NEW YORK STATE | Office of the Medicaid Inspector General

OMIG AUDIT PROTOCOL
TRAUMATIC BRAIN INJURY (TBI)

Revised 03/09/2018

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 the 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.

OMIG AUDIT PROTOCOL
TRAUMATIC BRAIN INJURY (TBI)

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1. Missing/Incomplete Service Plan	
OMIG Audit Criteria	If the Initial (Form C-1.2) or Revised Service Plan (Form C-4.1) is missing or incomplete, the claim will be disallowed.
Regulatory References	Social Security Act § 1902(a)(27), 42 USC § 1396(a)(27) 42 CFR § 441.301(b)(1)(i) CMS State Medicaid Manual Section 2497.1 CMS State Medicaid Manual Section 4442.6 18 NYCRR § 504.3(a) and (i) 18 NYCRR § 540.7(a)(8) 18 NYCRR § 517.3(b)(1) and (2) NYS DOH – HCBS Provider Agreement, June 2008 Traumatic Brain Injury Program Manual, April 2009, Section V

2. Missing Documentation of Service	
OMIG Audit Criteria	If documentation of service is missing, the claim will be disallowed. Documentation of service is required in addition to the Initial/Revised Service Plan.
Regulatory References	Social Security Act § 1902(a)(27), 42 USC § 1396(a)(27) CMS State Medicaid Manual Section 2497.1 DOH Medicaid Update, January 2005, Vol. 20, No. 1 18 NYCRR § 504.3(a) and (i) NYS DOH – HCBS Provider Agreement, June 2008 Traumatic Brain Injury Program Manual, April 2009, Section VII

3. Service Plan Not Reviewed By Service Coordinator Within a 6-Month Period or When Otherwise Required	
OMIG Audit Criteria	If the Service Plan has not been reviewed within the specified period (6 months or as otherwise required) by the Service Coordinator, the participant, and/or any individual(s) legally responsible who participated in the development of the plan, the claim will be disallowed.
Regulatory References	Social Security Act § 1902(a)(27), 42 USC § 1396(a)(27) CMS State Medicaid Manual Section 2497.1 18 NYCRR § 504.3(a) and (i) NYS DOH – HCBS Provider Agreement, June 2008 Traumatic Brain Injury Program Manual, April 2009, Sections III and V

4. Billed Service Not Included in the Service Plan	
OMIG Audit Criteria	If a service is not included in the Initial/Revised Service Plan, or Addendum, then the claim will be disallowed.
Regulatory References	Social Security Act § 1902(a)(27), 42 USC § 1396(a)(27) CMS State Medicaid Manual Section 2497.1 CMS State Medicaid Manual Section 4442.6 42 CFR § 441.301(b)(1)(i) NYS DOH – HCBS Provider Agreement, June 2008 Traumatic Brain Injury Program Manual, April 2009, Sections VI and VII

5. Billed More Hours than Authorized in the Service Plan	
OMIG Audit Criteria	If the number of service hours billed is greater than the hours specified in the Service Plan or Addendum, then the hours exceeding the plan will be disallowed.
Regulatory References	CMS State Medicaid Manual Section 2497.1 CMS State Medicaid Manual Section 4442.6 42 CFR § 441.301(b)(1)(i) Traumatic Brain Injury Program Manual, April 2009, Section VI

6. Billed More Hours than Documented	
OMIG Audit Criteria	If the service hours noted in the case/progress notes are less than the number of hours billed, then the excess hours will be disallowed.
Regulatory References	Social Security Act § 1902(a)(27), 42 USC § 1396(a)(27) CMS State Medicaid Manual Section 2497.1 18 NYCRR § 504.3(a) and (i) 18 NYCRR § 517.3(b)(1) and (2) NYS DOH – HCBS Provider Agreement, June 2008 DOH Medicaid Update, January 2005, Vol. 20, No. 1 Traumatic Brain Injury Program Manual, April 2009, Section VII

