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OMIG AUDIT PROTOCOL – OPWDD MEDICAID SERVICE COORDINATION

REVISED 06/13/2016

Audit protocols assist the Medicaid provider community in developing programs to evaluate compliance with Medicaid requirements under federal and state statutory and regulatory law. Audit protocols are intended solely as guidance in this effort. This guidance does not constitute rulemaking by the New York State Office of the Medicaid Inspector General (OMIG) 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 audit protocols alters any statutory or regulatory requirement and the absence of any statutory or regulatory requirement from a protocol does not preclude OMIG from enforcing the requirement. In the event of a conflict between statements in the protocols and either statutory or regulatory requirements, the requirements of the statutes and regulations 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. OMIG cannot provide individual advice or counseling, whether medical, legal, or otherwise. If you are seeking specific advice or counseling, you should contact an attorney, a licensed practitioner or professional, a social services agency representative, or an organization in your local community.

Audit protocols are applied to a specific provider type or category of service in the course of an audit and involve OMIG'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, OMIG will review and consider any relevant contemporaneous documentation maintained and available in the provider's records to substantiate a claim.

OMIG, 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 OMIG's authority to recover improperly expended Medicaid funds and OMIG 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.

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1.	Missing Recipient Record
OMIG Audit Criteria	If the recipient record is not available for review, claims for all dates of service associated with the recipient record will be disallowed.
Regulatory References	18 NYCRR Section 504.3(a) 18 NYCRR Section 540.7(a)(8)
2.	Missing Documentation of Intermediate Care Facility/Mental Retardation (ICF/MR) Level of Care Eligibility Determination (LCED) Annual Redetermination
OMIG Audit Criteria	Claims will be disallowed if the ICF/MR LCED is missing or if the annual redetermination lacks the required signature of a physician, physician assistant, nurse practitioner or Qualified Mental Retardation Professional (QMRP) dated within 365 days of the previous redetermination. As of September 2012, a QMRP is referred to as a Qualified Intellectual Disability Professional (QIDP). Note: This finding applies only if the recipient is enrolled in the Home and Community-Based Services waiver.
Regulatory References	14 NYCRR Section 635-10.3(a) and (b)(2) 14 NYCRR Section 671.4(b)(1)(ii) Medicaid Service Coordination Vendor Manual*, Chapter 2 OPWDD ADM #2010-03, p. 5 OPWDD ADM #2011-01, p. 2
3.	No Documentation of Service
OMIG Audit Criteria	If the recipient record does not document that a Medicaid Service Coordination service was provided, the claim will be disallowed.
Regulatory References	18 NYCRR Section 504.3(a) 18 NYCRR Section 517.3(b)(2) OPWDD ADM #2010-03, p. 7
4.	Services Performed by Unqualified Medicaid Service Coordinator (MSC) Staff
OMIG Audit Criteria	Claims for services that were delivered by MSC staff that did not meet the minimum qualification standards for education, experience, [core] training, and professional development requirements (including annual professional development requirements) will be disallowed.
Regulatory References	Medicaid Service Coordination Vendor Manual, Chapter 2 OPWDD ADM #2010-03, p. 5
5.	Missing Medicaid Service Coordination Agreement
OMIG Audit Criteria	Claims will be disallowed if evidence that the Medicaid Service Coordination agreement (Agreement) was executed is missing from the recipient record. Evidence may include a copy of the Agreement or a monthly service note indicating the Agreement was reviewed.
Regulatory References	Medicaid Service Coordination Vendor Manual, Chapter 4, Section 3 OPWDD ADM #2010-03, p. 5

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6.	Completion of the Initial Individualized Service Plan (ISP) Exceeded the 60-Day Timeframe
OMIG Audit Criteria	The initial ISP must be completed within 60 days of the Home and Community-Based Services (HCBS) enrollment date or within 60 days of the MSC enrollment date, whichever is earlier. The claim will be disallowed if the ISP is not completed within 60 days of the HCBS enrollment date or the MSC enrollment date, whichever is earlier.
Regulatory References	OPWDD ADM #2010-03, p. 6

7.	Missing Individualized Service Plan (ISP)
OMIG Audit Criteria	Claims will be disallowed if the ISP is missing. If no ISP is in place for a particular time period, there will be disallowances for the dates of service within that time period.
Regulatory References	14 NYCRR Section 635-10.2(a) Medicaid Service Coordination Vendor Manual, Chapter 4

8.	The Medicaid Service Coordinator Caseload Exceeds Caseload Requirements
OMIG Audit Criteria	If the Medicaid Service Coordinator's (MSC) caseload exceeds established limits, the claims representing the dates of service within the period of time exceeding established limits will be disallowed. In the event an MSC is temporarily absent, the documentation must clearly indicate the reason for and the length of the absence as contributing factors for other MSC caseloads increasing.
Regulatory References	Medicaid Service Coordination Vendor Manual, Chapter 2

