NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

OMIG AUDIT PROTOCOL – OASAS OUTPATIENT CHEMICAL DEPENDENCE SERVICES FOR HOSPITAL-BASED AND FREE-STANDING CLINICS

11/15/2018

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 OUTPATIENT CHEMICAL DEPENDENCE SERVICES

11/15/2018

1.	**Missing Patient Record**
OMIG Audit Criteria	If the patient record is not available for review, 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) **For Services Prior to 8/25/2015:** 14 NYCRR § 822-2.2(e) **For Services 8/25/2015 and After:** 14 NYCRR § 822.10(f)

2.	**No Substance Use Disorder (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 in the case of services to a significant other or for court-ordered patients who were not necessarily diagnosed with specific alcohol-related or psychoactive substance-related abuse.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-4.3(a)(1) **For Services 8/25/2015 and After:** 14 NYCRR § 822.8(b)(1)

3.	**Missing Comprehensive Evaluation**
OMIG Audit Criteria	Claims will be disallowed in the absence of a comprehensive evaluation. Claims will be disallowed from the 45th day after admission through the 60th day or until the completion of the initial treatment/recovery plan, whichever comes first.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-2.3(a)(2) 14 NYCRR § 822-4.4(a)

4.	**Missing Admission Assessment**
OMIG Audit Criteria	Claims will be disallowed in the absence of an admission assessment. Claims will be disallowed from the 1st day of admission through the 30th day or until the completion of the initial treatment/recovery plan, whichever comes first.
Regulatory References	**For Services 8/25/2015 and After:** 14 NYCRR § 822.7(g)(1)

5.	Missing/Late Initial Individual Treatment/Recovery Plan
OMIG Audit Criteria	**For Services Prior to 8/25/2015:** A written individual treatment/recovery plan based on the comprehensive evaluation must be developed within 45 days of admission. Claims will be disallowed for services provided on the 45th day after admission date if the written individual treatment/recovery plan is missing or late. **For Services 8/25/2015 and After:** Within 30 days of admission to the outpatient program/outpatient rehabilitation program, a written comprehensive individualized patient-centered treatment/recovery plan must be developed by the responsible clinical staff member. Claims will be disallowed from the 30th day after admission date if the treatment/recovery plan is missing or not completed timely.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-2.2(b)(4) 14 NYCRR § 822-4.5(a) **For Services 8/25/2015 and After:** 14 NYCRR § 822.9(a) 14 NYCRR § 822.10(b)(4)

6.	Missing/Late Individual Treatment/Recovery Plan Review
OMIG Audit Criteria	A treatment/recovery plan review must be reviewed and revised at least every 90 days from the date of admission for the first year in treatment, and at least every 180 days thereafter. Claims will be disallowed for service dates during any time period for which the treatment/recovery plan review is either missing or late. **Note:** For services prior to 8/25/2015, in order for a treatment/recovery plan review to be considered complete, it must be signed and dated by a member of the multi-disciplinary team. For services 8/25/2015 and after, in order for a treatment/recovery plan review to be considered complete, it must be signed by one of the following: physician, physician assistant, licensed psychologist, nurse practitioner, or licensed clinical social worker.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-2.2(b)(4) 14 NYCRR § 822-4.5(g) **For Services 8/25/2015 and After:** 14 NYCRR § 822.9(c) 14 NYCRR § 822.10(b)(4)

7.	**Missing/Late Signature on Initial Individual Treatment/Recovery Plan**
OMIG Audit Criteria	Approval of the treatment/recovery plan is substantiated by the signature of the responsible clinical staff member. For services prior to 8/25/2015, signatures of the multi-disciplinary team are also required. If any of the signatures are missing or late, claims will be disallowed during any period for which there is no signed treatment/recovery plan in place. **Note:** The multi-disciplinary team is a team of health professional staff including one medical staff member, one credentialed alcoholism and substance abuse counselor (CASAC) and one other staff member who is a qualified health professional in a discipline other than alcoholism and substance abuse counseling.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 800.2(a)(12) 14 NYCRR § 822-4.5(c)(10) 14 NYCRR § 822-4.5(c)(11) **For Services 8/25/2015 and After:** 14 NYCRR § 800.3(f) 14 NYCRR § 822.9(b)(3)

