GENERAL EXPECTATIONS AND GUIDELINES

All staff, managers and administrators involved with any aspect of Medicaid Services and all Board Members are expected to be knowledgeable and comply with Challenge’s policies and produces regarding provision, documentation and billing of Medicaid funded services.

Such staff, managers, administrators and all Board Members will receive orientation and at minimum yearly training on Challenge’s policies and procedures on Medicaid compliance including, but not limited to, state and federal regulations regarding provision of services, required documentation and timelines, definitions and consequences of abuse and fraud, and Challenge’s policies and procedures for reporting, investigating and resolving compliance issues.

All staff, managers and administrators directly involved with provision, documentation and billing of Medicaid funded services are responsible for knowing and carrying out the service provision, documentation, billing and quality assurance activities outlined in this document relevant to their job responsibilities. Such staff, managers, and administrators are required to report suspected Medicaid or other fraud or other compliance problems, including failure to follow the expectations and guidelines outlined in this document. Failure to report suspected problems, assisting or participating in fraud or other non-compliant behavior, and/or encouraging, directing, permitting or facilitating such activities (whether actively or passively) will result in disciplinary action, up to and including termination.

SERVICE SPECIFIC EXPECTATIONS AND GUIDELINES

I. Supported Employment

A. Minimum Fiscal Requirements for Supported Employment Service Provision

In accordance with OPWDD Administrative Memorandum #2002-02, Supported Employment (SE) Services will, at minimum, include: two face-to-face services at the worksite provided per month for participants who are employed or four distinct services (two of which are face-to-face) if the participant is unemployed.

B. Supported Employment Documentation

In accordance with OPWDD Administrative Memorandum #2002-02 and ACESS-VR guidelines, SE staff develops the supported employment plan which includes the participant name, Medicaid number and TABS ID, waiver service, agency name, type of placement, job title and employer, current wages and hours, valued outcome, frequency and duration of services, an individualized range of service frequency, locations where services will be provided, description of individualized services to be provided, safeguards to ensure health and safety, the date the plan was reviewed, and contact number for questions or concerns. The plan must be signed and dated by the participant, staff and staff supervisor and the participant must sign that either he/she was given a copy of the plan or declined to receive a copy. Plans must be reviewed every six months.

The SE Staff completes a contact note for each service provided that includes a description of the service provided, whether there was face-to-face contact with the participant, the date and location of the service, signature and title of the staff, and the date the note was written for each contact recorded. If there are more frequent than one contact per week, multiple contacts can be combined into one
weekly note that includes all dates of contact during that week. Participant response to services is recorded in each contact note and at minimum one of the contact notes during the month includes employer contact and integration level. At the beginning of each month, the SE staff completes the HCBS Services Documentation Record (Attendance Sheet) for the previous month.

C. Supported Employment Services Documentation Assurance Process

The SE staff completes the SE Monthly Checklist for each participant in supported employment, indicating if there is an accurate and active ISP that accurately reflects the SE service in the file, that required contact notes are complete and in the file, that there is an up-to-date SE plan in place and in the file, and that the attendance sheet is complete. The SE staff signs and dates both the checklist and attendance sheet, confirming the information is complete and accurate.

The SE staff hands in the checklist, attendance sheet and contact notes for that month to the Manager of Employment Planning. The manager reviews the checklist to ensure that all required items on the checklist are complete, reviews the contact notes for completeness, accuracy, presence of dates and signatures, and reviews the attendance sheet to ensure that there are adequate numbers and types of contacts that support billing. The Manager of Employment Planning signs initials and dates both the checklist and attendance sheet, confirming the information is complete and accurate.

If any of the required items (ISP, monthly notes, and required signatures) are missing, the Manager of Employment Planning follows up with the SE staff to complete the missing items, making sure that any additions or corrections are initialed and dated accurately as to when the change(s) was made. If the additions/changes are made within timetable for contemporaneous documentation, no alteration is made to the billing. If the changes/additions are made beyond the timelines for contemporaneous documentation, the Manager of Employment Planning notifies the finance office of the problem, and the affected claim(s) is voided. All voided claims are listed on the Medicaid Voided Payment Log.

When an individual’s new supported plan is developed and every six months after when the plan is reviewed and updated, the SE staff hands in the plan to the Manager of Employment Planning who reviews and signs the plan, confirming that the plan meets supported employment standards.

