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OMIG AUDIT PROTOCOL – OFFICE OF MENTAL HEALTH (OMH) REHABILITATIVE SERVICES – FAMILY-BASED TREATMENT (0268)

For service dates prior to 08/29/13

Effective 08/29/13

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. 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 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. 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.

Audit protocols are amended as necessary. 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 – OFFICE OF MENTAL HEALTH (OMH) REHABILITATIVE SERVICES – FAMILY BASED TREATMENT (FBT) (0268)
Effective 08/29/13

1.	**Missing Documentation of Rehabilitative Service**
OMIG Audit Criteria	By enrolling in the Medical Assistance (MA) program, the provider agrees to prepare and maintain contemporaneous records demonstrating its right to receive payment under the MA program and to keep for a period of six years from the date the payment for the care, services or supplies furnished, all records necessary to disclose the nature and extent of services furnished. If the record did not document the rehabilitative services billed, the claim will be disallowed.
Regulatory References	18 NYCRR Section 504.3(a**)** 14 NYCRR Section 594.15(a) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

2.	**Missing Progress Note**
OMIG Audit Criteria	Progress notes shall be prepared at least monthly and shall indicate the type of community rehabilitative services which have been provided, any significant events which have occurred and, if appropriate, any recommendations for changes to the goals and objectives of the service plan. If the required progress note for the billed month is missing, the claim will be disallowed.
Regulatory References	14 NYCRR Section 593.6(e) 14 NYCRR Section 594.10(c) 14 NYCRR Section 594.15(b)(7)

3.	Failure to Document Eleven Rehabilitative Contacts for a Full Month Claim
OMIG Audit Criteria	A full monthly claim must include at least 11 billable contacts rendered on different days, with at least three provided by authorized program staff other than family. At least four different services must be provided. If between six and ten billable contacts were performed on different days, with at least two provided by program staff, and if at least two different services were provided, the monthly claim will be reduced to a half monthly claim and only the difference disallowed. If less than six billable contacts were documented, the entire claim will be disallowed. For reimbursement purposes, a contact shall be at least 15 minutes in duration and shall involve the performance of at least one of the following services as indicated in the resident's current service plan: (1) Behavior Management Training (2) Counseling Services (3) Daily Living Skills (4) Family Support Services (5) Health Services (6) Independent Living Skills Training (7) Medication Management & Training (8) Socialization
Regulatory References	14 NYCRR Section 593.7(b)(1) and (4) 14 NYCRR Section 593.4(c) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Sections II and III

4.	**Failure to Document At Least Four Different Rehabilitative Services for a Full Month Claim**
OMIG Audit Criteria	A full monthly claim must include at least 11 billable contacts rendered on different days, with at least three provided by authorized program staff other than family. At least four different services must be provided. If between six and ten billable contacts were performed on different days, with at least two provided by program staff, and if at least two different services were provided, the monthly claim will be reduced to a half monthly claim and only the difference disallowed. If the case record does not document at least two different community rehabilitation services, the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 593.7(b)(1) and (4) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

5.	**Failure to Document At Least Three Rehabilitative Contacts Provided by Authorized Program Staff for a Full Month Claim**
OMIG Audit Criteria	A full monthly claim must include at least 11 billable contacts rendered on different days, with at least three provided by authorized program staff other than family. At least four different services must be provided. If between six and ten billable contacts were performed on different days, with at least two provided by program staff, and if at least two different services were provided, the monthly claim will be reduced to a half monthly claim and only the difference disallowed. If less than two billable contacts were provided by program staff, the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 593.7(b)(1) and (4) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

6.	**Failure to Document Six Rehabilitative Contacts for a Half Month Claim**
OMIG Audit Criteria	A half monthly claim must include at least six billable contacts rendered on different days, with at least two provided by authorized program staff other than the family. At least two different services must be provided. If less than six billable contacts were documented, the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 593.7(b)(2) and (4) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

7.	**Failure to Document At Least Two Different Rehabilitative Services for a Half Month Claim**
OMIG Audit Criteria	A half monthly claim must include at least six billable contacts rendered on different days, with at least two provided by authorized program staff other than the family. At least two different services must be provided. If the case record does not document at least two different billable services, the entire claim will be disallowed
Regulatory References	14 NYCRR Section 593.7(b)(2) and (4) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

8.	**Failure to Document At Least Two Rehabilitative Contacts Provided By Authorized Program Staff for a Half Month Claim**
OMIG Audit Criteria	A half monthly claim must include at least six billable contacts rendered on different days, with at least two provided by authorized program staff other than the family. At least two different services must be provided. If the case record does not document at least two billable contacts performed by program staff, the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 593.7(b)(2) and (4) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

