DEPARTMENT OF SOCIAL SERVICES
AUDIT PROTOCOL - HOSPITAL OUTPATIENT SERVICES
UPDATED APRIL 2017

Listed are the most common audit findings noted for hospital outpatient services provided under the State Medicaid program, and clarification of the criteria the Connecticut Department of Social Services (the "Department") uses when it makes those findings. The hospital outpatient services provided under the Medicaid program are governed mainly by the policies included in the Connecticut Medical Assistance Program Provider Manual (PM), the Medicaid Provider Enrollment Agreement (PA), Provider Bulletins (PB), the Current Procedure Terminology Codebook (CPT), the Medical Services Policy, the Regulations of Connecticut State Agencies (Conn. Agencies Regs.), the Connecticut General Statutes (Conn. Gen. Stat.), the Code of Federal Regulations (C.F.R), and the United States Code (U.S.C). This audit protocol is for dates of services prior to July 1, 2016.

Finding	Department Criteria	Regulatory References
Billing - Automated Test Panel	The Department will adjust the payment if the paid service is for laboratory tests that are part of the Automated Test Panel and are not billed individually, which causes the payment in aggregate to be in excess of the approved ATP fee for the sum of the tests provided.	PB 2002-56; 2005-09 Conn. Agencies Regs. § 17b-262-530 42 U.S.C. §1396b(i)(7)
Billing - Duplicate Services	The Department will disallow payment for the professional component of a visit and/or service if a hospital is paid for the facility and professional component of a visit and/or service and a separate physician or other licensed practitioner is also paid a professional component. The Department will determine whether the disallowance applies to the hospital or the physician, depending on the specific circumstances of the paid service.	PM Section 150.2J.I.g; 150.2J.I.h; 150.2J.I.i. Conn. Agencies Regs. §§ 17-134d-86(b); 17b-262-348(c); 17b-262-524(g), (h), and (i); 17b-262-584(c) and (d); 17b-262-611(b); 17b-262-617(f) (each as amended and/or repealed by the inpatient hospital operational policy in effect starting 1/1/15)

Billing - Emergency room service same day as inpatient stay	The Department will disallow payment for service if the payment was for an emergency room service provided on the same day as an inpatient admission.	PM Section 150.2J.V.n Conn. Agencies Regs. §§ 17-134d-86(b)(3); 17b-262-909(c) (each as amended and/or repealed by the inpatient hospital operational policy in effect starting 1/1/15)
Billing - Failure to Utilize Third Party Liability	The Department will disallow payment for service if there is a private insurance/third-party payor, including Medicare, that the provider failed to first attempt payment from the third-party payor.	Conn. Agencies Regs. §§ 17b-262-526(2) and (3); 17b-262-529(3); 17b-262-531(c) 42 U.S.C. § 1396a (a)(25)
Billing - Incorrect Revenue Center Code (RCC)/Procedure Code/Modifier	The Department will disallow the difference between the paid code and the correct code if the paid service was billed with the incorrect RCC or procedure code/modifier.	PM Section 150.2E.I.a Current Procedural Terminology (CPT) codebook National Uniform Billing Committee (NUBC) Guidelines Official UB-04 Data Specifications Manual PB 2013-11; 2014-06; 2013-44; 2010-60
Billing - Incorrect Units	The Department will disallow the difference between the amount paid and the correct amount if the number of units paid differs from the documentation and/or exceeds the number of units allowed.	PM Section 150.2F.I; 150.2E.I.a.
Billing - Ineligible Client	The Department will disallow payment for service if the service is paid for an individual who is not currently receiving benefits under the Medicaid program.	PM Section 150.2H; 150.2D Conn. Agencies Regs. § 17b-262-531(a)
Billing - Non-Billable Services	The Department will disallow payment for service if the paid service was billed for services that are not approved to be billed separately.	PM Section 150.2J. Conn. Agencies Regs. § 17b-262-530
Billing - Services not approved for Revenue Center Code (RCC)	The Department will disallow payment for service if the paid service is not included in the approved RCC request.	PM Section 150.2F.III.

