



STATE OF NEW YORK  
OFFICE OF THE MEDICAID INSPECTOR GENERAL  
800 North Pearl Street  
Albany, New York 12204

ANDREW M. CUOMO  
GOVERNOR

JAMES C. COX  
MEDICAID INSPECTOR GENERAL

## **OMIG AUDIT PROTOCOL – OASAS OUTPATIENT CHEMICAL DEPENDENCE SERVICES**

**For Service Dates Prior to October 1, 2010, for Hospitals and Prior to July 1, 2011,  
for Free-Standing Clinics**

**Effective May 9, 2013**

---

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. 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 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. 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.

Audit protocols are amended as necessary. 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 – OASAS OUTPATIENT  
CHEMICAL DEPENDENCE SERVICES  
Effective May 9, 2013**

---

<b>1.</b>	<b>Missing Patient Record</b>
<b>OMIG Audit Criteria</b>	If no patient record is available for review, claims for all dates of service associated with the patient record will be disallowed.
<b>Regulatory References</b>	18 NYCRR Section 504.3(a) 18 NYCRR Section 540.7(a)(8)
<b>2.</b>	<b>No Chemical Dependence Diagnosis</b>
<b>OMIG Audit Criteria</b>	Claims will be disallowed in the absence of a diagnosis of alcohol related or psychoactive substance related use disorder, except 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.
<b>Regulatory References</b>	14 NYCRR Section 822.4(c)(1)
<b>3.</b>	<b>Missing Comprehensive Evaluation</b>
<b>OMIG Audit Criteria</b>	Claims will be disallowed in the absence of a comprehensive evaluation. If a comprehensive evaluation is missing, claims will be disallowed from the 14 <sup>th</sup> day after admission through the 29 <sup>th</sup> day or until the completion of the initial treatment plan, whichever comes first.
<b>Regulatory References</b>	14 NYCRR Section 822.4(a)(4)
<b>4.</b>	<b>Missing Initial Individual Treatment Plan</b>
<b>OMIG Audit Criteria</b>	A written individual treatment plan based on the comprehensive evaluation must be developed within 30 days of admission. Claims will be disallowed for services provided on the 30 <sup>th</sup> day after the admission date if the written individual treatment plan is missing.
<b>Regulatory References</b>	14 NYCRR Section 822.4(f)

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by the 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.

**OMIG AUDIT PROTOCOL – OASAS OUTPATIENT  
CHEMICAL DEPENDENCE SERVICES  
Effective May 9, 2013**

---

<b>4a.</b>	<b>Late Initial Individual Treatment Plan</b>
<b>OMIG Audit Criteria</b>	If the individual treatment plan is prepared late, claims will be disallowed from the 30th day from admission and after until a written individual treatment plan is completed. The treatment plan is considered completed upon the approval of the responsible clinical staff member as denoted by his or her signature.
<b>Regulatory References</b>	14 NYCRR Section 822.4(f)

<b>5.</b>	<b>Missing Treatment Plan Review</b>
<b>OMIG Audit Criteria</b>	A treatment plan review must be in place at least every 90 days. Claims will be disallowed for service dates during any time period for which there is no treatment plan review in place.
<b>Regulatory References</b>	14 NYCRR Section 822.4(n)

<b>6.</b>	<b>Missing Signature on Treatment Plan</b>
<b>OMIG Audit Criteria</b>	Approval of the treatment plan is substantiated by signature of the responsible clinical staff member. If the responsible clinical staff member's signature on the treatment plan is missing, claims will be disallowed during any period for which there is no signed treatment plan in place.
<b>Regulatory References</b>	14 NYCRR Section 822.4(f) 14 NYCRR Section 822.4(l)(10)

<b>7.</b>	<b>Missing Physician Signature on Treatment Plan</b>
<b>OMIG Audit Criteria</b>	Physician review and approval of the treatment plan is substantiated by physician signature. Claims will be disallowed in the absence of a physician signature on the treatment plan from the seventh day after review and approval from the multidisciplinary team until completion of the first treatment plan review or its due date, whichever comes first.
<b>Regulatory References</b>	14 NYCRR Section 822.4(l)(10)

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by the 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.

