NEW YORK STATE | Office of the Medicaid Inspector General

OMIG AUDIT PROTOCOL – OFFICE OF MENTAL HEALTH COMMUNITY REHABILITATION SERVICES FOR ADULTS

Revised 5/20/16

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 Documentation of Rehabilitation Service**
OMIG Audit Criteria	If the record does not document the rehabilitation services billed, the claim will be disallowed.
Regulatory References	18 NYCRR Section 504.3(a) 14 NYCRR Section 595.14(a) 14 NYCRR Section 595.14(b)(8) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

2.	**Missing Progress Note**
OMIG Audit Criteria	If a progress note or notes were not documented during the sampled month, the claim will be disallowed.
Regulatory References	14 NYCRR Section 593.6(e) 14 NYCRR Section 595.11(c) 14 NYCRR Section 595.14(b)(7)

3.	**Failure to Document Four Different Rehabilitation Services For a Full Month Claim**
OMIG Audit Criteria	A full month claim must include at least 4 different community rehabilitation services. (1) Assertiveness/Self advocacy Training (2) Community Integration (3) Daily Living Skills (4) Health Services (5) Medication Management & Training (6) Parenting Training (7) Rehabilitation Counseling (8) Skill Development (9) Socialization (10) Substance Abuse Services (11) Symptom Management If two or three different community rehabilitation services were provided, the full month claim will be reduced to a half month claim and the difference will be disallowed. If less than two different community rehabilitation services were provided, the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 593.4(b) 14 NYCRR Section 593.7(b)(1) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

4.	**Failure to Document Two Different Rehabilitation Services for a Half Month Claim**
OMIG Audit Criteria	If less than two different community rehabilitation services were provided, the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 593.4(b) 14 NYCRR Section 593.7(b)(2) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

5.	Recipient Not in Residence 21 Days in Month
OMIG Audit Criteria	If the client was in residence less than 21 days but 11 days or more, the full month claim will be reduced to a half month claim and the difference will be disallowed. If the client was in residence less than 11 days in the month, the entire full month claim will be disallowed.
Regulatory References	14 NYCRR Section 593.7(b)(1) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

6.	Recipient Not in Residence 11 Days in Month
OMIG Audit Criteria	If the client was in residence less than 11 days in the month, the entire half month claim will be disallowed.
Regulatory References	14 NYCRR Section 593.7(b)(2) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

7.	Failure to Perform Rehabilitation Services on Different Days
OMIG Audit Criteria	If more than one rehabilitation service was performed on any day of the month, only one billable contact is counted for that day. If 2 or 3 billable contacts are counted and a full month claim was billed, the claim will be reduced to a half month claim and the difference will be disallowed. If fewer than 2 billable contacts are counted, then the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 593.7(b)(3) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

8.	Failure to Meet Minimum Duration Requirements
OMIG Audit Criteria	A rehabilitation service lasting less than 15 minutes in duration will not be counted as a billable contact. If 2 or 3 billable contacts are counted and a full month claim was billed, the claim will be reduced to a half month claim and the difference will be disallowed. If fewer than 2 billable contacts are counted, then the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 595.14(b)(8) 14 NYCRR Section 593.7(b)(3) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

9.	Rehabilitation Service Provided Not Included in Service Plan
OMIG Audit Criteria	If the community rehabilitation service provided is not specified on the resident's service plan, then that service is not counted as a billable contact. If 2 or 3 billable contacts are counted and a full month claim was billed, the claim will be reduced to a half month claim and the difference will be disallowed. If fewer than 2 billable contacts are counted, then the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 595.11(b)(5) 14 NYCRR Section 593.7(b)(4) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

10.	Duration of Rehabilitation Service Not Documented
OMIG Audit Criteria	If the duration of service is not documented, the service will not be counted as a billable contact. If 2 or 3 billable contacts are counted and a full month claim was billed, the claim will be reduced to a half month claim and the difference will be disallowed. If fewer than 2 billable contacts are counted, then the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 595.14(b)(8) 14 NYCRR Section 593.7(b)(3) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

11.	Failure to Document Date Rehabilitation Service Performed
OMIG Audit Criteria	If the record does not indicate the date that the service was performed, the service will not be counted as a billable contact. If 2 or 3 billable contacts are counted and a full month claim was billed, the claim will be reduced to a half month claim and the difference will be disallowed. If fewer than 2 billable contacts are counted, then the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 595.14(b)(8) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

