Office of the Medicaid Inspector General

OMIG AUDIT PROTOCOL
OMH Mental Health Outpatient Treatment and Rehabilitative Services*
Revised 11/14/2024

(For Service Dates 01/01/2017 through 11/14/2024)

*Part 599 Clinic Treatment Programs were renamed Mental Health Outpatient Treatment and Rehabilitative Services effective November 23, 2022.

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 OMH pertaining to OMH Outpatient Treatment and Rehabilitative 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
OMH	Use of Telephone and Two-way Video Technology by OMH-Licensed, Funded or Designated Providers and Clients Affected by the COVID-19 Pandemic	03/30/20	02/12/21
OMH	COVID-19 Billing Guidance for OMH-Licensed Clinic Programs	05/15/20	01/22/21
OMH	COVID-19 Documentation Guidance for Clinic Treatment Programs	04/13/20	
OMH	New York State Office of Mental Health COVID-19 Disaster Emergency FAQ	04/16/20	07/13/20
OMH	Commissioner's Regulatory Waiver	06/25/21	06/28/21, 08/23/21, 10/23/21, 12/07/21, 02/05/22, 06/06/22, 10/04/22, 02/01/23

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 OMH through formal regulatory waivers. The OMH Commissioner's waiver, which was last renewed on February 1, 2023 and contained the COVID-19-related flexibilities, terminated on the same date that the PHE ended.

OMIG AUDIT PROTOCOL
OMH Mental Health Outpatient Treatment and Rehabilitative Services

(For Service Dates 01/01/2017 through 11/14/2024)

1.	Missing Recipient Record
OMIG Audit Criteria	The claim will be disallowed if the recipient record is not available for review.
Regulatory References	14 NYCRR § 599.11(a) 18 NYCRR § 504.3(a) 18 NYCRR § 540.7(a)(8)

2.	Missing Documentation of Clinic Service
OMIG Audit Criteria	If the recipient record lacks documentation that a face-to-face clinic treatment service was provided, the claim will be disallowed. "Face to face" services include services provided using audio-visual or audio-only telehealth, where approved or otherwise authorized during the PHE.
Regulatory References	14 NYCRR § 599.8(b) and (c) 14 NYCRR § 599.14(d) 18 NYCRR § 504.3(a) 18 NYCRR § 505.25(e)(5) 18 NYCRR § 505.25(f)(1) 18 NYCRR § 505.25(h)(1)(ii) 18 NYCRR § 540.7(a)(8) **For Services 08/19/20 and After:** 14 NYCRR § 599.10(g) **For Services 03/14/12 through 08/18/20:** 14 NYCRR § 599.10(k)

3.	Missing Progress Note
OMIG Audit Criteria	For clinic treatment services, progress notes related to treatment plan goals must be recorded after each visit and/or contact. If the required progress note is missing, the claim will be disallowed.
Regulatory References	14 NYCRR § 599.11(a)(3) 14 NYCRR § 599.11(b)(8) and (9) **For Services 08/19/20 and After:** 14 NYCRR § 599.10(g) **For Services 03/14/12 through 08/18/20:** 14 NYCRR § 599.10(k)

4.	Duration of Service Not Documented
OMIG Audit Criteria	The claim will be disallowed if the duration of the billed service was not documented as required.
Regulatory References	**For Services 08/19/20 and After:** 14 NYCRR § 599.10(g) **For Services 03/14/12 through 08/18/20:** 14 NYCRR § 599.10(k)

