

# OMIG AUDIT PROTOCOL OMH OUTPATIENT CLINIC TREATMENT SERVICES

**Revised 08/12/15**

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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 the 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. 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 type 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. 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, the 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 the OMIG's authority to recover improperly expended Medicaid funds and the 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 – OMH OUTPATIENT CLINIC TREATMENT SERVICES

Revised 08/12/15

<b>1.</b>	<b>Missing Recipient Record</b>
<b>OMIG Audit Criteria</b>	If the recipient record is not available for review, claims for all dates of service associated with the recipient record will be disallowed.
<b>Regulatory References</b>	18 NYCRR Section 504.3(a) 18 NYCRR Section 540.7(a)(8) For services prior to <b>10/1/2010</b> , 14 NYCRR Section 587.18(a) For services <b>10/1/2010 and after</b> , 14 NYCRR Section 599.11(a)
<b>2.</b>	<b>No Documentation of Clinic Service</b>
<b>OMIG Audit Criteria</b>	If recipient records lack documentation that a face-to-face clinic treatment service was provided, the claim will be disallowed.
<b>Regulatory References</b>	18 NYCRR Section 504.3(a) 18 NYCRR Section 540.7(a)(8) 18 NYCRR Section 505.25(d)(1) and (5) 18 NYCRR Section 505.25(e)(5) 18 NYCRR Section 505.25(f)(1) 18 NYCRR Section 505.25(h)(1)(ii) For services prior to <b>10/1/2010</b> : 14 NYCRR Section 587.18(b)(7), 14 NYCRR Section 588.4(a) and (b) <i>For clinic programs serving adults, 14 NYCRR Section 587.8(c) through (h)</i> <i>For clinic programs serving children, 14 NYCRR Section 587.9(c) through (h)</i> For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.8(b) and (c) 14 NYCRR Section 599.10(k) 14 NYCRR Section 599.14(d)(1) through (9)
<b>3.</b>	<b>Excessive Preadmission Visit</b>
<b>OMIG Audit Criteria</b>	Claims for preadmission visits in excess of the maximum allowed three preadmission visits will be disallowed. For services 10/1/2010 and after, claims for service dates that involve more than one collateral preadmission visit for an adult recipient will be disallowed.
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> , 14 NYCRR Section 588.5(k)(4) For services <b>10/1/2010 and after</b> , 14 NYCRR Section 599.14(b)

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<b>4.</b>	<b>Missing Individual Treatment Plan</b>
<b>OMIG Audit Criteria</b>	A written individual treatment plan must be completed prior to the fourth visit or within 30 days of admission. Claims for services provided on the fourth visit after admission or on the 30 <sup>th</sup> day after the admission date will be disallowed if the written individual treatment plan is missing. For service dates 10/1/2010 and after, claims for services provided on the 30 <sup>th</sup> day after from the admission date will be disallowed if the written individual treatment plan is missing.
<b>Regulatory References</b>	18 NYCRR Section 505.25(d)(2) For services prior to <b>10/1/2010</b> : 14 NYCRR Section 587.18(b)(6) 14 NYCRR Section 588.5(c) 14 NYCRR Section 588.6(g) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.10(g) 14 NYCRR Section 599.11(b)(7)
<b>5.</b>	<b>Late Individual Treatment Plan</b>
<b>OMIG Audit Criteria</b>	A written individual treatment plan must be completed prior to the fourth visit or within 30 days of admission. Claims for services provided on the fourth visit after admission or on the 30 <sup>th</sup> day after the admission date will be disallowed if the written individual treatment plan is not completed timely. For service dates 10/1/2010 and after, claims for services provided on the 30 <sup>th</sup> day after the admission date will be disallowed if the written individual treatment plan is not completed timely.  Claims for services will be disallowed until a written individual treatment plan is completed. The treatment plan is considered completed upon the signature of the primary counselor or supervisor.
<b>Regulatory References</b>	18 NYCRR Section 505.25(d)(2) For services prior to <b>10/1/2010</b> : 14 NYCRR Section 587.18(b)(6) 14 NYCRR Section 588.5(c) 14 NYCRR Section 588.6(g) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.10(c) 14 NYCRR Section 599.10(g) 14 NYCRR Section 599.11(b)(7)