When an individual is discharged from services, the Employment Advisor completes the DDP1 and/or discharge summary, places it in the participant’s file and gives a copy to the Manager of Employment Planning so the services roster can be adjusted. Currently, the Manager sends the DDPI (and other required information) to OPWDD but in the future the Manager will input the information into the OPWDD web data base (Choices). The Manager then sends an e-mail to QA and billing staff notifying staff of the discharge date. This will ensure that no future billing is submitted, internal audits can double check billing to discharge dates, and final file reviews can be started in a timely manner following discharge (new 9/4/2012).

D. Supported Employment Billing

Once the above services and documentation assurance process is completed, substantiating that all required services and documentation are in place, billing is done by the Manager of Employment Planning using the Attendance Sheet.

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If at a later date, required documentation is found to be incorrect or missing (beyond the timetable for contemporaneous documentation), the finance office is notified and the billing for that affected claim(s) is voided. All voided claims are listed on the Medicaid Voided Payment Log.

E. Supported Employment Internal Audits
SE staff forward the ISP to Challenge’s Quality Assurance (QA) Associate who reviews the participant’s ISP to ensure that the ISP reflects the provision of supported employment services, that the valued outcome is accurately stated, that it is a monthly, ongoing service, that the participant is enrolled prior to billing, and that a current LCED is in place. A checklist is completed and attached to the ISP before it is filed in the participant’s case record and the QA Associate follows up with the MSC if any information is missing or incorrect.

All files are reviewed every six months by Challenge’s Quality Assurance staff prior to or in conjunction with the timing of annual and semi-annual reviews. If any errors are found, these are reported to the Manager of Employment Planning and the Challenge Compliance Officer. If required documentation is found to be incorrect or missing (beyond the timetable for contemporaneous documentation), the finance office is notified and the billing for that affected claim(s) is voided. All voided claims all listed on the Medicaid Voided Payment Log.

II. Blended Day Habilitation/Pre-Vocational Services

A. Minimum Fiscal Requirements for Blended DH/PV Service Provision
In accordance with Appendix B re. Documentation Requirements for OPTS Blended DP, a full day of Blended Services will include a minimum of a program day of four hours or more (excluding lunch time as appropriate) and two face-to-face services delivered in accordance with the participant’s habilitation plan and ISP. A half-day of OPTS Blended Services will include a minimum of a program day of two hours or more (excluding lunch time as appropriate) and one face-to-face service.

B. Determination of Eligibility for Prevocational Services
In order to be eligible for Prevocational Services, a participant must be working at less than 50% productivity.

For participants working full or part-time in the work center, productivity is determined by calculating their average wages for work performed in the work center (all current jobs are paid on a piece rate basis). Average wages are reviewed quarterly and a statement of the average wage/productivity is distributed to program management and quality assurance and kept on file in the finance office.

The Compliance Officer, Chief Financial Officer and Program Management review all average wages for participants working in the work center. If the quarterly review indicates the participant’s productivity is greater than 50%, a note is made on the Quarterly Review of Productivity Sheet (completed by the Compliance Officer) as to whether this is an accurate representation of productivity. If there are no special circumstances that warrant continued eligibility for prevocational services, the Compliance Officer contacts OPWDD to notify them that the participant is ineligible for billing for the Pre-Vocational Services portion under the HCBS Waiver. If the average productivity does not accurately reflect expected future productivity (for example, the increase in productivity occurred as a result of a one time job and productivity is expected to decrease to below 50%), billing is continued.
and the participant(s) productivity is reviewed at the next quarterly review. If the productivity is now under 50%, no further action is needed, and billing for services is continued. If the participant’s productivity continues to be greater than 50%, the Compliance Officer will contact the OPWDD that the participant is ineligible for billing for the Pre-Vocational Services portion under the HCBS Waiver. Productivity will continue to be assessed on a monthly basis, and, if the participant’s productivity falls below 50%, the Compliance Officer will contact OPWDD to notify them of this change in eligibility.