**OMIG AUDIT PROTOCOL – OASAS OUTPATIENT  
CHEMICAL DEPENDENCE SERVICES  
Effective May 9, 2013**

---

<b>8.</b>	<b>Missing Signature on Treatment Plan Review</b>
<b>OMIG Audit Criteria</b>	<p>The entire treatment plan shall be reviewed and revised at least every 90 calendar days. Review and approval of the treatment plan review is substantiated by signature of a member of the multidisciplinary team*. Claims will be disallowed for service dates during any period for which there is no treatment plan review signed by a multidisciplinary team member in effect.</p> <p>*Multidisciplinary team means 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.</p>
<b>Regulatory References</b>	<p>14 NYCRR Section 822.4(n) *Per 14 NYCRR Part 800 Section 800.2(a)(11, 12 &amp; 15)</p>
<b>9.</b>	<b>Missing Record of Attendance</b>
<b>OMIG Audit Criteria</b>	<p>There must be a record of attendance for each visit, which includes the date, type and duration of the service provided. This includes initial evaluation and appointments with the physician. Claims will be disallowed in the absence of such documents unless alternate documentation can be provided in satisfaction of audit criteria.</p>
<b>Regulatory References</b>	<p>14 NYCRR Section 822.4(r)</p>
<b>10.</b>	<b>Duration of Clinic Visit Less Than Thirty Minutes</b>
<b>OMIG Audit Criteria</b>	<p>A clinic service visit must last at least 30 minutes. Claims will be disallowed for clinic services lasting less than 30 minutes in duration.</p>
<b>Regulatory References</b>	<p>For services prior to <b>12/27/2006</b>, 14 NYCRR Section 822.10(e)(3) For services <b>12/27/2006</b> and after, 14 NYCRR Section 822.11(e)(3)</p>
<b>11.</b>	<b>Duration of Visit Not Documented</b>
<b>OMIG Audit Criteria</b>	<p>There must be a record of attendance for each visit, which includes services provided and duration. Claims will be disallowed for clinic services not indicating duration.</p>
<b>Regulatory References</b>	<p>14 NYCRR Section 822.4(r)</p>

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by the 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.

**OMIG AUDIT PROTOCOL – OASAS OUTPATIENT  
CHEMICAL DEPENDENCE SERVICES  
Effective May 9, 2013**

---

<b>12.</b>	<b>No Service Provided</b>
<b>OMIG Audit Criteria</b>	If the patient record does not document that a service was provided, the claim will be disallowed.
<b>Regulatory References</b>	18 NYCRR Section 505.27(b)(5) For services prior to <b>12/27/2006</b> , 14 NYCRR Section 822.10(f) For services <b>12/27/2006</b> and after, 14 NYCRR Section 822.11(f)

<b>13.</b>	<b>Missing Progress Note</b>
<b>OMIG Audit Criteria</b>	Progress notes, related to treatment plan goals, must be recorded at least every five visits or twice per month, whichever comes first. Claims will be disallowed for missing progress notes for all billed services that were to have been summarized by a fifth visit or twice per month progress note unless alternate documentation can be provided in satisfaction of the audit criteria.
<b>Regulatory References</b>	14 NYCRR Section 822.4(s)

<b>14.</b>	<b>Nonreimbursable Services</b>
<b>OMIG Audit Criteria</b>	Claims will be disallowed for services consisting of <b>only</b> vocational/educational, recreational (for clinic programs only), social, companionship, attendance at AA meetings, nutrition services, urinalysis services, acupuncture and group meetings, workshops or seminars which are primarily informational or organizational.
<b>Regulatory References</b>	18 NYCRR Section 505.27(c)(2) For services prior to <b>12/27/2006</b> , 14 NYCRR Section 822.10(g) For services <b>12/27/2006</b> and after, 14 NYCRR Section 822.11(g)

<b>15.</b>	<b>Recreation Only Services</b> (For Chemical Dependence Outpatient Rehabilitation Program Services)
<b>OMIG Audit Criteria</b>	Recreation only services will not constitute a threshold visit eligible for reimbursement. Claims will be disallowed for billed services consisting of recreation only services.
<b>Regulatory References</b>	For services prior to <b>12/27/2006</b> , 14 NYCRR Section 822.10(g)(3) For services <b>12/27/2006</b> and after, 14 NYCRR Section 822.11(g)(3)

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by the 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.