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<b>6.</b>	<b>Missing Documentation of Individual Treatment Plan Review</b>
<b>OMIG Audit Criteria</b>	For services prior to 10/1/2010, a treatment plan review must take place at least every three months. For services 10/1/2010 and after, a treatment plan review must take place at least every 90 days, or the next provided service, whichever shall be later. Claims will be disallowed for billed service dates during any time for which there is no documentation of a treatment plan review in the recipient's record.
<b>Regulatory References</b>	18 NYCRR Section 505.25(d)(2) For services prior to <b>10/1/2010</b> : 14 NYCRR Section 588.5(c) 14 NYCRR Section 588.6(g) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.10(i) 14 NYCRR Section 599.10(j)(1)
<b>7.</b>	<b>Missing Physician Signature on Individual Treatment Plan or Treatment Plan Review</b>
<b>OMIG Audit Criteria</b>	Physician review and approval of the treatment plan or review is substantiated by physician signature. Claims will be disallowed in the absence of a physician signature on the treatment plan or review for the billed service dates within the relevant time frame.
<b>Regulatory References</b>	18 NYCRR Section 505.25(e)(1) 18 NYCRR Section 505.25(h)(1)(i) For services prior to <b>10/1/2010</b> : 14 NYCRR Section 587.16(e)(1) 14 NYCRR Section 587.16(g)(5) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.10(c) 14 NYCRR Section 599.10(j)(4)
<b>8.</b>	<b>Brief Visit Billed as a Regular/Extended Clinic Visit</b>
<b>OMIG Audit Criteria</b>	For services prior to 10/1/2010, a regular clinic service visit lasts at least 30 minutes; a brief clinic visit lasts at least 15 minutes. If a regular visit rate is billed when a brief visit is documented, the amount of the claim disallowed will be the difference between the regular visit rate amount and the brief visit rate amount.  For services 10/1/2010 and after, an extended clinic service visit lasts at least 45 minutes; a brief clinic visit lasts at least 30 minutes. If an extended visit rate is billed when a brief visit is documented, the amount of the claim disallowed will be the difference between the extended visit rate amount and the brief visit rate amount.
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> : 14 NYCRR Section 588.6(a)(1) and (2) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.14(d)(1)(ii)(b) and (c) 14 NYCRR Section 599.14(d)(6)(i)(a) and (b)

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**Revised 08/12/15**

<b>9.</b>	<b>Duration of Visit Not Documented</b>
<b>OMIG Audit Criteria</b>	There must be a record of all face-to-face contacts with the recipient, the type of service provided and the duration of the contact. If the duration is not documented, the claim will be disallowed.
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> : 14 NYCRR Section 587.18(b)(7) 14 NYCRR Section 588.6(a)(1) and (2) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.10(k)
<b>10.</b>	<b>Missing Progress Note</b>
<b>OMIG Audit Criteria</b>	For clinic treatment services, progress notes related to treatment plan goals must be recorded after each visit and/or contact. If the required progress note is missing, the claim will be disallowed.
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> : 14 NYCRR Section 587.16(f)(1), 14 NYCRR Section 587.18(b)(8) and (9) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.10(k) 14 NYCRR Section 599.11(b)(8) and (9)
<b>11.</b>	<b>Group Clinic Visit Billed as Regular Clinic Visit</b>
<b>OMIG Audit Criteria</b>	A regular clinic service visit lasts at least 30 minutes; a group clinic visit lasts at least 60 minutes. If a regular visit rate is billed when a group visit is documented, the amount of the claim disallowed will be the difference between the regular visit rate amount and the group visit rate amount.
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> : 14 NYCRR Section 588.6(a)(2) and (4) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.14(d)(6)
<b>12.</b>	<b>Incorrect Collateral Billings</b>
<b>OMIG Audit Criteria</b>	Collateral persons are defined as (1) members of the recipient’s family or household; (2) significant others ... identified in the treatment plan; or, (3) significant others ... identified in preadmission notes. Claims for services billed for individuals not meeting the definition of collateral persons, or if the collateral person is not listed on the recipient’s treatment plan or in preadmission notes, will be disallowed.
<b>Regulatory References</b>	18 NYCRR Section 505.25(e)(5) For services prior to <b>10/1/2010</b> : 14 NYCRR Section 587.4(a)(3) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.4(i)