For participants working in one of Challenge’s supervised community enclaves or businesses, productivity is determined by comparing the amount of work performed by the participant (day rate) to the time it takes three non-disabled workers to perform those job tasks (calculated through a time study). Day rates are done after the participant has worked in the setting for the equivalent of no more than two weeks (6-10 working days), than re-done every six months. The day rate for assessing productivity may differ from the actual wages received by the participant. Some community worksites pay minimum wage as an agency policy regardless of productivity. Also, the wages paid at some worksites includes a day rate determination (per U.S. Department of Labor Standards) that reimburses participants at 100% for job tasks not performed by the participant, but are performed by other participants or workers working in the same worksite.

The results of the initial assessment of productivity (within 2 weeks/6-10 working days) and then every six months will reviewed by Service Director, the Compliance Officer and the Chief Financial Officer. If the assessed productivity is found to be greater than 50%, a second assessment of productivity will be completed prior to the end of the month to confirm productivity. If both assessments are over 50%, the Compliance Officer will contact OPWDD to notify them that the participant is ineligible for billing for the Pre-Vocational Services portion under the HCBS Waiver. If the second assessment is less than 50%, billing will continue. All participants enrolled in pre-vocational services (and those for whom billing has been discontinued) will continue to be assessed for productivity every six months (or more often) to determine eligibility for pre-vocational funding through the HCBS Waiver and OPWDD will be notified of any changes.

C. Blended Day Habilitation/Pre-Vocational Services Documentation
In accordance with OPWDD OPTS Contract Appendix B, the Advisor develops the Blended DP Plan. This plan includes valued outcomes, description of the services and supports to be provided for day habilitation and pre-vocational services, frequency and duration of services, and safeguards to ensure health and safety. The plan must be signed and dated. Plans are reviewed every six months.

A daily documentation record listing the services identified in the Blended DP plan is developed to record delivery of daily services. Staff providing the service initial the Daily Documentation Record signifying what services were provided during each program day and sign, initial, and print their name on the bottom of the Daily Documentation Record. Separate Daily Documentation Records are kept at community work sites and other Challenge businesses where participants work and receive services.

A daily attendance Record is kept to document when participants arrive in the morning, leave at the end of the day, and if they leave and return after an appointment. Staff providing support to participants entering and exiting the building complete the attendance sheet and sign it signifying that the information is correct. The attendance sheet is used to determine time in program by calculating the program time less half an hour if the participant was at Challenge during lunch time. Production Sheets and Time Cards are maintained for the Work Center and supervised community worksites and
other Challenge-run businesses and used to determine time in program services if the participant is transported to or leaves program services directly from the worksite. Production Sheets and Time Cards are also used as a back-up source to determine time in program if there is missing information on the attendance sheet. A half hour is subtracted from the total number of hours unless the participant was not present during lunch time.

Challenge supervisors ensure that all participants punch in and out of work using the time clock which records the paid program hours for the day. If a participant forgets to punch in or out or makes an error in using the time clock, the supervisor writes in the time on the time card. The supervisor uses the hours from the time card to fill out a production sheet (production sheets are used in the work center and in some, but not all Challenge-operated community worksites and business operations). In some community worksites, a production sheet only is used to record work time. The supervisor notes on the production sheet if a participant takes a half hour for lunch (if no production sheet is used, the supervisor subtracts a half hour for lunch and notes this directly on the time card).

The Advisor completes a monthly summary notes that describes the services and supports provided, participant progress, participant response to services, and any issues or concerns.

**D. Blended Day Habilitation/Pre-Vocational Services Documentation Assurance Process**

The staff assigned to each participant reviews the Daily Documentation Record on a daily basis to ensure that services have been initialed on the Daily Documentation Record for that day. If the assigned staff is absent, a back-up staff completes this review. If there are omissions, the assigned staff (or back-up) notifies other program staff to complete the Daily Documentation Record.

The staff assigned to end of the day bus duty reviews the attendance to ensure that time in and out has been recorded for all participants who were in work/program services that day. If information is missing, staff will refer to time cards and/or production sheets to complete missing information.

The supervisors double check the hours recorded on the time card and/or production sheets to ensure time is recorded accurately and consistently on all documentation (prior to sending the information to the finance office).

A final check of the time recorded on the time sheets and production sheets is completed by the finance office prior to billing. If inaccuracies are found, they are reviewed to determine if changes need to be made to payroll and changes are made to payroll (only in underpayment situations). The finance office contacts the Job Supports Coordinator with any change in hours in program services. The Coordinator notes any inaccuracies on the Daily Documentation Record, initials and dates the record.