7. Duplicate Billing for Service	
OMIG Audit Criteria	If a service is billed and paid more than once, each additional claim after the initial will be disallowed.
Regulatory References	CMS State Medicaid Manual Section 2497.1

8. Incorrect Rate Code Billed	
OMIG Audit Criteria	If a service was billed with an incorrect rate code, the difference between the correct and incorrect rate codes will be disallowed.
Regulatory References	Social Security Act § 1902(a)(27), 42 USC § 1396(a)(27) CMS State Medicaid Manual Section 2497.1 18 NYCRR § 504.3(a) and (i) 18 NYCRR § 517.3(b)(1) and (2) 18 NYCRR § 540.7(a)(8) NYS DOH – HCBS Provider Agreement, June 2008

9. Partial Service Hours Were Billed Incorrectly	
OMIG Audit Criteria	Service of less than one hour should be carried forward to the next service date and combined to accumulate billable time in whole hours. The provider must have an hour of service documented in order to bill. Claims billed that are documented for less than one hour will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) HCBS/TBI Waiver Provider Manual, Section V DOH Medicaid Update, January 2005, Vol. 20, No. 1 Traumatic Brain Injury Program Manual, April 2009, Section VI

10. Failure to Meet Ongoing Service Coordination Billing Requirements	
OMIG Audit Criteria	If the Service Coordinator cannot provide evidence of at least one face-to-face with the participant per month, the claim for that month will be disallowed.
Regulatory References	Social Security Act § 1902(a)(27), 42 USC § 1396(a)(27) 18 NYCRR § 504.3(a) and (i) NYS DOH – HCBS Provider Agreement, June 2008 Traumatic Brain Injury Program Manual, April 2009, Section VI

11. No Identification of Service Plan Goals Under Current Pursuit	
OMIG Audit Criteria	All Service Plans must contain current goals, which are being pursued by the participant and the provider. Failure to document the pursuit of these goals will result in the claims being disallowed.
Regulatory References	Social Security Act § 1902(a)(27), 42 USC § 1396(a)(27) 42 CFR § 441.301(b)(1)(i) CMS State Medicaid Manual Section 4442.6 18 NYCRR § 504.3(a) and (i) NYS DOH – HCBS Provider Agreement, June 2008 DOH Medicaid Update, January 2005, Vol. 20, No. 1 Traumatic Brain Injury Program Manual, April 2009, Sections V, VI and VII

12. Overlapping of Services Not Authorized in Service Plan	
OMIG Audit Criteria	If more than one service is provided during the same time frame, and overlapping services are not authorized in either the Service Plan or the Addendum, then the overlapping claims will be disallowed.
Regulatory References	Social Security Act § 1902(a)(27), 42 USC § 1396(a)(27) 42 CFR § 441.301(b)(1)(i) 18 NYCRR § 504.3(a) and (i) NYS DOH – HCBS Provider Agreement, June 2008 Traumatic Brain Injury Program Manual, April 2009, Section V

13. Services Performed by Unqualified Service Coordinator Staff	
OMIG Audit Criteria	If the Service Coordinator does not meet the qualification requirements for the position (education/experience) at the date of service, all claims provided by the unqualified Service Coordinator will be disallowed.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Section VI

14. Services Performed by Unqualified Independent Living Skills Training (ILST) and Development Staff	
OMIG Audit Criteria	If the provided service was performed by staff who did not meet the standards required for the ILST position (education/experience) at the date of service, the claims provided by the unqualified staff will be disallowed.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Section VI

15. Services Performed by Unqualified Behavioral Specialist	
OMIG Audit Criteria	If the provided service was performed by staff who did not meet the standards required for the Behavioral Specialist position (education/experience) at the date of service, the claims provided by the unqualified staff will be disallowed.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Section VI