5.	Failure to Meet Minimum Duration Requirements
OMIG Audit Criteria	Claims for clinic services not meeting the minimum required durations will be disallowed: **Minimum required durations for services prior to 11/23/22*:** • 45 minutes for initial assessments (40 minutes for school-based services); • 30 minutes for brief psychiatric assessments; • 15 minutes for injectable psychotropic medication administration with monitoring and education; • 15 minutes for psychotropic medication treatment services; • 30 minutes for brief individual psychotherapy services (Effective 1/1/15 – 11/22/22: 20 minutes for a 30% reimbursement reduction); • 60 minutes for psychotherapy – family/collateral with the recipient present the majority of the time; • 30 minutes for psychotherapy – family/collateral without the recipient; • 60 minutes for multi-recipient groups (40 minutes for school-based services); and, • 60 minutes for multi-family/collateral groups. ***For Services 03/07/20 through 11/22/22:** Services with durations conforming with American Medical Association (AMA) time standards as described in OMH's *COVID-19 Billing Guidance for OMH-Licensed Clinic Programs* will not be subject to disallowance. Clinic services not listed in this guidance continued to have the minimum durations as indicated above through 11/22/22. **Minimum required durations for services 11/23/22 and after**:** Providers may bill for services consistent with applicable AMA and CMS coding guidelines for service duration ranges, unless otherwise specified in OMH's Billing and Fiscal Guidance. Where there is no duration range defined within those guidelines, the minimum duration cited in OMH regulations and guidance must be followed. ****Note:** the flexibilities regarding minimum service durations for the clinic services covered in *OMH's COVID-19 Billing Guidance for OMH-Licensed Clinic Programs* remained in effect through the end of the PHE on 5/11/23.

Regulatory References	14 NYCRR § 599.14(d)(4)(ii) 14 NYCRR § 599.14(d)(5) 14 NYCRR § 599.14(d)(6)(ii) 14 NYCRR § 599.14(d)(6)(iii) 14 NYCRR § 599.14(d)(6)(iv) 14 NYCRR § 599.14(d)(6)(v) **For Services 04/01/23 and After:** NYS Office of Mental Health 14 NYCRR Part 599 Mental Health Outpatient Treatment and Rehabilitative Services Medicaid Billing and Fiscal Guidance Versions April 2023 and November 2023, pages 24-33 **For Services 11/23/22 and After:** 14 NYCRR § 599.14(d)(1)(ii) 14 NYCRR § 599.14(d)(1)(iv)(b) and (d) 14 NYCRR § 599.14(d)(6)(i)(a) and (d) **For Services 04/01/15 through 11/22/22:** 14 NYCRR § 599.14(d)(1)(i)(b) 14 NYCRR § 599.14(d)(1)(ii)(b) 14 NYCRR § 599.14(d)(6)(i)(a)(1) and (2)

6.	**Group Counseling Recipient Limit Exceeded**
OMIG Audit Criteria	If the number of recipients in the multi-recipient group counseling session exceeds the maximum of 12 recipients, or the number of recipients in the multi-family/collateral group counseling session exceeds the maximum of eight multi-family/collateral units or 16 individuals, the claim will be disallowed for the recipient under review.
Regulatory References	14 NYCRR § 599.14(d)(6)(iv) 14 NYCRR § 599.14(d)(6)(v)

7.	**Excessive Preadmission Procedures / Visits**
OMIG Audit Criteria	Claims for preadmission services in excess of the maximum allowed three preadmission procedures for adults or three preadmission visits for children will be disallowed. Additionally, claims for preadmission services for adults in excess of one collateral procedure will be disallowed. Note: Peer/Family Support Services will not count toward the three service/visit limit as this service has no pre-admission reimbursement limit.
Regulatory References	14 NYCRR § 599.14(b)

8.	Missing Individual Treatment Plan
OMIG Audit Criteria	A written individual treatment plan must be completed no later than 30 days after admission. Claims for services provided without a treatment plan completed as required will be disallowed.
Regulatory References	14 NYCRR § 599.11(b)(7) 18 NYCRR § 505.25(d)(2) **For Services 8/19/20 and After:** 14 NYCRR § 599.10(b) **For Services 03/14/12 through 08/18/20:** 14 NYCRR § 599.10(g)

