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

OMIG AUDIT PROTOCOL
OASAS Substance Use Disorder Outpatient Programs
Revised 09/25/2024

(For Service Dates 11/23/2015 through 06/30/2024)

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.

Public Health Emergency (PHE)

During the PHE, services provided and billed in accordance with COVID-19 PHE guidance issued by the NYS Department of Health (DOH) and OASAS pertaining to OASAS Outpatient and OTP services will not be subject to disallowance if all other requirements not specifically addressed in the guidance were met.

This includes the following guidance:

Agency	Guidance Title	Date Issued	Date(s) Revised
OASAS	Continued COVID-19 Regulatory Waivers	06/24/21	10/25/21, 12/20/21, 04/20/22, 10/17/22, 01/20/23
OASAS	OASAS Assistance for Service Providers During the COVID-19 Disaster Emergency	03/20/20	
OASAS	Telepractice Waiver	03/09/20	03/13/20 03/18/20
OHIP	Waiver Draft – Letter to the Field – SPA 20-48	08/25/20	
NYS Executive Chamber	Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency • Executive Order No. 202.5 • Executive Order No. 202.18	 03/18/20 04/16/20	Expired on 06/24/21

The Federal Government announced that the PHE expired at the end of the day on May 11, 2023. On the date the PHE ended, the flexibilities afforded providers regarding minimum billing standards and documentation requirements also ended, unless otherwise specified by OASAS through formal regulatory waivers.

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 01/27/21 and After:** 14 NYCRR § 822.8(p) **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.7(a) **For Services 11/23/15 through 01/26/21:** 14 NYCRR § 822.10(f)

2.	**Missing Service Documentation**
OMIG Audit Criteria	The type, content, duration and outcome of each service delivered to or on behalf of a patient must be documented in the patient's case record, described and verified as follows: (1) be written and signed (physical or electronic signature) by the staff member providing the service; (2) indicate the date the service was delivered; (3) record the relationship to the patient's developing treatment goals described in the treatment / recovery plan; (4) include any recommendations, or determinations for initial, continued or revised patient goals and/or treatment. Claims will be disallowed if the service documentation is missing or incomplete. **Note:** These requirements are in place for claims reimbursed using APG Methodology. For services reimbursed by bundling methodology, face-to-face contact or telemedicine / telephonic visit needs to be documented as required.
Regulatory References	18 NYCRR § 505.27(b)(5) **For Services 01/27/21 and After:** 14 NYCRR § 822.8(j) **For Services 11/23/15 through 01/26/21:** 14 NYCRR § 822.11(a)

3.	**Service Documentation Does Not Meet Required Standards**
OMIG Audit Criteria	Providers are required to meet standards when documenting a service. The standards for service documentation are as follows: • written and signed (physical or electronic signature) by the staff member providing the service • indicate the date the service was delivered • record the relationship to the patient's developing treatment goals described in the treatment / recovery plan • include any recommendations, or determinations for initial, continued or revised patient goals and/or treatment Claims will be disallowed if the service documentation does not meet required standards. **Note:** These requirements are in place for claims reimbursed using APG Methodology. For services reimbursed by bundling methodology, face-to-face contact or telemedicine / telephonic visit needs to be documented as required.
Regulatory References	18 NYCRR § 505.27(b)(5) **For Services 01/27/21 and After:** 14 NYCRR § 822.8(j) **For Services 11/23/15 through 01/26/21:** 14 NYCRR § 822.11(a)

4.	**Group Counseling Patient Limit Exceeded**
OMIG Audit Criteria	**For Services 11/23/2015 through 3/26/2019:** 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. **For Services 3/27/2019 and After:** Group counseling sessions must be structured in size and duration to maximize therapeutic benefit for each participant. Program policies must include a process for determining group size, group purpose, monitoring patient experience, and assessing group efficacy. Claims will be disallowed if the group size is larger than the amount expressed in the program policies.
Regulatory References	**For Services 01/27/21 and After:** 14 NYCRR § 822.5(m) **For Services 11/23/15 through 01/26/21:** 14 NYCRR § 822.5(o)

5.	**Failure to Meet Brief Admission Assessment Requirements** [i]
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. **Note 1:** During the PHE (3/16/20 – 4/11/23), a telephonic Brief Admission Assessment only required a 5-minute visit. **Note 2:** From 3/16/20 through 7/15/21, an on-site Brief Admission Assessment only required an 11-minute visit.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(1)

