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OMIG AUDIT PROTOCOL – DIAGNOSTIC & TREATMENT CENTER SERVICES

For service dates prior to September 1, 2009

Effective June 14, 2013

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. The 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 the 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.

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1.	Billing for Services Unauthorized by the Operating Certificate
OMIG Audit Criteria	The claim will be disallowed when the services billed were not authorized by the operating certificate.
Regulatory References	18 NYCRR Section 485.5(f) 18 NYCRR Section 504.1(c) MMIS Provider Manual Policy Guidelines for Article 28, Certified Clinics: Version 2007-2, Section II Version 2007-1, Section II
2.	Services Billed Separately that are Included in the PAC Rate
OMIG Audit Criteria	Products of Ambulatory Care (PAC) rates are all-inclusive. The Diagnostic and Treatment Center (D&TC) must provide audit staff with an Agreement or Memorandum of Understanding (MOU) regarding the billing of services resulting from PAC referrals between the facility and the provider performing these services. The Agreement should state that the performing provider should bill the D&TC instead of billing Medicaid for services rendered. If there is no Agreement or MOU in place and the performing provider bills Medicaid, the amount of the service billed separately will be disallowed from the PAC clinic claim.
Regulatory References	10 NYCRR Section 86-4.37(d)
3.	Emergency Room Visit and Clinic Visit on Same Day
OMIG Audit Criteria	When a patient was treated in a facility's emergency room and clinic on the same day for the same illness, the claim paid to the clinic will be disallowed.
Regulatory References	MMIS Provider Manual Policy Guidelines for Article 28 Certified Clinics, Version 2007-2, Section I Version 2007-1, Section I
4.	Services Not Medically Necessary or Excessive
OMIG Audit Criteria	Claims will be disallowed for services that are excessive and/or not medically necessary as determined by licensed medical professionals.
Regulatory References	18 NYCRR Section 500.1(b) 18 NYCRR Section 504.3(e) 18 NYCRR Section 517.3(b)(1) 18 NYCRR Section 518.3(b)

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5.	Ordered Services Not Medically Necessary or Excessive
OMIG Audit Criteria	Claims will be disallowed for services (physical therapy, occupational therapy or speech therapy services) that are not medically necessary, in excess of the recipients' needs, and where there was little or no follow-up of the physical symptoms in regards to medical histories, physical examinations or proper monitoring of therapy programs. This determination will be made by a licensed medical professional.
Regulatory References	18 NYCRR Section 500.1(b) 18 NYCRR Section 504.3(e) 18 NYCRR Section 505.11(a) 18 NYCRR Section 505.11(e) 18 NYCRR Section 517.3(b)(1) 18 NYCRR Section 518.3(b)
6.	Failure to Meet Medical Standards for Therapy Services Ordered
OMIG Audit Criteria	Claims will be disallowed for services when a clear pattern of deviation from acceptable and standard medical practice is established as determined by a licensed medical professional.
Regulatory References	18 NYCRR Section 500.1(b) 18 NYCRR Section 518.3(b)
7.	Improper Medicaid Payments for Dual Eligible Recipients
OMIG Audit Criteria	If the provider bills an incorrect Medicaid co-payment, the difference between the amount billed to Medicaid and the amount that should have been billed will be disallowed.
Regulatory References	18 NYCRR Section 360-7.2
8.	Incorrect HIV Rate Code
OMIG Audit Criteria	When an incorrect HIV rate code is billed, the difference between the billed amount and the correct amount will be disallowed.
Regulatory References	10 NYCRR Section 86-4.35(a) 10 NYCRR Section 86-4.35(c) 10 NYCRR Section 86-4.35(h)(1)

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9.	Incorrect PAC Rate Code
OMIG Audit Criteria	When an incorrect PAC rate code is billed, the difference between the billed amount and the correct amount will be disallowed.
Regulatory References	10 NYCRR Section 86-4.37(a) 10 NYCRR Section 86-4.37(c) 10 NYCRR Section 86-4.37(h)

10.	Incorrect Servicing Provider on Claim
OMIG Audit Criteria	The claim will be disallowed when the servicing practitioner was not accurately identified.
Regulatory References	18 NYCRR Section 504.3(h)&(i) DOH Medicaid Update, June 2002, Vol. 17, No. 6

11.	Medical Entry Not Signed
OMIG Audit Criteria	The claim will be disallowed when the practitioner did not sign the entry in the medical record.
Regulatory References	10 NYCRR Section 751.7(f)

12.	Missing Documentation
OMIG Audit Criteria	The claim will be disallowed when the services were not documented.
Regulatory References	18 NYCRR Section 504.3(a) 18 NYCRR Section 505.25(e)(5) 18 NYCRR Section 505.25(f)(1) 18 NYCRR Section 517.3(b)(1) 18 NYCRR Section 540.7(a)(8) 10 NYCRR Section 751.7

