DEPARTMENT OF SOCIAL SERVICES
AUDIT PROTOCOL – PHYSICIAN SERVICES
UPDATED APRIL 2017

Listed are the most common audit findings noted for physician 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 physician services 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 CMS Guidelines for Teaching Physicians, Interns, and Residents, 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). The below protocols apply to claims billed by physicians or physician groups and do not apply to any Allied Health Professionals (AHP) who are separately enrolled as Medicaid billing providers.

Audit Finding	**Department Criteria**	**Regulatory References**
Billing - Cancelled Visits or Appointments Not Kept	The Department will disallow payment if the provider bills for service where the recipient was a "no-show" or where the recipient cancelled the visit.	Conn. Agencies Regs. §§ 17b-262-531(h); 17b-262-342(7)
Billing - Client Pays for Covered Services.	The Department will disallow payment if a recipient pays the provider for a portion of a covered service, unless the provider refunds the recipient's payment.	Conn. Agencies Regs. §§ 17b-262-531(j), (k), (l) and (m)
Billing - Duplicate Services	The Department will disallow payment for service if the service provided was included in the reimbursement of the same or another billed and paid service; or if it is included in the follow-up care of another billed and paid service; or if a service was previously paid to the same or related provider. Concurrent services and skills of two or more persons may be paid if necessary because of the client's medical condition.	Conn. Agencies Regs. § 17b-262-340

Billing - Hospital Setting	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 or other licensed practitioner 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 - Failure to Utilize Third Party Liability.	The Department will disallow payment if there is a private insurance/third party payor, including Medicare that the provider failed to bill first.	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 Procedure Code	If the provider has billed an incorrect procedure code, the Department will disallow payment in excess of the correct procedure.	Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 17b-262-347; 19a-14-40; 17b-262-349 Current Procedure Terminology (CPT) codebook or, as applicable, the current Healthcare Common Procedure Coding System (HCPCS) codebook
Billing - Lack of documentation	The Department will disallow payment for a time-based code if the provider fails to document the length of the encounter.	Conn. Agencies Regs. § 17b-262-349(e)
Billing - Payment Limitations	The Department will disallow any excess payment for service if the payment exceeds the fee contained in the physician fee schedule; exceeds the usual and customary charge to the public; the lowest Medicare rate or exceeds the amount billed by the provider.	Conn. Agencies Regs. § 17b-262-346(b)

Billing - Service Billed Prior to Signing the Record	The Department will disallow payment for service if the provider bills for the service prior to the provider signing the clinical record.	Conn. Agencies Regs. §§ 17b-262-343(a) and (b); 17b-262-349 (a)
Enrollment - Performer Not Licensed	The Department will disallow payment if the provider performing the service for which the claim is made is not licensed in Connecticut at the time the service was performed.	Conn. Gen. Stat. § 20-9 Conn. Agencies Regs. §§ 17b-262-338; 17b-262-348(a)
Enrollment - Un-enrolled Provider in Group Practice	The Department will disallow payment for services rendered by a physician, APRN, CNM, or physician assistant who is not enrolled and is not enrolled in the provider's practice, or the date of the services provided is not within six months of the date of the application for enrollment, unless the provider was granted a retroactive enrollment effective date by specific written approval from the department (generally such approval is given only in extenuating circumstances beyond the provider's control).	Conn. Agencies Regs. §§ 17b-262-531(e); 17b-262-524(a)(2) – (3); 17b-262-526(9) and (11); 17b-262-339; 17b-262-341a(c) 42 U.S.C. § 1396a(a)(27) 42 C.F.R. § 431.107
Limitation - Anesthesia Services	If the paid service is not billed in accordance with the anesthesia reimbursement guidelines (billed in 1 minute increments, no local infiltration or digital block by operating surgeon, provider in constant attendance while rendering anesthesia), the Department will disallow the difference between the paid amount and the amount allowed.	Conn. Agencies Regs. § 17b-262-348(j) PB 2003-55; 2016-40
Limitation - billed by MD, performed by APRN, PA or CNM	If the Department pays for a service billed by a physician or physician group, but the service was actually performed by an Advanced Practice Registered Nurse (APRN), Certified Nurse-Midwife (CNM) or Physician Assistant (PA), the Department will disallow the amount paid in excess of the allowed amount for an APRN, CNM or PA. The effective date of services performed by a PA that are affected by this finding is 9/1/2013. Having the physician sign off on the medical record that was prepared by the APRN, PA or CNM is not acceptable, on its own, to be paid at the physician rate. When there is a shared/split medical visit, services can be billed under the physician's provider number if the documentation has a clearly stated reason why the work of the physician was required during the visit; the part(s) of the service that the physician personally provided; and	Conn. Agencies Regs. § 17b-262-617(b) PB 2005-45; 2013-40; 2016-68

