NEW YORK STATE | Office of the Medicaid Inspector General

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OMIG AUDIT PROTOCOL
CERTIFIED HOME HEALTH AGENCY (CHHA)
FOR PAYMENTS MADE VIA EPISODIC PAYMENT SYSTEM
May 2, 2012 Through July 12, 2017
Revised: XX/XX/XXXX

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.

1.	**Missing or Insufficient Documentation of Hours/Visits Reported**
OMIG Audit Criteria	If there is no chart, the aide failed to document hours of services reported, or if professional staff failed to document the visit, the portion of the undocumented claim will be disallowed. **Note:** The nature of the facts surrounding the missing records and/or claims for services not rendered should be evaluated for additional action.
Regulatory References	18 NYCRR § 505.23(c)(1) 10 NYCRR § 763.7(a)(6) & (7) 10 NYCRR § 86-1.44(a) & (d) Episodic Payment System for CHHAs – Billing Guidelines; updated as of April 9,2013 Episodic Payment System for CHHAs – Updated Q & A – Claims and Billing; March 27, 2012

2.	**Reported Services in Excess of Ordered Hours/Visits**
OMIG Audit Criteria	If the CHHA reported more hours, nursing or therapy visits than plan of care (POC)/medical orders authorized, the hours/visits exceeding the order will be disallowed. If the number of hours on any date of service exceeds the total maximum number of hours per visit on the approved POC (and no supplemental order was obtained), the additional hours will be disallowed. **Note:** OMIG will consider exceptional situations, where ordered services were exceeded for good cause (situation must be documented).
Regulatory References	18 NYCRR § 505.23(a)(1)(i) 18 NYCRR § 518.3(b) 18 NYCRR § 505.23(a)(2)(i)-(iii) 10 NYCRR § 763.6(d) NYS Medicaid Program Home Health Manual, Policy Guidelines, Version 2012-1, Section III Episodic Payment System for CHHAs – Billing Guidelines; updated as of April 9,2013 Episodic Payment System for CHHAs – Updated Q & A – Claims and Billing; March 27, 2012

3.	Billed Medicaid Before Services Were Authorized
OMIG Audit Criteria	If the CHHA submitted the final bill before the POC or written order was signed by the practitioner, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.7(a)(3)(i)-(iii) 10 NYCRR § 763.6(d) 10 NYCRR § 763.7(c) 18 NYCRR § 505.23(a)(2)(i)-(iii) 42 CFR § 484.18(b) NYS Medicaid Program Home Health Manual, Policy Guidelines, Version 2012-1, Section III DOH Medicaid Update, August 2016, Vol. 32, No. 8

4.	Plan of Care/Orders Not Signed by an Authorized Practitioner
OMIG Audit Criteria	If the practitioner was not authorized to sign the POC/medical orders, the claim will be disallowed. If the POC or written order lacks a physician's signature, the episode will be disallowed, unless it is accompanied by a signed medical order, indicating approval.
Regulatory References	18 NYCRR § 540.1 18 NYCRR § 505.23(a)(2)(i)-(iii) 10 NYCRR § 763.5 10 NYCRR § 763.7(a)(3)(i)-(iii) 10 NYCRR § 763.7(c) 42 CFR § 484.18 NYS Medicaid Program Home Health Manual, Policy Guidelines, Version 2012-1, Section III

5.	Comprehensive Assessment Not Documented/Late
OMIG Audit Criteria	The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care and within 5 days of the start of the episode. The comprehensive assessment must be updated and revised (including Outcome and Assessment Information Set (OASIS)) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than the last 5 days of every 60 days, beginning with the start-of-care date, unless there is a beneficiary elected transfer; significant change in condition resulting in a new case-mix assignment; or discharge and return to the same HHA during the 60 day episode. If there is no comprehensive assessment in the record the episode will be disallowed.
Regulatory References	10 NYCRR § 763.6(a) 42 CFR § 484.55(b)(1) 42 CFR § 484.55(d)(1)(i)-(iii) 10 NYCRR § 763.7(a)(4) 10 NYCRR § 763.7(c) Episodic Payment System for CHHAs – Additional Billing Guidance as of July 1, 2012