6.	**Failure to Meet Normative Admission Assessment Requirements** [i]
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. **Note:** From 3/16/20 through 7/15/21, an on-site Normative Admission Assessment only required a 23-minute visit.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(1)

7.	**Failure to Meet Extended Admission Assessment Requirements** [i]
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. **Note:** From 3/16/20 through 7/15/21, an on-site Extended Admission Assessment only required a 56-minute visit.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(1)

8.	**Failure to Meet Brief Intervention Requirements** [i]
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. **Note 1:** During the PHE (3/16/20 – 4/11/23), a telephonic Brief Intervention only required a 5-minute visit. **Note 2:** From 3/16/20 through 7/15/21, an on-site Brief Intervention only required an 11-minute visit.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(2)

9.	**Failure to Meet Brief Treatment Requirements** [i]
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. **Note 1:** During the PHE (3/16/20 – 4/11/23), a telephonic Brief Treatment only required a 5-minute visit. **Note 2:** From 3/16/20 through 7/15/21, an on-site Brief Treatment only required an 11-minute visit.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(3)

10.	**Failure to Meet Collateral Visit Requirements** [i]
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 the collateral person If any of these requirements are not met, the claim will be disallowed. **Note 1:** During the PHE (3/16/20 – 4/11/23), a telephonic Collateral Visit only required a 5-minute visit. **Note 2:** From 3/16/20 through 7/15/21, an on-site Collateral Visit only required a 23-minute visit.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(4)

11.	**Failure to Meet Complex Care Coordination Requirements** [i]
OMIG Audit Criteria	Complex Care services have the following requirements: **For Services 11/23/2015 through 1/25/2022:** • 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 **For Services 1/26/2022 and After:** • service is billed in 5-minute units • no more than 4 billed units per day • no more than 12 units billed per week 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 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(5)

12.	**Failure to Meet Group Counseling Requirements** [i]
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 the patient If any of these requirements are not met, the claim will be disallowed. **Note 1:** During the PHE (3/16/20 – 4/11/23), a telephonic Group Counseling Service only required a 15-minute visit. **Note 2:** From 3/16/20 through 7/15/21, an on-site Group Counseling Service only required a 45-minute visit.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(6)

13.	**Failure to Meet Brief Individual Counseling Requirements** [i]
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 the patient If any of these requirements are not met, the claim will be disallowed. **Note 1:** During the PHE (3/16/20 – 4/11/23), a telephonic Brief Individual Counseling Service only required a 15-minute visit. **Note 2:** From 3/16/20 through 7/15/21, an on-site Brief Individual Counseling Service only required a 19-minute visit.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(7)

14.	**Failure to Meet Normative Individual Counseling Requirements** [i]
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 the patient If any of these requirements are not met, the claim will be disallowed. **Note 1:** During the PHE (3/16/20 – 4/11/23), a telephonic Normative Individual Counseling Service only required a 15-minute visit. **Note 2:** From 3/16/20 through 7/15/21, an on-site Normative Individual Counseling Service only required a 34-minute visit.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(7)

15.	**Failure to Meet Intensive Outpatient Services (IOS) Requirements** [i]
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 1:** 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. **Note 2:** During the PHE (3/16/20 – 4/11/23), Intensive Outpatient Services will have a temporary minimum service requirement of 2.25 hours per day.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(8)

16.	**Failure to Meet Half Day Outpatient Rehabilitation Requirements** [i]
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 but less than four hours of services • must include documentation of an individual counseling service of at least 25 minutes or a 60-minute group counseling service If any of these requirements are not met, the claim will be disallowed. **Note:** During the PHE (3/16/20 – 4/11/23), Half Day Outpatient Rehabilitation Services will have a temporary minimum service requirement of 1.5 hours per day.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(11)

17.	**Failure to Meet Full Day Outpatient Rehabilitation Requirements** [i]
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 documentation of an individual counseling service of at least 25 minutes or a 60-minute group counseling service If any of these requirements are not met, the claim will be disallowed. **Note:** During the PHE (3/16/20 – 4/11/23), Full Day Outpatient Rehabilitation Services will have a temporary minimum service requirement of 3 hours per day.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(11)

18.	**Failure to Meet Medication Administration and Observation Requirements** [i]
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 the patient If any of these requirements are not met, the claim will be disallowed. **Note:** There is no time requirement for this type of visit.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(9)

