Office of the Medicaid Inspector General
NEW YORK STATE

OMIG AUDIT PROTOCOL
OMH SED SERVICES
INDIVIDUALIZED CARE COORDINATION (ICC)

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 patient 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 Individualized Care Coordination (ICC)**
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)

3.	**Missing Initial Level of Care (LOC) Determination**
OMIG Audit Criteria	Claims will be disallowed if the initial LOC determination was missing.
Regulatory References	OMH HCBS Waiver Guidance Document 300.4 OMH HCBS Waiver Guidance Document 500.2

4.	**Missing LOC Recertification**
OMIG Audit Criteria	The LOC determination must be reviewed and completed every 12 months for continued eligibility and enrollment in the HCBS Waiver. The recertification date is 1 year from the date of the initial/previous LOC. The claim will be disallowed if the LOC recertification was missing or not in effect as authorized by the Local Governmental Unit (LGU) by the recertification date.
Regulatory References	OMH HCBS Waiver Guidance Document 500.6 OMH HCBS Waiver Guidance Document 500.3

5.	**Improper Initial Billing**
OMIG Audit Criteria	ICC Agencies must not begin billing for Waiver services until specifically advised to do so by the Operations Support Unit (OSU). The claim will be disallowed if the initial billing was completed before notification.
Regulatory References	OMH HCBS Waiver Guidance Document 600.1 OMH HCBS Waiver Guidance Document 500.2 OMH HCBS Waiver Guidance Document 500.5

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6.	**Missing Initial Service Plan (ISP)**
OMIG Audit Criteria	The original ISP, approved and signed by the LGU, must be maintained by the Individualized Care Coordinator (ICC) in the child's record. If the ISP was missing, the claim will be disallowed.
Regulatory References	OMH HCBS Waiver Guidance Document 400.1 OMH HCBS Waiver Guidance Document 500.5

7.	**Missing Signature on ISP**
OMIG Audit Criteria	The ISP must be signed and dated by the ICC, the ICC Supervisor, the family and recipient, and the LGU. The claim will be disallowed if one of the signatures was missing.
Regulatory References	OMH HCBS Waiver Guidance Document 400.1 OMH HCBS Waiver Guidance Document 500.5

8.	**Service Plan Review Missing or Not Completed Within Required Timeframe**
OMIG Audit Criteria	The service plan shall be reviewed 30 days from the enrollment date. Subsequent service plan reviews are due every 90 days thereafter. All parties, except the LGU, must sign each service plan review. The claim will be disallowed in the absence of a timely* service plan review and/or required signatures. **At no time should a service plan be completed, including signatures, more than five business days prior to its due date. All completed service plans, including signatures, after the due date will be considered late. ICC Supervisors may be allowed an extra three business days after the due date if needed, to review and sign the service plan.*
Regulatory References	OMH HCBS Waiver Guidance Document 400.1

9.	**Incomplete Service Plan Budget Review**
OMIG Audit Criteria	The individualized service plan budget is to be reviewed at each 90-day service plan review. The claim will be disallowed if the budget was missing from the 90-day service plan review.
Regulatory References	OMH HCBS Waiver Guidance Document 500.5

10.	**Incorrect Services Documented on the Individualized Service Plan Budget**
OMIG Audit Criteria	The type and number of all waiver services listed on the service plan budget must include all the waiver services indicated in the service plan. The claim will be disallowed if the waiver services on the budget did not include those on the service plan.
Regulatory References	OMH HCBS Waiver Guidance Document 500.5

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11.	**Failure to Meet Criteria for Qualifying Face-to-Face Contacts**
OMIG Audit Criteria	A qualifying face-to-face contact must meet the following criteria: (1) contact the Individualized Care Coordinator (ICC) has with the recipient or collaterals. (2) contacts are limited to one per day with the recipient and one per day with the collateral. (3) A progress note must be present for each contact. The note must be complete and timely. (4) Each contact must be a minimum of 15 minutes. (5) An ICC face-to-face contact with a Medicaid provider is allowed if the Medicaid provider is identified in the recipient's service plan as a collateral. The Medicaid provider cannot bill at the same time for the contact. The claim will be disallowed if one or more of the criteria were missing.
Regulatory References	OMH HCBS Waiver Guidance Document 600.2 OMH HCBS Waiver Guidance Document 400.4

12.	**Missing Progress Note**
OMIG Audit Criteria	A progress note must be present for each qualifying contact. A face-to-face contact will not be counted as a billable contact if the progress note is missing. The claim will be disallowed for a missing progress note.
Regulatory References	OMH HCBS Waiver Guidance Document 400.4 OMH HCBS Waiver Guidance Document 600.2