	the aspects of the plan of care, response to care and changes/revisions to the plan of care that are different from that documented by the APRN, PA or CNM, or if the documentation provided by the APRN, PA or CNM is accurate, complete and sufficient, the physician must attest agreement with this portion of the APRN, PA or CNM's note.	
Limitation - Performed by PA,APRN or CNM outside of scope of a delegated/collaborative agreement	The Department will disallow payment if the paid service was performed by a PA, CNM, or an APRN and is outside of the signed delegated service/collaborative agreement, if applicable, with the supervising physician. This requirement does not apply to APRNs who have been approved to practice without a collaborative agreement pursuant to Connecticut Public Act 14-12.	Conn. Agencies Regs. §§ 17b-262-341(a); 17b-262-337 Conn. Gen. Stat. §§ 20-12-c and 12d; 20-86b Conn. Gen. Stat. § 20-87a(b), as amended by Public Act 14-12 PB 2014-56; 2004-03
Limitation - Performed by PA,APRN or CNM without a delegated/collaborative agreement	The Department will disallow payment for service if the paid service was performed by a PA, APRN, or CNM, and there is not a delegated service agreement or collaborative agreement in place with a supervising physician, if applicable. This requirement does not apply to APRNs who have been approved to practice without a collaborative agreement pursuant to Connecticut Public Act 14-12.	Conn. Agencies Regs. §§ 17b-262-341(a); 17b-262-337 Conn. Gen. Stat. §§ 20-12-c and 12d; 20-86b Conn. Gen. Stat. § 20-87a(b), as amended by Public Act 14-12 PB 2014-56; 2004-03
Limitation - Drugs	If the paid service is not billed in accordance with the drug reimbursement guidelines (payment up to the actual acquisition cost for oral medications that are part of the office visit; payment for injectables and legend devices administered by the provider based on the DSS fee schedule), the Department will disallow the difference between the amount paid and the amount allowed.	Conn. Agencies Regs. § 17b-262-348(n)
Limitation - Family Planning, Abortion and Hysterectomy	If the paid service is not billed in accordance with the family planning, abortion and hysterectomy reimbursement guidelines (sterilization, hysterectomies, abortions), the Department will disallow payment.	Conn. Agencies Regs. § 17b-262-348(r)

Limitation - Laboratory Services	If the paid service is not billed in accordance with the laboratory reimbursement guidelines (no billing for urinalysis without microscopy, hemoglobin and urine glucose determination in conjunction with an office visit; laboratory physician services the provider is authorized to perform in the provider's office), the Department will disallow the difference between the amount paid and the amount allowed.	Conn. Agencies Regs. § 17b-262-348(m)
Limitation - Newborn Care	If the paid service is not billed in accordance with the newborn care reimbursement guidelines (routine care and subsequent hospital care/critical care/newborn resuscitation), the Department will disallow the difference between the amount paid and the amount allowed.	Conn. Agencies Regs. § 17b-262-348(o)
Limitation - Nursing Facility, ICF/IID or Chronic Disease Hospital Care	If the paid service is not billed in accordance with the nursing facility, ICF/IID or chronic disease hospital assessment and subsequent care reimbursement guidelines (maximum of one annual assessment per client per year, service performed in a nursing facility, ICF/IID or chronic disease hospital), the Department will disallow the difference between the amount paid and the amount allowed	Conn. Agencies Regs. § 17b-262-348(p)
Limitation - Radiology Services	If the paid service is not billed in accordance with the radiology reimbursement guidelines (use of appropriate modifier for professional component, technical component if use of equipment only, written documentation to the referring provider), the Department will disallow the difference between the amount paid and the amount allowed.	Conn. Agencies Regs. § 17b-262-348(k) PB 2011-38
Limitation - Radiotherapy Services	If the paid service is not billed in accordance with the radiotherapy reimbursement guidelines (allowed fees include concomitant office visits, billing for follow up within 1 year of completion of service), the Department will disallow the difference between the amount paid and the amount allowed.	Conn. Agencies Regs. § 17b-262-348(l)

