Bassett Healthcare Network
Community Health Navigation

# Billing Compliance Guide

| Source | Requirement Finding | Quality Indicator for Audit Process | Activity to Minimize Risk |
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| OMIG Protocol | Missing Record | • If a record is not available for review, then claims cannot be billed. | • All members enrolled are provided with a unique member ID and chart once a segment begins.<br>• Service provision is not allowable until chart/episode is created. |
| OMIG Protocol | No Documentation of Service provision | • Service provided must be documented in the member's record.<br>• Must include the date the service was performed.<br>• If no service is documented, claim cannot be billed. | • An HML cannot be entered into a chart without an "800" note finalized in the member's record each month.<br>• CMA's will have a process to verify a percentage of member charts each month to validate a billable note in comparison to a billable HML. |
| OMIG Protocol | Service Documentation Does Not Meet Required Standards. | • If the members record does not document that one of the CORE Health Home Services, then the claim will be disallowed.<br>• Health Home Core Billable Services are defined as;<br>  ○ Comprehensive Care Management<br>  ○ Care Coordination and Health Promotion<br>  ○ Comprehensive Transition Care<br>  ○ Enrollee and Family Support<br>  ○ Referral to Community and Social Supports<br>  ○ Use of Health Information Technology to Link Services<br><br>*HH+ members have additional requirements | • An HML cannot be entered into a chart without an "800" note finalized in the member's record each month.<br>• CMA's will have a process to verify a percentage of member charts each month to validate a billable note in comparison to a billable HML.<br>  ○ Each CMA will verify the contact was billable per policy definition and allowable service provision types. |
| OMIG Protocol | Incorrect Rate Code Billed | • If an incorrect rate code was billed, the difference between the correct and incorrect rates will be disallowed. | • Billing checks completed for all members billed at the high rate, monthly. |

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| | | ○ For example, if a member was billed at the high rate, but did not meet billing requirements at that amount the difference between high and medium would be disallowed. | • Billing verified in comparison to documentation in member charts for all HH+ members. |
| OMIG Protocol | Incorrect Billing During Inpatient Stay | Billing for Health Home services that do not meet the guidance for billing during inpatient stays will be disallowed. | • HIXNY Alerts Set up to ensure that Care managers are informed of ED and Inpatient Stay.<br>• Policy states that members should be placed in Excluded Setting on the 1st of the month after admittance.<br>○ This will allow for billing to occur for services rendered prior to inpatient admittance in a given month.<br>○ Services rendered on or after the date of admittance and throughout the members' stay are not allowable. Unless within 30 days of discharge from inpatient setting.<br>• Continuity of Care Follow-up forms are completed for members at discharge. |
| OMIG Protocol | Excessive Outreach and Engagement Billing | • Payments for Outreach are eliminated. | • No risk for services 7/1/20-Present |
| OMIG Protocol | Failure to Document Outreach and Engagement | • Active, Ongoing, and progressive engagement with the member must be documented in the care record. Claims for outreach and engagements that fail to document active, ongoing, and progressive engagement with the member will be disallowed. | • No risk for services 7/1/20-Present |
| OMIG Protocol | Duplicate Billing for Service | • Claims submitted for services that are duplicative will be disallowed. | • CMA's will not be able to created more than one HML in a month in the EHR.<br>• MAPP-HHTS will not allow for a new billing submission, until the original billing submission is voided. |

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| OMIG Protocol | Missing Care Plan | • Health Home service providers are required to develop a care plan.<br>• The care manager will be responsible for the overall management and coordination of members' care plan.<br>• If the care plan is not made available in the member's record, the claim will be disallowed. | • CMA's in collaboration with the HH will check all initial and annual plans of care completed and finalized each month, prior to billing.<br>• All Plan of Care signatures are checked to ensure accuracy in the MAPP system since 11/2025.<br>• Starting 5/1/2026, CMA's will be required to complete a Compliance Review Form in Member's charts at the time and Initial POC or Annual POC are completed.<br>  ○ The number of compliance reviews required of each CMA may reduce after a period of time that shows a minimum 90% compliance with billing requirements. |
| MAPP-HHTS Billing Block | Plan of Care Error | • Plan of Care Required submit the member's POC ASAP using the Plan of Care Upload file.<br>• Depending on the signature date on the newly submitted POC, you may or may not be able to bill for this month.<br>• This error will display if a member has no POC in the HHTS or if the member's most recent POC is expired.<br>• (W) Warning: Last billable service month before POC expires.<br>• (R) Does not have Complete POC submitted within 56 days of Consent to Enroll. | • Per policy a plan of care is considered final and complete when a member has signed the plan of care. And signature is present in the member's chart.<br>• Only Initial and Annual plans of care are reported to the MAPP system as Comprehensive updates.<br>• Each month finalized plans of care are reviewed for accuracy, prior to submission to MAPP-HHTS.<br>• MAPP-HHTS Enrollment file is pulled to verify accurate POC date submission prior to billing being processed.<br>• Starting 5/1/2026, CMA's will be required to complete a Compliance Review Form in Member's charts at the time and Initial POC or Annual POC are completed.<br>  ○ The number of compliance reviews required of each CMA may reduce after a period of time that shows a minimum 90% compliance with billing requirements. |