13.	**Incomplete Progress Note**
OMIG Audit Criteria	The progress note must be present for each qualifying contact. Each 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; and the name of person/agency providing the service. The Progress Note shall also be used to document progress toward the service plan goals and objectives, the level of participation of the recipient/family, and specify any revisions to the service plan, and barriers to timely service plan completion, if any. A face-to-face contact will not be counted as a billable contact if the progress note does not include the required information to substantiate the contact. The claim will be disallowed if the progress note was not complete, timely, or does not accurately relate to, and identify, the child's service plan goal and objective(s).
Regulatory References	OMH HCBS Waiver Guidance Document 400.4

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14.	Failure to Meet Required Face-to-Face Contacts for Full-Month ICC Billing
OMIG Audit Criteria	The claim for a full month billing will be disallowed if the following requirements were not met: a minimum of six qualifying face-to-face contacts in a calendar month; at least 3 of those contacts must be with the recipient; the remaining contacts to make the minimum of 6 must be with collaterals identified in the recipient's service plan; and the recipient must be enrolled in the program for at least 21 *consecutive* days in the calendar month. **Note**: The claim will be reduced to a half month billing if the requirements for a half month billing are met.
Regulatory References	OMH HCBS Waiver Guidance Document 600.2

15.	Failure to Meet Required Face-to-Face Contacts for Half-Month ICC Billing
OMIG Audit Criteria	The claim for a half month billing will be disallowed if the following requirements were not met: a minimum of 3 qualifying face-to-face contacts in a calendar month; at least 2 of those contacts must be with the recipient; the remaining contacts to make the minimum of three must be with collaterals identified in the recipient's service plan; and the recipient must be enrolled in the program for at least 11 *consecutive* days in the calendar month.
Regulatory References	OMH HCBS Waiver Guidance Document 600.2

16.	Failure to Meet Required Face-to-Face Contacts for Two Half-Months ICC Billing
OMIG Audit Criteria	The claim for 2 half months billing will be disallowed if the following requirements were not met: a minimum of 6 qualifying face-to-face contacts in a calendar month; at least 3 of those contacts must be with the recipient; the remaining contacts to make the minimum of 6 must be with collaterals identified in the recipient's service plan; and the recipient must be enrolled for at least 21 days in a calendar month. **Note:** The claim will be reduced to a half-month billing if the requirements for 2 half-month billings are not met.
Regulatory References	OMH HCBS Waiver Guidance Document 600.2

17.	Failure to Meet Minimum Duration Requirements
OMIG Audit Criteria	Each qualifying face-to-face contact must be a minimum of 15 minutes. The claim will be disallowed if the duration of the contact was less than 15 minutes. **Note**: A full month billing may be reduced to a half month billing if the number of contacts that meet the duration requirements for a half month billing are met.
Regulatory References	OMH HCBS Waiver Guidance Document 600.2

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18.	**Duration of Contact Not Documented**
OMIG Audit Criteria	Each qualifying face-to-face contact must be a minimum of 15 minutes. The claim will be disallowed if there was no documentation of the duration of the contact.
Regulatory References	OMH HCBS Waiver Guidance Document 600.2 OMH HCBS Waiver Guidance Document 400.4

19.	**Improper Billing for ICC Start-Up Services**
OMIG Audit Criteria	An enhanced ICC rate is available for the period before HCBS Waiver enrollment is determined. Billing can be for 1 full month, 1 half month, or for 2 consecutive half months, as long as the required number and types of ICC contacts have been made. The start-up period is the time between the date the waiver application is signed and the effective date of the waiver enrollment on the Notice of Decision – Acceptance. The claim will be disallowed if more than 1 start-up service was billed or if another waiver service was provided (e.g., respite, family support or skill building). **Note:** Start-up services can only be billed after the enrollment date.
Regulatory References	OMH HCBS Waiver Guidance Document 600.2 OMH HCBS Waiver Guidance Document 500.4

20.	**Improper Billing for ICC Services While in Out of the Home Placement**
OMIG Audit Criteria	The claim will be disallowed if any of the criteria for the following billing situations were missing: **Psychiatric or Medical Hospitalization**: The service delivery minimum remains the same as in the home placement if the *expectation* is that the recipient will be discharged to the waiver. To qualify for reimbursement, the recipient *must return* to the waiver upon discharge from the hospital. **Jail or Detention:** A recipient may be in jail or detention for up to 1 month (up to 31 consecutive days) and remain in the waiver. ICC billing may occur for the part of the *calendar* month the recipient is not in jail or detention. Services may be billed if during that time the recipient is home for the minimum 11 days for a half-month billing or 21 days for a full month billing and the minimum ICC face-to-face contacts have been made. **Residential Assessment Program or Substance Abuse Treatment Program:** The recipient may be placed in a residential assessment program or a substance abuse treatment program for up to 45 days and remain in the waiver as long as the required ICC monthly or half-monthly contacts are made and the recipient returns to home within 45 days. **Residential Treatment Facility and Psychiatric Hospitalization during Start Up:** ICC Start-Up services can begin 30-days prior to a child's discharge from a Residential Treatment Facility (RTF) or a psychiatric hospital.
Regulatory References	OMH HCBS Waiver Guidance Document 600.2

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