Office of Mental Health Rehabilitation Services Audit Protocols

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OMIG Webinar

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OMIG MISSION STATEMENT

Our mission is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high-quality patient care.

Agenda

- OMIG Background and History
- Introduction to OMH Rehab Audit Protocols
- The Protocols
- Final Notes

OMIG - BACKGROUND AND HISTORY

Statewide Presence

Regional Offices:

- Albany
- Buffalo
- Hauppauge
- New York City
- Rochester
- Syracuse
- White Plains

OMIG History

- Established in 2006
- Approximately 450 employees
- Division of Medicaid Audit
- Division of Medicaid Investigations
- Executive
- Information Technology now being handled through central ITS

Introduction to OMH Rehabilitation Audit Protocols

OMH Rehabilitative Services – Adults (0268) Effective April 30, 2013 – Guidance Information

Audit protocols

- assist the Medicaid auditors in developing programs to evaluate compliance with Medicaid requirements under federal and state statutory and regulatory law
- 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
- provide some guidance to providers

Guidance Information (*continued*)

Audit protocols

- may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person
- do not alter 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

Guidance Information (*continued*)

Audit protocols do not encompass all 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; applicable federal and state statutory and regulatory law determine a Medicaid provider's legal obligations

Guidance Information (*continued*)

Audit protocols

- applied to a specific provider type or category of service in the course of an audit and involve the OMIG's application of articulated Medicaid agency policy and the exercise of agency discretion
- amended as necessary

Guidance Information (*continued*)

- reasons for amending protocols include, but are not limited to, responding to a hearing decision, litigation decision, or statutory or regulatory change
- the OMIG cannot provide individual advice or counseling, whether medical, legal, or otherwise
- contact an attorney, a licensed practitioner or professional, a social services agency representative, or an organization in your local community for specific advice or counseling

Guidance Information (continued)

- Protocols use Rate Codes 4369 (full month) and 4370 and 4371 (first half month and second half month, respectively).
- The sampled claim date refers to services rendered in the *month prior.*
- Relevant regulations: 18 NYCRR Parts 360, 504, 518 and 540; 14 NYCRR Parts 593 and 595

The Protocols

Protocol 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 care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished.

18 NYCRR §504.3 (a) Duties of the provider

1 - Missing Documentation of Rehabilitative Service (*continued*)

If the record did not document the rehabilitative services billed, the claim will be disallowed.

This finding should only be used in the event that the provider cannot produce evidence of any rehabilitative services being rendered during the sampled month.

1 - Missing Documentation of Rehabilitative Service (*continued*)

Regulatory References:

- 18 NYCRR Section 504.3(a)
- 14 NYCRR Section 595.14(a)
- 14 NYCRR Section 595.14(b)(8)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

Protocol 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 a progress note or notes were not documented during the sampled month, the claim will be disallowed.

Regulatory References:

- 14 NYCRR Section 593.6(e)
- 14 NYCRR Section 595.11(c)
- 14 NYCRR Section 595.14(b)(7)

Protocol 3
Failure to Document Four Different Rehabilitative Services For a Full-Month Claim

OMIG Audit Criteria: The case record should document the type of community rehabilitative service that was provided. A full-month claim must include at least four different billable services rendered.

Services are defined in 14 NYCRR Section 593.4(b) as follows:

- Assertiveness/Self-Advocacy Training
- Community Integration
- Daily Living Skills
- Health Services
- Medication Management and Training
- Parenting Training

3 - Failure to Document Four Different Rehabilitative Services For a Full-Month Claim

(***continued***)

- ❑Rehabilitation Counseling
- ❑Skill Development
- ❑Socialization
- ❑Substance Abuse Services
- ❑Symptom Management

3 - Failure to Document Four Different Rehabilitative Services For a Full-Month Claim

(*continued*)

If two or three discrete services have been rendered on different days, the monthly claim should be reduced to a half-monthly claim and only the difference disallowed.

Regulatory References:

- 14 NYCRR Section 593.7(b)(1)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

Protocol 4
Failure to Document Two Different Rehabilitative Services for a Half-Month Claim

OMIG Audit Criteria: A half-month rate will be paid for services provided to an eligible resident who has received at least two different community rehabilitative services. If the case record does not document that two different community rehabilitative services were performed, the entire claim will be disallowed. This is used when only one billable service has been documented as rendered. If no billable services were documented as rendered, refer to Protocol #1, *No Documentation of Rehabilitative Service*.

