NEW YORK STATE OF OPPORTUNITY. Office of the Medicaid Inspector General

OMIG AUDIT PROTOCOL
OPWDD ARTICLE 16 CLINIC SERVICES

REVISED 04/03/2017

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.

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 §504.3(a) 18 NYCRR § 540.7(a)(8) 14 NYCRR § 679.4(j)

2.	**No Documentation of Clinic Service**
OMIG Audit Criteria	If the recipient's record does not document that a clinical service was provided, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) 18 NYCRR § 517.3(b)(2) 14 NYCRR § 679.5(c)

3.	**No Diagnosis of Developmental Disability**
OMIG Audit Criteria	For persons 8 years of age and older, claims will be disallowed in the absence of a clinical assessment substantiating a specific diagnosis of developmental disability.
Regulatory References	14 NYCRR § 679.3(r)

4.	**No Annual Physician (Re)Assessment**
OMIG Audit Criteria	Claims will be disallowed in the absence of the initial assessment, annual assessment or annual reassessment by the medical director or designee (physician) as to the recipient's continuing need for treatment.
Regulatory References	14 NYCRR § 679.3(t) *OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 5.5*

5.	**Late Physician Signature for Annual Reassessment**
OMIG Audit Criteria	If the physician completed, signed, and dated the annual reassessment later than 31 days after a full calendar year has elapsed since the date of the last completed physician reassessment, the claim(s) will be disallowed.
Regulatory References	OPWDD *Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual,* July 2011, 5.5

6.	**Missing Elements of Annual Physician (Re)Assessment**
OMIG Audit Criteria	The annual physician (re)assessment must include the following elements: date of the (re)assessment; signature of the physician; the physician's recommendations; and, briefly, the rationale involved in the determination. If one or more of the required elements are missing the claim(s) will be disallowed.
Regulatory References	*OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 5.5*

7.	**Missing Treatment Plan or Treatment Plan Review for Clinic Treatment Program**
OMIG Audit Criteria	For ongoing treatment services, claims will be disallowed in the absence of a treatment plan or treatment plan review. If a treatment plan or treatment plan review is not in place for the relevant clinic service and for a particular time period, there will be a disallowance for the claims within that time period.
Regulatory References	14 NYCRR § 679.7(a)(3) 14 NYCRR § 679.4(j)(5) 14 NYCRR § 679.4(k)(1) and (2) *OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 5.3*

8.	**Missing Elements of the Treatment Plan**
OMIG Audit Criteria	For ongoing treatment services, the treatment plan must include the following elements: treatment diagnosis; the developmental disability and other diagnoses that may relate to or demonstrate the person's need for the service; identification of therapy(ies), treatment goals; frequency of service delivery; and location of service delivery. Claims will be disallowed in the absence of one or more required elements. **Note:** Location of service delivery is only required if the service delivery is in an OPWDD-certified residence, like an IRA.
Regulatory References	*OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 5.3*
9.	**Missing Physician Signature on Treatment Plan**
OMIG Audit Criteria	For ongoing treatment services, physician review and approval of the treatment plan is substantiated by physician signature. Claims will be disallowed in the absence of physician signature on the treatment plan or for changes to the elements of the treatment plan.
Regulatory References	14 NYCRR § 679.3(q) *OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 5.3*

10.	**Late Physician Signature on Treatment Plan**
OMIG Audit Criteria	For ongoing treatment services, claims will be disallowed if the signature of the physician on the treatment plan required at least annually (by the end of the calendar month in which the clinic treatment plan is effective, or by the end of the month when the changes to the elements of the treatment plan are effective), is late.
Regulatory References	*OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 5.3*

11.	**Missing Written Order**
OMIG Audit Criteria	For *non*-ongoing treatment services, claims will be disallowed in the absence of a written order by the physician or dentist at least annually and subsequent to an intake visit or assessment documenting need for admission.
Regulatory References	14 NYCRR § 679.4(h)

12.	**Missing Documentation of Recipient's Face-to-Face Clinic Service**
OMIG Audit Criteria	If the claim for clinic services doesn't include a face-to-face service including associated observations, the claim(s) will be disallowed.
Regulatory References	14 NYCRR § 679.5(c) *OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 5.1*

13.	**Missing Elements of Clinic Service Documentation**
OMIG Audit Criteria	The claim(s) will be disallowed if the clinic service documentation is missing the recipient's name and CIN; and/or treatment notes do not include ALL of the following: service date; location of service; duration of face-to-face, signature and title of staff providing service; and the date the note was written. **Note:** The treatment note should also describe the specific clinical intervention(s)/service(s) rendered by the clinician during the visit. This may be done by written description in support of the specific CPT/HCPCS service code(s) for the service(s) rendered.
Regulatory References	*OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 5.2*

14.	**Improper Billing for Medication Administration Only Service**
OMIG Audit Criteria	Claims for services that involve routine medication administration only will be disallowed.
Regulatory References	*OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 5.6*