9.	Incorrect Rate Code Billed
OMIG Audit Criteria	Medicaid Service Coordination is reimbursed as a monthly rate. The claim will be adjusted if the incorrect rate code is billed. The disallowance will be the difference between the amount of the incorrect rate code billed and amount of the correct rate code.
Regulatory References	Medicaid Service Coordination Vendor Manual, Chapter 5

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10.	Missing Required Elements of Medicaid Service Coordination Notes
OMIG Audit Criteria	Claims will be disallowed if one or more of the required elements of the Medicaid Service Coordination (MSC) note is missing: 1) the individual's name; 2) identification of service provided; 3) identification of the vendor providing the MSC; 4) the month and year the service was provided; 5) a description of the activity(s) provided: -if the activity involves a face-to-face service meeting, the purpose, outcome, and location of the service meeting must be included, -if the activity involves contact with a qualified contact, the purpose and outcome of the meeting, and the identity and relationship of the contact should be included; 6) a monthly summary; 7) the full name, title, and signature of the MSC service coordinator; and, 8) the date the note was written (i.e., the signature date) which must include the day, the month, and the year.
Regulatory References	OPWDD ADM #2010-03, p. 4
11.	Missing/Late Medicaid Service Coordination Notes
OMIG Audit Criteria	Claims will be disallowed if the MSC note is missing or not completed by the fifteenth of the month following the month of service.
Regulatory References	Medicaid Service Coordination Vendor Manual, Chapter 4, Overview and Section 4 OPWDD ADM #2010-03, p. 5
12.	Missing Required Elements in the Individualized Service Plan (ISP)
OMIG Audit Criteria	Claims will be disallowed if one or more of the required elements of the ISP is missing: 1) assessment information and recommendations; 2) identification of each service, service provider, the amount, frequency, duration of each service, and effective dates for service delivery; 3) identification of personal goals, preferences, capabilities and capacities relative to needs stated in terms of outcomes; and, 4) service coordination, including assessment, service planning and coordination, linkage and referral, follow-up and monitoring. The claim will also be disallowed if documentation of the safeguards that must be in place to protect the recipient's health and safety, including a summary of fire safety needs, is missing.
Regulatory References	14 NYCRR Section 635-99.1(b) Medicaid Service Coordination Vendor Manual, Chapter 2 and Chapter 4, Section 3 OPWDD ADM #2010-04 (ISP Instructions, p. 2) OPWDD ADM #2010-03, p. 5
13.	Missing Individualized Service Plan (ISP) Review
OMIG Audit Criteria	Claims will be disallowed if the ISP review is missing or not completed twice annually from the prior ISP review. Also, claims will be disallowed if at least one of the twice annual reviews is not a face-to-face meeting with the recipient.
Regulatory References	14 NYCRR Section 635-99.1(b) Medicaid Service Coordination Vendor Manual, Chapter 2 OPWDD ADM #2010-03, p. 5

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14.	Distribution of the Individualized Service Plan (ISP) Exceeded 60 Days
OMIG Audit Criteria	Claims will be disallowed if the distribution of the ISP to the recipient, advocate, and major service providers, with or without requisite signatures, exceeds 60 days from the date of the ISP review.
Regulatory References	OPWDD ADM #2010-03, p. 6
15.	Failure to Meet Minimum Requirement of a Monthly Service Meeting
OMIG Audit Criteria	Claims will be disallowed for failure to document the monthly service meeting for recipients who receive face-to-face meetings on an as-needed basis (except for Willowbrook Class recipients who always receive a monthly face-to-face service meeting).
Regulatory References	OPWDD ADM #2010-03, p. 4
16.	Failure to Deliver or Document Minimum Required Service Activity
OMIG Audit Criteria	To bill for a month of service, the MSC staff must deliver and document an activity according to the requirements specified in OPWDD ADM # 2010-03. The claim will be disallowed if the recipient record does not document the activity.
Regulatory References	OPWDD ADM #2010-03, pp. 2-4
17.	Failure to Meet Minimum Required Face-to-Face Meetings or In-Home Visit Meeting
OMIG Audit Criteria	Except for Willowbrook Class recipients, the claim will be disallowed if the minimum required face-to-face meetings were not held or if the at least once annually in-home visit meeting was not held.
Regulatory References	Medicaid Service Coordination Vendor Manual, Chapter 2
18.	Missing Medicaid Service Coordination Agreement Review
OMIG Audit Criteria	If the Medicaid Service Coordination agreement review is missing from the recipient record the claim will be disallowed.
Regulatory References	OPWDD ADM #2010-03, p. 6

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NOTES:

***MSC Vendor Manual – *Medicaid Service Coordination Manual*. This manual is written for service coordinators and administrative staff of vendors that provide Medicaid Service Coordination (MSC) services under contract with the Office for People With Developmental Disabilities (OPWDD).**

MSC is a Medicaid State Plan service provided by OPWDD.

The Medicaid State Plan represents a contract between New York State and the Federal Government.