Enrollment - Unenrolled Ordering, Referring, or Prescribing Provider	The Department will disallow payment for service if the paid service was based on an order, referral or prescription from an ordering provider, referring provider, or prescribing provider who is not properly enrolled in the Medicaid program or if the NPI of the ordering provider, referring provider, or prescribing provider is not listed on the claim, or if the medical record documenting the order, referral or prescription for the service was not signed by a properly enrolled provider.	[For OPR requirement:] 42 U.S.C. §§ 1396a (a)(77) and (kk) 42 C.F.R. §§ 455.410 and 455.410 [For medical record not being signed by an enrolled provider:] Conn. Agencies Regs. §§ 17b-262-531(e); 17b-262-524(a)(2) – (3); 17b-262-526(9) and (11) PM Section 150.2C. PB 2014-48; 2013-24; 2013-56
Enrollment - Unenrolled Rendering Provider	The Department will disallow payment for service if the paid service was rendered by a provider who is not properly enrolled in the Medicaid program and the medical record for the service was not signed by a properly enrolled provider.	Conn. Agencies Regs. §§ 17b-262-531(e); 17b-262-524(a)(2) – (3); 17b-262-526(9) and (11) PM Section 150.2C. PB 2014-48; 2013-24; 2013-56 42 U.S.C. § 1396a(a)(27) 42 C.F.R. § 431.107
Limitation - Observation Services Provided Beyond 23 hours	The Department will disallow payment for service if the paid service was for observation service that occurred 23 hours after the time appearing on the practitioner's observation admission note and if services are not ordered within 23 hours of the start of the observation admission note.	PM Section 150.2B.XVIII. Conn. Agencies. Regs. § 17-134d-86(a)(7) PB 2011-46; 2010-11
Limitation - Observation Services Provided Beyond 23 hours	The Department will disallow payment for paid observation services for hours that occurred in excess of 23 hours after the start of admission. The time appearing on the practitioner's observation admission note is used as the start of the observation service.	PM Section 150.2B.XVIII. Conn. Agencies Regs. § 17-134d-86(a)(7) PB 2011-46; 2010-11
Limitations - Prior Authorization	The Department will disallow payment for service if the paid service is not in conformance with prior authorization requirements.	PM Section 150.2G. Conn. Agencies Regs. § 17b-262-527
Medical Record - No Documentation of Service	The Department will disallow payment for service if service documentation is not made available for audit.	Conn. Agencies Regs. §§ 17b-262-526 (7); 17b-262-526 (8); 19a-14-40

Medical Record - No written order or excess of order	The Department will disallow the difference between the service ordered and the paid service if the service was not ordered or was paid in excess of the order.	PM Section 150.2F.I; 150.2E.I.a; 150.2F.II. Conn. Agencies Regs. § 19a-14-40
Medical Record - Not Signed by Rendering Provider	The Department will disallow payment for service if the medical record of the paid service was not signed by the rendering provider or if a rubber stamp was used in place of a signature or if an electronic signature on an electronic health record does not comply with the requirements of the Department’s Electronic Signature Policy. Please see "Medical Record - Resident Rendering Services" for services rendered by a resident and the signing requirements.	Conn. Agencies Regs. §§ 17b-262-526 (7); 17b-262-526 (8); 19a-14-40 Department’s Electronic Signature Policy (Section J of the Provider Enrollment Application)
Medical Record - Resident Supervising Physician Present	When the resident performs the elements required for an E/M service in the presence of, or jointly with, the supervising/teaching physician and the resident documents the service, the Department will disallow payment if the supervising/teaching physician’s documentation does not support that he/she was directly involved in the management of the patient and that he/she physically saw and evaluated the patient. The supervising/teaching physician’s note should reference or supplement the resident’s note. There will be no disallowance if the resident performs an E/M services eligible under the primary care exception through the GME program.	Conn. Agencies Regs. §§ 17b-262-346(d); 17b-262-346 (e); 17b-262-526 (7); 17b-262-526 (8); 19a-14-40 PB 2016-40; PB 2016-82
Medical Record - Resident Supervising Physician Not Present	When the resident performs some or all of the required elements of an E/M service in the absence of the supervising/teaching physician, the Department will disallow payment if the supervising/teaching physician does not document that he/she personally saw the patient and document their role in the key and critical portions of the service. The physician’s note should reference or supplement the resident’s note and should document any changes in the patient’s condition. There will be no disallowance if the resident performs an E/M services eligible under the primary care exception through the GME program.	Conn. Agencies Regs. §§ 17b-262-346(d); 17b-262-346 (e); 17b-262-526 (7); 17b-262-526 (8); 19a-14-40 PB 2016-40; PB 2016-82

