NEW YORK STATE | Office of the Medicaid Inspector General

OMIG AUDIT PROTOCOL
HEALTH HOME (Adults)
For Services Dates 01/09/2014 - 07/01/2019

5/31/2023

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.	**No Documentation of Service**
OMIG Audit Criteria	If the recipient record does not document that one of the core Health Home services was provided, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) Health Home Provider Manual Version 2014-1, Sections I, III, and IX

2.	**Missing Recipient Record**
OMIG Audit Criteria	If the recipient record is not available for review, the claims for the dates of service associated with the recipient record will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) Health Home Provider Manual Version 2014-1, Section IX

3.	**Incorrect Rate Code Billed**
OMIG Audit Criteria	If an incorrect rate code was billed, the difference between the correct and incorrect rate codes will be disallowed.
Regulatory References	18 NYCRR § 504.3(h) and (i) 18 NYCRR § 518.1(c) Health Home Provider Manual Version 2014-1, Section III **For Services on or After 12/01/2016:** Billing and Documentation Standards for Health Home: High, Medium, and Low (HML) Rates with Clinical and Functional Adjustments, December 1, 2016 **For Services on or After 05/01/2018:** Billing and Documentation Guidance for Health Home Adult Rates with Clinical and Functional Adjustments, May 1, 2018

4.	**Incorrect Billing During Inpatient Stay**
OMIG Audit Criteria	Billing for Health Home services that do not meet the guidance for billing during inpatient stays will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Health Home Provider Manual Version 2014-1, Sections III and VI

5.	Excessive Outreach and Engagement Billing
OMIG Audit Criteria	For Services Prior to 10/1/2017 The outreach and engagement rate codes may only be billed for three consecutive months, a lapse of three months must occur before outreach and engagement can be billed again. For Services on or After 10/1/2017 Outreach services will not exceed two consecutive months. The second month must be a face to face contact. Outreach cannot be billed more than four months in a rolling twelve-month period. Claims billed in excess will be disallowed. This finding only applies to sample claims in which outreach and engagement rate codes were billed.
Regulatory References	18 NYCRR § 518.1(c) 18 NYCRR § 504.3(i) Health Home Provider Manual Version 2014-1, Sections III and VI **For Services on or After 10/1/2017:** Interim Guidance Addressing Outreach Modifications, October 18, 2017

6.	Failure to Document Progressive Outreach and Engagement
OMIG Audit Criteria	Active, ongoing and progressive engagement with the recipient must be documented in the care management record. Claims for outreach and engagement that fail to document active, ongoing and progressive engagement with the recipient will be disallowed. This finding only applies to sample claims in which outreach and engagement rate codes were billed.
Regulatory References	18 NYCRR § 504.3(i) Health Home Provider Manual Version 2014-1, Section IX

7.	Duplicate Billing for Service
OMIG Audit Criteria	Claims submitted for services that are duplicative will be disallowed.
Regulatory References	18 NYCRR § 518.1(c) 18 NYCRR § 504.3(e)

8.	Missing Care Plan
OMIG Audit Criteria	Health Home service providers are required to develop a care plan. The care manager will be responsible for overall management and coordination of the recipient care plan. If the care plan is not made available, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Health Home Provider Manual Version 2014-1, Sections I, VIII, and IX

9.	Missing Comprehensive Assessment
OMIG Audit Criteria	If the care management record does not contain an initial comprehensive assessment, and if applicable, an annual reassessment has not been completed or reassessed as a result of a significant change in the recipient's health/behavioral health or social needs status the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Health Home Provider Manual Version 2014-1, Section IX Health Home Comprehensive Assessment Policy (Adult and Children), June 1, 2017

10.	No Face to Face Encounter
OMIG Audit Criteria	If the care management record is missing a face to face contact at the assessment or development of the plan the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Health Home Provider Manual Version 2014-1, Section IX

11.	Missing FACT-GP© and Health Home Functional Assessment Questionnaire
OMIG Audit Criteria	**For Services Prior to 6/1/2017:** FACT-GP© is required at the initial assessment, annually, and at disenrollment. If the record did not contain the required FACT - GP© and the Health Home Functional Assessment the claim will be disallowed.
Regulatory References	**For Services Prior to 6/1/2017:** 18 NYCRR § 504.3(i) Health Home Provider Manual Version 2014-1, Sections IV and IX

12.	Failure to Obtain Recipient's Signed Consent
OMIG Audit Criteria	The provider must obtain a signed Health Home Patient Information Sharing Consent Form, DOH-5055 prior to sharing protected health information. Recipients who continually refuse to sign the consent form should be disenrolled. If consent was not obtained the claim will be disallowed. This finding does not apply to outreach service claims. This finding only applies if PHI is shared without a signed consent
Regulatory References	18 NYCRR § 504.3(i) Health Home Provider Manual Version 2014-1, Sections VI and IX

13.	Failure to Document Health Home Eligibility
OMIG Audit Criteria	Individuals served in a Health Home must have at least two (2) chronic conditions or a single qualifying condition as defined in Section 1945(h)(2) of the Social Security Act. If the record does not document the chronic or qualifying condition(s), the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Health Home Provider Manual Version 2014-1, Section I

14.	Failure to Identify Recipient as Lost to Service
OMIG Audit Criteria	A Home Health recipient is considered Lost to Services when the Health Home is no longer able to locate the recipient to provide services. Health Homes must document in the recipient's care management record the date of determination of "Lost to Services." If the provider failed to document the recipient as lost to service, including a *Diligent Search Effort*, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Health Home Provider Manual Version 2014-1, Sections III and VI Continuity of Care and Re-engagement for Enrolled Health Home Members, *October 1, 2017*