9.	Missing Documentation of Individual Treatment Plan Review / Update
OMIG Audit Criteria	**For Services 11/23/22 and After:** Treatment plans shall be reviewed no less frequently than annually based on the date of admission, the most recent treatment plan review, or additionally as determined by the recipient's treating clinician. Treatment plans must be updated when new services are added, service intensity is increased or as necessary as determined by the recipient's treating clinician. All other changes to information in the treatment plan may be recorded in progress notes. **For Services 08/19/20 through 11/22/22:** Treatment plans shall be reviewed no less frequently than annually based on the date of admission or additionally as determined by the recipient's treating clinician. Treatment plans must be updated when new services are added, service intensity is increased or as necessary as determined by the recipient's treating clinician. All other changes to information in the treatment plan may be recorded in progress notes. **For Services 03/14/12 through 08/18/20:** A treatment plan review must take place at least every 90 days, or the next provided service, whichever shall be later. Claims will be disallowed for services without documentation of a corresponding treatment plan review or updated treatment plan, as appropriate, within the required time frames.
Regulatory References	18 NYCRR § 505.25(d)(2) **For Services 11/23/22 and After:** 14 NYCRR § 599.10(d)(1) and (2) **For Services 08/19/20 and After:** 14 NYCRR § 599.10(d)(1)-(3) 14 NYCRR § 599.10(e) **For Services 03/14/12 through 08/18/20:** 14 NYCRR § 599.10(i) 14 NYCRR § 599.10(j)(1)

10.	**Missing Physician / Treating Clinician Signature on Treatment Plan or Treatment Plan Review / Update**
OMIG Audit Criteria	**For Services 11/23/22 and After:** Claims will be disallowed if the initial treatment plan, or a treatment plan updated for the addition of new services or an increase in service intensity, was not signed by a psychiatrist, Nurse Practitioner of Psychiatry, or other physician. For treatment plan reviews not resulting in the addition of new services or an increase in service intensity, which may be documented in progress notes, the claim will be disallowed in the absence of the treating clinician's signature. **For Services 08/19/20 through 11/22/22:** Claims will be disallowed if the initial treatment plan, or a treatment plan updated for the addition of new services or an increase in service intensity, was not signed by a psychiatrist or other physician. For treatment plan reviews not resulting in the addition of new services or an increase in service intensity, which may be documented in progress notes, the claim will be disallowed in the absence of the treating clinician's signature. **For Services 03/14/12 through 08/18/20:** Claims will be disallowed in the absence of a physician signature on the treatment plan or treatment plan review for the billed service dates within the relevant time frame.
Regulatory References	18 NYCRR § 505.25(a)(1) 18 NYCRR § 505.25(e)(1) 18 NYCRR § 505.25(h)(1)(i) New York State Office of Mental Health 14 NYCRR Part 599 "Clinic Treatment Programs" Interpretive/Implementation Guidance Versions 01-04-2012 through 01-01-2021, Section VI Mental Health Outpatient Treatment and Rehabilitative Service Guidance Issued July 2023, pages 34-35 **For Services 08/19/20 and After:** 14 NYCRR § 599.10(c)(7) 18 NYCRR § 599.10(e) **For Services 03/14/12 through 08/18/20:** 14 NYCRR § 599.10(c)-(e) 14 NYCRR § 599.10(j)(4)

11.	Billing for Services Not Authorized by Operating Certificate
OMIG Audit Criteria	Claims for services that are not authorized by the provider's operating certificate will be disallowed.
Regulatory References	14 NYCRR § 599.5(a) and (b) 14 NYCRR § 599.8(b) and (c) 18 NYCRR § 505.25(a)(1) 18 NYCRR § 505.25(b)(1) 18 NYCRR § 505.25(d)(3) 18 NYCRR § 505.25(f)(1) and (3)