The Advisor completes the Advisor Monthly Checklist for each participant in OPTS Blended DP or Blended DP service, indicating if there is an accurate and active ISP in the file that accurately reflects the services, that the required monthly summary note is complete and in the file, and that there is an up-to-date Blended DP services plan in place and in the file. The Advisor signs and dates the checklist, confirming the information is complete and accurate.

The staff assigned to each participant on a bi-weekly basis fills in the program hours for each day (as described above in section) The staff then totals the number of services for DH and PV provided for
each day from the Daily Documentation Record(s), making sure to count a particular service only once for each day, even if it has been provided by more than one staff that day. The total number of DH and PV Services provided for each day are recorded on the Daily Documentation Record.

If there are inadequate hours or services to support billing, staff put a line through that day on the Daily Documentation Record, signifying that no billing should occur. Staff put a line through (to exclude from billing) all days where the participant worked or received services on the week-end, worked in an unsupervised setting (unless staff provided direct services at that site evidenced by services initialed on the Daily Documentation Record and time recorded on the attendance sheet, production sheet, and/or time card) or worked or received services starting after 3:00 pm. Staff complete a Daily Documentation Record Checklist for each participant and sign and date the checklist signifying that the information is accurate and complete.

If correction of an error results in change of attendance or participant may be due extra pay, staff e-mail the finance office so any needed changes in work hours or compensation can be made.

The completed and reviewed Daily Documentation Records are given to the Job Supports Coordinator who reviews the accuracy and completeness of the information prior to entering the data for billing.

The Advisor hands in the Advisor Monthly Checklist to the Director of Services or Designee. The Director of Services or Designee reviews the checklist to ensure that all required items on the checklist are complete and spot checks contact notes for completeness, accuracy, presence of dates and signatures. The Director of Services or Designee signs/initials and dates the checklist and, confirming the information is complete and accurate.

If any of the required items (goal plan, monthly note, and required signatures) are missing, the Director of Services or Designee follows up with the Advisor to complete the missing items, making sure that any additions or corrections are initialed and dated accurately as to when the change(s) was made. If the additions/changes are made within funding timetable for contemporaneous documentation, no alteration is made to billing. If the changes/additions are made beyond the timelines for contemporaneous documentation, the Director of Services or Designee notifies the Job Supports Coordinator and the Corporate Compliance Officer of the problem, and the affected billing is voided. All voided claims are listed on the Medicaid Voided Payment Log.

Every six months when a new Blended plan is developed, the Advisor hands in the plan to the Director of Services or Designee who reviews and signs the plan, confirming that the plan meets Blended DP service standards.

When an individual is discharged from services, the Advisor completes the DDP1 and/or discharge summary, places it in the participant’s file, and gives a copy to the Manager of Employment Planning so the services roster can be adjusted. The Advisor pulls the Service Documentation Record once the participant is no longer receiving services. If the participant will continue to receive services for a short period of time, the Advisor leaves the Service Documentation Record and crosses off the days following the discharge date on the Record and clearly documents the discharge date on the Record. The Advisor e-mails all Challenge staff involved in providing this service to let them know of the discharge date. The Manager inputs the information into the OPWDD web data base and sends an e-mail to QA and billing staff.
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notifying staff of the discharge date. This will ensure that no future billing is submitted, internal audits can double check billing to discharge dates, and final file reviews can be started in a timely manner following discharge (new 9/4/2012).

D. Determination of Eligibility for Waiver Funded Prevocational Services

In order to be eligible for Waiver Funded Prevocational Services, a participant must be working at less than 50% productivity.

For participants working full or part-time in the work center, productivity is determined by calculating their average wages for work performed in the work center (all current jobs are paid on a piece rate basis). Average wages are reviewed quarterly and a statement of the average wage and productivity is distributed by the finance office to program and quality assurance staff.

