NEW YORK STATE | Office of the Medicaid Inspector General

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OMIG AUDIT PROTOCOL – OASAS CHEMICAL DEPENDENCE INPATIENT REHABILITATION SERVICES

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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.

OMIG AUDIT PROTOCOL – OASAS INPATIENT CHEMICAL DEPENDENCE REHABILITATION SERVICES

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1.	**Missing Patient Record**
OMIG Audit Criteria	If the patient record is missing, claims for all dates of service associated with the patient record will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) 18 NYCRR § 540.7(a)(8)

2.	**No Chemical Dependence Diagnosis**
OMIG Audit Criteria	Claims will be disallowed in the absence of a diagnosis of alcohol-related or psychoactive substance-related use disorder, except for court ordered patients, who were not necessarily diagnosed with specific alcohol-related or psychoactive substance-related abuse.
Regulatory References	14 NYCRR § 818.4(c)(1)

3.	**Comprehensive Evaluation Not Done Within Required Time Period**
OMIG Audit Criteria	Each patient admitted must have a comprehensive evaluation completed by staff no later than 3 days after admission. When missing the comprehensive evaluation, claims will be disallowed from the third day after admission until the completion of the comprehensive treatment plan or its due date, whichever comes first.
Regulatory References	14 NYCRR § 818.4(a)(4) 14 NYCRR § 818.5(f)(4)

4.	**Missing Preliminary Individual Treatment Plan**
OMIG Audit Criteria	For service dates prior to July 11, 2012, the preliminary individual treatment plan shall be developed and implemented within 3 days after admission. If the preliminary individual treatment plan is missing, claims will be disallowed from the third day after the admission date until the completion of the comprehensive treatment plan or its due date, whichever comes first.
Regulatory References	**For Services Prior to 7/11/2012**, 14 NYCRR § 818.4(f) 14 NYCRR § 818.5(f)(6)

5.	**Late Preliminary Individual Treatment Plan**
OMIG Audit Criteria	For service dates prior to July 11, 2012, the preliminary individual treatment plan shall be developed and implemented within 3 days after admission. If the preliminary individual treatment plan is prepared late, claims will be disallowed from the third day after admission until the completion of the preliminary individual treatment plan, or until the completion of the comprehensive treatment plan or its due date, whichever comes first.
Regulatory References	**For Services Prior to 7/11/2012**, 14 NYCRR § 818.4(f)

6.	**Missing Comprehensive Individual Treatment Plan**
OMIG Audit Criteria	The comprehensive individual treatment plan shall be developed and implemented within 7 days after admission. If the comprehensive individual treatment plan is missing, claims will be disallowed from the seventh day after admission until the completion of the first treatment plan review or its due date, whichever comes first.
Regulatory References	14 NYCRR § 818.4(f) 14 NYCRR § 818.5(f)(6)

7.	**Late Comprehensive Individual Treatment Plan**
OMIG Audit Criteria	The comprehensive individual treatment plan shall be developed and implemented within 7 days after admission. If the comprehensive individual treatment plan is prepared late, claims will be disallowed from the seventh day after admission until the completion of the comprehensive treatment plan.
Regulatory References	14 NYCRR § 818.4(f)

8.	**Missing Treatment Plan Review**
OMIG Audit Criteria	For service dates prior to July 11, 2012, if the treatment plan review (update) is not in place for the required 14-day time period, claims will be disallowed for the dates of service within that time period.
Regulatory References	**For Services Prior to 7/11/2012**, 14 NYCRR § 818.4(l) 14 NYCRR § 818.5(f)(6)

9.	**Missing Physician Signature on Treatment Plan**
OMIG Audit Criteria	For service dates prior to July 11, 2012, physician review and approval of the treatment plan is substantiated by a physician signature. Claims will be disallowed in the absence of a physician signature on the treatment plan for services from the seventh day after admission until the completion of the first treatment plan review or its due date, whichever comes first. For service dates July 11, 2012, and after, claims will be disallowed in the absence of a physician signature on the treatment plan for services from the tenth day after admission (a maximum of 14 days will be disallowed).
Regulatory References	14 NYCRR § 818.4(i)(9)

10.	**Missing Patient Signature on Treatment Plan**
OMIG Audit Criteria	Patient review and approval of the comprehensive individual treatment plan is substantiated by the patient's signature. Claims will be disallowed in the absence of the patient's signature on the treatment plan for services from the seventh day after admission until the first treatment plan review is completed or its due date, whichever comes first. No disallowances will be taken if the patient's refusal to sign the plan is documented in the case record.
Regulatory References	14 NYCRR § 818.4(i)(1)

11.	Missing Responsible Clinical Staff Member Signature on Treatment Plan
OMIG Audit Criteria	The comprehensive treatment plan must be reviewed and signed by the responsible clinical staff member within 7 days of admission.* Claims will be disallowed in the absence of the responsible clinician's signature on the treatment plan for services from the seventh day after admission until the first treatment plan review is completed or its due date, whichever comes first. ***Note**: * For service dates prior to July 11, 2012, although 14 NYCRR § 818.4(i)(8) states that the comprehensive treatment plan must be reviewed and signed by the responsible clinical staff member within 3 days of admission, for purposes of internal consistency with § 818.4(f), the standard to be applied upon audit shall be 7 days.*
Regulatory References	14 NYCRR § 818.4(f) 14 NYCRR § 818.4(i)(8)

12.	Missing Medical Order for Services Provided
OMIG Audit Criteria	All medical services provided must be provided pursuant to a physician's, physician's assistant's, or nurse practitioner's order. Claims will be disallowed for services provided without a medical order.
Regulatory References	14 NYCRR § 818.5(d)