12.	Incorrect Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) Service Classification
OMIG Audit Criteria	The CPT or HCPCS procedure code(s) billed must be consistent with the service(s) documented in the case record. The claim will be adjusted to reflect payment based on the correct procedure code(s) for the documented service(s).
Regulatory References	14 NYCRR § 599.14(a) **For Services 04/01/23 and After:** NYS Office of Mental Health 14 NYCRR Part 599 Mental Health Outpatient Treatment and Rehabilitative Services Medicaid Billing and Fiscal Guidance Versions April 2023 and November 2023, page 21 **For Services 01/04/12 through 03/31/23:** New York State Office of Mental Health 14 NYCRR Part 599 "Clinic Treatment Programs" Interpretive/Implementation Guidance Versions 01-04-2012 through 01-01-2021, Section X

13.	Incorrect Collateral Billings
OMIG Audit Criteria	Services for individuals not meeting the definition of collateral persons, or if the collateral person is not listed on the recipient's treatment plan or in preadmission notes, will be disallowed. Note: A collateral person could also be identified in the subsequent treatment plan review or a progress note.
Regulatory References	18 NYCRR § 505.25(e)(5) **For Services 11/23/22 and After:** 14 NYCRR § 599.4(a)(7) **For Services 12/17/14 through 11/22/22:** 14 NYCRR § 599.4(i)

14.	Insufficient Documentation to Support the Modifier
OMIG Audit Criteria	If the modifier adjustment was incorrectly used, the amount of the claim disallowed is the percentage the modifier added to the APG portion of the claim.
Regulatory References	14 NYCRR § 599.4(a)(22) 14 NYCRR § 599.14(e) **For Services 04/01/23 and After:** NYS Office of Mental Health 14 NYCRR Part 599 Mental Health Outpatient Treatment and Rehabilitative Services Medicaid Billing and Fiscal Guidance Versions April 2023 and November 2023, page 8 **For Services 11/23/22 and After:** 14 NYCRR § 599.4(a)(24) 14 NYCRR § 599.14(d)(1)(iii) **For Services 12/17/14 through 11/22/22:** 14 NYCRR § 599.4(aj) 14 NYCRR § 599.14(d)(1)(i)(c) **For Services 08/19/20 and After:** 14 NYCRR § 599.10(c)(6) **For Services 03/14/12 through 08/18/20:** 14 NYCRR § 599.10(h)

15.	Failure to Submit Claim Using the U5 Modifier Adjustment
OMIG Audit Criteria	If the U5 modifier adjustment was not used for the following services, then 30% of the APG portion of the payment will be disallowed. **For Services 11/23/22 and After:** • Psychotherapy – Multi Individual Group with a duration of at least 40 minutes but less than 60 minutes. **Note:** this requirement applied to school-based multi-recipient groups as of 12/17/14 • Psychotherapy – Multi Family/Collateral Group with a duration of at least 40 minutes but less than 60 minutes. **For Services 01/01/15 through 11/22/22:** • Brief individual psychotherapy services of at least 20 minutes but less than 30 minutes.
Regulatory References	14 NYCRR § 599.4(a)(22) 14 NYCRR § 599.14(d)(6)(iv) **For Services 04/01/23 and After:** NYS Office of Mental Health 14 NYCRR Part 599 Mental Health Outpatient Treatment and Rehabilitative Services Medicaid Billing and Fiscal Guidance Versions April 2023 and November 2023, page 20 **For Services 11/23/22 and After:** 14 NYCRR § 599.14(d)(6)(v) **For Services 01/01/15 through 11/22/22:** New York State Office of Mental Health 14 NYCRR Part 599 “Clinic Treatment Programs” Interpretive/Implementation Guidance Versions 06-12-2015 through 01-01-2021, Section VIII **For Services 04/01/15 through 11/22/22:** 14 NYCRR § 599.14(d)(6)(i)(a)(2)