16. Services Performed by Unqualified Community Integration Counseling (CIC) Staff	
OMIG Audit Criteria	If the provided service was performed by staff who did not meet the standards required for the CIC position (education/experience) at the date of service, the claims provided by the unqualified staff will be disallowed.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Section VI

17. TBI Training Not Completed – Service Coordinator	
OMIG Audit Criteria	The HCBS/TBI Waiver Program Manual states that there are three components of required training: Basic Orientation Training, Service-Specific Training, and Annual Training. If the Service Coordinator has not received or is not current on any of these trainings at the time service is rendered, then all claims provided within that time frame will be disallowed.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Section VIII

18. TBI Training Not Completed – Behavioral Specialist	
OMIG Audit Criteria	The HCBS/TBI Waiver Program Manual states that there are three components of required training: Basic Orientation Training, Service-Specific Training, and Annual Training. If the Behavioral Specialist provider has not received or is not current on any of these trainings at the time service is rendered, then all claims provided within that time frame will be disallowed.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Sections VI and VIII

19. TBI Training Not Completed – Home and Community Support Services (HCSS)	
OMIG Audit Criteria	The HCBS/TBI Waiver Program Manual states that there are three components of required training: Basic Orientation Training, Service-Specific Training, and Annual Training. If the HCSS provider has not received or is not current on any of these trainings at the time service is rendered, then all claims provided within that time frame will be disallowed.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Sections VI and VII

20. Patient Excess Income (Spend-down) Not Applied Prior to Billing Medicaid	
OMIG Audit Criteria	If the provider did not apply a client spend-down to a claim, the difference between the paid claim amount and the correct claim amount (had the spend-down been properly applied) will be disallowed. Note: This finding only applies where the relevant county has assigned responsibility for the spend-down to the provider and the sampled claim must be impacted by the spend-down.
Regulatory References	18 NYCRR § 360-4.8(c)(1) and (c)(2)(ii) 18 NYCRR § 504.3(e)

21. Services Performed by Unqualified Home and Community Support Services (HCSS) Staff	
OMIG Audit Criteria	If services were performed by staff who did not meet the standards required for the HCSS position, then the paid claims provided by the unqualified staff will be disallowed. **Note:** Effective December 31, 2009, HCSS staff must successfully complete a 40-hour training program for Level II PCA or PCA Alternate Competency Demonstration equivalency testing that is approved by DOH.
Regulatory References	18 NYCRR Section 505.14(e)(2)(i)(e) 18 NYCRR Section 505.14(e)(4) Traumatic Brain Injury Program Manual, April 2009, Section VI

22. TBI Training Not Completed – Structured Day Program (SDP)	
OMIG Audit Criteria	The HCBS/TBI Waiver Program Manual states that there are three components of required training: Basic Orientation Training, Service-Specific Training, and Annual Training. If the SDP staff has not received or is not current on any of these trainings at the time service is rendered, then all claims provided within that time frame will be disallowed.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Section VIII

23. Failure To Complete Required HCSS In Service Training	
OMIG Audit Criteria	If services were performed by HCSS staff who did not receive six hours of in-service education per year, the claims will be disallowed.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Section VI

24. Failure to Complete Health Requirements	
OMIG Audit Criteria	Services provided by HCSS staff who failed to complete health requirements will be disallowed. All health requirements specified in 10 NYCRR 766.11 must be met, inclusive of the following: • Health status assessment at time of hire, (prior to assuming patient care duties) or annual health status assessment (whichever pertains to the sampled claim). • Certificate of immunization against rubella and a certificate of immunization against measles (for all personnel born on or after January 1, 1957). • Record of either tuberculin skin test or Food and Drug Administration (FDA) approved blood assay for the detection of latent tuberculosis infection, prior to assuming patient care duties and no less than every year thereafter for negative findings (whichever pertains to the sampled claim). • For dates of service after 7/31/2013: documentation of vaccination against influenza, or wearing of a surgical or procedure mask during the influenza season, for personnel who have not received the influenza vaccine for the influenza season.
Regulatory References	10 NYCRR § 766.11(c) and (d)(1)(2)(4)(5)(6) Traumatic Brain Injury Program Manual, April 2009, Section VI NYS Department of Education – Office of the Professions – Nursing Guide to Practice - page 37 NYS Department of Education – Office of the Professions – Nursing Practice Alerts and Guidelines – PPD Protocol – June 30, 2009

