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

OMIG AUDIT PROTOCOL
OASAS OPIOID TREATMENT PROGRAMS

REVISED 3/11/2020

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 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	**For Services Prior to 11/23/2015:** 14 NYCRR § 822-2.2(e) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.10(f)

2.	No Opioid Dependence or Addiction Diagnosis
OMIG Audit Criteria	**For Services Prior to 11/23/2015:** Prior to admission and within 72 hours of the first on-site visit, a physician must determine that a prospective patient has a current physiological dependence on opioids for a minimum period of one year, and to diagnose addiction or dependence. Claims will be disallowed in the absence of this diagnosis. **For Services 11/23/2015 through 3/26/2019:** In order to provide the first medication dose, a physician must make an in-person evaluation of each prospective patient within 72 hours of the first on-site visit to determine that the prospective patient has had a psychological dependence on opioids for at least the previous 12-month period, and must diagnose and document an addiction or dependence. **Note 1:** A prospective patient may be admitted without confirming current opioid dependence if the opioid treatment program (OTP) confirms that the prospective patient voluntarily completed treatment at another OTP within the previous 24 months, and that the previous treatment lasted at least 6 months. **Note 2:** A prospective patient who is less than 18 years old may be admitted if such patient has had at least 2 unsuccessful treatment episodes at a chemical dependence withdrawal and stabilization service, or inpatient service within a 12-month period and a current physiological dependence to opioids for a minimum period of 24 months. **Note 3:** A prospective patient who resided in a correctional or chronic care facility for at least one month, if assessed within 6 months after release or discharge, may be admitted if the prospective patient would have been eligible for admission prior to residing in such facility.
Regulatory References	**For Services Prior to 11/23/2015:** 14 NYCRR § 822-5.4(a) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.8(d)(2)

3.	Missing Central Registry Verification
OMIG Audit Criteria	All providers must verify with the central registry system that a prospective patient is not currently enrolled in another OTP, and they must document this verification in the case record. Claims will be disallowed in the absence of this verification.
Regulatory References	**For Services Prior to 11/23/2015:** 14 NYCRR § 822-5.4(c) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.16(a)(3)

4.	Missing Signed Written Consent Form
OMIG Audit Criteria	**For Services Prior to 11/23/2015:** Prior to admission, a physician must ensure that a prospective patient is provided with and signs an informed written consent to participate in opioid treatment. Claims will be disallowed in the absence of this signed consent form. **For Services 11/23/2015 through 3/26/2019:** A physician must ensure, prior to the first dose, the prospective patient is provided and signs (physical or electronic signature) an informed written consent to participate in opioid treatment, which shall include notice of the risks and benefits of the prescribed medicine. **Note:** Would not apply to services for significant others.
Regulatory References	**For Services Prior to 11/23/2015:** 14 NYCRR § 822-5.4(e) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.8(e)(2)

5.	Missing Admission Assessment
OMIG Audit Criteria	Each program must directly provide an admission assessment. Claims will be disallowed in the absence of an admission assessment. **Note:** Admission assessment is a face-to-face pre-admission service.
Regulatory References	**For Services 11/23/2015 through 3/26/2019**: 14 NYCRR § 822.5(c) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.7(g)(1)

6.	**Missing/Late Physical Examination**
OMIG Audit Criteria	During the first week after admission, the prescribing professional must conduct a full physical examination. Claims will be disallowed from the 7th day after admission if the examination is missing or not done timely. **Note:** For services 11/23/2015 and after, a patient may choose to have a licensed practitioner outside the OTP complete the initial physical examination to determine health condition(s) and OTP staff shall make diligent efforts to record all required results, including ordered tests, in the patient's case record.
Regulatory References	**For Services Prior to 11/23/2015:** 14 NYCRR § 822-5.4(q)(3) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.8(e)(1)

7.	**Physical Examination Not Updated Annually**
OMIG Audit Criteria	The prescribing professional must update the physical examination annually. Claims will be disallowed in the absence of this physical examination update. **Note:** A patient may choose to have a licensed practitioner outside of the OTP perform this update. Staff shall make diligent efforts to record results of an exam outside of the OTP in the patient record.
Regulatory References	**For Services Prior to 11/23/2015:** 14 NYCRR § 822-5.4(r) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.8(e)(1)