19.	**Failure to Meet Routine Medication Management Requirements** [i]
OMIG Audit Criteria	Routine Medication Management services have the following requirements: • no more than one routine medication management service per day • for services 11/23/2015 through 1/25/2022, at least 10 minutes of services including face-to-face contact with the patient and patient observation • for services 1/26/2022 and after, the minimum time required will be based on HCPCS / CPT code billed If any of these requirements are not met, the claim will be disallowed. **Note 1:** Not all 10 minutes needs to be face-to-face. **Note 2:** During the PHE (3/16/20 – 4/11/23), a telephonic Routine Medication Management Service only required a 5-minute service.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(10)

20.	**Failure to Meet Complex Medication Management Requirements** [i]
OMIG Audit Criteria	Complex Medication Management services have the following requirements: • no more than one complex medication management service per day • for services 11/23/2015 through 1/25/2022, at least 15 minutes of services including face-to-face contact with the patient and patient observation • for services 1/26/2022 and after, the minimum time required will be based on HCPCS / CPT code billed If any of these requirements are not met, the claim will be disallowed. **Note 1:** Not all 15 minutes needs to be face-to-face. **Note 2:** During the PHE (3/16/20 – 4/11/23), a telephonic Complex Medication Management Service only required a 5-minute service.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(10)

21.	**Failure to Meet Addiction Medication Induction Requirements** [i]
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. **Note:** Not all 30 minutes needs to be face-to-face.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(10)

22.	**Failure to Meet Peer Support Service Requirements** [i]
OMIG Audit Criteria	**For Services 11/23/2015 through 1/25/2022:** 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 **For Services 1/26/2022 and After:** Peer Support services have the following requirements: • service is billed in 15-minute units • a maximum of 24 units (6 hours) can be billed per service date If any of these requirements are not met, the claim will be disallowed. **Note 1:** There can be more than five peer support services in a given episode of care if the clinical staff document in the treatment / recovery plan that additional peer support services are clinically necessary and appropriate. **Note 2:** During the PHE (3/16/20 – 4/11/23), a telephonic Peer Support Service only required a 5-minute visit. **Note 3:** From 3/16/20 through 7/15/21, an on-site Peer Support Service only required an 11-minute visit.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(12)

23.	Failure to Meet Telehealth Service Requirements
OMIG Audit Criteria	Telehealth services are required to meet the following requirements: • the patient or significant other is present during the service • it is documented in the case record that telepractice occurred • all of the service is delivered in accordance with part 841
Regulatory References	**For Services 01/24/18 and After:** 14 NYCRR § 830.5(d)(2) and (3) 14 NYCRR § 830.5(d)(5) 14 NYCRR § 830.5(d)(6) 14 NYCRR § 830.5(d)(8)

24.	Missing Patient Acknowledgement of Required Information (Telehealth)
OMIG Audit Criteria	Telehealth claims will be disallowed in the absence of the patient's acknowledgement of required information. **Note:** This consent could be written or verbal.
Regulatory References	**For Services 01/24/18 and After:** 14 NYCRR § 830.5(c)(1)(iii)

25.	Missing Patient Consent to Record Telehealth Sessions
OMIG Audit Criteria	Telehealth claims will be disallowed in the absence of the patient's documented consent to records telehealth sessions.
Regulatory References	**For Services 01/24/18 and After:** 14 NYCRR § 830.5(c)(5)

26.	No Substance Use Disorder Diagnosis
OMIG Audit Criteria	Claims will be disallowed in the absence of a diagnosis of alcohol-related or psychoactive substance related-use disorder, except no disallowance should be taken 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 01/27/21 and After:** 14 NYCRR § 822.8(b)(1)(i) **For Services 03/27/19 through 01/26/21:** 14 NYCRR § 822.8(a)(2) **For Services 11/23/15 through 03/26/19:** 14 NYCRR § 822.8(b)(1)

27.	Missing Admission Assessment
OMIG Audit Criteria	Claims will be disallowed in the absence of an admission assessment.
Regulatory References	**For Services 01/27/21 and After:** 14 NYCRR § 822.8(b)(3) **For Services 03/27/19 and After:** 14 NYCRR § 822.7(f)(1) **For Services 11/23/15 through 01/26/21:** 14 NYCRR § 822.10(c)(1) **For Services 11/23/15 through 03/26/19:** 14 NYCRR § 822.7(g)(1)

