identify the CH category of waiver service (i.e., Community Habilitation).

C. *A daily description of at least one face-to-face service provided by staff during each "session" (or continuous period of CH service provision).* Face-to-face services are individualized services based on the person's CH Staff Action Plan (e.g., the staff person documents that they "taught [Person's Name] to follow instructions in a recipe.")

D. *Documentation of start and stop times.* The provider must document the service start time and service stop time for each continuous period of CH service provision or "session."

E. *Documentation of the staff-to-individual receiving CH ratio.* If the person resides in a non-certified setting, the provider must document if a staff person was serving one individual, two individuals, or three or four individuals at the time-of-service delivery. If the person resides in a certified setting, the provider must document if the ratio was one staff to one individual or one staff to a group (between at least two and no more than four individuals) (*see* Section 3. Fee Structure on page 3).

F. *The person's response to the service.* For example, the staff person documents that, "[Name] was able to follow the grocery list." Note: This element of the documentation does not have to be recorded for every service session, if the person's response is documented in a monthly summary. A provider may choose to include the person's response more frequently (e.g., daily).

G. *The date the service was provided.*

H. *The primary service location* (e.g., the person's home or various community locations).

I. *Verification of service provision by the CH staff person delivering the service.* Either a signature or initials and title must be provided. Initials are allowed if a "key" is provided which identifies the title, signature, and full name associated with the staff initials.

J. *The date the service was documented and signed by the CH staff person.*

6. Service Documentation Format

Acceptable formats for the service documentation supporting a provider's billing submittal include either:

i. a narrative note; or
ii. a checklist/chart with an entry made contemporaneously during CH service delivery.

Both the Narrative Note format and the Checklist/Chart format must include all the Service Documentation elements listed in section 5.

A. Narrative Note Format

If the narrative note format is selected, the documentation can be completed either as:

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

- A daily service note describing at least one face-to-face individualized service delivered by CH staff for each CH "session" and the person'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 CH Staff Action Plan and address any issues or concerns.

B. Checklist/Chart Format

For each service session, a provider may elect to document the face-to-face CH service delivered by CH staff using a checklist or chart. If this format is selected, a monthly summary is also required. The monthly summary must summarize:

i. The implementation of the person's CH Staff Action Plan;
ii. The person's response to services provided; and
iii. Any other issues or concerns.

7. Other Documentation Requirements

In addition to the service note(s) supporting the CH billing claim, the agency providing CH services must maintain the following documentation:

- A copy of the person's **Life Plan**, developed by the person's Care Manager if the person is HCBS Waiver enrolled or receives care coordination. For CH, the following elements must be included in the Life Plan:
  a) Identification of the CH category of waiver service (i.e., Community Habilitation).
  b) Identification of the agency providing the CH services.
  c) Specification of an effective date for CH that is on or before the first date of service for which the agency bills CH for the person.
  d) Specification of the frequency for CH as "hour" or "hourly."
  e) Specification of the duration for CH as "ongoing."

- The **CH Staff Action Plan** developed by the agency providing CH services that conforms to the Staff Action Plan requirements found in ADM #2018-09R. For CH, the Staff Action Plan should clearly identify that the plan is for Community Habilitation (e.g., titled "Community Habilitation Staff Action Plan"). The CH Staff Action Plan must "cover" the time period of the CH claim.

- If a person lives in a certified residence and will receive in-residence CH-R services, the Care Manager must document in the Life Plan that the person, and/or their family/representative, when appropriate, has chosen to receive in-residence CH-R services. The Care Manager must also confirm that the provider's Staff Action Plan allows for safe and effective delivery of in-residence CH-R services. The person and/or their family/representative, when appropriate, must reaffirm their choice to continue receiving in-residence CH-R services at least every six (6) months or with each semi-annual Life Plan review, whichever comes first. Additionally, the Care Manager must document the condition(s) that qualify the person for in-residence CH-R services (*see* ADM #2021-02R):
  a) Elderly: Documentation that the person is age sixty-five (65) or older; or
  b) Medically frail: Documentation supporting the delivery of in-residence CH-R

services from the person's physician or other health care professional is required to document that the person would benefit from in-residence services because of their health status; or

c) Complex behavioral needs: A Behavior Support Plan is required to support the delivery of in-residence CH-R services.

- If a person chooses to self-direct all or part of their CH services and receives any additional OPWDD services, at least one representative from the outside service(s) must participate at least annually in the person's Life Plan review.

- If a person chooses to self-direct part of their CH services, the agency providing CH services only needs to maintain one CH Staff Action Plan.

> Note: The management of self-hired and agency supported CH where the provider agency is co-managing the delivery of CH services must be described in a co-management agreement between the person/designee and the CH provider.

Additional billing guidance for self-hired CH services is available at:
https://opwdd.ny.gov/system/files/documents/2022/03/sd_guidance-final_march2022.pdf

BILLING IDENTIFIERS

ADM 2021-03 *Ability to use Technology to Remotely Deliver Home and Community-Based Services (HCBS)* and ADM 2021-02, *Requirement for Community Habilitation-Residential (CH-R) Services Delivered in the Individual's Certified Residence* have both been updated with the required identifiers and modifiers that must be used to submit claims for CH services delivered remotely and for in-residence CH-R.

RECORDS RETENTION

New York State regulations require Medicaid providers to prepare records demonstrating their right to receive Medicaid payment for a service. All documentation specified above, including the Life Plan and service documentation, must be prepared contemporaneously with the corresponding service and retained for a period of at least ten (10) years from the date the service was delivered or when the service was billed, whichever is later.