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13.	Missing Documentation (Dialysis Services)
OMIG Audit Criteria	The claim will be disallowed when the services were not documented.
Regulatory References	10 NYCRR Section 757.1(a) 42 CFR Section 405.2139 42 CFR Section 494.170 10 NYCRR Section 751.7
14.	Missing Plan Of Care for Rehabilitation Services
OMIG Audit Criteria	The claim will be disallowed when the Plan Of Care was missing.
Regulatory References	10 NYCRR Section 752-1.1(d)(1)
15.	Missing Explanation of Medical Benefits (EOB) For Medicare/TPHI Covered Services
OMIG Audit Criteria	The claim will be disallowed when no EOB was found for a Medicare eligible patient and/or for a patient who has third-party insurance coverage and Medicare and/or TPHI was not billed for specific services paid by Medicaid.
Regulatory References	18 NYCRR Section 360-7.2 MMIS Provider Manual, Information for all Providers, General Policy: Version 2008-2, Section I Version 2008-1, Section I Version 2006-1, Section I Version 2004-1, Section I
16.	No Written Order by Physician and/or Dentist for Rehabilitation Services
OMIG Audit Criteria	The claim will be disallowed when there was no written order or a referral from a physician or a dentist for physical therapy and/or speech language pathology services and when there was no written order or referral from a physician for occupational therapy services billed.
Regulatory References	10 NYCRR Section 752-1.1(d)

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17.	Review of Plan Of Care Not Completed within 90 Days of the Date of Service
OMIG Audit Criteria	The claim will be disallowed when there was insufficient documentation verifying that the written Plan Of Care and the results of the physical therapy, occupational therapy or speech therapy treatment were reviewed by the physician and appropriate professional staff at least every 30 days, except where treatment of a longer duration is specified, in which case the review is to take place at least every 90 days. The review should be completed within 90 days prior to the date of service.
Regulatory References	10 NYCRR Section 752-1.1(d)(1)

18.	Service Delivery Document Not Signed by a Licensed Health Professional – (Dialysis Services)
OMIG Audit Criteria	The claim will be disallowed when the signature of a licensed health care professional attesting to the delivery of the treatment service was missing on the hemodialysis flow sheet and/or the Plan Of Care.
Regulatory References	10 NYCRR Section 751.7(f)

19.	Psychotherapy Services Provided by an Unsupervised Practitioner
OMIG Audit Criteria	The claim will be disallowed when a Licensed Master Social Worker provided psychotherapy to a patient without the necessary documentation to support appropriate supervision.
Regulatory References	10 NYCRR Section 86-4.9(g) Education Law Article 154 Section 7701(1)(d) 8 NYCRR Section 74.6 (d)(1)

20.	Services Provided by Unregistered/Unlicensed Practitioner
OMIG Audit Criteria	The claim will be disallowed when the practitioner rendered services without his/her license and/or registration from the New York State Education Department.
Regulatory References	18 NYCRR Section 504.1(c)

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21.	Threshold Visit Billed for Incomplete Therapy Session
OMIG Audit Criteria	The claim will be disallowed when a threshold visit billed for a therapy session was terminated before the treatment was completed. The determination is based on information found in the patient’s progress notes.
Regulatory References	18 NYCRR Section 504.3(e) 18 NYCRR Section 505.25(f)(1) MMIS Provider Manual, Information for All Providers, General Policy: Version 2008-2, Section II Version 2008-1, Section II Version 2006-1, Section II Version 2004-1, Section II
22.	Threshold Visit Billed for Non-Reimbursable Service
OMIG Audit Criteria	The claim will be disallowed when a threshold visit was billed solely for the purpose of receiving: ordered ambulatory services, pharmacy, nutrition, medical social services, respiratory therapy and/or recreation therapy.
Regulatory References	10 NYCRR Section 86-4.9(c)
23.	Federally Qualified Health Center (FQHC) Threshold Visit Billed For Services Rendered in Long Term Care Facility
OMIG Audit Criteria	The claim will be disallowed when an FQHC off-site threshold visit was incorrectly billed for a service rendered in a long term care facility (when the patient is expected to remain in that facility).
Regulatory References	10 NYCRR Section 86-4.9(i)(1)(v)
24.	Threshold Visit Billed for Follow-up Service
OMIG Audit Criteria	The claim will be disallowed when a threshold visit was billed for a visit that was completing the services initiated at an earlier visit.
Regulatory References	MMIS Provider Manual Policy Guidelines for Article 28 Certified Clinics, Version 2007-2, Section I Version 2007-1, Section I