4 - Failure to Document Two Different Rehabilitative Services for a Half Month Claim

(*continued*)

Regulatory References:

- 14 NYCRR Section 593.7(b)(2)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

Protocol 5
Recipient Not in Residence 21 Days in Month

OMIG Audit Criteria: A full-month rate will be paid for services provided to an eligible resident who is in residence for at least 21 days in a calendar month. If the client is in residence less than 21 days in the month, the claim will be disallowed. If the client is in residence less than 21 days but 11 days or more, the claim will be reduced to a half-month fee and only the difference will be disallowed.

5 - Recipient Not in Residence 21 Days in Month (*continued*)

Regulatory References:

- 14 NYCRR Section 593.7(b)(1)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

Protocol 6
Recipient Not In Residence 11 Days in Month

OMIG Audit Criteria: A half-month 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 11 days in the month, the **entire** claim will be disallowed.

Regulatory References:

- 14 NYCRR Section 593.7(b)(2)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

Protocol 7
Failure to Perform Rehabilitative Services 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 a staff person of the program. Only one contact can be counted each day. If more than one rehabilitative service is performed on any day of the month, only one service will be accepted as a billable contact.

7 - Failure to Perform Rehabilitative Services on Different Days (*continued*)

If two or three billable contacts are counted and a full-month claim was billed, the claim will be reduced to a half month claim and the difference disallowed. If fewer than two billable contacts are counted, 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

Protocol 8
Failure to Meet Minimum Duration Requirements

OMIG Audit Criteria: Reimbursement for the provision of community rehabilitation services will be paid based upon a minimum number of contacts between an eligible resident and a staff person of the program. Such contact shall be at least 15 minutes in duration. Rehabilitative services lasting less than 15 minutes in duration will not be counted as a billable contact.

8 - Failure to Meet Minimum Duration Requirements (*continued*)

This finding is to be used only when the duration is documented and is less than 15 minutes. If two or three billable contacts are counted and a full-month claim was billed, the claim should be reduced to a half-month claim and the difference disallowed. If fewer than two billable contacts are counted, then the entire claim will be disallowed.

8 - Failure to Meet Minimum Duration Requirements (*continued*)

Regulatory References:

- 14 NYCRR Section 595.14(b)(8)
- 14 NYCRR Section 593.7(b)(3)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

Protocol 9
Rehabilitative Service 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. If the community rehabilitative service rendered is not specified on the resident service plan, that service is not considered a billable service. Auditor must review the entire month's record for at least four billable services included in the most recent service plan.

9 - Rehabilitative Service Provided Not Included in Service Plan (*continued*)

Regulatory References:

- 14 NYCRR Section 595.11(b)(5)
- 14 NYCRR Section 593.7(b)(4)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

Protocol 10
Duration of Rehabilitative Service Not Documented

OMIG Audit Criteria: The case record must document the duration of each rehabilitative service that was performed, and each service must be at least 15 minutes in duration. If the duration of service is not documented, the service will not be counted as a billable contact. If two or three billable contacts are counted and a full-month claim was billed, the claim will be reduced to a half-month claim and the difference disallowed. If fewer than two billable contacts are counted, then the entire claim will be disallowed.

10 - Duration of Rehabilitative Service Not Documented (*continued*)

Regulatory References:

- 14 NYCRR Section 595.14(b)(8)
- 14 NYCRR Section 593.7(b)(3)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

Protocol 11
Failure to Document Date Rehabilitative Service Performed

OMIG Audit Criteria: The case record should document the date that the rehabilitative service was performed in order for auditors to determine that services were delivered. If the record does not indicate the date that the service was performed, the service will not be counted as a billable contact.

11 - Failure to Document Date Rehabilitative Service Performed (*continued*)

If two or three billable contacts are counted and a full-month claim was billed, the claim will be reduced to a half-month claim and the difference disallowed. If fewer than two billable contacts are counted, then the entire claim will be disallowed.

Regulatory References:

- 14 NYCRR Section 595.14(b)(8)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

Protocol 12
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 or 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 a staff person of an approved provider of community rehabilitative services.

12 - Billing for Non- Reimbursable Contact

(*continued*)

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 will not be counted as a billable contact. If two or three billable contacts are counted and a full-month claim was billed, the claim will be reduced to a half-month claim and the difference disallowed. If fewer than two billable contacts are counted, then the entire claim will be disallowed.