8.	**Missing Physician Signature on Initial Individual Treatment/Recovery Plan**
OMIG Audit Criteria	Physician review and approval of the treatment/recovery plan is substantiated by physician signature. Claims will be disallowed from the 10th day after review until completion of the first treatment/recovery plan review or its due date, whichever comes first.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-4.5(c)(11)

9.	**Missing/Late Signature on Initial Individual Treatment/Recovery Plan**
OMIG Audit Criteria	Within 10 days of development of the treatment/recovery plan, a physician, physician assistant, licensed psychologist, nurse practitioner, or licensed clinical social worker, must review, approve, and sign the plan. Claims will be disallowed from the 10th day after development of the treatment/recovery plan if the signature is missing or not completed timely.
Regulatory References	**For Services 8/25/2015 and After:** 14 NYCRR § 822.9(b)(4)

10.	Missing/Late Signature on Individual Treatment/Recovery Plan Review
OMIG Audit Criteria	The entire treatment/recovery plan shall be reviewed and revised at least every 90 calendar days. Review and approval of the treatment/recovery plan review is substantiated by signature of a member of the multidisciplinary team. Claims will be disallowed for service dates during any period for which the treatment/recovery plan review signed by a multidisciplinary team member is either missing or late. **Note:** The multidisciplinary team is a team of health professional staff including one medical staff member, one credentialed alcoholism and substance abuse counselor (CASAC) and one other staff member who is a qualified health professional in a discipline other than alcoholism and substance abuse counseling.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 800.2(a)(12) 14 NYCRR § 822-4.5(g)

11.	Missing/Late Signature on Individual Treatment/Recovery Plan Review
OMIG Audit Criteria	A treatment/recovery plan review must be signed by a physician, physician assistant, licensed psychologist, nurse practitioner, or licensed clinical social worker. Claims will be disallowed if the signature is either missing or not completed timely.
Regulatory References	**For Services 8/25/2015 and After:** 14 NYCRR § 822.9(c)

12.	Missing Element of Service Documentation
OMIG Audit Criteria	Patient record needs to document the following: (1) notation of service, signed by the staff member who provided the service; (2) date the service was delivered; (3) results of the service including any recommendations or determinations; (4) duration of service provided; and (5) the notation must be included in a patient's case record. If one or more, but not all, of the preceding elements are not met, the claim will be disallowed.
Regulatory References	18 NYCRR § 505.27(b)(5) **For Services Prior to 8/25/2015:** 14 NYCRR § 822-2.5(a) **For Services 8/25/2015 and After:** 14 NYCRR § 822.11(a)

13.	**No Documentation of Service Provided**
OMIG Audit Criteria	Patient record needs to document the following: (1) notation of service, signed by the staff member who provided the service; (2) date the service was delivered; (3) results of the service including any recommendations or determinations; (4) duration of service provided; and (5) the notation must be included in a patient's case record. If all five of the preceding elements are not met, the claim will be disallowed.
Regulatory References	18 NYCRR § 505.27(b)(5) **For Services Prior to 8/25/2015:** 14 NYCRR § 822-2.2(b)(9) 14 NYCRR § 822-2.5(a) **For Services 8/25/2015 and After:** 14 NYCRR § 822.11(a)

14.	**Non-Reimbursable Services**
OMIG Audit Criteria	Claims will be disallowed for services consisting of **only** nutrition services, educational/ vocational, recreational (for clinic programs only) and social activity services, group meetings, workshops or seminars which are primarily informational or organizational, or acupuncture.
Regulatory References	18 NYCRR § 505.27(c)(2) **For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(d) **For Services 8/25/2015 and After:** 14 NYCRR § 822.6(e)