13.	Missing Progress Note
OMIG Audit Criteria	For service dates prior to July 11, 2012, if a progress note written by the responsible clinical staff member is missing for the weekly time period beginning on the day after admission and/or is missing for each weekly time period thereafter, the last paid date of the weekly time period will be disallowed. For service dates July 11, 2012, and after, progress notes may also be written by a clinical staff member familiar with the patient's care.
Regulatory References	14 NYCRR § 818.4(n)(1) 14 NYCRR § 818.5(f)(7)

14.	Missing Required Signature on Progress Note
OMIG Audit Criteria	For service dates July 11, 2012, the progress note shall be written, signed, and dated by the responsible clinical staff member. If the signature is missing for the weekly time period beginning on the day after admission and/or is missing for each weekly time period thereafter, the last paid date of the weekly time period will be disallowed. For service dates July 11, 2012, and after, progress notes may also be written by a clinical staff member familiar with the patient's care.
Regulatory References	14 NYCRR § 818.4(n)(1) 14 NYCRR § 818.5(f)(7)

15.	**Certified Bed Capacity Exceeded**
OMIG Audit Criteria	Claims will be disallowed for services provided to patients associated with beds in excess of the provider's certified bed capacity.
Regulatory References	14 NYCRR § 818.2(f)

16.	**No Explanation of Benefits (EOB) For Medicare-Covered Services** (Hospital-Based Chemical Dependence Inpatient Rehabilitation Providers Only)
OMIG Audit Criteria	If an EOB for a Medicare-covered service cannot be found, the claim will be disallowed.
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2) NYS Medicaid Program, Information For All Providers, Policy Guidelines, Versions 2011- 2, Section I

17.	**Improper Medicaid Co-Payment Billings for Medicare Crossover Patients** (Hospital-Based Chemical Dependence Inpatient Rehabilitation Providers Only)
OMIG Audit Criteria	If a review of Medicare's EOB shows Medicaid's billed co-payment to be incorrect, the disallowance will be the difference between the Medicaid incorrect co-payment billed and the correct co-payment amount.
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2) NYS Medicaid Program, Information For All Providers, Policy Guidelines, Versions 2011- 2, Section I

18.	**No EOB for Third-Party Health Insurance (TPHI) Covered Service (Excluding Medicare)**
OMIG Audit Criteria	If an EOB for a TPHI (commercial carrier) covered service cannot be found, the claim will be disallowed. Other documentation sources, such as an email, a phone call log, or a print-out of a benefits rejection notice from the carrier's website may be accepted when denial of service by a third-party health insurance carrier is clearly indicated.
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2) NYS Medicaid Program, Information For All Providers, Policy Guidelines, Versions 2011- 2, Section I

19.	**Improper Medicaid Co-Payment Billings for TPHI Patients (Excluding Medicare)**
OMIG Audit Criteria	If Medicaid's co-payment is incorrect, the amount of the claim disallowed will be the difference between Medicaid's incorrect co-payment billed and the correct co-payment amount.
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2)

20.	Missing Discharge Plan
OMIG Audit Criteria	A discharge plan is to be developed in collaboration with the patient and any significant other(s) the patient chooses to involve. A missing discharge plan will result in the disallowance of the last paid date of service prior to discharge.
Regulatory References	14 NYCRR § 818.4(p) 14 NYCRR § 818.5(f)(10)

21.	Missing Discharge Summary
OMIG Audit Criteria	A summary which includes the course and results of care and treatment must be prepared and included in each patient's record within 20 days of discharge. A missing discharge summary will result in the disallowance of the last paid date of service prior to discharge.
Regulatory References	14 NYCRR § 818.4(s)

22.	Improper Length of Stay Billing
OMIG Audit Criteria	In computing patient days, the day of admission is counted, but not the day of discharge. Claims will be disallowed for services dates exceeding the allowed billable service days.
Regulatory References	14 NYCRR § 841.10(a)(2)

23.	Missing or Incomplete Level of Care Determination
OMIG Audit Criteria	A level of care determination shall be completed and signed and dated by the responsible clinical staff member. If a signed level of care determination is missing, claims will be disallowed beginning 1 patient day after the first on-site visit until it is completed, or until the comprehensive treatment plan is completed.
Regulatory References	14 NYCRR § 818.3(c) 14 NYCRR § 818.5(f)(11)

24.	Late Level of Care Determination
OMIG Audit Criteria	If the level of care determination is prepared late, claims will be disallowed beginning 1 patient day after the first on-site visit until it is completed, or until the comprehensive treatment plan is completed.
Regulatory References	14 NYCRR § 818.3(c)

25.	Missing Documentation of Medical History/Physical Examination
OMIG Audit Criteria	Within 3 days after admission, the patient record must be updated to include the patient's medical history. If a physical examination was not done within the last 12 months, one must be performed and the results placed in the patient's medical record. Claims will be disallowed from the third day after admission to the date of the comprehensive evaluation if documentation of medical history or of a physical examination is not found.
Regulatory References	14 NYCRR § 818.4(b)(1)

26.	Missing/Late Identification of Initial Services
OMIG Audit Criteria	Each patient admitted must have their initial service needs identified by staff in the Comprehensive Evaluation which shall be completed no later than 3 days after admission. When the identification of initial services is missing or late because of a missing or late Comprehensive Evaluation, claims will be disallowed from the third day after admission until either the completion of the Comprehensive Evaluation or completion of the comprehensive individual treatment plan or its due date, whichever comes first.
Regulatory References	14 NYCRR § 818.4(a)(4) 14 NYCRR § 818.4(a)(5)