9.	**Required Minimum Days in Residence Not Met**
OMIG Audit Criteria	A full monthly rate will be paid for services provided to an eligible resident in residence for at least 21 days in a calendar month. A half monthly rate will be paid for services provided to an eligible resident in residence for at least 11 days in a calendar month. If the client is in residence less than 21 days but equal to or more than 11 days, a full monthly claim will be reduced to a half monthly claim and only the difference will be disallowed. If the client is in residence less than 11 days in the month, the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 593.7(b)(1) and (2) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

10.	Failure to Perform Rehabilitative Contacts on Different Days
OMIG Audit Criteria	Reimbursement for the provision of community rehabilitative services will be paid based upon a minimum number of contacts between an eligible resident and an authorized program staff person or the professional family. Only one contact can be counted each day. If between six and ten billable contacts were performed on different days and a full monthly claim was billed, the claim will be reduced to a half monthly claim and the difference disallowed. If less than six billable contacts were performed on different days then the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 593.7(b)(3) and (4) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

11.	Failure to Meet Minimum Duration Requirements
OMIG Audit Criteria	Reimbursement for the provision of community rehabilitative services will be paid based upon a minimum number of contacts between an eligible resident and an authorized program staff person or the professional family. Such contact shall be at least 15 minutes in duration. A community rehabilitative service lasting less than 15 minutes in duration will not be counted as a billable contact. If between six and ten billable contacts were documented as at least 15 minutes in duration and a full monthly claim was billed, the claim will be reduced to a half monthly claim and the difference disallowed. If fewer than six billable contacts were documented as at least 15 minutes in duration, 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

12.	Rehabilitative Service(s) Provided Not Included in Service Plan
OMIG Audit Criteria	Each resident must have a service plan in the case record which identifies the appropriate community rehabilitative services to be delivered. A community rehabilitative service not specified on the resident's service plan will not be counted as a billable contact. Auditors must review the entire month's record for at least 11 billable contacts that involved the performance of a service indicated on the relevant service plan. If between six and ten billable contacts involved a service indicated on the service plan and a full monthly claim was billed, the claim will be reduced to a half monthly claim and the difference disallowed. If fewer than six billable contacts involved a service indicated on the service plan, then the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 593.7(b)(4) 14 NYCRR Section 594.10(b) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

13.	Duration of Rehabilitative Contact(s) Not Documented
OMIG Audit Criteria	The case record should document the duration of each contact. Such contact must be at least 15 minutes in duration. If the duration of the contact is not documented, it will not be counted as a billable contact. This finding is to be used only when the duration of contact is not documented. If the duration is documented but is less than 15 minutes, refer to protocol #11, *Failure to Meet Minimum Duration Requirements.* If between six and ten billable contacts indicate the duration and a full monthly claim was billed, the claim will be reduced to a half monthly claim and the difference disallowed. If fewer than six billable contacts indicate the duration, 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

14.	Failure to Document Date Rehabilitative Service(s) Performed
OMIG Audit Criteria	The case record should document the date of each contact in order for auditors to determine that services were discrete. If the record does not indicate the date of the contact, it will not be counted as a billable contact. If between six and ten billable contacts indicate the date and a full monthly claim was billed, the claim will be reduced to a half monthly claim and the difference disallowed. If fewer than six billable contacts indicate the date, then the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 594.15(a)(4) and (b)(7) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

15.	Billing For Non Reimbursable Contact
OMIG Audit Criteria	A reimbursable contact may occur at or away from the program, except that a reimbursable contact may not occur at the site of a licensed mental health outpatient program nor when the otherwise eligible resident is an inpatient of any hospital or temporarily residing in any other licensed residential facility. Such contact must be face-to-face between an eligible resident of the program and an authorized staff person of an approved provider of community rehabilitative services or the professional family. A rehabilitative 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 by an authorized staff person or the professional family, will not be counted as a billable contact. If between six and ten documented contacts are billable and a full monthly claim was billed, the claim should be reduced to a half monthly claim and the difference disallowed. If fewer than six documented contacts are billable, then the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 593.7(b) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

16.	Failure to Document Staff Person/FBT Parent Providing Rehabilitative Service(s)
OMIG Audit Criteria	The case record must include the name of the person rendering the service. If the staff person/family member who provided the community rehabilitative service was not documented, the service will not be counted as a billable contact. If between six and ten contacts indicate the staff person/family member who provided the service and a full monthly claim was billed, the claim should be reduced to a half monthly claim and the difference disallowed. If fewer than six contacts indicate the staff person/family member who provided the service, then the entire claim will be disallowed.
Regulatory References	14 NYCRR Section 594.15(a)

17.	Missing Initial Physician Authorization
OMIG Audit Criteria	In order to receive reimbursement for the provision of community rehabilitative services to a child, the provider of service must ensure that the child has been authorized in writing by a physician, prior to or upon admission, to receive services as provided by the program. The written authorization must be retained as a part of the individual's case record. If the record does not have the initial physician authorization or the 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

