

MEDICAID BILLING SELF-ASSESSMENT

FOR USE IN ASSESSING MEDICAID BILLING FOR THE FOLLOWING OASAS CERTIFIED SERVICES:

Chemical Dependence Outpatient Services (Medically Supervised) [Part 822]

Chemical Dependence Outpatient Rehabilitation Services (Medically Supervised) [Section 822.9]

BACKGROUND

This Medicaid Billing Self-Assessment tool is a voluntary risk management tool and is designed to assist clinical supervisors and program directors in the periodic assessment of their Medicaid patients' case record documentation for adherence to the Office of Alcoholism and Substance Abuse Services' (OASAS) case record compliance standards and Medicaid billing requirements. Consistent and appropriate use of the Self-Assessment tool promotes continuous improvement of case record documentation procedures and practices and minimizes potential Medicaid audit disallowances. The self assessment results do not have to be submitted to OASAS.

Important Notes on Use of the Medicaid Billing and Utilization Review Self-Assessment Worksheets:

- *Self-Assessments are to be completed based on written documents found in the program files at the time of the self-assessment, and not based on what should have occurred or what is known to have occurred when not supported by written evidence.*
- *Self-Assessments are not to be used to correct past errors but to identify record-keeping procedures and practices that need to be improved to avoid continuing non-compliance with OASAS and Medicaid billing requirements, which could lead to significant Medicaid audit disallowances if left unaddressed.*
- *Self-Assessments are intended to simulate Medicaid audits and are only useful if uncovered deficiencies in case record documentation procedures are timely and effectively addressed.*
- *Please note that completion of the Medicaid Billing Self Assessment form neither guarantees immunity against Medicaid audit disallowances nor supersedes State OASAS Regulatory requirements or Federal Medicaid billing requirements.*

Important Notes on Use of the Utilization Review Self-Assessment Worksheet

- *The utilization review instructions apply only to cases with a continued stay greater than 365 days.*

FREQUENCY OF SELF-ASSESSMENTS

Self-Assessments should be completed routinely, with the frequency dependent on the particular circumstances of the program. In determining the frequency of self-assessments, use of the following guideline is recommended:

The frequency of self-assessments may be set based on the compliance rating received on the *Case Record* portion of the program's last OASAS Quality Assurance (QA) site visit review [or the lower of the Case Record compliance score or Quality Indicator portion of the Case Record compliance score.]

Specifically:

Case Record Review Compliance Score	Recommended Frequency*
Noncompliance (score of 0 - 1.75)	Monthly
Minimal compliance (score of 1.76 - 2.50),	At Least Quarterly
Partial compliance (score of 2.51 - 3.25)	At Least Semi-Annually
Substantial compliance (score of 3.26 - 4.00).	At Least Annually

*If there has been significant staff turnover or key staff vacancies that could affect the quality of services and/or recordkeeping, more frequent self-assessments should be considered.

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SAMPLE SELECTION

The following approach is provided as a guide for selecting the records sample to undergo a Self-Assessment. Note: Separate guidance for selecting a records sample for completing the Self-Assessment in regard to Utilization Review requirements is provided in the Utilization Review section of these instructions.

	Medicaid Billing Frequency	Sample Source
STEP #1 SAMPLE SOURCE	Monthly	The Medicaid Remittance Statement for the Last Month Billed
	Semi-Monthly	The Two Remittance Statements for the Last Month Billed
	Weekly	The Four Remittance Statements for the Last Month Billed

	Using the Medicaid remittance statement(s) selected in Step #1:	
STEP #2 SAMPLE SIZE	Total number of paid dates of service from the remittance statement(s)	
	Multiply by 10%	X 10%
	Paid dates of services sample size	=
	<i>Note: The sample size should be at least 10 and may be limited to 50.</i>	

	Using the following criteria, select a sufficient number of specific paid dates of service from the remittance statements selected in Step #1, totaling the sample size determined in Step #2:
STEP #3 SAMPLE SELECTION	<ul style="list-style-type: none"> ✓ Pick paid dates of service from as many different patients as possible. <i>Example: If the sample size is 10 and there are 20 different patients on the remittance statement(s), pick 1 date of service from 10 different patients.</i> ✓ Pick paid dates of service from as many different primary counselors as possible.