On a quarterly basis, the Director of Services, the Compliance Officer and the Director of Finance review all average wages for participants working in the work center. If the quarterly review indicates the participant’s productivity is greater than 50%, a note is made on the Quarterly Review of Productivity Sheet (completed by the Compliance Officer) as to whether this is an accurate representation of productivity. If there are no special circumstances that warrant continued eligibility for Waiver funded Prevocational Services, the Compliance Officer or other Services staff will contact the OPTS Unit at OWPDD to notify them of this change in eligibility for Waiver funded Prevocational Services. If the average productivity does not accurately reflect expected future productivity (for example, the increase in productivity occurred as a result of a one time job and productivity is expected to decrease to below 50%), billing is continued and the participant(s) productivity is reviewed at the next quarterly review. If the productivity is now under 50%, no further action is needed, and billing for Waiver funded Prevocational Services by OWPDD is continued. If productivity continues to be over 50% for a second concurrent quarter, the Compliance Officer or other Services staff will contact the OPTS Unit at OWPDD to notify them that the participant is not eligible for Waiver funded Prevocational Services. Productivity will continue to be assessed on a quarterly basis, and, if the participant’s productivity falls below 50%, OPWDD will be contacted and Waiver funded Prevocational billing by OPWDD will be resumed. This review process is documented on the Quarterly Review of Productivity for Prevocational Services Recipients sheet, completed by the Compliance Officer.

For participants working in one of Challenge’s supervised community enclaves or businesses, productivity is determined by comparing the amount of work performed by the participant (day rate) to the time it takes three non-disabled workers to perform those job tasks (calculated through a time study). Day rates are done after the participant has worked in the setting for the equivalent of no more than two weeks, than re-done every six months. The day rate for assessing productivity may differ from the actual wages received by the participant. Some community worksites pay minimum wage as an agency policy regardless of productivity. Also, the wages paid at some worksites includes a day rate determination (per U.S. Department of Labor Standards) that reimburses participants at 100% for job tasks that cannot be rated (such as clean up). In this instance, the assessed productivity of job tasks performed is utilized to determine productivity (rather than the day rate based on DOL regulations) and this will be noted on the quarterly report.

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The results of the initial assessment of productivity (within 2 weeks) and then every six months will reviewed by the Director of Services, the Compliance Officer and the Director of Finance. If the assessed productivity is found to be greater than 50%, a second assessment of productivity will be completed prior to the end of the month to confirm productivity. If both assessments are over 50%, the Compliance Officer and other Services staff will contact the OPTS Unit at OWPDD to notify them that the participant is not eligible for Waiver funded Prevocational Services. All participants enrolled in Blended DH/PV services will continue to be assessed for productivity every six months (or more often) to determine eligibility for Waiver funded Prevocational Services. If productivity falls below 50%, the Compliance Officer or other Services staff will contact the OPTS Unit at OWPDD to notify them that the participant is now eligible again for Waiver funded Prevocational Services billing.

E. Blended Day Habilitation/Pre-Vocational Services Billing

Once the above services and documentation assurance process is completed, substantiating that all required services and documentation are in place, billing is done by the Job Supports Coordinator using the completed Daily Documentation Record.

If at a later date, required documentation is found to be incorrect or missing (beyond the timetable for contemporaneous documentation), the Job Supports Coordinator and Corporate Compliance Officer are notified and the billing for that affected claim(s) is voided.

F. Blended Day Habilitation/Pre-Vocational Services Internal Audits

Program staff forward the ISP to Challenge’s Quality Assurance (QA) Associate who reviews the participant’s ISP to ensure that the ISP reflects the provision of Blended DH/PV services, that the valued outcome is accurately stated, that it is a daily, ongoing service, that the participant is enrolled prior to billing, and that a current LCED is in place. A checklist is completed and attached to the ISP before it is filed in the participant’s case record and the QA Associate follows up with the MSC if any information is missing or incorrect.

All files are reviewed every six months by Challenge’s Quality Assurance staff prior to or in conjunction with the timing of annual and semi-annual reviews. If any errors are found, these are reported to the Director of Services and the Challenge Compliance Officer. If required documentation is found to be incorrect or missing (beyond the timetable for contemporaneous documentation), the Job Supports Coordinator and the Corporate Compliance Officer are notified of the problem and the affected billing is voided. All voided claims all listed on the Medicaid Voided Payment Log.