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| OMIG Protocol | Care Plan Does Not Meet Required Standards | • Health Home service providers are required to develop a care plan.<br>• The care manager will be responsible for the overall management and coordination of members care plan.<br>• If the care plan is not made available, the claim will be disallowed. | • Plan of care must be developed in tandem with the Comprehensive Assessment and Social Determinants of Health Assessment.<br>• Plan of care must contain Goals and Objectives based on the findings of the Comprehensive assessment.<br>• Starting 5/1/2026, CMA's will be required to complete a Compliance Review Form in Member's charts at the time and Initial POC or Annual POC are completed.<br>  ○ The number of compliance reviews required of each CMA may reduce after a period of time that shows a minimum 90% compliance with billing requirements. |
| OMIG Protocol | Missing Comprehensive Assessment | • 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 significate change in the members health/behavioral health or social needs status, the claim will be disallowed.<br>• If the comprehensive assessment is not made available, the claim will be disallowed. | • Comprehensive assessments must be present in all charts and are completed at intake and annually thereafter.<br>• Reports/Worklists have been developed for Care Managers and Supervisor indicating all Comprehensive Assessment due "This Month", "Next Month", and "Past Due".<br>• Health Home notifies CMA's of any comprehensive assessments left in draft, past due, or missing on a monthly basis.<br>• Starting 5/1/2026, CMA's will be required to complete a Compliance Review Form in Member's charts at the time and Initial POC or Annual POC are completed.<br>  ○ The number of compliance reviews required of each CMA may reduce after a period of time that shows a minimum 90% compliance with billing requirements.<br>• CMA's are responsible for monitor care and maintaining procedures to ensure an Abbreviated Comprehensive Assessment is |

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| | | | completed at the time of a defined "Significant Event/Change" in an individual's life. |
| OMIG Protocol | Comprehensive Assessment Does Not Meet Required Standards | • 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 significate change in the members health/behavioral health or social needs status, the claim will be disallowed. | • All areas of the Comprehensive Assessment are required in order to Finalize.<br>• Starting 5/1/2026, CMA's will be required to complete a Compliance Review Form in Member's charts at the time and Initial POC or Annual POC are completed.<br>  ○ The number of compliance reviews required of each CMA may reduce after a period of time that shows a minimum 90% compliance with billing requirements.<br>• CMA's are responsible for monitor care and maintaining procedures to ensure an Abbreviated Comprehensive Assessment is completed at the time of a defined "Significant Event/Change" in an individual's life. |
| OMIG Protocol | No Face- to- Face Encounter | • If the care management record is missing a face to face contact at the initial assessment or development of the initial plan of care, the claim will be disallowed. | • The EHR has a report available to indicate the last Face-to-Face with a Member.<br>• Policy indicates that Plans and Assessment are to be completed Face-to-Face. |
| OMIG Protocol | Missing FACT-GP and Health Home Functional Assessment Questionnaire | • For Services Prior to 1/1/17:<br>FACT-GP is required at the initial assessment, annual and at disenrollment. Compliance is evaluated based on the date the assessment was required to be completed and submitted. If the record did not contain the required FACT-GP and the Health Home Functional Assessment Questionnaire in accordance with timing requirements, the claim will be disallowed. | • No longer required. |
| OMIG Protocol | Failure to Obtain Member's Signed Consent | • The provider must obtain a signed Health Home Patient Information Sharing Consent Form (DOH-5055) prior to sharing protected health information.<br>• Members who continually refuse to sign the consent form should be disenrolled.<br>• If consent was not obtained the claim will be disallowed. | • Effective 8/1/18 enrollment cannot occur or continue without signed consent.<br>• Member's are not enrolled in via the EHR until a DOH-5055 consent is signed and present in the record.<br>• Starting 5/1/2026, CMA's will be required to complete a Compliance Review Form in |