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MEDICAID BILLING SELF-ASSESSMENT WORKSHEET INSTRUCTIONS

For each of the paid dates of service included in the selected sample from the Medicaid Remittance statement(s), complete the following information on the Self-Assessment Worksheet.

Note: Where no service category distinction is noted, the instruction applies to all service categories.

WORKSHEET COLUMN TITLE	INSTRUCTIONS
Medicaid Recipient I.D.# & Patient I.D. #	✓ Enter the Medicaid Recipient Identification Number and the provider-assigned Patient Identification Number. <i>Note: For confidentiality purposes, patient names should not be noted on the Worksheet.</i>
1. Paid Service Date	✓ Enter the date of service from the Medicaid Remittance Statement(s).
2. Level of Care (LOC) Determination	<p>✓ For Chemical Dependence Outpatient Services And Outpatient Rehabilitation Services: Indicate by a “Y” for yes or an “N” for no if:</p> <ol style="list-style-type: none"> 1. a level of care (LOC) determination was completed within two visits to the service; and 2. the OASAS Level of Care for Alcohol and Drug Treatment Referral Protocol (LOCADTR) or other OASAS approved protocol was used; and 3. a LOC determination was developed, signed, and dated by a clinical staff member who meets the OASAS Part 800.2 definition of a qualified health provider (QHP). 4. the LOC determination was made by a clinical staff member who is not a QHP, LOC was signed and dated by the clinical staff member’s supervising QHP.
3. Date of Admission	✓ Enter the date the patient was admitted. If the patient was only provided assessment services and was not admitted to treatment, enter N/A.
4. Evaluation/Assessment	✓ Indicate by a “Y” or an “N” if a comprehensive evaluation or assessment was done within appropriate regulatory item frames as specified in Part 822.4 (a) (4). If the patient was not admitted, write “ASSESSMENT ONLY” across the rest of the columns for the patient.

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WORKSHEET COLUMN TITLE	INSTRUCTIONS
5. Admission Criteria	<p>For all admitted patients, indicate by “Y” or “N” whether the patient meets applicable admission criteria, including having a qualifying diagnosis:</p> <ul style="list-style-type: none"> - 14 NYCRR 822.3 for Chemical Dependence Outpatient Services - 14 NYCRR 822.3 and 822.9(b) for Chemical Dependence Outpatient Rehabilitation Services
6. Individual Treatment Plan	<p>Indicate by “Y” or “N” whether an individual treatment plan was developed for the patient by the primary counselor or therapist and reviewed and approved by a multi-disciplinary team.</p>
7. Date of Treatment Plan	<p>Indicate the date of the individual treatment plan.</p>
8. Within Required Time	<p>Indicate by “Y” or “N” if the individual treatment plan was signed by all members of the multidisciplinary team within 30 days of the patient admission.</p>
9. Physician Signature	<p>Indicate by “Y” or “N” whether the physician’s signature is present on the individual treatment plan.</p>
10. Physician Signature Date	<p>Indicate by “Y” or “N” if the physician’s signature on the individual treatment plan is dated and if so, enter the date.</p>
11. Within Required Time	<p>Indicate by “Y” or “N” if the date of the physician’s review and signature on the individual treatment plan is within seven days of the multi-disciplinary team’s review and approval.</p> <p>Note: If the physician has already signed the treatment plan as part of the multidisciplinary team, then the physician does not have to sign a second time within the seven days.</p>
12. Treatment Plan Review	<p>For Chemical Dependence Outpatient Services and Chemical Dependence Outpatient Rehabilitation Services: Indicate by “Y” or “N” if the treatment plan was: reviewed and updated at least every 90 calendar days from the date of development by the responsible clinical staff member in consultation with the patient; and, the update was signed by a member of the multi-disciplinary team.</p>