12 - Billing for Non- Reimbursable Contact

(*continued*)

Regulatory References:

- 14 NYCRR Section 593.7(b)
- 14 NYCRR Section 593.7(b)(5)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section III

Protocol 13
Failure to Document Staff Person Providing Rehabilitative Service

OMIG Audit Criteria: The case record shall be available to all program staff who are participating in the provision of services to the resident. The contact note must include the name of the person rendering the service. If the name of the staff person who provided the community rehabilitative service was not documented, the service will not be counted as a billable contact.

13 - Failure to Document Staff Person Providing Rehabilitative Service (*continued*)

If two or three billable contacts are counted and a full-month claim was billed, the claim will be reduced to a half-month claim and the difference disallowed. If fewer than two billable contacts are counted, then the entire claim will be disallowed.

Regulatory Reference:

- 14 NYCRR Section 595.14(b)(8)

Protocol 14
Missing Initial Physician Authorization

OMIG Audit Criteria: In order to receive reimbursement for the provision of community rehabilitative services to an individual, the provider of service must ensure that the individual 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.

14 - Missing Initial Physician Authorization

(*continued*)

If the record does not have the initial physician authorization or the initial authorization is signed by an unauthorized person (e.g., nurse practitioner, social worker, or therapist), the claim will be disallowed. This finding is used only if the sample month is within the first six months of residency for congregate and 12 months for apartment.

Regulatory References:

- 14 NYCRR Section 593.6(a)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

Protocol 15
Missing Renewal/Reauthorization of Authorization

OMIG Audit Criteria: Physician authorizations must be renewed/reauthorized as follows: every six months for individuals residing within congregate residences; every 12 months for individuals residing within an apartment program; and upon transfer to a different category of adult program. The authorization renewal must, in the case of a transfer from congregate to apartment, occur upon the expiration date of the current authorization, or, in the case of a transfer from apartment to congregate, within six months of admission to the new program or the expiration of the current authorization, whichever comes first.

15 - Missing Renewal/Reauthorization of Authorization (*continued*)

Reauthorizations may be signed by physicians or physician assistants and nurse practitioners specializing in psychiatry (effective 2/24/10). If the physician reauthorization is missing from the record or the reauthorization is signed by an unauthorized person (e.g., a social worker or therapist), the claim will be disallowed. This finding will not be taken if the authorization is late but is prior to the sampled month.

Regulatory References:

- 14 NYCRR Section 593.6(b)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

Protocol 16
Authorization Lacks Required Authorization Period

OMIG Audit Criteria: The provider of service must ensure that the individual has been authorized in writing by a physician to receive services as provided by the program. The physician's authorization must delineate the maximum duration of the authorization to receive such services as follows: every six months for individuals residing within congregate residences; every 12 months for individuals residing within an apartment program; and upon transfer to a different category of adult program.

16 - Authorization Lacks Required Authorization Period (*continued*)

The authorization renewal must, in the case of a transfer from congregate to apartment, occur upon the expiration date of the current authorization or in the case of a transfer from apartment to congregate, within six months of admission to the new program, or the expiration of the current authorization, whichever comes first. The physician's authorization must be dated.

16 - Authorization Lacks Required Authorization Period (*continued*)

If it is dated but fails to delineate an authorization period, the auditor shall assume that the authorization is six months for congregate or 12 months for apartment from the date of signature and shall not take a disallowance.

If the authorization is not dated and lacks an authorization period, a disallowance shall be taken.

Regulatory Reference:

- 14 NYCRR Section 593.6(a)(2)

Protocol 17
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. If the record does not have a service plan developed within four weeks of admission to the program, the claim will be disallowed. 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.

17 - Missing Service Plan/Service Plan Review

(*continued*)

If the record does not have a service plan or quarterly service plan review effective for the sample month, the claim will be disallowed. Once a late service plan or service plan review is prepared, subsequent billings should be allowed.

Regulatory References:

- 14 NYCRR Section 593.6(c),(f)
- 14 NYCRR Section595.1(b)
- 14 NYCRR Section 595.11(a),(d)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

Protocol 18
Service Plan/Service Plan Review Not Reviewed and 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 a QMHSP does not sign the plan/review effective for the sample month, the claim will be disallowed.