15.	**Recreation Only Services** (For Chemical Dependence Outpatient Rehabilitation Program Services)
OMIG Audit Criteria	Recreation only services will not constitute a service eligible for reimbursement. Claims will be disallowed for billed services consisting of recreation only services.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(d)(3) **For Services 8/25/2015 and After:** 14 NYCRR § 822.6(e)(3)

16.	**Incorrect Healthcare Common Procedure Coding System (HCPCS) Code Billed**
OMIG Audit Criteria	For outpatient rehabilitation services billed that used an incorrect HCPCS code resulting in a higher reimbursement (full day-4 hours) than indicated for the correct HCPCS code (half day 2-4 hours), the amount of the claim disallowed will be the difference between the incorrect HCPCS code billed amount and the correct HCPCS code amount.
Regulatory References	18 NYCRR § 505.27(d)(1) 18 NYCRR § 504.3(h)

17.	No Explanation of Benefits (EOB) / Documentation for Medicare-Covered Service
OMIG Audit Criteria	If an EOB for a Medicare-covered service provided by an enrolled practitioner is not found, the claim will be disallowed. Under its mental health outpatient benefit, Medicare does cover outpatient chemical dependence services when such services are delivered by the following Medicare-approved practitioners: • physicians • psychiatrists • clinical psychologists • licensed clinical social workers • psychiatric nurse practitioners • clinical nurse specialists • physicians assistants *See OASAS' Medicaid FAQ Webpage for more information.*
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2) NYS Medicaid Program, Information For All Providers, General Policy Guidelines, Version 2011-2, Section I

18.	Incorrect Co-Payment Billed to Medicaid for Medicare Crossover Recipients
OMIG Audit Criteria	If a review of Medicare's EOB shows 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. *See OASAS' Medicaid FAQ Webpage for more information.*
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2) NYS Medicaid Program, Information For All Providers, General Policy Guidelines, Version 2011-2, Section I

19.	**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 is not found, the claim will be disallowed. **Note**: 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 TPHI carrier is clearly indicated. *See OASAS' Medicaid FAQ Webpage for more information.*
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2) NYS Medicaid Program, Information For All Providers, General Policy Guidelines, Version 2011-2, Section I

20.	**Incorrect Co-Payment Billed to Medicaid for TPHI Recipients (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. *See OASAS' Medicaid FAQ Webpage for more information.*
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2)

21.	**Group Counseling Patient Limit Exceeded**
OMIG Audit Criteria	If the number of patients in the group counseling session exceeds the maximum of 15 patients, the claim will be disallowed for the date of service under review. **Note**: Under extenuating circumstances, two sessions may be merged; however, the Medicaid billing limit remains 15. See OASAS' Medicaid FAQ Webpage for more information.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-4.2(c)(3) **For Services 8/25/2015 and After:** 14 NYCRR § 822.5(o)

22.	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. If the service date is after the treatment/recovery plan start date, the claim will be disallowed if the discharge plan is missing.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-2.3(a)(4) 14 NYCRR § 822-4.6(b) **For Services 8/25/2015 and After:** 14 NYCRR § 822.12(b)

23.	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 45 days of discharge. The claim will be disallowed if the discharge summary is missing or not prepared within 45 days of discharge.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-2.3(a)(4) 14 NYCRR § 822-4.6(e) **For Services 8/25/2015 and After:** 14 NYCRR § 822.12(d)

24.	Missing Level of Care Determination
OMIG Audit Criteria	A level of care determination must be completed by the appropriate clinical staff member. If a level of care determination is missing, claims will be disallowed for dates of service subsequent to the second visit after admission until the comprehensive evaluation is completed. No disallowance will be taken when a level of care determination is missing for a court-ordered patient.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-4.3(d)(5)

25.	Missing Decision to Admit
OMIG Audit Criteria	The patient record must contain the name of the clinical staff member who made the decision to admit, and it must be documented by the staff member's dated signature.
Regulatory References	**For Services 8/25/2015 and After:** 14 NYCRR § 822.8(b)(2)

26.	Missing Comprehensive Evaluation Update
OMIG Audit Criteria	If the comprehensive evaluation has not been updated annually, claims will be disallowed for services covered by each annual treatment/recovery plan review.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-4.5(g) 14 NYCRR § 822-2.3(a)(2)