8.	**Missing/Late Initial Individual Treatment/Recovery Plan**
OMIG Audit Criteria	Within 30 days of admission to the OTP, 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 11/23/2015:** 14 NYCRR § 822-5.5(d) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.9(a)

9.	**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 11/23/15, 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 11/23/2015:** 14 NYCRR § 822-5.5(d) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.9(b)(3)

10.	**Missing/Late Qualified Health Professional (QHP) Signature on Initial Individual Treatment/Recovery Plan**
OMIG Audit Criteria	Within 10 days of development of the treatment/recovery plan, a QHP must review, approve, and sign the plan. Claims will be disallowed from the 10th day after development of the treatment/recovery plan if the QHP signature is missing or not completed timely. **Note:** A QHP for these purposes is limited to a physician, physician assistant, licensed psychologist, nurse practitioner, or licensed clinical social worker.
Regulatory References	**For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.9(b)(4)

11.	Missing/Late Individual Treatment/Recovery Plan Review
OMIG Audit Criteria	A treatment/recovery plan review must be reviewed and revised at least every 90 calendar days for the first year in treatment and at least every 180 calendar days thereafter. Claims will be disallowed for service dates during any time period for which the treatment/recovery plan review is either missing or not completed timely. **Note:** For services prior to 11/23/2015, in order for a treatment/recovery plan review to be considered complete, it must be signed and dated by 3 members of the multi-disciplinary team. For services 11/23/2015 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 11/23/2015:** 14 NYCRR § 822-5.5(f) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.9(c)

12.	Missing/Late Signature on Individual Treatment/Recovery Plan Review
OMIG Audit Criteria	A treatment/recovery plan review must be signed and dated by at least 3 members of the multi-disciplinary team. Claims will be disallowed if the signatures are either missing or not completed timely. **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 11/23/2015:** 14 NYCRR § 822-5.5(f)

13.	Missing/Late QHP Signature on Individual Treatment/Recovery Plan Review
OMIG Audit Criteria	A treatment/recovery plan review must be signed by a QHP. Claims will be disallowed if the QHP signature is either missing or not completed timely. **Note:** A QHP for these purposes is limited to a physician, physician assistant, licensed psychologist, nurse practitioner, or licensed clinical social worker.
Regulatory References	**For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.9(c)

14.	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. The claim will be disallowed if one or more of the preceding elements is missing.
Regulatory References	18 NYCRR § 505.27(b)(5) **For Services Prior to 11/23/2015:** 14 NYCRR § 822-2.5(a)(1) through (5) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.11(a)(1) through (4)

15.	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. The claim will be disallowed if all of the preceding elements are missing.
Regulatory References	18 NYCRR § 505.27(b)(5) **For Services Prior to 11/23/2015:** 14 NYCRR § 822-2.5(a)(1) through (5) 14 NYCRR § 822-2.2(b)(9) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.11(a)(1) through (4)

16.	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 • physician assistants *Please refer to OASAS' Medicaid FAQ Webpage for the OASAS/OMIG audit agreement standard:* http://www.oasas.ny.gov/admin/hcf/faq.cfm
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2) NYS Medicaid Program, Information For All Providers, General Policy Guidelines, Versions 2011-2, Section I

17.	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. *Please refer to OASAS' Medicaid FAQ Webpage for the OASAS/OMIG audit agreement standard:* http://www.oasas.ny.gov/admin/hcf/faq.cfm
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2) NYS Medicaid Program, Information For All Providers, General 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 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. *Please refer to OASAS' Medicaid FAQ Webpage for the OASAS/OMIG audit agreement standard:* http://www.oasas.ny.gov/admin/hcf/faq.cfm
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2) NYS Medicaid Program, Information For All Providers, General Policy Guidelines, Versions 2011-2, Section I

19.	**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. *Please refer to OASAS' Medicaid FAQ Webpage for the OASAS/OMIG audit agreement standard:* http://www.oasas.ny.gov/admin/hcf/faq.cfm
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(2)

20.	**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**: Per OASAS' FAQ Webpage, under extenuating circumstances, two sessions may be merged; however, the Medicaid billing limit remains 15. *Please refer to OASAS' Medicaid FAQ Webpage for the OASAS/OMIG audit agreement standard:* http://www.oasas.ny.gov/admin/hcf/faq.cfm
Regulatory References	**For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.5(o)

