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

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OMIG AUDIT PROTOCOL
DIAGNOSTIC and TREATMENT CENTER SERVICES (DTC)

Revised 03/16/2018

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.

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DIAGNOSTIC and TREATMENT CENTER SERVICES (DTC)
Revised 03/16/18

1.	**Unlicensed or Excluded Service Provider on Claim**
OMIG Audit Criteria	The claim will be disallowed when the servicing practitioner was unlicensed or excluded from the Medicaid program.
Regulatory References	18 NYCRR § 504.1(b)(1) & (c) 18 NYCRR § 515.5(a), (b), (c), & (e) Policy Guidelines Manual for Article 28 Certified Clinics, Version 2007-2, Section I

2.	**Incorrect Servicing Provider on Claim**
OMIG Audit Criteria	The claim will be disallowed when the servicing provider's name on the claim does not match the name of the practitioner who signed the medical entry.
Regulatory References	18 NYCRR § 504.3(h) Policy Guidelines Manual for Article 28, Certified Clinics, Version 2007-2, Section I

3.	**Medical Entry Not Signed and Dated**
OMIG Audit Criteria	The claim will be disallowed when the entry in the medical record was not signed and dated by the person making the entry.
Regulatory References	10 NYCRR § 751.7(f)

4.	**Emergency Room Visit and Clinic Visit on Same Day**
OMIG Audit Criteria	When a patient is treated in a facility's emergency room and clinic on the same day for the same illness, the claim paid to the clinic will be disallowed.
Regulatory References	Policy Guidelines Manual for Article 28, Certified Clinics, Version 2007-2, Section I

5.	**Services Not Medically Necessary as Determined by Medicare**
OMIG Audit Criteria	Claims will be disallowed for services that are not medically necessary as determined by Medicare.
Regulatory References	Information for All Providers, General Policy, Version 2011-2, Section II

6.	**Missing Service Documentation**
OMIG Audit Criteria	The claim will be disallowed when the services were not documented. Examples of missing documentation include missing patient records, missing test report results, and missing entries.
Regulatory References	10 NYCRR § 751.7 (a), (d)-(f), (h), & (j) 18 NYCRR § 504.3(a) 18 NYCRR § 517.3(b)(1)

7.	Missing Written Order for Rehabilitation Services
OMIG Audit Criteria	The claim will be disallowed when there was no written order or referral from a physician or a dentist for physical therapy and speech language pathology services, and when there was no written order or referral from a physician for occupational therapy services.
Regulatory References	10 NYCRR § 752-1.1(d) 18 NYCRR § 505.11(a) & (e)

8.	Missing Plan of Care for Rehabilitation Services
OMIG Audit Criteria	The claim will be disallowed when the plan of care is missing.
Regulatory References	10 NYCRR § 752-1.1(d)(1)

9.	Plan of Care Not Reviewed by Physician and Professional Staff Within the Required Time Frames
OMIG Audit Criteria	The claim will be disallowed when the written plan of care and results of treatment were not reviewed at least every 30 days by the physician and appropriate professional staff. Where ordered treatment of a longer duration is specified, the claim will be disallowed if the review did not take place at least every 90 days.
Regulatory References	10 NYCRR § 752-1.1 & (d)(1)

10.	Billed Services Not Provided
OMIG Audit Criteria	The claim will be disallowed when services were billed but not provided.
Regulatory References	18 NYCRR § 504.3(e) Information for All Providers - General Policy, Version 2011-2, Section II

11.	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	18 NYCRR § 504.3(e), (h), & (i) Policy and Billing Guidance, Ambulatory Patient Group (APGs) Provider Manual, Revision 2.1, August 2012, Chapter 3

12.	Billed for Services Not Authorized by the Operating Certificate
OMIG Audit Criteria	The claim will be disallowed when the services billed were not authorized by the operating certificate.
Regulatory References	10 NYCRR § 401.1(d) Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual, Revision 2.1, August 2012, Chapter 3 Policy Guidelines Manual for Article 28 Certified Clinics, Version 2007-2, Section II Medicaid Update, December 2007, Volume 23, Number 12

13.	Billing Exceeded Acquisition Cost for Supplies and/or Materials
OMIG Audit Criteria	Reimbursement for supplies and materials (including drugs, vaccines and immune globulins) furnished by practitioners to their patients is based on the acquisition cost to the practitioner.
Regulatory References	18 NYCRR § 505.3(f)(2) 18 NYCRR § 505.5(d)(1)(iv) 18 NYCRR § 505.5(d)(2)(ii)(a) and (b) Policy Guidelines Manual for Article 28, Certified Clinics, Version 2007-2, Section II Ordered Ambulatory Procedure Codes, Versions 2011-1 through 2017, General Information

14.	Failed to Maximize Third Party and/or Medicare Benefit
OMIG Audit Criteria	Medicaid providers must take reasonable measures to determine legal liability to pay for medical care and services. No claim for reimbursement shall be submitted without provider investigation of the existence of such third parties. When it is determined that a sample service was covered or reimbursed by third party insurance in whole or in part, the amount Medicaid incorrectly paid will be disallowed. Any service to a Medicaid eligible patient for which Medicare made no payment will NOT be evaluated for possible Medicare coverage. A statewide sample of these claims is evaluated by OMIG and an outside contractor for possible Medicare eligibility.
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(1) & (2) Information for all Providers - General Policy, Version 2011-2, Section I