18 - Service Plan/Service Plan Review Not Reviewed and Signed by QMHSP (*continued*)

A QMHSP can be/have:

❑ Physician	❑ Therapist
❑ Psychologist	❑ Mental health counselor
❑ Social worker	❑ Associate's degree in human services and three years experience in human services
❑ Registered nurse	❑ High school degree and five years experience in human services
❑ Nurse practitioner	❑ Other professional disciplines w/written approval of the Office of Mental Health
❑ Psychoanalyst	❑ Bachelor's or master's degree in human services

18 - Service Plan/Service Plan Review Not Reviewed and Signed by QMHSP (*continued*)

Regulatory References:

- 14 NYCRR Section 593.6(d),(f)(3)
- 14 NYCRR Section 595.4(a)(10)
- 14 NYCRR Section 595.11(b)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

Protocol 19
Missing Admission Note

OMIG Audit Criteria: An admission note is to be completed at the time of admission. If there is no documented admission note, the claim will be disallowed. This finding should only be used if the sampled claim is the first month or half month of service.

Regulatory References:

- 14 NYCRR Section 593.6(c),(f)
- 14 NYCRR Section595.1(b)
- 14 NYCRR Section 595.11(a),(d)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

Protocol 20
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 Qualified Mental Health Staff Person (QMHSP). If the admission note is not signed by a QMHSP, the claim will be disallowed. This finding should only be used if the sampled claim is the first month or half month of service.

20 - Admission Note Not Completed by a QMHSP (*continued*)

A QMHSP can be/have:

❑ Physician	❑ Therapist
❑ Psychologist	❑ Mental health counselor
❑ Social worker	❑ Associate's degree in human services and three years experience in human services
❑ Registered nurse	❑ High school degree and five years experience in human services
❑ Nurse practitioner	❑ Other professional disciplines w/written approval of the Office of Mental Health
❑ Psychoanalyst	❑ Bachelor's or master's degree in human services

20 - Admission Note Not Completed by a QMHSP (*continued*)

Regulatory References:

- ❑ 14 NYCRR Section 595.4(a)(10)
- ❑ 14 NYCRR Section 595.11(a)
- ❑ 14 NYCRR Section 593.6 (c)

Protocol 21
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 from the provider at the beginning of the audit.

Regulatory References:

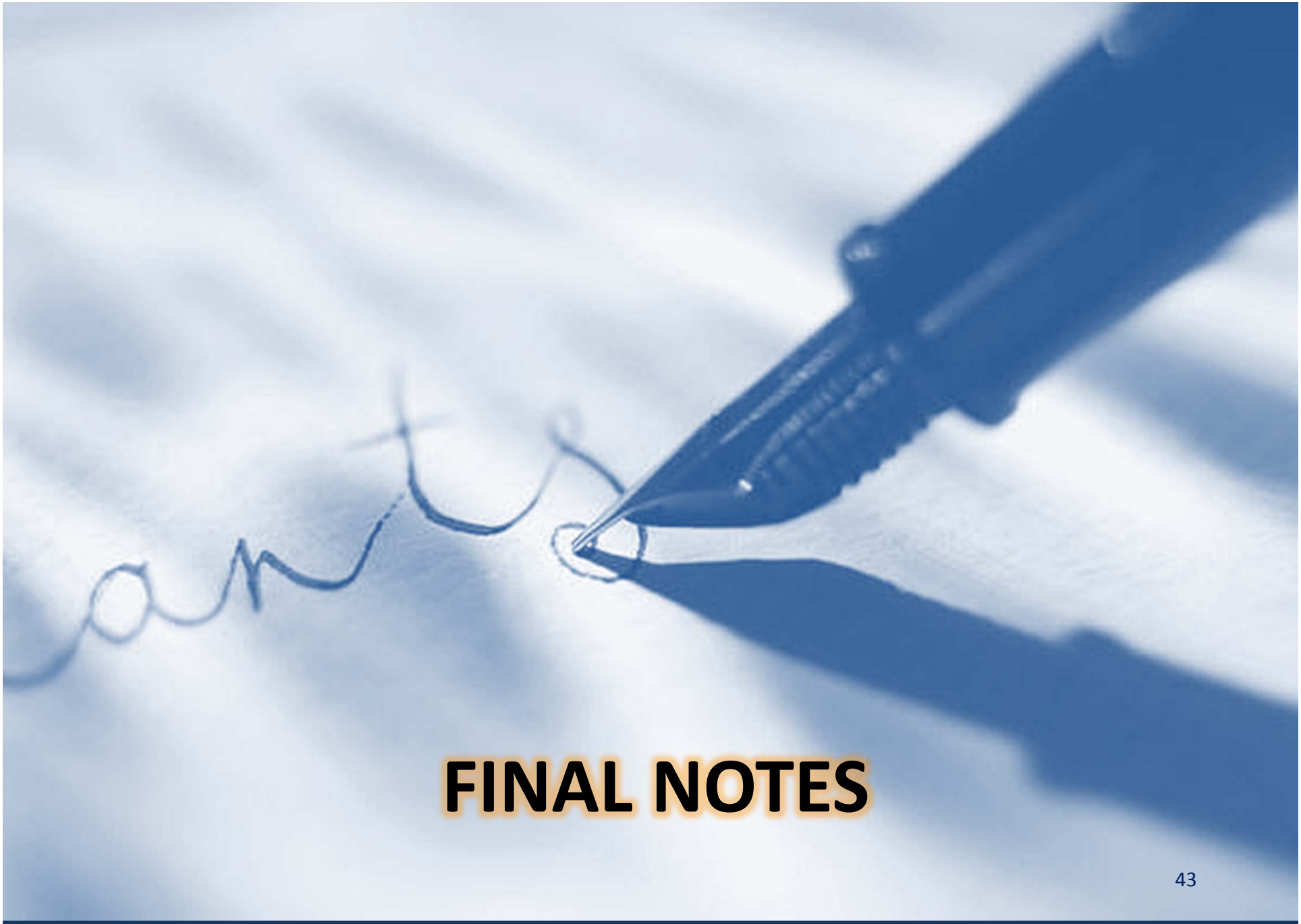
- 14 NYCRR Section 593.6(c),(f)
- 14 NYCRR Section595.1(b)
- 14 NYCRR Section 595.11(a),(d)
- Office of Mental Health Rehabilitation in Community Residences, Policy Guidelines, Version 2006-1, Section I