28.	**Missing Decision to Admit**
OMIG Audit Criteria	The patient record must contain documentation of the clinical staff member who made the decision to admit, and it must be documented by the staff member's dated signature. This staff member must be a qualified health professional. **For Services 1/27/2021 and After:** The Decision to Admit must be approved by the dated signature of a physician, physician's assistant, nurse practitioner, licensed psychologist, or licensed clinical social worker. Claims will be disallowed in the absence of the proper documentation of the decision to admit.
Regulatory References	**For Services 01/27/21 and After:** 14 NYCRR § 822.8(b)(3)(iii) and (iv) **For Services 03/27/19 through 01/26/21:** 14 NYCRR § 822.8(a)(4) **For Services 11/23/15 through 03/26/19:** 14 NYCRR § 822.8(b)(2)

29.	**Failure to Meet Screening Requirements** [i]
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 the patient If any of these requirements are not met, the claim will be disallowed. **Note 1:** During the PHE (3/16/20 – 4/11/23), a telephonic Screening Service only required a 5-minute visit. **Note 2:** From 3/16/20 through 7/15/21, an on-site Screening Service only required an 11-minute visit.
Regulatory References	**For Services 01/26/22 and After:** Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance Manual Versions January 2022 through February 2024, Section 4 **For Services 11/23/15 through 01/25/22:** 14 NYCRR § 841.14(i)(13)

30.	**Missing Level of Care Determination**
OMIG Audit Criteria	Claims will be disallowed in the absence of a level of care determination.
Regulatory References	**For Services 01/27/21 and After:** 14 NYCRR § 822.8(a)(7) 14 NYCRR § 822.8(b)(3)(i) **For Services 11/23/15 through 01/26/21:** 14 NYCRR § 822.10(b)(7)

31.	Missing Initial Individual Treatment / Recovery Plan
OMIG Audit Criteria	**For Services 11/23/2015 through 1/26/2021:** Within 30 days of admission, a written individualized patient-centered treatment / recovery plan must be developed by the responsible clinical staff member. Claims will be disallowed from the 30th day after the admission date if the treatment / recovery plan is missing or not completed timely. **For Services 1/27/2021 and After:** Claims will be disallowed in the absence of a complete initial individual treatment plan.
Regulatory References	**For Services 01/27/21 and After:** 14 NYCRR § 822.8(a)(4) 14 NYCRR § 822.8(h)(1) 14 NYCRR § 822.8(h)(2) **For Services 11/23/15 through 01/26/21:** 14 NYCRR § 822.9(a) **For Services 11/23/15 through 03/26/19:** 14 NYCRR § 822.10(b)(4)

32.	Initial Individual Treatment / Recovery Plan Does Not Meet Required Standards
OMIG Audit Criteria	**For Services 11/23/2015 through 1/26/2021:** Providers are required to meet standards for the Initial Individual Treatment / Recovery Plan. These standards are as follows: • documentation of the diagnosis for which the patient is being treated • address treatment goals • identify a responsible clinical staff member • be reviewed and signed within 10 days by either a physician, physician's assistant, licensed psychologist, nurse practitioner, or licensed clinical social worker **For Services 1/27/2021 and After:** Providers are required to meet standards for the Initial Individual Treatment / Recovery Plan. These standards are as follows: • documentation of the diagnosis for which the patient is being treated • address treatment goals • identify a responsible clinical staff member • be reviewed and approved by responsible clinical staff member, patient, and clinical supervisor Claims will be disallowed if the Initial Individual Treatment / Recovery Plan does not meet required standards.
Regulatory References	**For Services 01/27/21 and After:** 14 NYCRR § 822.8(h)(2) **For Services 11/23/15 through 01/26/21:** 14 NYCRR § 822.9(b)

33.	Missing Individual Treatment / Recovery Plan Review
OMIG Audit Criteria	**For Services 11/23/2015 through 1/26/2021:** 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. **For Services 1/27/2021 and After:** Claims will be disallowed when treatment plan review is not reviewed regularly through progress notes. Progress notes are to be documented up to the standards described in 14 NYCRR § 822.8(j).
Regulatory References	**For Services 01/27/21 and After:** 14 NYCRR § 822.8(h)(1) 14 NYCRR § 822.8(i) 14 NYCRR § 822.8(j) **For Services 11/23/15 through 01/26/21:** 14 NYCRR § 822.9(c) 14 NYCRR § 822.10(b)(4)