Medical Record - Signature on Order for Services	The Department will disallow payment for service if the paid service was based on an order not signed by the ordering physician/resident or if a rubber stamp was used as the physician/resident signature.	Conn. Agencies Regs. §§ 17b-262-526 (7); 17b-262-526 (8); 19a-14-40
Medical Record - Timely Completion	The Department will disallow payment for service if the paid service was based on a medical record that was not completed (including authentication by the provider) within 30 days after the billable outpatient visit or procedure.	PB 2014-23 Conn. Agencies Regs. § 19-13-D3(d)(7); 19-13D4a(d)(5) 42 C.F.R. § 482.24(c)(4)
Services - Emergent vs. Urgent	The Department will disallow the difference between the paid emergency service and an urgent service if the medical record does not support circumstances consistent with an emergency. The medical records must be specific about when the problem started that led the person to come to the emergency department, including the criteria of the situation arising no more than 72 hours before the person came to the emergency department.	Conn. Agencies Regs. §§ 17-134d-86(a)(3); 17-134d-86(a)(6) PM Section 150.2B XI; 150.2B XVI PB 2014-37
Services - Limitations	The Department will disallow payment for service if the paid service exceeds the limitations of the Medicaid program. Some of the more common limitation errors are listed separately in this protocol.	PM Section 150.2E.II; 150.2J.V. Conn. Agencies Regs. § 17-134d-86(b)
Services - Medically Necessary	The Department will disallow payment for service if the service provided is not medically necessary.	PM Section 150.2F.I Conn. Gen. Stat. § 17b-259b Conn. Agencies Reg
Services - Non Covered Services	The Department will disallow payment for service if the paid service is not covered under the Medicaid program.	Conn. Agencies Regs. §§ 17b-262-531(b); 17-134d-86(b) PM Section 150.2E.III.

Services - Ordered by Physician Assistants, APRNs, and Certified Nurse Midwife	The Department will disallow payment for service if the paid service is based on an order made by a Physician Assistant, Certified Nurse Midwife, or APRN and is not listed as a service in his or her respective approved protocol and/or collaborative agreement, if applicable, that may be ordered. This requirement does not apply to APRNs who have been approved to practice without a collaborative agreement pursuant to Connecticut Public Act 14-12. The paid service will be allowed if the order is signed by a physician.	Conn. Gen. Stat. §§ 20-12c and 12d; 20-87a(b), as amended by Public Act 14-12; 20-86b Connecticut Public Act 14-12 PM Section 150.2E.I.a Conn. Agencies Regs. § 17b-262-337 PB 2014-56
Services - Rendered by Physician Assistants, APRNs, and Certified Nurse Midwife	The Department will disallow payment for service if the paid service was rendered by a Physician Assistant, Certified Nurse Midwife, or APRN and the paid service was not listed in their respective approved protocol and/or collaborative agreement, if applicable, as a service that may be rendered. This requirement does not apply to APRNs who have been approved to practice without a collaborative agreement pursuant to Connecticut Public Act 14-12. The paid service will be allowed if the medical record is signed by a physician.	Conn. Gen. Stat. §§ 20-12c and 12d; 20-87a(b), as amended by Public Act 14-12; 20-86b Connecticut Public Act 14-12 PM Section 150.2E.I.a Conn. Agencies Regs. § 17b-262-337 PB 2014-56