Protocol 22
Recipient Excess Income (Spend Down) Not Applied Prior to Billing Medicaid

OMIG Audit Criteria: Each sampled service subject to spend down application that was inappropriately billed to Medicaid will be disallowed.

Regulatory References:

- ❑18 NYCRR Section 504.3(a)
- ❑18 NYCRR Section 518.1(c)
- ❑18 NYCRR Section 360-4.8(c)(1)
- ❑18 NYCRR Section 360-4.8(c)(2)(ii)



FINAL NOTES

Let Us Hear from YOU

- Our Web site: www.omig.ny.gov
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Ways to Work With Us

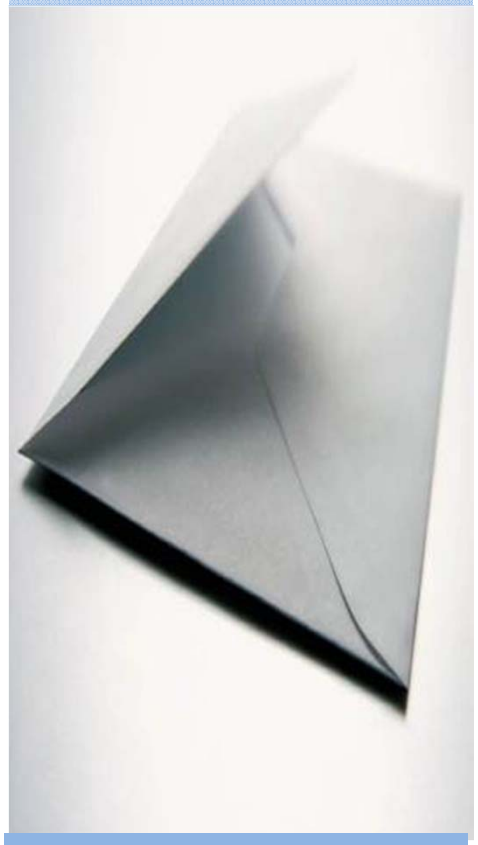
Fraud Hotline

Fraud Hotline
1-877-87-FRAUD

E-mail

bmfa@
omig.ny.gov

U.S. Mail



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Thank You

- Thanks for listening
- Thanks for your diligence and achievements in serving those in your community
- Thanks for working to improve program integrity

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