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WORKSHEET COLUMN TITLE	INSTRUCTIONS
Item Number 13 may be satisfied by either Attendance or Progress Notes as described below.	
<p>13. Attendance Notes <i>Note: Attendance notes are not required if a progress note specifying duration of service is written after every visit.</i></p>	<p>✓ For Chemical Dependence Outpatient Services And Chemical Dependence Outpatient Rehabilitation Services: Indicate by “Y” or “N” (or “N/A” if progress notes per visit are completed noting duration of visit) whether attendance notes document all three of the following elements in the case record: 1) date of service, 2) type of service and 3) duration of service.</p>
OR	
<p>13. Progress Notes for All Visits</p>	<p>For Chemical Dependence Outpatient Services And Outpatient Rehabilitation Services Indicate by “Y” or “N” whether progress notes are written for all visits.</p>
<p>14. Adequacy of Notes</p>	<p>For Chemical Dependence Outpatient Services And Outpatient Rehabilitation Services Indicate by “Y” or “N” whether the progress notes meet the adequacy criteria described below. For all visits, progress notes shall:</p> <ol style="list-style-type: none"> 1. be written, signed and dated by the clinical staff member providing the service; 2. provide a chronology of the patient's progress related to the goals established in the treatment plan; 3. be sufficient to delineate the course and results of treatment; 4. indicate the patient’s participation in all significant services that are provided; and 5. fully document in the individual patient’s treatment record the content and/or outcome of all visits.

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WORKSHEET COLUMN TITLE	INSTRUCTIONS
15. Type of Visit	<p>For Chemical Dependence Outpatient Services enter one of the following service types:</p> <ul style="list-style-type: none"> - Assessment (A) - Individual (I) - Group (G) <p>For Chemical Dependence Outpatient Rehabilitation Services, enter one of the following service types:</p> <ul style="list-style-type: none"> - Assessment (A) - Full day (F) - Half day (H)
16. Sufficient Individual Visits	<p>For Chemical Dependence Outpatient Services: Indicate “Y” or “N” if case record indicates that at least one out of every ten counseling sessions provided to the patient was an individual counseling session of at least one half hour in duration with the individual patient’s primary counselor. Such frequency must be met unless a different frequency or intensity is otherwise determined, with supporting documentation, by the multidisciplinary team.</p>
17. Group Counseling Session ≤ 15 patients	<p>For Chemical Dependence Outpatient Services: Indicate “Y” or “N” if documentation exists e.g., sign in sheets, verifying that the group counseling session did not contain more than 15 patients.</p>
18. Duration of Visit Indicated	Indicate by “Y” or “N” as appropriate.
19. Duration of Visit Adequate	<p>Indicate by “Y” or “N” if the duration matches or exceeds the following:</p> <ul style="list-style-type: none"> - Chemical Dependence Outpatient Services– all visits at least 30 minutes - Chemical Dependence Outpatient Rehabilitation Services: - Assessments – at least 30 minutes - Full day – at least 4 hours - Half day – at least 2 hours
20. Treatment According to Plan	Indicate by “Y” or “N” if the type of service, frequency and progress notes are in accord with the treatment plan.

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WORKSHEET COLUMN TITLE	INSTRUCTIONS
Score	<ul style="list-style-type: none"> ✓ Enter a "1" in the score column if an "N" is indicated <u>IN ONE OR MORE COLUMNS</u> for the reviewed paid service date. ✓ Enter a "0" in the score column if a "Y" is indicated <u>IN ALL OF THE COLUMNS</u> for the reviewed paid service date. ✓ Add all the scores in the score column to arrive at the total score. <p><i>Example: Twenty paid service dates were reviewed in the sample. Ten had one or more deficiencies and ten had no deficiencies. The total score would be ten.</i></p>
Deficiency Rate <i>(Upper right corner of Work Sheet)</i>	<ul style="list-style-type: none"> ✓ Divide total score by the total number of paid service dates reviewed in the sample to arrive at the Deficiency Rate. <p><i>Example: A total score of ten, divided by the sample size of twenty would result in a deficiency rate of 50%.</i></p>