16.	Brief Individual Psychotherapy Billed as Extended Individual Psychotherapy
OMIG Audit Criteria	A brief individual psychotherapy service visit lasts at least 30 minutes; an extended individual psychotherapy service lasts at least 45 minutes. If an extended visit rate is billed when a brief visit is documented, the amount of the claim disallowed will be the difference between the extended visit rate amount and the brief visit rate amount. **For Services 11/23/22 and After:** Where clinically appropriate and consistent with applicable AMA coding guidelines for service duration ranges for Current Procedural Terminology (CPT) psychotherapy codes, programs may bill Brief or Extended Individual Psychotherapy for shorter service durations than those specified in 14 NYCRR 599.14.
Regulatory References	**For Services 11/23/22 and After:** 14 NYCRR § 599.14(d)(6)(i) **For Services 04/01/15 through 11/22/22:** 14 NYCRR § 599.14(d)(6)(i)(a)-(b)

17.	Brief Psychiatric Assessment Billed as Extended Psychiatric Assessment
OMIG Audit Criteria	A brief psychiatric assessment should consist of at least 30 minutes of documented face-to-face interaction between the recipient and Psychiatrist or NPP; an extended psychiatric assessment should consist of at least 45 minutes of documented face-to-face interaction between the recipient and Psychiatrist or NPP. If an extended assessment rate is billed when a brief assessment is documented, the amount of the claim disallowed will be the difference between the extended assessment rate amount and the brief assessment rate amount. **For Services 11/23/22 and After:** Where clinically appropriate and consistent with applicable AMA coding guidelines for service duration ranges for Current Procedural Terminology (CPT) psychotherapy codes, programs may bill for Brief or Extended Psychiatric Assessments for shorter service durations than those specified in 14 NYCRR 599.14. The psychiatric assessment duration may include face-to-face time with the individual, or family or other collaterals.
Regulatory References	**For Services 11/23/22 and After:** 14 NYCRR § 599.14(d)(1)(iv)(b)-(d) **For Services 12/17/12 through 11/22/22:** 14 NYCRR § 599.14(d)(1)(ii)(b) and (c)

18.	Improper Billing for Resident of a Residential Health Care Facility
OMIG Audit Criteria	Claims billed directly to Medicaid for clinic services rendered to residents of a residential health care facility will be disallowed.
Regulatory References	14 NYCRR § 599.14(f)(4)

19.	Failure to Meet Billing Requirements for Complex Care Management
OMIG Audit Criteria	The claim will be disallowed if complex care management was not provided within 14 days of a psychotherapy, psychotropic medication treatment, or crisis service; or if more than four five-minute units were billed after an eligible clinic visit; or if the billed complex care management lasted less than five full minutes. If the units of complex care management billed exceeded the units documented, the disallowance amount is the difference between the payment amount for the units billed and the payment amount for the units documented.
Regulatory References	**For Services 11/23/22 and After:** 14 NYCRR § 599.14(d)(8) **For Services 12/17/14 through 11/22/22:** 14 NYCRR § 599.14(d)(9)

20.	Failure to Meet Billing Requirements for Crisis Services
OMIG Audit Criteria	The claim will be disallowed if crisis intervention services do not meet the following requirements: • Brief crisis intervention services with a duration of at least 15 minutes, one unit of service shall be billed. For each additional service increment of at least 15 minutes, an additional unit of service may be billed, up to a maximum of six units per day. • Complex crisis intervention requires a minimum of one hour of face-to-face contact by two or more clinicians. Both clinicians must be present for the majority of the duration of the total contact. • Per diem crisis intervention requires three hours or more of face-to-face contact by two or more clinicians. Both clinicians must be present for the majority of the duration of the total contact. Where appropriate, the amount disallowed will be the difference between the amount paid and the amount that should have been paid for the level of crisis service documented.
Regulatory References	14 NYCRR § 599.14(d)(3)(ii)(a)-(c)