25. Missing Documentation of Nursing Supervision Visit	
OMIG Audit Criteria	Home and Community Support Services (HCSS) must be provided under the direction and supervision of a Registered Professional Nurse (RN). The RN must conduct an initial home visit on the day and time HCSS staff begins providing services to the participant. Claims will be disallowed if the record does not include documentation of RN's participation in the initial home visit.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Section VI

26. Duration of Services Not Documented	
OMIG Audit Criteria	A record of the start and/or end time of the service is to be established by the provider through the case note, time record, or any other document used by the provider. If the start and/or end time of the service cannot be established from the case note, time record, or any other document used by the provider, the undocumented time will be disallowed.
Regulatory References	Social Security Act § 1902(a)(27), 42 USC § 1396(a)(27) CMS State Medicaid Manual Section 2497.1 18 NYCRR § 504.3(a) and (i) 18 NYCRR § 517.3(b)(1) and (2) 18 NYCRR § 540.7(a)(8) DOH Medicaid Update, January 2005, Vol. 20, No. 1

	NYS DOH – HCBS Provider Agreement, June 2008 Traumatic Brain Injury Program Manual, April 2009, Section VII

27. Services Performed by Unqualified Structured Day Program (SDP) Provider	
OMIG Audit Criteria	If the SDP Provider does not meet the qualification requirements for the position (education/experience) at the date of service, all claims provided by the unqualified SDP Provider will be disallowed.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Section VI

28. TBI Training Not Completed – Community Integration Counseling (CIC)	
OMIG Audit Criteria	The HCBS/TBI Waiver Program Manual states that there are three components of required training: Basic Orientation Training, Service-Specific Training, and Annual Training. If the CIC staff has not received or is not current on any of these trainings at the time service is rendered, then all claims provided within that time frame will be disallowed.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Section VIII

29. TBI Training Not Completed – Independent Living Skills Training and Development Staff	
OMIG Audit Criteria	The HCBS/TBI Waiver Program Manual states that there are three components of required training: Basic Orientation Training, Service-Specific Training, and Annual Training. If the ILST staff has not received or is not current on any of these trainings at the time service is rendered, then all claims provided within that time frame will be disallowed.
Regulatory References	Traumatic Brain Injury Program Manual, April 2009, Section VIII

30. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame	
OMIG Audit Criteria	If the medical order was signed late, the claim will be disallowed. Signed medical orders are required within 30 calendar days after the authorized practitioner conducts a medical examination of the patient. If the medical order is not reviewed and revised at least every six months, the claim will be disallowed (except where an authorized practitioner, as part of an authorization, orders personal care services for up to one year for a Medicaid patient). If the medical order for personal care services exceeds six months, the claim will be disallowed.
Regulatory Reference	18 NYCRR § 505.14(b)(3)(i)(1) 10 NYCRR §766.4(c) 18 NYCRR § 505.14(b)(4)(iii) 10 NYCRR § 763.7(a)(3)(i)-(iii)

31. Failure to Conduct Required Criminal History Check	
OMIG Audit Criteria	The record will be reviewed to determine if the provider or its contractor initiated a background check within the specified time frames and provided appropriate monitoring of the aide while waiting for the results of the background check. (This pertains to services provided by an employee hired after 9/1/06). If the criminal history check requirement has not been completed, the claim will be disallowed.
Regulatory Reference	10 NYCRR § 402.9(a)(1) & (2) 10 NYCRR § 402.1(a) 10 NYCRR § 402.6(a) 10 NYCRR § 763.13(h)