CORRECTIVE ACTION ON SELF-ASSESSMENT RESULTS

To promote improved prospective compliance with OASAS regulations and minimize potential Medicaid audit billing disallowances, providers should take appropriate corrective action as soon as possible in regard to **all deficiencies uncovered**. This may include implementing improved case record documentation procedures and practices to address systemic problems and/or provision of additional training to clinical staff on case record documentation requirements.

Providers that uncover serious deficiencies through the self-assessment process may request technical assistance from OASAS. **Technical assistance requests should be directed to the appropriate Regional Field Office. Additionally, if providers have regulatory compliance questions, they should direct them to the Training / Technical Assistance unit within the OASAS Bureau of Standards Compliance.**

Questions regarding completion of self-assessments should be directed to:

Provider Relations Unit

Division of Financial Administration

Bureau of Health Care Financing and Third Party Reimbursement

1450 Western Avenue

Albany, NY 12203

Telephone: (518) 485-2207

E-mail: HealthcareFinancing@oasas.state.ny.us

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UTILIZATION REVIEW SELF-ASSESSMENT WORKSHEET INSTRUCTIONS

The utilization review instructions apply only to cases with a continued stay greater than 365 days.

WORKSHEET COLUMN TITLE	INSTRUCTIONS						
<p>Utilization Review Self Assessment</p>	<p>For Chemical Dependence Outpatient Services And Chemical Dependence Outpatient Rehabilitation Services</p> <p><i>Note: The following instructions apply to the case records described below, and not to the case record sample selected for the Self-Assessment.</i></p>						
<p>Sample Selection For Utilization Review Self Assessment</p>	<table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <thead> <tr> <th style="width: 50%; text-align: center;"><u>Continued Length of Stay Beyond 365 days</u></th> <th style="width: 50%; text-align: center;"><u>Recommend Self Assessment Sample Size</u></th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Less than 100 cases</td> <td style="text-align: center;">Self Assess all cases that meet UR criteria</td> </tr> <tr> <td style="text-align: center;">Greater than 100 cases</td> <td style="text-align: center;">Self Assess a 25 percent sample of all cases that meet UR criteria</td> </tr> </tbody> </table> <p>For all self assessed cases indicate by a “Y” or “N” if the patient’s case records indicate:</p> <p style="text-align: center;">Admission Date Date of Initial 365 Day UR Review</p>	<u>Continued Length of Stay Beyond 365 days</u>	<u>Recommend Self Assessment Sample Size</u>	Less than 100 cases	Self Assess all cases that meet UR criteria	Greater than 100 cases	Self Assess a 25 percent sample of all cases that meet UR criteria
<u>Continued Length of Stay Beyond 365 days</u>	<u>Recommend Self Assessment Sample Size</u>						
Less than 100 cases	Self Assess all cases that meet UR criteria						
Greater than 100 cases	Self Assess a 25 percent sample of all cases that meet UR criteria						
<p>Score</p>	<p>Enter a “1” in the score column if an “N” is indicated <u>IN ONE OR MORE COLUMNS</u> for the reviewed paid service date.</p> <p>Enter a “0” in the score column if a “Y” is indicated <u>IN ALL OF THE COLUMNS</u> for the reviewed paid service date.</p> <p>Add all the scores in the score column to arrive at the total score.</p> <p><i>Example: Ten paid service dates were reviewed in the sample. Five had one or more deficiencies and five had no deficiencies. The total score would be five .</i></p>						
<p>Deficiency Rate</p>	<p>The deficiency rate is then calculated by taking the score above and dividing it by the total number of cases reviewed.</p> <p>Example: A score of 5 from a total case sample of 10 would result in a fifty percent deficiency rate.</p>						