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Revised 08/12/15

<b>13.</b>	<b>Failure to Meet Minimum Duration Requirements</b>
<b>OMIG Audit Criteria</b>	For services prior to 10/1/2010, claims for clinic visits of less than 15 minutes in duration will be disallowed. For services 10/1/2010 and after, Current Procedural Terminology (CPT) codes billed that did not meet the minimum duration as specified in the following CPT crosswalk will be disallowed: <a href="http://www.omh.ny.gov/omhweb/clinic_restructuring/CPT_crosswalk_20121130.pdf">http://www.omh.ny.gov/omhweb/clinic_restructuring/CPT_crosswalk_20121130.pdf</a>
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> : 14 NYCRR Section 588.6(a)(1) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.14(d)(4)(ii) 14 NYCRR Section 599.14 (d)(5)
<b>14.</b>	<b>Failure to Meet Collateral Billing Duration Requirements</b>
<b>OMIG Audit Criteria</b>	Claims for services between one or more collaterals and one therapist, with or without the recipient, of less than 30 minutes in duration will be disallowed. For services 10/1/2010 and after, claims for family/collateral services <i>without</i> the recipient of less than 30 minutes in duration or family/collateral services <i>with</i> the recipient of less than 60 minutes in duration will be disallowed.
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> : 14 NYCRR Section 588.6(a)(5)(i) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.14(d)(6)(ii) and (iii)
<b>15.</b>	<b>Failure to Meet Preadmission Duration Requirements</b>
<b>OMIG Audit Criteria</b>	For services prior to 10/1/2010, claims for preadmission visits less than 30 minutes in duration will be disallowed.
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> : 14 NYCRR Section 588.5(k)(1)
<b>16.</b>	<b>Excessive Clinic Visits</b>
<b>OMIG Audit Criteria</b>	Claims for more than five clinic visits per month for a recipient concurrently admitted to an intensive psychiatric rehabilitation treatment program and a clinic program will be disallowed.
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> : 14 NYCRR Section 588.5(e)(2) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.14(f)(3)

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# OMIG AUDIT PROTOCOL – OMH OUTPATIENT CLINIC TREATMENT SERVICES

**Revised 08/12/15**

<b>17.</b>	<b>Duration of Preadmission or Initial Assessment Visit Not Documented</b>
<b>OMIG Audit Criteria</b>	There must be a record of all face-to-face contacts with the recipient, the type of service provided and the duration of the contact. If the duration is not documented, the claim will be disallowed.
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> : 14 NYCRR Section 588.5(k)(1) 14 NYCRR Section 587.18(b)(7) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.10(k)
<b>18.</b>	<b>Failure to Meet Initial Assessment Duration Requirements</b>
<b>OMIG Audit Criteria</b>	For services 10/1/2010 and after, claims for visits for initial assessment services lasting less than 45 minutes in duration, or school-based services lasting less than 40 minutes in duration, will be disallowed.
<b>Regulatory References</b>	For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.14(d)(1)(i)(b)
<b>19.</b>	<b>Failure to Meet Group Clinic Visit Duration Requirements</b>
<b>OMIG Audit Criteria</b>	Claims for group clinic visits of less than 60 minutes in duration will be disallowed. For services 10/1/2010 and after, claims for school-based group visits less than 40 minutes in duration will be disallowed.
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> : 14 NYCRR Section 588.6(a)(4) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.14(d)(6)(iv)
<b>20.</b>	<b>No Explanation of Benefits (EOB) for Medicare Covered Service</b>
<b>OMIG Audit Criteria</b>	If an EOB for a Medicare covered service provided by an enrolled practitioner is not found, the claim will be disallowed.
<b>Regulatory References</b>	18 NYCRR Section 360-7.2 18 NYCRR Section 540.6(e)(2) <i>NYS Medicaid Program, Information For All Providers, Policy Guidelines, Version 2004-1, Section I</i> <i>Version 2006-1, Section I</i> <i>Version 2008-1 &amp; 2, Section I</i> <i>Version 2010-1 &amp; 2, Section I</i> <i>Version 2011-1 &amp; 2, Section I</i>