12.	Billing for Non-Reimbursable Contact
OMIG Audit Criteria	A rehabilitation service performed while the client was at an outpatient clinic, an inpatient at a hospital, residing at another residential facility or not performed face-to-face, will not be counted as a billable contact. If 2 or 3 billable contacts are counted and a full month claim was billed, the claim will be reduced to a half month claim and the difference will be disallowed. If fewer than 2 billable contacts are counted, then the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 593.7(b) 14 NYCRR Section 593.7(b)(5) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

13.	Failure to Document Staff Person Providing Rehabilitation Service
OMIG Audit Criteria	If the staff person's name who provided the community rehabilitation service was not documented, the service will not be counted as a billable contact. If 2 or 3 billable contacts are counted and a full month claim was billed, the claim will be reduced to a half month claim and the difference will be disallowed. If fewer than 2 billable contacts are counted, then the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 595.14(b)(8)

14.	Missing Initial Physician Authorization
OMIG Audit Criteria	If the record does not have the initial physician authorization or the initial authorization is signed by an unauthorized person (e.g., nurse practitioner, social worker or therapist) the claim will be disallowed.
Regulatory References	14 NYCRR Section 593.6(a) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

15.	Missing Renewal/Reauthorization of Authorization
OMIG Audit Criteria	If the reauthorization is missing from the record or the reauthorization is signed by an unauthorized person (social worker or therapist) the claim will be disallowed.
Regulatory References	14 NYCRR Section 593.6(b) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

16.	Authorization Lacks Required Authorization Period
OMIG Audit Criteria	If the authorization for the recipient to receive services is not dated and/or lacks an authorization period, the claim will be disallowed.
Regulatory References	14 NYCRR Section 593.6(a)(2)

17.	Missing Service Plan/Service Plan Review
OMIG Audit Criteria	If the record does not have a service plan developed within four weeks of admission to the program or a service plan review effective for the sample month, the claim will be disallowed.
Regulatory References	14 NYCRR Section 593.6(c) and (f) 14 NYCRR Section 595.1(b) 14 NYCRR Section 595.11(a) and (d) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

18.	**Service Plan/Service Plan Review Not Reviewed and Signed by Qualified Mental Health Staff Person (QMHSP)**
OMIG Audit Criteria	If the service plan/review effective for the sample month is not signed by a Qualified Mental Health Staff Person, the claim will be disallowed.
Regulatory References	14 NYCRR Section 593.6(d) and (f)(3) 14 NYCRR Section 595.4(a)(10) 14 NYCRR Section 595.11(b) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

19.	**Missing Admission Note**
OMIG Audit Criteria	If an admission note was not documented at the time of admission, the claim will be disallowed.
Regulatory References	14 NYCRR Section 593.6(c) 14 NYCRR Section 595.11(a)

20.	**Admission Note Not Completed by a Qualified Mental Health Staff Person (QMHSP)**
OMIG Audit Criteria	If the admission note is not signed by a Qualified Mental Health Staff Person, the claim will be disallowed.
Regulatory References	14 NYCRR Section 595.4(a)(10) 14 NYCRR Section 595.11(a) 14 NYCRR Section 593.6(c)

21.	**Billing Medicaid for Unlicensed Residence**
OMIG Audit Criteria	If the residence does not have an operating certificate or the certificate is invalid, the claim will be disallowed.
Regulatory References	14 NYCRR Section 593.5(a) 14 NYCRR Section 595.5(a) and (e) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

22.	Recipient Excess Income (Spend Down) Not Applied Prior to Billing Medicaid
OMIG Audit Criteria	The spend-down amount should be applied beginning with the first service rendered in the month and each service thereafter until the spend-down is exhausted. Each sampled claim subject to spend-down application that was billed to Medicaid before the spend-down was met will be disallowed. **NOTE:** This finding only applies where the relevant county has assigned responsibility for the spend-down to the provider and the sample claim must be impacted by the spend-down
Regulatory References	18 NYCRR Section 504.3(a) 18 NYCRR Section 518.1(c) 18 NYCRR Section 360-4.8(c)(1) 18 NYCRR Section 360-4.8(c)(2)(ii)