27.	**Missing Schedules of Individual and Group Counseling**
OMIG Audit Criteria	Claims will be disallowed for services associated with a missing service schedule (indicating the provision of services on the individual treatment/recovery plan).
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-2.2(b)(4) 14 NYCRR § 822-4.5(c)(5)

28.	**Service Rendered After Discharge**
OMIG Audit Criteria	Claims will be disallowed for services rendered after the patient is discharged.
Regulatory References	**For Services Prior to 8/25/2015:** 18 NYCRR § 505.27(b)(2), (3) & (4) 14 NYCRR § 841.8(c)

29.	**Failure to Meet Brief Admission Assessment Requirements**
OMIG Audit Criteria	Brief Admission Assessments have the following requirements: • No more than one assessment per day • No more than three assessment visits per episode of care • At least 15 minutes of face-to-face contact with the patient If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(1) 14 NYCRR § 822-3.1(h)(1)(i) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(1) 14 NYCRR § 841.14(i)(1)(i)

30.	**Failure to Meet Normative Admission Assessment Requirements**
OMIG Audit Criteria	Normative Admission Assessments have the following requirements: • No more than one assessment per day • No more than three assessment visits per episode of care • At least 30 minutes of face-to-face contact with the patient If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(1) 14 NYCRR § 822-3.1(h)(1)(ii) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(1) 14 NYCRR § 841.14(i)(1)(ii)

31.	**Failure to Meet Extended Admission Assessment Requirements**
OMIG Audit Criteria	Extended Admission Assessments have the following requirements: • No more than one assessment per day • No more than three assessment visits per episode of care • No more than one extended admission assessment per episode of care • At least 75 minutes of face-to-face contact with the patient If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(1) 14 NYCRR § 822-3.1(h)(1)(iii) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(1) 14 NYCRR § 841.14(i)(1)(iii)

32.	**Failure to Meet Brief Intervention Requirements**
OMIG Audit Criteria	Brief Interventions have the following requirements: • No more than one brief intervention per day • No more than three brief intervention services per episode of care • At least 15 minutes of face-to-face contact with the patient If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(2) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(2)

33.	**Failure to Meet Brief Treatment Requirements**
OMIG Audit Criteria	Brief Treatments have the following requirements: • No more than one brief treatment per day • At least 15 minutes of face-to-face contact with the patient If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(3) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(3)

34.	**Failure to Meet Collateral Visit Requirements**
OMIG Audit Criteria	Collateral Visits have the following requirements: • No more than one collateral visit per day • No more than five collateral visits per episode of care. • At least 30 minutes of face-to-face contact with collateral person If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(4) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(4)

35.	Failure to Meet Complex Care Coordination Requirements
OMIG Audit Criteria	Complex Care services have the following requirements: • No more than one complex care service per day • No more than three complex care services per episode of care • At least 45 minutes of services • Must occur within five working days of another billable service If any of these requirements are not met, the claim will be disallowed. **Note**: There can be more than three visits in a given episode of care if the clinical staff document in the treatment/recovery plan that additional complex care services are clinically necessary and appropriate.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(5) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(5)

36.	Failure to Meet Group Counseling Requirements
OMIG Audit Criteria	Group Counseling services have the following requirements: • No more than one group counseling service per day • At least 60 minutes of face-to-face contact with patient • Must have progress note that documents attendance and individual participation of each patient If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-2.5(b)(6)(ii) 14 NYCRR § 822-3.1(h)(6) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(6)

37.	Failure to Meet Brief Individual Counseling Requirements
OMIG Audit Criteria	Brief Individual Counseling services have the following requirements: • No more than one individual counseling service per day • At least 25 minutes of face-to-face contact with patient If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(7) 14 NYCRR § 822-3.1(h)(7)(i) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(7) 14 NYCRR § 841.14(i)(7)(i)

