NEW YORK STATE | Office of the Medicaid Inspector General

OMIG AUDIT PROTOCOL
HOSPITAL OUTPATIENT DEPARTMENT (OPD)
ORDERED AMBULATORY – OTHER THAN LABORATORY
For service dates from January 1, 2012
Revised 03/29/17

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. Missing Documentation of Service	
OMIG Audit Criteria	If service documentation is missing or incomplete, the paid claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) 18 NYCRR § 540.7(a)(8) 18 NYCRR § 517.3(b)(1) 10 NYCRR § 405.10(c)(1)

2. No Written Order	
OMIG Audit Criteria	The paid claim will be disallowed if the written order by the recipient's attending physician, nurse practitioner, physician's assistant, dentist, or podiatrist is not provided.
Regulatory References	10 NYCRR § 405.10(b)(2)(vi) NYS Medicaid Program Policy Guidelines Manual for Article 28 Certified Clinics Version 2007-2, Section II NYS DOH Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual, Chapter 4, 4.18

3. Incorrect Procedure Code Billed	
OMIG Audit Criteria	If the provider billed an incorrect procedure code, the difference between the amount related with the incorrect procedure code and correct procedure code will be disallowed.
Regulatory References	18 NYCRR § 504.3(h) NYS Medicaid Program, Information for all Providers, General Policy. Versions 2011-1 & 2, Section II

4. Tests Billed in Excess of Those Ordered by Qualified Practitioner	
OMIG Audit Criteria	Tests billed and reimbursed in excess of those ordered by a qualified practitioner will be disallowed.
Regulatory References	NYS Medicaid Program Policy Guidelines Manual for Article 28 Certified Clinics Version 2007-2, Section II NYS Medicaid Program, Information for All Providers, General Policy Versions 2011-1 & 2, Section II

5. Incorrect Reduction for Radiology Procedures	
OMIG Audit Criteria	The provider is required to reduce the amount claimed for radiological services to reflect the technical/administrative component and/or multiple procedure factors. If this is not done, the paid amount that was not properly reduced to reflect the technical/administrative component and/ or multiple procedure factors will be disallowed.
Regulatory References	18 NYCRR § 533.6(b) 18 NYCRR § 533.6(b)(1)(d)(ii) 18 NYCRR § 533.6(c)(2)(i)

6. Order Not Signed by Qualified Practitioner	
OMIG Audit Criteria	If the order is not signed by a qualified practitioner, the paid claim will be disallowed.
Regulatory References	10 NYCRR § 405.10(b)(2)(vi) NYS Medicaid Program Policy Guidelines Manual for Article 28 Certified Clinics Version 2007-2, Section II

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 § 360-7.7(a) 18 NYCRR § 360-7.7(b) 18 NYCRR § 360-7.2

8. No Explanation of Benefits (EOB) for Medicare/Third Party Health Insurance Covered Service	
OMIG Audit Criteria	If no Explanation of Benefits (EOB) is provided, the paid claim will be disallowed.
Regulatory References	18 NYCRR § 360-7.2 NYS Medicaid Program, Information for All Providers, General Policy Versions 2011-1 & 2, Section I

9. Services Not Authorized by Operating Certificate	
OMIG Audit Criteria	If the service is not authorized by the operating certificate, the paid claim will be disallowed.
Regulatory References	18 NYCRR § 504.1(c) NYS Medicaid Program Policy Guidelines Manual for Article 28 Certified Clinics, Version 2007-2, Section II

10. 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 the 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 § 360-7.7(a)(1) and (2) 18 NYCRR § 500.1(b) 18 NYCRR § 504.3(e) 18 NYCRR § 517.3(b)(1) NYS Medicaid Program, Information for All Providers, General Policy Versions 2011-1 & 2, Section II

11. Incorrect Ordering Provider on Claim	
OMIG Audit Criteria	If the ordering provider is incorrectly identified on the claim, the paid claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(h) and (i) 18 NYCRR § 518.1(c) NYS Medicaid Program Policy Guidelines Manual for Article 28 Certified Clinics Version 2007-2, Section II

12. Incorrect Diagnosis Code on Claim	
OMIG Audit Criteria	If the diagnosis code is incorrectly identified on the claim, the paid claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(h)(i) 18 NYCRR § 518.1(c) NYS Medicaid Program Provider Manual for Hospital Based/Free Standing Ordered Ambulatory Billing Guidelines, Version 2008-4, Section II Versions 2009- 1 thru 3, Section II NYS Electronic Medicaid System, Free Standing or Hospital Based Ordered Ambulatory, 150002 Billing Guidelines, Version 2010-1, Section II NYS Electronic Medicaid System, Free Standing or Hospital Based Ordered Ambulatory, 150003 Billing Guidelines, Version 2010-1, Section II

13. Therapy Services Included in an ICF/DD Rate	
OMIG Audit Criteria	If a therapy service billed was included in an ICF/DD rate, it will be disallowed.
Regulatory References	DOH *Medicaid Update* September 2006 Vol. 21, No.9