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25.	Threshold Visit Billed for Managed Care Enrollee
OMIG Audit Criteria	The claim will be disallowed when the provider billed Medicaid for services for patients enrolled in the provider's HMO network.
Regulatory References	18 NYCRR Section 360-7.2 MMIS Provider Manual, Information For All Providers, General Policy: Version 2008-2, Section I Version 2008-1, Section I Version 2006-1, Section I Version 2004-1, Section I
26.	Medicaid Payment Denied Due to Lack of Medical Necessity as Determined by Medicare
OMIG Audit Criteria	The claim will be disallowed when payment is denied by Medicare due to lack of medical necessity for the services billed, as per the Medicare EOB. Medicaid will only pay for medically necessary services.
Regulatory References	18 NYCRR Section 360-7.7(a)(1) and (b) 18 NYCRR Section 500.1(b) 18 NYCRR Section 504.3(e) 18 NYCRR Section 517.3(b)(1) MMIS Provider Manual, Information for All Providers, General Policy: Version 2008-2, Section II Version 2008-1, Section II Version 2006-1, Section II Version 2004-1, Section II
27.	Billing Exceeded Acquisition Cost
OMIG Audit Criteria	NYS Medicaid does not intend to pay more than the acquisition cost as established by invoice to the practitioner. The amount disallowed will be the difference between the claim amount and the actual invoice cost.
Regulatory References	MMIS Provider Manual Policy Guidelines for Article 28 Certified Clinics, Version 2007-1, Section II MMIS Ordered Ambulatory Procedure Codes Manual: Version 2008-1 Version 2007-1 Version 2006-1 Version 2005-1

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28.	Billing for Services Covered by the Medicaid in Education Program
OMIG Audit Criteria	The claim will be disallowed for therapy services billed for children with an Individual Education Plan when the services were rendered at the school instead of the Article 28 facility.
Regulatory References	18 NYCRR Section 485.5(f) 18 NYCRR Section 504.1(c) MMIS Provider Manual Policy Guidelines for Article 28 Certified Clinics, Version 2007-2, Section I Version 2007-1, Section I
29.	Billed for Incomplete Hemodialysis Sessions
OMIG Audit Criteria	The claim will be disallowed when an individual hemodialysis session billed was terminated before the treatment was completed.
Regulatory References	18 NYCRR Section 504.3(e) MMIS Provider Manual, Information For All Providers, General Policy: Version 2008-2, Section II Version 2008-1, Section II Version 2006-1, Section II Version 2004-1, Section II
30.	HIV Primary Care Laboratory Services Billed Fee-for-Service
OMIG Audit Criteria	When a D&TC provider bills a claim at the enhanced rates and a separate laboratory provider also bills for the ancillary lab work ordered at the visit, the amount that was billed by the outside laboratory provider will be disallowed. Laboratory costs were paid for twice by Medicaid. This is to be controlled by contract with the provider of enhanced rates and the laboratory performing the ancillary services. The amount that was billed by the outside laboratory provider is disallowed from the D&TC claim.
Regulatory References	10 NYCRR Section 86-4.35(d) For Services Prior to 11/1/06: NYS Department of Health Memorandum 93-26, page 11, November 3, 1993: NYS Department of Health Memorandum 93-26, The HIV Primary Care Medicaid Program #6, page 7, November 3, 1993 For Services After 11/1/06: NYS Department of Health Memorandum #AI 06-01, Part 1, PCMP Program Agreement pages 1 & 2 #AI 06-01, Section 3, PCMP Billing Instructions page 1, September 1, 2006

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31.	Incorrect Claiming of Enhanced HIV Primary Care Initial/Annual Visit
OMIG Audit Criteria	Multiple lab tests and assessments are required to be completed when a provider bills the enhanced HIV initial/annual visit rate. (Rate codes 1697). If the provider did not meet all of the necessary requirements, as indicated in guidance set forth by DOH pertaining to an Initial/Annual Comprehensive HIV Medical Evaluation Visit, but the recipient was examined by a physician or nurse practitioner, the difference between a threshold clinic visit rate and the enhanced visit rate will be disallowed.
Regulatory References	10 NYCRR Section 86-4.35(c)(3) For Services Prior to 11/1/06: NYS Department of Health Memorandum 93-26, Attachment 1, #4 page 28, November 3, 1993 NYS Department of Health Memorandum 93-26, The HIV Primary Care Medicaid Program #4, page 5, November 3, 1993 For Services After 11/1/06: NYS Department of Health Memorandum #AI 06-01, Section 3, PCMP Billing Instructions Chart 2, September 1, 2006
32.	Incorrect Claiming of Enhanced CD4 Monitoring Visit
OMIG Audit Criteria	Multiple lab tests and assessments are required to be completed when a provider bills the enhanced CD4 monitoring visit rate. (Rate codes 1699). If the provider did not meet all of the necessary requirements, but the recipient was examined by a physician or nurse practitioner the difference between a threshold clinic visit rate and the enhanced visit rate will be disallowed.
Regulatory References	10 NYCRR Section 86-4.35(c)(5) For Services Prior to 11/1/06: NYS Department of Health Memorandum 93-26, Attachment 1, #6 page 31, November 3, 1993 NYS Department of Health Memorandum 93-26, The HIV Primary Care Medicaid Program #6, page 7, November 3, 1993 For Services After 11/1/06: NYS Department of Health Memorandum #AI 06-01, Section 3, PCMP Billing Instructions Chart 2, September 1, 2006

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