NEW YORK STATE | Office of the Medicaid Inspector General

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OMIG AUDIT PROTOCOL
OMH SED SERVICES
RESPITE SERVICES

REVISED 12/5/2017

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 was not available for review, claims for all dates of service associated with the recipient record will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) 18 NYCRR § 540.7(a)(8) 18 NYCRR § 517.3(b)(1)

2.	**No Documentation of Respite Service**
OMIG Audit Criteria	If the recipient record does not document that a Home and Community-Based Services (HCBS) Waiver service was provided, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) 18 NYCRR § 540.7(a)(8) 18 NYCRR § 517.3(b)(1) OMH HCBS Waiver Guidance Document 100.1

3.	**Missing Progress Note**
OMIG Audit Criteria	A progress note must be present for every contact. The note must be complete and timely. The claim will be disallowed if the progress note was missing.
Regulatory References	OMH HCBS Waiver Guidance Document 400.4 OMH HCBS Waiver Guidance Document 600.3 OMH HCBS Waiver Guidance Document 600.4

4.	**Incomplete Progress Note**
OMIG Audit Criteria	Each progress note must include the following information: the date the note is being recorded; the service provided; to whom the service was provided; the type of contact; the contact date for the unit of service; the duration of the service that was provided; the progress toward the service plan goals and objectives; the level of participation of recipient/family; the name of person/agency providing the service; and the name(s) of person(s)/agency with whom services were coordinated. The claim will be disallowed if the progress note was incomplete.
Regulatory References	OMH HCBS Waiver Guidance Document 400.4

5.	**Incomplete Group Progress Note**
OMIG Audit Criteria	The group progress note must include the following information: the date the note is being recorded; the service provided; to whom the service was provided; the type of contact; the contact date for the unit of service; the duration of the service that was provided; the progress toward the service plan goals and objectives; the level of participation of recipient/family; the name of person/agency providing the service; the name(s) of person(s)/agency with whom services were coordinated; the type of group; and the worker to child ratio. The claim will be disallowed if the group progress note was incomplete. **Note: The OMH Group Progress Note form should be used.**
Regulatory References	OMH HCBS Waiver Guidance Document 400.4 OMH HCBS Waiver Guidance Document 600.4

6.	**Missing Face-to-Face Contact**
OMIG Audit Criteria	For respite services, reimbursement is only for face-to-face contacts. The claim will be disallowed if the contact was not face-to-face.
Regulatory References	OMH HCBS Waiver Guidance Document 600.3 OMH HCBS Waiver Guidance Document 600.3a

7.	**Improper Billing Units for Respite Services**
OMIG Audit Criteria	Billing for respite services must be made in 15 minute increments. The claim will be disallowed if the billing was not rounded down to the closest 15 minutes of service delivered.
Regulatory References	OMH HCBS Waiver Guidance Document 600.3

8.	**Failure to Meet Minimum Duration for Respite Services**
OMIG Audit Criteria	In order to bill, each respite service must be conducted for a **minimum of 30 minutes a day**. The claim will be disallowed if the service was conducted for less than 30 minutes a day.
Regulatory References	OMH HCBS Waiver Guidance Document 600.3

9.	**Missing Documentation for Respite Services in Service Plan**
OMIG Audit Criteria	Respite services must be documented in the recipient's service plan and pertain to the recipient's goal. The claim will be disallowed if respite service was not documented in the service plan.
Regulatory References	OMH HCBS Waiver Guidance Document 100.1 OMH HCBS Waiver Guidance Document 600.3

10.	**Improper Service Identification for Billing for Respite Services**
OMIG Audit Criteria	The claim will be disallowed if the service identified on the claim did not match the service definition.
Regulatory References	OMH HCBS Waiver Guidance Document 600.3 OMH HCBS Waiver Guidance Document 100.1

11.	**Limit Exceeded for Billing for Respite Services**
OMIG Audit Criteria	Billing for respite services is limited to six hours per recipient per day. The claim will be disallowed if billing was more than six hours per recipient per day.
Regulatory References	OMH HCBS Waiver Guidance Document 600.3

12.	**Missing Group Support in Service Plan**
OMIG Audit Criteria	The service plan must support the group composition and the group activities. The claim will be disallowed if the service plan did not support the group composition and the group activities.
Regulatory References	OMH HCBS Waiver Guidance Document 600.4 OMH HCBS Waiver Guidance Document 100.1

13.	**Improper Billing Units for Group Respite Services**
OMIG Audit Criteria	Billing for group respite services must be in 15 minute increments, rounded down to the closest 15 minutes of service delivered, and claimed for the actual date of service. The claim will be disallowed if the billing for group respite services was not rounded down to the closest 15 minutes of service delivered.
Regulatory References	OMH HCBS Waiver Guidance Document 600.4

14.	**Failure to Meet Minimum Billing for Group Respite Services**
OMIG Audit Criteria	Billing for group respite services must be of at least 30 minutes in duration and continuous per billable contact in a day. The claim will be disallowed if the service was less than 30 minutes in duration.
Regulatory References	OMH HCBS Waiver Guidance Document 600.4

15.	Maximum Worker to Participant Ratio Exceeded for Group Respite Services
OMIG Audit Criteria	The maximum worker to participant ratio allowed for billing for group respite services is 1 worker to 3 group members. The claim will be disallowed if the ratio of worker to group members was exceeded.
Regulatory References	OMH HCBS Waiver Guidance Document 600.4

16.	Incorrect Rate Code Billed - Respite
OMIG Audit Criteria	Respite service billings must be done in 15 minute increments using the group rate code appropriate for the total number of participants. If an individual service rate is billed when a group service is documented, the amount of the claim disallowed will be the difference between the individual service rate and the group service rate amount.
Regulatory References	OMH HCBS Waiver Guidance Document 600.4