On a monthly basis, a half month of billing for each participant is selected and daily documentation records, attendance sheets and production and time sheets (if needed) are reviewed and compared to billing to ensure accuracy. Minor clerical errors such as incorrectly counting the number of services that do not affect billing are noted on the documentation record and changes are made on the online billing system. Recurrent or unusual errors that don’t affect billing are noted on the documentation record and changes are made on the online billing system and, in addition, the errors are documented on the Corporate Compliance Log and brought to the attention of the Corporate Compliance Officer. Any billing that needs to be reduced from full day to half day or completely voided is brought to the attention of the Corporate Compliance Officer and documented on the Medicaid Voided Payment Log.

While conducting the billing check, the services listed on the daily documentation record is compared to the services listed on the goal plan for all participant records for which a new goal plan was

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developed the preceding month to ensure that any changes in services on the goal plan have been reflected on the daily documentation record. If there are any inconsistencies, a full review of all daily documentation records back to the last goal plan change is conducted and any billing that is found to not be supported by existing documentation is voided and noted on the Medicaid Voided Payment Log.

III. Medicaid Service Coordination

A. Minimum Fiscal Requirements for MSC Provision
In accordance with OPWDD Administrative Memorandum #2010-03, Medicaid Service Coordination (MSC) will, at a minimum, deliver and document at least one activity from List A or at least two activities from List B each service billing unit (see attachment #1). Activities that are documented must serve to develop, monitor, or implement the valued outcomes of the person’s ISP.

B. Medicaid Service Coordination Documentation
Including Contemporaneous Notes and the Individual Service Plan (ISP)
In accordance with OPWDD Administrative Memorandum #2010-03, MSC documentation must include the following monthly service notes elements:
1. The individual’s name.
2. Identification of the service provided (e.g., Medicaid Service Coordination).
3. Identification of the vendor providing MSC.
4. The month and year that the MSC service was provided.
5. A description of the activity(s) provided by the service coordinator, which serves to develop, monitors, or implements the valued outcomes in the person’s ISP (List A or B activities).
   - If the activity involves a face to face service meeting with the individual then the purpose and the outcome of the contact must be included. The location of the service meeting must also be included.
   - If the activity involves a contact with a qualified contact then the purpose and outcome of the contact must be included. The identity of the qualified contact and the relationship to the person should also be included.
6. A monthly summary that includes the person’s satisfaction with services along with any follow-up taken, changes in the person’s life, and any issues or concerns identified over the month regarding the person’s health and safety.
7. The full name, title, and signature of the MSC service coordinator 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 date of the note was written (i.e., the signature date) which must include the day, the month and the year.

The date the note was written must be contemporaneous, “at the time the service was delivered or shortly after” to the date of the MSC activity was provided. For MSC, contemporaneous is defined as having a monthly service note, including the documentation of service coordination activities and a monthly summary, completed and signed by the 15th day of the month following the service month. In addition to the service note supporting each month MSC claim, the MSC Vendor must maintain the following documentation to support claims for payment:

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Evidence that the service coordinator attended basic (i.e., core) training or received instruction using an approved OPWDD curriculum. Evidence may include, but is not limited to, a training certificate or an attestation from OPWDD that the service coordinator attended training.

If the individual is enrolled in HCBS waiver, a copy of the individuals ICF/MR level of care eligibility determination (LCED) annual redetermination that has been completed and signed within 365 days from the prior review and authorized signature date.

Evidence that a Service Coordination Agreement was executed. Evidence may include, but is not limited to a copy of the Service Coordination Agreement or a monthly service note indicating the agreement was reviewed.

Any copy of the individual’s ISP that included identification of the service provided (e.g., Medicaid Service Coordination) and identification of the agency providing MSC.

Evidence that the person’s ISP has been reviewed twice annually. These two reviews must be completed within 12 months prior to or by the end of the service month under review. Evidence of a review may include, but is not limited to, a review sign-in sheet, a monthly service note indicating that the ISP was updated or revised, and ISP addendum, a revised ISP, or a review section on the ISP. All evidence of ISP reviews must include the following elements:

1. The individual’s name.
2. Name of the vendor providing MSC.
3. The name, signature and title of a service coordinator or a supervisor who conducted the review. Initials are permitted if a “key” is provided, which identifies the title, signature and full name associated with the staff initials.
4. The date of the review.
5. Description of any changes made to the ISP. If no changes were made, then this should be noted.