21.	Missing Discharge Information
OMIG Audit Criteria	The patient record must include discharge information, which includes, but is not limited to, a complete medication list, reason for discharge, and any referrals made. Claims will be disallowed in the absence of this information.
Regulatory References	**For Services Prior to 11/23/2015:** 14 NYCRR § 822-2.4(a)(4)

22.	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 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.12(d)

23.	Missing Medication Administration Schedule
OMIG Audit Criteria	A physician must determine and document a patient's initial medication dose and schedule of administration in the patient's record. Claims will be disallowed in the absence of this schedule.
Regulatory References	**For Services Prior to 11/23/2015:** 14 NYCRR § 822-5.6(a) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 822.16(b)(1)

24.	**Missing Documentation for Subsequent Change(s) to Medication, Dose, and/or Administration Schedule**
OMIG Audit Criteria	A physician or prescribing professional must document any changes to approved medication, dose, and/or administration schedule. If the documentation of these changes is missing, the claim will be disallowed. **Note:** The prescribing professional may issue verbal orders in emergencies only and must document such orders in writing within 72 hours.
Regulatory References	**For Services Prior to 8/25/2015:** 14 NYCRR § 822-5.6(a) and (b) 14 NYCRR 822-2.1(aa) **For Services 8/25/2015 through 3/26/2019:** 14 NYCRR § 822.16(b)(1) and (2) 14 NYCRR § 800.3(i)

25.	**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 11/23/2015:** 14 NYCRR § 822-3.1(h)(1) 14 NYCRR § 822-3.1(h)(1)(i) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(1) 14 NYCRR § 841.14(i)(1)(i)

26.	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 11/23/2015:** 14 NYCRR § 822-3.1(h)(1) 14 NYCRR § 822-3.1(h)(1)(ii) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(1) 14 NYCRR § 841.14(i)(1)(ii)

27.	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 visit 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 11/23/2015:** 14 NYCRR § 822-3.1(h)(1) 14 NYCRR § 822-3.1(h)(1)(iii) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(1) 14 NYCRR § 841.14(i)(1)(iii)

28.	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 11/23/2015:** 14 NYCRR § 822-3.1(h)(2) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(2)

29.	**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 11/23/2015:** 14 NYCRR § 822-3.1(h)(3) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(3)

30.	**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 11/23/2015:** 14 NYCRR § 822-3.1(h)(4) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(4)

31.	**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 11/23/2015:** 14 NYCRR § 822-3.1(h)(5) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(5)

32.	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 11/23/2015:** 14 NYCRR § 822-2.5(b)(6)(ii) 14 NYCRR § 822-3.1(h)(6) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(6)

33.	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 11/23/2015:** 14 NYCRR § 822-3.1(h)(7) 14 NYCRR § 822-3.1(h)(7)(i) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(7) 14 NYCRR § 841.14(i)(7)(i)

34.	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 11/23/2015:** 14 NYCRR § 822-3.1(h)(7) 14 NYCRR § 822-3.1(h)(7)(ii) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(7) 14 NYCRR § 841.14(i)(7)(ii)

35.	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 11/23/2015:** 14 NYCRR § 822-3.1(h)(9) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(9)

36.	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 11/23/2015:** 14 NYCRR § 822-3.1(h)(10) 14 NYCRR § 822-3.1(h)(10)(i) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(10) 14 NYCRR § 841.14(i)(10)(i)

37.	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 11/23/2015:** 14 NYCRR § 822-3.1(h)(10) 14 NYCRR § 822-3.1(h)(10)(ii) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(10) 14 NYCRR § 841.14(i)(10)(ii)

38.	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 11/23/2015:** 14 NYCRR § 822-3.1(h)(10) 14 NYCRR § 822 3.1(h)(10)(iii) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(10) 14 NYCRR § 841.14(i)(10)(iii)

39.	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 11/23/2015 :**14 NYCRR § 822-3.1(h)(12) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(12)

40.	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 11/23/2015:** 14 NYCRR § 822-3.1(h)(13) **For Services 11/23/2015 through 3/26/2019:** 14 NYCRR § 841.14(i)(13)