18.	Missing Renewal/Reauthorization of Authorization
OMIG Audit Criteria	**FOR DATES OF SERVICE PRIOR TO 2/24/10:** Physician's authorizations must be renewed/reauthorized as follows: Every six months for individuals residing within residential programs for children and adolescents. If the record does not have the physician reauthorization or the reauthorization is signed by an unauthorized person (e.g. physician's assistant, nurse practitioner, social worker or therapist) the claim will be disallowed. **FOR DATES OF SERVICE ON OR AFTER 2/24/10:** Authorizations must be renewed/reauthorized as follows: Reauthorizations can be signed by physicians, physician's assistants or nurse practitioners in psychiatry. Reauthorizations must be completed every six months for individuals residing within residential programs for children and adolescents. If the record does not have the reauthorization or the reauthorization is signed by an unauthorized person (e.g. 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

19.	Authorization Lacks Required Authorization Period
OMIG Audit Criteria	The provider of service must ensure that the individual has been authorized in writing to receive services as provided by the program. The physician's authorization must be dated. If the authorization is dated but fails to delineate an authorization period, the auditor shall assume that the authorization period is six months from the date of signature and claims within that time period will be allowed. If the authorization is not dated and lacks an authorization period, claims within that time period will be disallowed.
Regulatory References	14 NYCRR Section 593.6(a)

20.	**Improper Admission**
OMIG Audit Criteria	Claims within the first six months of residency will be disallowed if the assessments required for admission were not documented by the program. Assessments required for admission include the following documents: 1. updated medical report 2. psychosocial assessment 3. psychiatric evaluation 4. educational assessment 5. signed, parental/guardian informed consent form for admission 6. description of the child's current behaviors and significant strengths and problems 7. documentation that potentially less restrictive community, home and/or extended nonresidential services have been explored and are either not available or not successful The educational assessment must have been done within the last year and all other assessments done within 90 days of the referral.
Regulatory References	14 NYCRR Section 594.8(d) 14 NYCRR Section 594.15(b)

21.	**Missing Service Plan/Service Plan Review**
OMIG Audit Criteria	Community rehabilitative services shall be provided in accordance with a service plan developed within four weeks of admission to the program. The service plan shall be reviewed at least every three months with the initial review occurring three months from the date of admission to the program. If the record does not have a service plan or quarterly service plan review effective for the billed month, the claim will be disallowed. Once a late service plan or service plan review is prepared, subsequent billings will be allowed.
Regulatory References	14 NYCRR Section 593.6(c),(f) 14 NYCRR Section 594.10(a),(d) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

22.	**Service Plan/Service Plan Review Not Signed by Qualified Mental Health Staff Person (QMHSP)**
OMIG Audit Criteria	The service plan/review must be signed by a Qualified Mental Health Staff Person (QMHSP). If the plan/review effective for the billed month is not signed by a QMHSP, the claim will be disallowed. A QMHSP can be/have: - physician - therapist - psychologist - mental health counselor - social worker - bachelor's or master's degree in human services related field - registered nurse - other professional disciplines w/written approval of the Office of - nurse practitioner Mental Health - psychoanalyst
Regulatory References	14 NYCRR Section 593.6(d),(f)(3) 14 NYCRR Section 593.4(a)(2) 14 NYCRR Section 594.10(b) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

23.	**Missing Admission Note**
OMIG Audit Criteria	An admission note is to be completed at the time of admission and includes the services to be provided in the first 30 days. If there is no documented admission note, the claim will be disallowed.
Regulatory References	14 NYCRR Section 593.6(c) 14 NYCRR Section 594.10(a)

24.	**Admission Note Not Completed by a Qualified Mental Health Staff Person (QMHSP)**
OMIG Audit Criteria	An admission note is to be completed and signed at the time of admission by a QMHSP. If the admission note is not signed by a QMHSP, the claim will be disallowed.
Regulatory References	14 NYCRR Section 593.4(a)(2) 14 NYCRR Section 593.6(c) 14 NYCRR Section 594.10(a) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

25.	**Billing Medicaid for Unlicensed Residence**
OMIG Audit Criteria	If there is no operating certificate or the certificate is invalid, the claim will be disallowed. Auditor should obtain a list of addresses and operating certificates for all facilities from the provider at the beginning of the audit.
Regulatory References	14 NYCRR Section 593.5(a) 14 NYCRR Section 594.5(a),(d) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Sections I & III

26.	**Billing Medicaid for an Ineligible Recipient**
OMIG Audit Criteria	If a claim is submitted for an ineligible recipient, the claim will be disallowed. Eligible recipient criteria include: 1. Attainment of at least the 5th birthday but not the 18th (for admission). Once admitted to the program, the recipient may remain until the 19th birthday. 2. A designated mental illness diagnosis 3. Substantial problems in social functioning 4. Serious problems in family relationships, peer/social interaction or school performance
Regulatory References	14 NYCRR Section 594.4(a)(2)(i) 14 NYCRR Section 594.8(b) Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I