If a service coordinator writes a new ISP, re-writes the ISP or writes an addendum to the ISP, and the new or rewritten ISP or the addendum reflects a new service or change in service provider, the service coordinator must show evidence that the new or rewritten ISP or addendum was distributed within 60 days from the date of the ISP review or addendum or later if the 60 day timeframe cannot be met. If distribution exceeds the 60 day limit, the service coordinator must document the reason for the delay, and then sign and distribute the ISP or addendum. Evidence of distribution may include, but is not limited to, a sheet stating when the document was distributed, a monthly service note indicating that the document was distributed, a page attached to the ISP indicating when it was distributed, or a notation on the ISP or addendum indicating when it was distributed. Regardless of method of distribution used, documentation must include the parties to which the ISP was sent and the date (s) on which it was sent.

If the ISP was reviewed and there were not changes made to the ISP, an agency does not have to show evidence that an ISP or addendum was distributed.

An individual’s first ISP must be written and signed by the service coordinator within 60 days of the HCBS Waiver enrollment date or of the MSC enrollment date, whichever comes first.

For quality purposes, the MSC vendor should maintain evidence that the Service Coordination Agreement was reviewed within 365 days prior to the service month under review. Evidence of a review may include, but is not limited to, a monthly narrative note indicating the agreement was reviewed.
reviewed, a signed agreement by the service coordinator, or a dated agenda indicating the topics to be discussed at the an ISP review.

The MSC Vendor must use documentation that includes all of the elements of the OPWDD-developed format to document the provision of MSC services (see attachment #2).

C. Medicaid Service Coordination Documentation Assurance Process

The Medicaid Service Coordination Notes provide a chronological written record of services provided by the service coordinator during the month. The notes must indicate the types of services provided and whether the billing standard (see attachment #1) was met for the month.

The Medicaid Service Coordination Note must be completed by the 15th of the month following the month of service. This form must be signed and dated by the service coordinator.

MSC staff are expected to complete the Service Coordination Monthly Note (see attachment #2) documenting service provided; the notes is to be signed and dated confirming the information is complete and accurate.

The MSC staff hands in the Service Coordination Monthly Notes to the Supervisor of Medicaid Service Coordination. The MSC Supervisor reviews the Monthly Notes for completeness, accuracy, presence of dates and signatures and reviews provisional activities to ensure they support monthly billing. The Supervisor of Service Coordination initials and dates all Monthly Notes confirming the information is complete and accurate. The Director of Services or Quality Assurance staff complete the same process for a representative sample of the monthly notes completed by the MSC Supervisor.

If any of the required items (activities from List A or List B, dates, required signatures) is missing or is inaccurate, the Supervisor of Service Coordination follows up with MSC staff to complete or correct the noted items, making sure that any additions or corrections are initialed and dated accurately as to when the change(s) was made. The same process is followed for monthly notes completed by the MSC Supervisor. If the additions/changes are made within timetable for contemporaneous documentation, no alteration is made to the billing. If the changes/additions are made beyond the timelines for contemporaneous documentation, the Supervisor of Medicaid Service Coordination notifies the finance office of the problem, and the affected claim(s) is voided. All voided claims are listed on the Medicaid Voided Payment Log.

When an individual’s Individualized Service Plan (ISP) is developed and every six months after when the plan is reviewed and updated, the MSC staff hands in the plan to the Supervisor of Medicaid Service Coordination who reviews and signs the plan, confirming that the plan meets the Medicaid Service Coordination standards. ISP’s written by the MSC Supervisor are handed in to the Director of Services or Quality Assurance staff for review and signature.

When an individual is discharged from services, the MSC completes the DDPI and/or discharge summary, places it in the participant’s file and gives a copy to the MSC Supervisor so the services roster can be adjusted. The MSC Supervisor inputs the information into the OPWDD web data base and sends an e-mail to QA and billing staff notifying staff of the discharge date. This will ensure that no future billing is submitted, internal audits can double check billing to
discharge dates, and final file reviews can be started in a timely manner following discharge (new 9/4/2012).

**D. Medicaid Service Coordination Billing**

Once the above services and documentation assurance process is completed, substantiating that all required services and documentation are in place, billing is done by the Supervisor of Medicaid Service Coordination using the Medicaid Service Coordination Notes form (see attachment #2) to verify all necessary billing standard have been met to validate billing.