15.	**Incorrect Rate Code Billed**
OMIG Audit Criteria	If the rate code billed is not the correct rate code for the services provided, the difference between the appropriate claim amount and the paid claim amount will be disallowed.
Regulatory References	14 NYCRR § 679.9(a) and (c) *OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 3.1*

16.	**Incorrect Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) Service Classification**
OMIG Audit Criteria	The CPT or HCPCS procedure code(s) billed must be consistent with the services documented in the treatment note for the visit. If the treatment note fails to document the delivery of a specific CPT or HCPCS code, the service line and its associated contribution to the claim payment will be disallowed.
Regulatory References	14 NYCRR § 679.7(a)(7) *OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 3.3(4)*

17.	**Duplicate Billing**
OMIG Audit Criteria	If the Article 16 Clinic provider attempts to submit multiple APG claims for [the same] rate code for the same recipient/same date of service, only one claim will be paid. All others will be disallowed as a duplicative claim. **Note:** If an on-site clinic visit is provided on the same day as an off-site clinic visit, reimbursement for each visit is considered a separate unit of service.
Regulatory References	14 NYCRR § 679.5(b)(2) *OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 3.5*

18.	**Incorrect Collateral Billings**
OMIG Audit Criteria	If the service was provided to individuals not meeting the definition of collateral persons, the claim will be disallowed.
Regulatory References	14 NYCRR § 679.99(f)

19.	**Services Not Delivered by Authorized/Qualified Party**
OMIG Audit Criteria	If services were delivered by program staff not meeting the definition of an authorized or qualified party, the claim will be disallowed.
Regulatory References	14 NYCRR § 679.3(l) *OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 1.4 and 5.1*

20.	**No Explanation of Benefits (EOB)/Documentation for Medicare Covered Service**
OMIG Audit Criteria	The claim will be disallowed when no EOB was found for a Medicare-eligible patient where services were not billed to Medicare for payment prior to submission to Medicaid.
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2) *NYS Medicaid Program, Information For All Providers, Policy Guidelines,* Version 2011-1 & 2, Section I

21.	**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 § 360-7.2 18 NYCRR § 540.6(e)(2) *NYS Medicaid Program, Information For All Providers, Policy Guidelines*, Version 2011-1 & 2, Section I

22.	**No EOB for Third Party Health Insurance (TPHI) Covered Service (Excluding Medicare)**
OMIG Audit Criteria	The claim will be disallowed when no EOB was found for a patient who has TPHI coverage and the commercial carrier was not billed for specific services paid by Medicaid. **Note:** Other documentation sources, such as an email, a phone-call log, or a printout of a benefits rejection notice from the carrier's website may be accepted where denial of service by a TPHI 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*, Version 2011-1 & 2, Section I

23.	**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 § 360-7.2 18 NYCRR § 540.6(e)(2)

24.	**Billing for Unauthorized Services**
OMIG Audit Criteria	Claims will be disallowed for services performed that were not authorized by the operating certificate.
Regulatory References	14 NYCRR § 679.1(a)

25.	**Failure to Forward Written Treatment Recommendations**
OMIG Audit Criteria	Claims will be disallowed for written treatment recommendations that were not forwarded to the recipient's Medicaid service coordinator (or other parties) when the clinic treatment plan is either first developed or significantly changed.
Regulatory References	*OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 5.8*

26.	Nonreimburseable Service/Encounter Time
OMIG Audit Criteria	If time spent before and/or after the face-to-face service/encounter was inappropriately billed, or billed units of service included non-countable service time, the claim will be disallowed.
Regulatory References	*OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 5.1*

27.	Failure to Use Modifier Adjustment for Rehabilitation Counseling Services
OMIG Audit Criteria	If the required modifier for the service was not used, the APG portion of the claim will be reduced by the percentage assigned to the modifier.
Regulatory References	*OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 2.5 and 4.2*

28.	Incorrect CPT/HCPCS Unit Quantity Billed
OMIG Audit Criteria	If an OT, PT, nutrition or educational/collateral service was billed for more units than documented, the claim will be reduced to the correct number of units documented.
Regulatory References	*OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual, July 2011, 2.1*

29.	Failure to Meet Minimum Duration Requirements
OMIG Audit Criteria	The Mental Hygiene APG categories and the corresponding allowable CPT/HCPCS codes listed (in Section 4.2 of the *Manual*) are for the purpose of billing Article 16 Clinic services. Reimbursement for approved services provided during an Article 16 Clinic visit is based on face-to-face service, as defined by allowable CPT/HCPCS or CDT codes. If a minimum duration of service is included in a CPT/HCPCS code's official description, the total duration of face-to-face services documented in the treatment note must be consistent with the description (allowing for any officially sanctioned rounding). Claims will be disallowed if the duration of the service is less than the required minimum as specified in the descriptive terms and guidelines of the CPT/HCPCS code.
Regulatory References	*OPWDD Policy and Medicaid Billing Guidance for Ambulatory Patient Groups (APGs) and Standards for Article 16 Clinics Provider Manual*, *July 2011, 3.3(4), 4.1 and 5.1*