21.	Billing Requirements for Peer / Family Support Services Not Met
OMIG Audit Criteria	The claim will be disallowed if Peer / Family Support Services did not meet the following requirements: • Services may be provided to individuals, family or other collaterals, or groups of individuals not to exceed 12. • For services of a duration of at least 15 minutes, one unit of service shall be billed. For each additional service increment of at least 15 minutes, an additional unit of service may be billed, up to twelve units per day, or 3 hours maximum. Multiple units of Peer/Family Support Services may be provided consecutively or at different times of the day. Where appropriate, the amount disallowed will be the difference between the amount paid and the amount that should have been paid for the units of service documented.
Regulatory References	14 NYCRR § 599.14(d)(9) NYS Office of Mental Health 14 NYCRR Part 599 Mental Health Outpatient Treatment and Rehabilitative Services Medicaid Billing and Fiscal Guidance Versions April 2023 and November 2023, page 18

22.	No Documentation that Covered Service was Billed to Medicare
OMIG Audit Criteria	If an EOB for a Medicare covered service provided by an enrollable practitioner is not found, the claim will be disallowed.
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

23.	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 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 **For Services 04/01/23 and After:** NYS Office of Mental Health 14 NYCRR Part 599 Mental Health Outpatient Treatment and Rehabilitative Services Medicaid Billing and Fiscal Guidance Version November 2023, page 11 Version April 2023, page 10 **For Services 01/04/12 through 03/31/23:** New York State Office of Mental Health 14 NYCRR Part 599 "Clinic Treatment Programs" Interpretive/Implementation Guidance Versions 01-04-2012 through 01-01-2021, Section VIII

24.	No Documentation that Covered Service was Billed to Third Party Health Insurance (Excluding Medicare)
OMIG Audit Criteria	If an EOB for a TPHI (commercial carrier) covered service is not found, the claim will be disallowed.
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

25.	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 **For Services 04/01/23 and After:** NYS Office of Mental Health 14 NYCRR Part 599 Mental Health Outpatient Treatment and Rehabilitative Services Medicaid Billing and Fiscal Guidance Versions April 2023 and November 2023, page 13 **For Services 01/04/12 through 03/31/23:** New York State Office of Mental Health 14 NYCRR Part 599 "Clinic Treatment Programs" Interpretive/Implementation Guidance Versions 01-04-2012 through 01-01-2021, Section VIII

26.	Failure to Bill Medicaid Managed Care
OMIG Audit Criteria	Claims for services billed to Medicaid that bypass the Medicaid Managed Care company responsible for payment will be disallowed.
Regulatory References	18 NYCRR § 360-7.2 NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Sections I and II

27.	Services Provided by Unqualified Individual
OMIG Audit Criteria	Claims for services provided by staff who were unqualified for the type of service provided will be disallowed.
Regulatory References	14 NYCRR § 599.14(d) 18 NYCRR § 504.1(c) 18 NYCRR § 505.11(a)

28.	Services Ordered / Referred by Individual Not Enrolled in NYS Medicaid
OMIG Audit Criteria	Claims for services ordered/referred by an individual not enrolled in the New York State Medicaid program on the date of service, when required, will be disallowed. Note, this finding does not apply when the attending clinician was enrolled in NYS Medicaid on the date of service. If the attending clinician was not enrolled, then the clinician who signed the treatment plan or who supervises the attending clinician must be enrolled.
Regulatory References	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 **For Services 04/01/23 and After:** NYS Office of Mental Health 14 NYCRR Part 599 Mental Health Outpatient Treatment and Rehabilitative Services, Medicaid Billing and Fiscal Guidance Version November 2023, pages 11-12 Version April 2023, page 11 **For Services 06/12/15 through 03/31/23:** New York State Office of Mental Health 14 NYCRR Part 599 “Clinic Treatment Programs” Interpretive/Implementation Guidance Versions 06-12-2015 through 01-01-2021, Section VIII

29.	Services Ordered / Prescribed / Referred / Attended by Excluded Individual
OMIG Audit Criteria	Claims for services ordered, prescribed, referred, or attended by an individual excluded from the New York State Medicaid program on the date of service will be disallowed.
Regulatory References	18 NYCRR § 513.1(d),(e), and (g) 18 NYCRR § 515.1(b)(6) and (10) 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