34.	Missing Discharge / Transition Plan
OMIG Audit Criteria	**For Services 11/23/2015 through 3/26/2019:** For any patients that are discharged non-voluntarily, claims will be disallowed in the absence of a Discharge Plan. **For Services 3/27/2019 and After:** For any patients that are discharged non-voluntarily, claims will be disallowed in the absence of a Transition Plan.
Regulatory References	**For Services 01/27/21 and After:** 14 NYCRR § 822.8(r)(4)(i) 14 NYCRR § 822.8(r)(5) **For Services 03/27/19 through 01/26/21:** 14 NYCRR § 822.10(c)(5) 14 NYCRR § 822.12(b)(1) 14 NYCRR § 822.12(c) **For Services 11/23/15 through 01/26/21:** 14 NYCRR § 822.10(b)(8) **For Services 11/23/15 through 03/26/19:** 14 NYCRR § 822.10(c)(5) 14 NYCRR § 822.12(b) 14 NYCRR § 822.12(c)

35.	**Incorrect Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) Code Billed**
OMIG Audit Criteria	For services billed that used an incorrect HCPCS / CPT code resulting in a higher reimbursement (e.g., normative individual counseling – 45 minutes) rather than the correct HCPCS/CPT code (e.g., brief individual counseling – 25 minutes) for the service that actually took place, the amount of the claim disallowed will be the difference between the incorrect HCPCS / CPT code billed amount and the correct HCPCS / CPT code amount. **Note:** This only applies to services reimbursed using APG methodology
Regulatory References	18 NYCRR § 504.3(h) 18 NYCRR § 505.27(d)(1)

36.	**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's assistants
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(1) and (2) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section I

37.	**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)(1) and (2) 18 NYCRR § 540.6(e)(3) NYS Medicaid Program, Information for All Providers, General Policy Versions 2006-1 through 2022-2, Sections I and II

38.	**No Explanation of Benefits (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.
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(1) and (2) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section I

39.	**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 the incorrect co-payment billed and the correct co-payment amount.
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(1) and (2) 18 NYCRR § 540.6(e)(3) NYS Medicaid Program, Information for All Providers, General Policy Versions 2006-1 through 2022-2, Sections I and II

40.	Services Ordered / Prescribed / Referred / Attended by Individual Not Enrolled in NYS Medicaid
OMIG Audit Criteria	Medicaid claims submitted by OASAS providers must include the National Provider Identifier (NPI) of the ordering / referring / prescribing practitioner or they will be denied. Attending providers included in the claims must be affiliated with the facility NPI on the claim's date of service. Claims for services ordered, prescribed, referred, or attended by individuals not enrolled in the New York State Medicaid program as required, will be disallowed.
Regulatory References	42 C.F.R. § 455.440 18 NYCRR § 504.1(b) 18 NYCRR § 504.6(b)-(d) 18 NYCRR § 504.9(a) 18 NYCRR § 513.1(d),(e), and (g) NYS DOH Medicaid Update, Special Edition December 2013 NYS DOH Medicaid Update, June 2012, Vol. 28, No. 7 NYS DOH Medicaid Update, April 2011, Vol. 27, No. 5 Medicaid Ordering/Prescribing/Referring/Attending (OPRA) Guidance for OASAS Certified Providers [ii] Medicaid Fee for Service (FFS) Requirement for OASAS Certified Programs: New Ordering/Prescribing/Referring/Attending (OPRA) Requirements

41.	Services Ordered / Prescribed / Referred / Attended by Excluded Individual
OMIG Audit Criteria	Claims for services ordered, prescribed, referred, or attended by individuals excluded from the New York State Medicaid program will be disallowed.
Regulatory References	18 NYCRR § 504.1(b)(1) 18 NYCRR § 504.7(d)(1) 18 NYCRR § 513.1(d),(e), and (g) 18 NYCRR § 515.1(b)(6) and (10) 18 NYCRR § 515.2(b) 18 NYCRR § 515.5(a)-(c) and (e) NYS DOH Medicaid Update, Special Edition December 2013 NYS DOH Medicaid Update, April 2010, Vol. 26, No. 6

[i] It is recognized that a telephonic / telehealth visit qualifies as a "Face-to-Face Contact". The requirements are in place for claims reimbursed using APG Methodology.

[ii] There are certain licensed / credentialed practitioners that cannot become an enrolled Medicaid provider: Licensed Master Social Worker (LMSW), Licensed Marriage and Family Therapist, Licensed MH Counselor, Licensed Creative Arts Therapist, Applied Behavioral Analyst, Credentialed Alcohol and Substance Abuse Counselor (CASAC), and Peer.