Limitation - Surgical Services	If the paid service is not billed in accordance with the surgical reimbursement guidelines (multiple surgery, assistant surgeon, global fee, no related E&M encounters on the date of surgery), the Department will disallow the difference between the amount paid and the amount allowed.	Conn. Agencies Regs. § 17b-262-348(i)
Limitations - Prior Authorization	The Department will disallow payment for a service if the paid service is not in conformance with prior authorization requirements prior to payment.	Conn. Agencies Regs. § 17b-262-344; 17b-262-527
Medical Record - Cloning Documentation	The Department will disallow payment if the documentation for services rendered is the result of identical or similar entries from copying/pasting ("cloning"), which misrepresents the medical necessity required for the rendered service and/or does not reflect updated clinical information, including physical exams and assessments.	Conn. Gen. Stat. § 20-9 Conn. Agencies Regs. §§ 17b-262-526 (7) and (8); 17b-262-343; 19a-14-40
Medical Record - Incorrect Procedure Code	If the medical record does not support circumstances consistent with the procedure code that was billed, the Department will disallow the difference between the paid code and the correct code.	Conn. Agencies Regs. §§ 17b-262-526 (7) and (8); 17b-262-343; 19a-14-40; 17b-262-349; 17b-262-341 Current Procedure Terminology (CPT) codebook
Medical Record - Insufficient Documentation of Services Billed.	The Department will disallow payment for undocumented services (1) if there are no notes in the medical record to support that the service was rendered or that appropriate units were billed; or (2) there is no physical evidence of the service, such as CT Scan, PET Scans, MRI, etc. If the information needed to support a paid service is not available, the Department will disallow any amount paid for services that were dependent on that image to substantiate the services rendered.	Conn. Agencies Regs. §§ 17b-262-526 (7) and (8); 17b-262-343; 19a-14-40
Medical Record - No Documentation of Service	The Department will disallow payment for service if documentation of the service is not available for audit.	Conn. Agencies Regs. §§ 17b-262-526 (7) and (8); 17b-262-343; 19a-14-40; 17b-262-349

Medical Record - No written order or excess of order	If the paid service was not ordered by an allowed licensing practitioner (services include, but are not limited to consultations) or was paid in excess of a the order (ancillary services, which include, but are not limited to, lab work, x-rays, therapy, administration of medications/vaccines, diagnostic testing), the Department will disallow the difference between the paid services and the services actually ordered	Conn. Agencies Regs. § 17b-262-348(a)
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) 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) PB 2016-40; PB 2016-82
Medical Record - Signature	The Department will disallow payment for service if the paid service was based on medical records that are not signed by the performer; or if a rubber stamp was used as the performer signature; or if an electronic signature on an electronic health record does not comply with the requirements of the DSS Electronic Signature Policy.	Conn. Agencies Regs. §§ 17b-262-349; 17b-262-526; 19a-14-40 DSS Electronic Signature Policy (Section J of the Provider Enrollment Application)

Services - Limitations for All Clients	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 under Limitations.	Conn. Agencies Regs. §§ 17b-262-341; 17b-262-341a; 17b-262-348
Services - Non Covered Services for All Clients	The Department will disallow payment for service if the paid service is not covered under the Medicaid program.	Conn. Agencies Regs. § 17b-262-342