**OMIG AUDIT PROTOCOL – OASAS OUTPATIENT  
CHEMICAL DEPENDENCE SERVICES  
Effective May 9, 2013**

---

<b>16.</b>	<b>Duplicate Billing</b>
<b>OMIG Audit Criteria</b>	Only one occasion of service per patient day is reimbursable. Any additional claims will be disallowed if the service was billed more than once per patient day.
<b>Regulatory References</b>	18 NYCRR Section 505.27(b)(1) For services prior to <b>12/27/2006</b> , 14 NYCRR Section 822.10(a) For services <b>12/27/2006</b> and after, 14 NYCRR Section 822.11(a)

<b>17.</b>	<b>Improper Billing for Outpatient Rehabilitation Services</b>
<b>OMIG Audit Criteria</b>	Claims for outpatient rehabilitation services lasting less than two hours will be disallowed. No error will be cited for patients scheduled less than four hours (but more than two hours) as long as the half day rate code is billed. Documentation such as group attendance sheets indicating duration of more than two hours (but less than four hours) can be used to support the claim.
<b>Regulatory References</b>	14 NYCRR Section 822.2(g)

<b>18.</b>	<b>Incorrect Rate Code Billed</b>
<b>OMIG Audit Criteria</b>	For outpatient rehabilitation services billed that used an incorrect rate code resulting in a higher reimbursement (full day-4 hours) than indicated for the correct rate code (half day 2-4 hours), the amount of the claim disallowed will be the difference between the incorrect rate code billed amount and the correct rate code amount.
<b>Regulatory References</b>	18 NYCRR Section 505.27(d)(1)

<b>19.</b>	<b>Excessive Preadmission Visit</b>
<b>OMIG Audit Criteria</b>	Claims will be disallowed for service dates in excess of the maximum allowed two preadmission visits.
<b>Regulatory References</b>	For services prior to <b>12/27/2006</b> , 14 NYCRR Section 822.10(i) For services <b>12/27/2006</b> and after, 14 NYCRR Section 822.11(i)

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by the 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.

**OMIG AUDIT PROTOCOL – OASAS OUTPATIENT  
CHEMICAL DEPENDENCE SERVICES  
Effective May 9, 2013**

---

<b>20.</b>	<b>No Explanation of Benefits (EOB) for Medicare Covered Service</b>
<b>OMIG Audit Criteria</b>	<p>If an EOB for a Medicare covered service provided by a Medicare enrolled practitioner is missing, 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:</p> <ul style="list-style-type: none"> <li>• physicians</li> <li>• psychiatrists</li> <li>• clinical psychologists</li> <li>• licensed clinical social workers</li> <li>• psychiatric nurse practitioners</li> <li>• clinical nurse specialists</li> <li>• physicians assistants</li> </ul> <p><i>Please refer to OASAS' Medicaid FAQ Webpage for the OASAS/OMIG audit agreement standard: <a href="http://www.oasas.ny.gov/admin/hcf/faq.cfm">http://www.oasas.ny.gov/admin/hcf/faq.cfm</a></i></p>
<b>Regulatory References</b>	<p>18 NYCRR Section 360-7.2  <i>MMIS Provider Manual for Clinics</i>, Apr. 2004, Section 2.1.9</p>
<b>21.</b>	<b>Improper Medicaid Billings for Medicare Crossover Patients</b>
<b>OMIG Audit Criteria</b>	<p>If a review of Medicare's EOB shows Medicaid's co-payment is incorrect, the disallowance will be the difference between the Medicaid incorrect co-payment billed and the correct co-payment amount.</p> <p><i>Please refer to OASAS' Medicaid FAQ Webpage for the OASAS/OMIG audit agreement standard: <a href="http://www.oasas.ny.gov/admin/hcf/faq.cfm">http://www.oasas.ny.gov/admin/hcf/faq.cfm</a></i></p>
<b>Regulatory References</b>	<p>18 NYCRR Section 360-7.7(a)  <i>MMIS Provider Manual for Clinics</i>, Apr. 2004, Section 2.1.2</p>

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by the 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.