If at a later date, required documentation is found to be incorrect or missing (beyond the timetable for contemporaneous documentation), the finance office is notified and the billing for that affected claim(s) is voided. All voided are listed on the Medicaid Voided Payment Log.

**E. Medicaid Service Coordination Internal Audits**

MSC staff provide the Quality Assurance (QA) Associate with the MSC record containing all necessary documentation as outlined in the MSC Vendor Manual Chapter 4, Sections 1-4.

- Section 1: Eligibility/Enrollment Documentation (including the Medicaid Service Coordination Agreement.
- Section 2: Written Evaluations
- Section 3: The Individualized Service Plan (ISP) with Attachments (including the Service Coordination Activity Plan, if applicable)
- Section 4: Medicaid Service Coordination Notes

The QA Associate reviews all components of the Service Coordination Record ensuring that all required documents are filed in the record including ongoing service notes, current ISP and LCED document. Additionally, QA Associate completes a checklist that is filed in the MSC record; the QA follows up with the MSC is any information is missing or is incorrect.

All files are reviewed every six months by Challenge’s Quality Assurance staff prior to or in conjunction with the timing of annual and semi-annual reviews. If any errors are found, there are reported the Supervisor of Service Coordination and the Challenge Compliance Officer. If required documentation is found to be incorrect or missing (beyond the timetable for contemporaneous documentation), the finance office is notified and the billing for that affected claim(s) is voided. All voided claims are listed on the Medicaid Voided Payment Log.
Attachment # 1

The unit of service for MSC is a month. To bill for a month of service, and MSC service coordinator must deliver and document at least one activity from List A or at least two activities from List B. Activities that are documented must serve to develop, monitor, or implement the valued outcomes of the person’s ISP.

**List A:** When the service coordinator delivers and documents the provision of at least one activity from the following list, the minimum billing standard is met:
1. Face-to-face service meeting with the individual.
2. ISP reviews (which may include the creation of the initial ISP, a face-to-face ISP review, and any non-face-to-face ISP review).
3. Updates (addendum) to the ISP (this does not have to be a face-to-face service meeting).
4. Completion of the ICF/MR level of care eligibility determination or redetermination (this does not have to be a face-to-face service meeting).

**List B:** When the service coordinator delivers and documents the provision of at least two activities from the following list, the minimum billing standard is met. The documentation must also demonstrate that the purpose of the activity is related to referral/linkage, or monitoring to ensure that the ISP is implemented and addresses the needs of the person. It is allowable for the two activities to fall into the same category as described below.
1. Non-face-to-face contact with the individual (e.g., phone calls).
2. Direct contact with a qualified contact during which the service coordinator gathers information to assess or to monitor the status of the individual. This can include:
   - Phone call or personal contact;
   - Email exchange;
   - Letter/correspondence exchange.
3. Direct contact with other agencies to maintain benefits eligibility or to obtain referrals for services that might be appropriate for the individual. This can include:
   - Phone call or personal contact;
   - Email exchange;
   - Letter/correspondence exchange.

A qualified contact is someone directly related to the identification of the individual’s needs and care and who can help the service coordinator with the assessment, care plan development, referral, monitoring, and follow-up activities for the individual. Examples of qualified contacts include family members, medical providers, social workers, educators and service providers.

Activities from the lists above that are conducted during an individual’s first 30 days in the hospital can be counted toward the billing requirement. After the first 30 days of hospitalization, these activities can no longer be counted toward the billing requirement.

Note that to bill for a month of service for individuals who are members of the Willowbrook Class, service coordinators must continue to deliver and document a minimum of one face-to-face service meeting per month.

Revised 10/2/2012
OPWDD HCBW Services: Provision, Documentation, Billing and Quality Assurance

Revised 10/2/2012
INVESTIGATION OF SUSPECTED MEDICAID FRAUD OR ABUSE

All discovered or reported allegations of Medicaid fraud or abuse will be reported immediately to the President of Challenge. The President of Challenge, in conjunction with senior management, Human Resources Department, the Board of Directors and legal counsel where appropriate, will implement an investigation following Challenge’s policies and procedures outlined in the Corporate Compliance Plan.