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**Revised 08/12/15**

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<b>21.</b>	<b>Improper Medicaid Billings for Medicare Crossover Recipients</b>
<b>OMIG Audit Criteria</b>	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.
<b>Regulatory References</b>	18 NYCRR Section 360-7.2 18 NYCRR Section 540.6(e)(2) <i>NYS Medicaid Program, Information For All Providers, Policy Guidelines, Version 2004-1, Section I</i> <i>Version 2006-1, Section I</i> <i>Version 2008-1 &amp; 2, Section I</i> <i>Version 20010-1 &amp; 2, Section I</i> <i>Version 20011-1 &amp; 2, Section I</i>
<b>22.</b>	<b>No EOB for Third Party Health Insurance (TPHI) Covered Service (Excluding Medicare)</b>
<b>OMIG Audit Criteria</b>	If an EOB for a TPHI (commercial carrier) covered service is not found, the claim will be disallowed.
<b>Regulatory References</b>	18 NYCRR Section 360-7.2 18 NYCRR Section 540.6(e)(2) <i>NYS Medicaid Program, Information For All Providers, Policy Guidelines, Version 2004-1, Section I</i> <i>Version 2006-1, Section I</i> <i>Version 2008-1 &amp; 2, Section I</i> <i>Version 20010-1 &amp; 2, Section I</i> <i>Version 20011-1 &amp; 2, Section I</i>
<b>23.</b>	<b>Improper Medicaid Billings for TPHI Recipients (Excluding Medicare)</b>
<b>OMIG Audit Criteria</b>	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.
<b>Regulatory References</b>	18 NYCRR Section 360-7.2 18 NYCRR Section 540.6(e)(2)

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**Revised 08/12/15**

<b>24.</b>	<b>Duration of Group Visit Not Documented</b>
<b>OMIG Audit Criteria</b>	There must be a record of all face-to-face contacts with the recipient, the type of service provided and the duration of the contact. Clinic group visits must be at least 60 minutes in duration and school-based group visits must be at least 40 minutes in duration. If the duration of the group visit is not documented in recipient records, the claim will be disallowed.
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> : 14 NYCRR Section 587.18(b)(7) 14 NYCRR Section 588.6(a)(4) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.14(d)(6)(iv)
<b>25.</b>	<b>Billing for Unauthorized Services</b>
<b>OMIG Audit Criteria</b>	Claims for services that are not authorized by the provider's operating certificate will be disallowed.  <b>Note:</b> Documentation showing OMH approval of optional services not shown on the operating certificate will be reviewed.
<b>Regulatory References</b>	18 NYCRR Section 505.25(b)(1) 18 NYCRR Section 505.25(d)(3) 18 NYCRR Section 505.25(f)(1) and (3) For services prior to <b>10/1/2010</b> : 14 NYCRR Section 587.5(b)(7) <i>For clinic programs serving adults, 14 NYCRR Section 587.8(h)</i> <i>For clinic programs serving children, 14 NYCRR Section 587.9(h)</i> For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.5(a) and (b) 14 NYCRR Section 599.8(b) and (c)
<b>26.</b>	<b>Failure to Bill Medicaid Managed Care</b>
<b>OMIG Audit Criteria</b>	For services other than those provided to children with serious emotional disturbances in designated clinics or SSI eligible recipients, claims for services billed to Medicaid that bypass the Medicaid Managed Care company responsible for payment will be disallowed.
<b>Regulatory References</b>	18 NYCRR Section 360-7.2 <i>NYS Medicaid Program, Information For All Providers, Policy Guidelines, Version 2004-1, Section I</i> <i>Version 2006-1, Section I</i> <i>Version 2008-1 &amp; 2, Section I</i> <i>Version 2010-1 &amp; 2, Section I</i> <i>Version 2011-1 &amp; 2, Section I</i>