**OMIG AUDIT PROTOCOL – OASAS OUTPATIENT  
CHEMICAL DEPENDENCE SERVICES  
Effective May 9, 2013**

---

<b>22.</b>	<b>No EOB for Third Party Health Insurance (TPHI) Covered Service</b>
<b>OMIG Audit Criteria</b>	<p>If an EOB for a TPHI (commercial carrier) covered service cannot be found, the claim will be disallowed. Other documentation sources, such as an email, a phone call log, or a print-out of a benefits rejection notice from the carrier’s web-site may be accepted when denial of service by a TPHI carrier is clearly indicated.</p> <p><i>Please refer to OASAS’ Medicaid FAQ Webpage for the OASAS/OMIG audit agreement standard: <a href="http://www.oasas.ny.gov/admin/hcf/faq.cfm">http://www.oasas.ny.gov/admin/hcf/faq.cfm</a></i></p>
<b>Regulatory References</b>	<p>18 NYCRR Section 360-7.2  <i>MMIS Provider Manual for Clinics</i>, Apr. 2004, Section 2.1.9</p>
<b>23.</b>	<b>Improper Medicaid Billings for TPHI Patients</b>
<b>OMIG Audit Criteria</b>	<p>If a review of the TPHI EOB shows Medicaid’s co-payment is incorrect, the disallowance will be the difference between the Medicaid incorrect co-payment billed and the correct co-payment amount.</p> <p><i>Please refer to OASAS’ Medicaid FAQ Webpage for the OASAS/OMIG audit agreement standard: <a href="http://www.oasas.ny.gov/admin/hcf/faq.cfm">http://www.oasas.ny.gov/admin/hcf/faq.cfm</a></i></p>
<b>Regulatory References</b>	<p>18 NYCRR Section 360-7.2</p>
<b>24.</b>	<b>Group Counseling Patient Limit Exceeded</b>
<b>OMIG Audit Criteria</b>	<p>If the number of patients in the group counseling session exceeds the maximum of fifteen patients, the claim will be disallowed for the date of service under review. Per OASAS’ FAQ Webpage, under extenuating circumstances, two sessions may be merged; however, the Medicaid billing limit remains fifteen.</p> <p><i>Please refer to OASAS’ Medicaid FAQ Webpage for the OASAS/OMIG audit agreement standard: <a href="http://www.oasas.ny.gov/admin/hcf/faq.cfm">http://www.oasas.ny.gov/admin/hcf/faq.cfm</a></i></p>
<b>Regulatory References</b>	<p>For services prior to <b>12/27/2006</b>, 14 NYCRR Section 822.2(c)(1)  For services <b>12/27/2006</b> and after, 14 NYCRR Section 822.2(c)(2)</p>

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by the 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.

**OMIG AUDIT PROTOCOL – OASAS OUTPATIENT  
CHEMICAL DEPENDENCE SERVICES  
Effective May 9, 2013**

---

<b>25.</b>	<b>Missing Discharge Plan</b>
<b>OMIG Audit Criteria</b>	A discharge plan is to be developed in collaboration with the patient and any significant other(s) the patient chooses to involve. If the service date is after the treatment plan start date, the claim will be disallowed if the discharge plan is missing.
<b>Regulatory References</b>	For services prior to <b>12/27/2006</b> : 14 NYCRR Section 822.4(t) 14 NYCRR Section 822.4(u) For services <b>12/27/2006</b> and after: 14 NYCRR Section 822.4(u) 14 NYCRR Section 822.4(v)
<b>26.</b>	<b>Missing Discharge Summary</b>
<b>OMIG Audit Criteria</b>	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.
<b>Regulatory References</b>	For services prior to <b>12/27/2006</b> , 14 NYCRR Section 822.4(x) For services <b>12/27/2006</b> and after, 14 NYCRR Section 822.4(y)
<b>27.</b>	<b>Missing Level of Care Determination</b>
<b>OMIG Audit Criteria</b>	A level of care determination must be completed and signed by the appropriate clinical staff member. If a signed level of care determination is missing, claims will be disallowed for dates of service subsequent to the second visit after admission until the comprehensive evaluation is completed. No disallowance will be taken when a level of care determination is missing for a court ordered patient.
<b>Regulatory References</b>	14 NYCRR Section 822.3(c) 14 NYCRR Section 822.3(d)

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by the 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.

**OMIG AUDIT PROTOCOL – OASAS OUTPATIENT  
CHEMICAL DEPENDENCE SERVICES  
Effective May 9, 2013**

---

<b>28.</b>	<b>Missing Comprehensive Evaluation Update</b>
<b>OMIG Audit Criteria</b>	Every fourth treatment plan review must include a comprehensive evaluation update. If a comprehensive evaluation update is missing, claims will be disallowed for services covered by each fourth treatment plan review.
<b>Regulatory References</b>	14 NYCRR Section 822.4(n)
<b>29.</b>	<b>Missing Services Schedule</b>
<b>OMIG Audit Criteria</b>	Claims will be disallowed for services associated with a missing service schedule (indicating the provision of services on the treatment plan).
<b>Regulatory References</b>	14 NYCRR Section 822.4(l)(6)
<b>30.</b>	<b>Service Rendered After Discharge</b>
<b>OMIG Audit Criteria</b>	Claims will be disallowed for services rendered after the patient is discharged.
<b>Regulatory References</b>	14 NYCRR Section 841.8(c) For services prior to <b>12/27/2006</b> : 14 NYCRR Section 822.10(a) 14 NYCRR Section 822.10(b) 14 NYCRR Section 822.10(e)(2) For services <b>12/27/2006</b> and after: 14 NYCRR Section 822.11(a) 14 NYCRR Section 822.11(b) 14 NYCRR Section 822.11(e)(2)

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by the 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.