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| | | | Member's charts at the time and Initial POC or Annual POC are completed.<br>○ The number of compliance reviews required of each CMA may reduce after a period of time that shows a minimum 90% compliance with billing requirements. |
| OMIG Protocol | Failure to Document Health Home Eligibility | • Individuals serviced 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.<br>• If the record does not contain verification of diagnosis of the chronic or qualifying condition(s), or proof of HARP enrollment prior to the date of service, the claim will be disallowed. | • Per Policy, chronic conditions and appropriateness are checked at enrollment and at least annually thereafter.<br>• Each member is required to have a Verification of Diagnosis (VOD) upon enrollment and each annual review thereafter.<br>• Starting 5/1/2026, CMA's will be required to complete a Compliance Review Form in Member's charts at the time and Initial POC or Annual POC are completed.<br>○ The number of compliance reviews required of each CMA may reduce after a period of time that shows a minimum 90% compliance with billing requirements. |
| OMIG Protocol | Failure to provide Continuity of Care | • As soon as a member is determined to be disengaged from care management services, efforts to locate and re-engage the member must be intensified to beyond Standard CM activities.<br>• If the provider fails to intensify search efforts, the claim will be disallowed. | • Per HH Policy when a member has been disengaged for a full month after several attempts at contact above the standard, then the member would go into Diligent Search Efforts (DSE).<br>• In DSE, 3 progressive attempts should occur each month for two consecutive months in an attempt to reengage the member.<br>• CMA's must have a practice for verifying appropriate level of contact and service provision to bill during DSE. |
| OMIG Protocol | Failure to Complete Required Background Checks for Health | • The claim will be disallowed when the provider failed to complete the required background check for health home care managers. | • CMA's serving members under the age of 21 are required to inform the HH and produce upon request verification of background |

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| | Home Care Managers That Serve Members Under the Age of 21. | | checks for employees serving these populations. |
| OMIG Protocol | Services Ordered/ Prescribed/ Referred/ Attended by Excluded Individual | • Claims for services ordered, prescribed, referred, attended by excluded from the New York State Medicaid program when the services were ordered, prescribed, referred, or attended will be disallowed. | • Bassett Medicaid Checks are completed monthly to ensure active Medicaid prior to rendering services for each member.<br>• Worklists/Reports have been developed to monitor the completion of Bassett Medicaid Checks. |
| MAPP-HHTS Billing Blocks | Initial Appropriateness | • Appropriateness Criteria Required determine the member's appropriateness ASAP and submit to the system using the Consent and Member Program Upload file.<br>• If you determined a member's appropriateness within the IA grace period (EITHER consent to enroll or segment begin date, whichever is most recent) you'll be able to add this BI successfully after you upload an appropriateness code, as long as the Appropriateness Start Date is prior to the last day of the month during which the member first received the error.<br>• If the month where the member first received this error has passed without determining appropriateness you will never be able to bill for this month | • Initial Appropriateness must be completed within 28 days of intake and any reengagement post-pended status.<br>• Worklists/Reports have been developed to monitor the completion of Initial Appropriateness Tool at enrollment and post-pended status.<br>• The HH monitors these reports and provides reminder emails to ensure appropriate completion. |
| MAPP-HHTS Biling Block | Continuing Eligibility Screening Tool (CEST) | • CEST outcome required after grace period the member's segment has passed the initial CEST grace period.<br>  ○ Submit a CEST outcome for the member ASAP.<br>  ○ You may or may not be able to add this BI depending on the CEST Start Date<br>• Error Reason CEST outcome expired for the Member, the member's submitted CEST has expired.<br>  ○ Submit a CEST outcome for the member ASAP. | • Worklists/Reports have been developed to monitor the completion of CEST in alignment with policy.<br>  ○ CEST must be completed at 1 year post Initial Appropriateness completion and every 6 months thereafter unless the member is part of the HH+ population.<br>• The HH sends the Billing Support file weekly to each CMA, ensuring they are aware of Billing blocks that are preventing member billing. |

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| | | ○ You may or may not be able to add this BI depending on the CEST Start Date | • CMA's are required to completed CEST per policy to maintain member appropriateness and enrollment in the program. |