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**Revised 08/12/15**

<b>27.</b>	<b>Group Counseling Recipient Limit Exceeded</b>
<b>OMIG Audit Criteria</b>	If the number of recipients in the clinic group counseling session exceeds the maximum of 12 recipients, the claim will be disallowed for the recipient under review.
<b>Regulatory References</b>	For services prior to <b>10/1/2010</b> : 14 NYCRR Section 588.6(a)(4) For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.14(d)(6)(iv)
<b>28.</b>	<b>Incorrect Use of the Modifier Adjustment</b>
<b>OMIG Audit Criteria</b>	If the modifier adjustment was incorrectly used, the amount of the claim disallowed is the Ambulatory Patient Group (APG) portion of the claim reduced by the percentage of the modifier.
<b>Regulatory References</b>	For services <b>10/1/2010 and after</b> : 14 NYCRR Section 599.4(aj), 14 NYCRR Section 599.10(h) 14 NYCRR Section 599.14(d)(1)(i)(c) 14 NYCRR Section 599.14(e)
<b>29.</b>	<b>Failure to Meet Minimum Billing Requirements for Complex Care Management</b>
<b>OMIG Audit Criteria</b>	The claim will be disallowed: if there is no documentation the service was provided within 5 days of a psychotherapy or crisis visit; or, that the service lasted at least 15 minutes of continuous time; or, that the billed service exceeded the allowed frequency of one visit following each psychotherapy or crisis service.
<b>Regulatory References</b>	For services <b>10/1/2010 to 9/30/2014</b> : 14 NYCRR Section 599.14(d)(9) For services <b>10/1/2014 and after</b> : 14 NYCRR Section 599.14(d)(9)

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<b>30.</b>	<b>Failure to Meet Minimum Billing Requirements for Crisis Services</b>
<b>OMIG Audit Criteria</b>	<p>The claim will be disallowed if there is no documentation that the minimum required duration for a brief (15 minutes), complex (1 hour) or per diem (3 hours) crisis intervention service was met. If the duration for a complex or per diem crisis intervention visit was not met, but at least 15 minutes of service was documented, the amount of the claim disallowed will be the difference between the complex or per diem crisis intervention rate amount and the brief crisis intervention rate amount.</p> <p>For a complex or per diem crisis intervention service, if the recipient record documentation did not support that at least two approved staff (this includes a peer, family advisor, or non-licensed substitutes) provided the service or did not support that the service was provided face-to-face, the service will be disallowed. However, if the documentation did support at least the requirements for a brief crisis intervention service (including duration requirement), the amount of the claim disallowed will be the difference between the complex or per diem crisis intervention rate amount and the brief crisis intervention rate amount.</p> <p>Brief crisis intervention services lasting at least 15 minutes in duration may be billed as one unit. For each additional service increment of 15 minutes, an additional unit of service may be billed, up to a maximum of 6 units per day. For crisis intervention services billed that included more units than were documented, the amount of the claim disallowed will be the number of crisis intervention services units not documented.</p>
<b>Regulatory References</b>	For services <b>10/1/2010 and after:</b> 14 NYCRR Section 599.14(d)(3)(ii)(a), (b) and (c)

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