NEW YORK STATE | Office of the Medicaid Inspector General

OMIG AUDIT PROTOCOL
OMH PARTIAL HOSPITALIZATION

Revised 08/12/15

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 PARTIAL HOSPITALIZATION

Revised 08/12/15

1.	Missing Recipient Record
OMIG Audit Criteria	If the recipient record is not available for review, claims for all dates of service associated with the recipient record will be disallowed.
Regulatory References	18 NYCRR Section 504.3(a) 18 NYCRR Section 540.7(a)(8) 14 NYCRR Section 587.18(a)

2.	No Documentation of Partial Hospitalization Service
OMIG Audit Criteria	If recipient records lack documentation that a face-to-face partial hospitalization service was provided, the claim will be disallowed.
Regulatory References	18 NYCRR Section 504.3(a) 18 NYCRR Section 540.7(a)(8) 18 NYCRR Section 505.25(d)(1) 18 NYCRR Section 505.25(e)(5) 18 NYCRR Section 505.25(f)(1) and (3) 18 NYCRR Section 505.25(h)(1)(ii) 14 NYCRR Section 587.12(d), (e) and (f) 14 NYCRR Section 587.18(b)(7) 14 NYCRR Section 588.4(a) and (b)

3.	Excessive Preadmission Visits
OMIG Audit Criteria	Claims in excess of the maximum allowed three preadmission visits will be disallowed.
Regulatory References	14 NYCRR Section 588.5(k)(4)

4.	Missing Individual Treatment Plan
OMIG Audit Criteria	A written individual treatment plan must be developed prior to the fourth visit after admission (not including crisis visits). Claims for services provided on or after the fourth visit after the admission date will be disallowed if the written individual treatment plan is missing.
Regulatory References	18 NYCRR Section 505.25(d)(2) 14 NYCRR Section 587.18(b)(6) 14 NYCRR Section 588.5(c) 14 NYCRR Section 588.9(d)

5.	Late Individual Treatment Plan
OMIG Audit Criteria	A written individual treatment plan must be developed prior to the fourth visit after admission (not including crisis visits). Claims for services provided on or after the fourth visit after the admission date will be disallowed if the written individual treatment plan is not completed timely. Claims for services will be disallowed until an individual treatment plan is completed. The treatment plan is considered completed upon the signature of the primary counselor or supervisor.
Regulatory References	18 NYCRR Section 505.25(d)(2) 14 NYCRR Section 587.18(b)(6) 14 NYCRR Section 588.5(c) 14 NYCRR Section 588.9(d)

6.	Missing Documentation of Treatment Plan Review
OMIG Audit Criteria	A treatment plan review must take place every two weeks. 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.
Regulatory References	18 NYCRR Section 505.25(d)(2) 14 NYCRR Section 588.5(c) 14 NYCRR Section 588.9(d)

7.	Missing Physician Signature on Treatment Plan or Treatment Plan Review
OMIG Audit Criteria	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 that time frame.
Regulatory References	18 NYCRR Section 505.25(e)(1) 18 NYCRR Section 505.25(h)(1)(i) 14 NYCRR Section 587.16(e)(1) 14 NYCRR Section 587.16(g)(5)

8.	Missing Progress Note
OMIG Audit Criteria	For partial hospitalization services, progress notes related to treatment plan goals must be recorded after each visit and/or contact. The claim will be disallowed if the required progress note is missing.
Regulatory References	14 NYCRR Section 587.16(f)(3)

9.	Incorrect Rate Code Billed
OMIG Audit Criteria	For claims for partial hospitalization services that were billed using an incorrect rate code which resulted in a higher reimbursement than indicated for the proper rate code, the amount of the claim disallowed will be the difference between the incorrect rate code amount billed and the correct rate code amount.
Regulatory References	18 NYCRR Section 505.25(h)(2) 14 NYCRR Section 588.13(e)

10.	Incorrect Collateral Billings
OMIG Audit Criteria	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 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.
Regulatory References	18 NYCRR Section 505.25(e)(5) 14 NYCRR Section 587.4(a)(3)

11.	Failure to Meet Minimum Duration Requirements
OMIG Audit Criteria	Claims for partial hospitalization visits of less than four hours in duration for regular visits, less than 30 minutes for collateral visits, or less than 60 minutes for group collateral visits will be disallowed.
Regulatory References	14 NYCRR Section 588.9(a)(1), (4) and (5)

12.	Failure to Meet Preadmission Duration Requirements
OMIG Audit Criteria	Claims for preadmission visits less than one hour in duration will be disallowed.
Regulatory References	14 NYCRR Section 588.5(k)(2)

13.	No Explanation of Benefits (EOB) 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.
Regulatory References	18 NYCRR Section 360-7.2 18 NYCRR Section 540.6(e)(2) *NYS Medicaid Program, Information For All Providers, Policy Guidelines,* *Version 2004-1, Section I* *Version 2006-1, Section I* *Version 2008-1 & 2, Section I* *Version 20010-1 & 2, Section I* *Version 20011-1 & 2, Section I*

14.	**Improper Medicaid Billings 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.
Regulatory References	18 NYCRR Section 360-7.2 18 NYCRR Section 540.6(e)(2) *NYS Medicaid Program, Information For All Providers, Policy Guidelines,* *Version 2004-1, Section I* *Version 2006-1, Section I* *Version 2008-1 & 2, Section I* *Version 20010-1 & 2, Section I* *Version 20011-1 & 2, Section I*

15.	**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.
Regulatory References	18 NYCRR Section 360-7.2 18 NYCRR Section 540.6(e)(2) *NYS Medicaid Program, Information For All Providers, Policy Guidelines,* *Version 2004-1, Section I* *Version 2006-1, Section I* *Version 2008-1 & 2, Section I* *Version 20010-1 & 2, Section I* *Version 20011-1 & 2, Section I*

16.	**Improper Medicaid Billings 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.
Regulatory References	18 NYCRR Section 360-7.2 18 NYCRR Section 540.6(e)(2)

17.	**Duration of Visit Not Documented**
OMIG Audit Criteria	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 of the partial hospitalization visit is not documented in recipient records, the claim will be disallowed.
Regulatory References	14 NYCRR Section 587.18(b)(7) 14 NYCRR Section 588.9(a)(1),(4) and (5)

18.	**Billing for Unauthorized Services**
OMIG Audit Criteria	Claims for services billed that are not authorized by the provider's operating certificate will be disallowed.
Regulatory References	18 NYCRR Section 505.25(d)(3) 18 NYCRR Section 505.25(f)(1) and (3) 14 NYCRR Section 587.5(b)(7) 14 NYCRR Section 587.12(d) 14 NYCRR Section 587.12 (e) 14 NYCRR Section 587.12 (f)

19.	**Failure to Bill Medicaid Managed Care**
OMIG Audit Criteria	Claims for services billed to Medicaid that bypass the Medicaid managed care company responsible for payment will be disallowed.
Regulatory References	18 NYCRR Section 360-7.2 *NYS Medicaid Program, Information For All Providers, Policy Guidelines,* *Version 2004-1, Section I* *Version 2006-1, Section I* *Version 2008-1 & 2, Section I* *Version 20010-1 & 2, Section I* *Version 20011-1 & 2, Section I*

20.	**Reimbursement in Excess of Allowed Billable Hours per Course of Treatment and/or Calendar Year**
OMIG Audit Criteria	Partial hospitalization services billed in excess of 180 hours per course of treatment per recipient and/or in excess of 360 hours per calendar year per recipient will be disallowed.
Regulatory References	14 NYCRR Section 588.9(a)(2) and (3) 14 NYCRR Section 588.12(f)