38.	**Failure to Meet Normative Individual Counseling Requirements**
OMIG Audit Criteria	Normative Individual Counseling services have the following requirements: • No more than one individual counseling service per day • At least 45 minutes of face-to-face contact with patient If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(7) 14 NYCRR § 822-3.1(h)(7)(ii) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(7) 14 NYCRR § 841.14(i)(7)(ii)

39.	**Failure to Meet Intensive Outpatient Services Requirements**
OMIG Audit Criteria	Intensive Outpatient Services (IOS) have the following requirements: • No more than six weeks of intensive outpatient services per patient • At least nine scheduled service hours per week • At least three hours per day If any of these requirements are not met, the claim will be disallowed. **Note**: More than six weeks of IOS can be provided, if during the final week of scheduled IOS, clinical staff document in the treatment/recovery plan that additional IOS are clinically necessary and appropriate. Additionally, more than six weeks of IOS can be provided if a court order or an order by the LDSS is issued.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(8) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(8)

40.	**Failure to Meet Medication Administration and Observation Requirements**
OMIG Audit Criteria	Medication Administration and Observation services have the following requirements: • No more than one medication administration and observation service per day • Must have face-to-face contact with patient If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(9) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(9)

41.	Failure to Meet Routine Medication Management Requirements
OMIG Audit Criteria	Routine Medication Management services have the following requirements: • No more than one routine medication management service per day • At least 10 minutes of services including face-to-face contact with the patient and patient observation If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(10) 14 NYCRR § 822-3.1(h)(10)(i) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(10) 14 NYCRR § 841.14(i)(10)(i)

42.	Failure to Meet Complex Medication Management Requirements
OMIG Audit Criteria	Complex Medication Management services have the following requirements: • No more than one complex medication management service per day • At least 15 minutes of services including face-to-face contact with the patient and patient observation If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(10) 14 NYCRR § 822-3.1(h)(10)(ii) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(10) 14 NYCRR § 841.14(i)(10)(ii)

43.	Failure to Meet Addiction Medication Induction Requirements
OMIG Audit Criteria	Addiction Medication Induction services have the following requirements: • No more than one addiction medication induction service per day • At least 30 minutes of services including face-to-face contact with the patient and patient observation If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(10) 14 NYCRR § 822-3.1(h)(10)(iii) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(10) 14 NYCRR § 841.14(i)(10)(iii)

44.	Failure to Meet Half-Day Outpatient Rehabilitation Requirements
OMIG Audit Criteria	Half-Day Rehabilitation Services have the following requirements: • No more than one outpatient rehabilitation service per day • Cannot bill for any other service categories (Excluding medication administration and observation, medication management, complex care coordination, peer support services, and collateral visits) • At least two hours of services • Must include a daily attendance note If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-2.5(b)(11)(i) 14 NYCRR § 822-3.1(h)(11) 14 NYCRR § 822-3.1(h)(11)(i) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(11) 14 NYCRR § 841.14(i)(11)(i)

45.	Failure to Meet Full Day Outpatient Rehabilitation Requirements
OMIG Audit Criteria	Full Day Rehabilitation Services have the following requirements: • No more than one outpatient rehabilitation service per day • Cannot bill for any other service categories (Excluding medication administration and observation, medication management, complex care coordination, peer support services, and collateral visits) • At least four hours of services • Must include a daily attendance note If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-2.5(b)(11)(i) 14 NYCRR § 822-3.1(h)(11) 14 NYCRR § 822-3.1(h)(11)(ii) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(11) 14 NYCRR § 841.14(i)(11)(ii)

46.	Failure to Meet Peer Support Service Requirements
OMIG Audit Criteria	Peer Support services have the following requirements: • No more than one peer support service per day • No more than five peer support services per episode of care • At least 30 minutes of face-to-face contact with the patient If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(12) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(12)

47.	Failure to Meet Screening Requirements
OMIG Audit Criteria	Screening services have the following requirements: • No more than one screening service per episode of care • At least 15 minutes of face-to-face contact with patient If any of these requirements are not met, the claim will be disallowed.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-3.1(h)(13) **For Services 8/25/2015 and After:** 14 NYCRR § 841.14(i)(13)