6.	Missing Plan of Care/Order
OMIG Audit Criteria	If there is no POC/medical order in the record for the relevant date of service, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.6(b) 10 NYCRR § 763.7(a)(5) 10 NYCRR § 763.7(a)(3)(i)-(iii) 10 NYCRR § 763.6(d) 10 NYCRR § 763.7(c) 42 CFR § 484.18 42 CFR § 484.18(b) 42 CFR § 484.18(c) NYS Medicaid Program Home Health Manual, Policy Guidelines, Version 2012-1, Section III

7.	Supervision Visit Not Performed Within Required Time Frame
OMIG Audit Criteria	If the required home health aide supervision visit was not documented within the required time period, the associated reported services will be disallowed. If the patient is receiving skilled services, the RN (or appropriate therapist if the only skilled service is OT, PT, or Speech) must make an on-site visit to the patient's home at least once every two weeks. The home health aide does not need to be present at the time of the on-site visit. If the patient is not authorized to receive skilled services, the RN must make a supervisory visit every 60 days while the home health aide is providing patient care. If the supervisory visit has not occurred within the 60 days during the dates of reported services, those services will be disallowed.
Regulatory References	18 NYCRR § 505.23(a)(2) & (2)(iii) 10 NYCRR § 763.7(a)(6) 10 NYCRR § 763.7(c) 42 CFR § 484.36(d)(1) & (2) 42 CFR § 484.36(d)(3)

8.	Failed to Maximize Third Party/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. Services that are determined to have been paid by a third party will be disallowed. When reviewing claims for patients who are eligible for both Medicaid and Medicare, it is possible to have a claim for an episodic payment with no professional services indicated by the revenue codes because those professional services would be covered by Medicare. The revenue codes may indicate only home health aide services, while the record should reflect all of the services provided to the patient.
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(1) & (2) 18 NYCRR § 540.6(e)(3)(i)-(v) 18 NYCRR § 505.23(c)(2) & (2)(ii) 42 USC § 1395X(m)(1), (4) & (7) 42 CFR § 409.45(b)(1),(3)(i) & (4) CMS Medicare Benefit Policy Manual, Chapter 7, Home Health Services, Section 50.2 NYS Medicaid Program Information for All Providers, General Policy, Versions 2011- 1, Section I

9.	Billed for Services Performed by Another Provider/Entity
OMIG Audit Criteria	If the services reported by the CHHA are duplicative (i.e., already paid for by Medicaid or by another entity), those services will be disallowed. Specific case circumstances will be evaluated through a review of the record. **Note**: Guidance will be sought from the appropriate program division as needed. Relevant program regulations will be cited as appropriate.
Regulatory References	18 NYCRR § 505.23(a)(1)(i)

10.	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 claim will be disallowed.
Regulatory References	18 NYCRR § 505.23(c)(1) 18 NYCRR § 504.3(e),(f),(h) & (i) 10 NYCRR § 86-1.13(b) DOH Medicaid Update, May 2007, Vol. 23, No. 5

11.	**Ordering Practitioner Conflicts With Claim Practitioner**
OMIG Audit Criteria	If the ordering/referring practitioner on the claim differs from the practitioner that ordered the services, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(e),(f),(h) & (i) DOH Medicaid Update, May 2009, Vol. 25, No. 6 NYS Medicaid General Institutional Billing Guidelines – UB-04 Billing Guidelines, Version 2011-02, Section 2.4.2 Version 2013-02, Section 2.4.2 Version 2015-01, Section 2.4.2

12.	**Patient Excess Income ("spend-down") Not Applied Prior to Billing Medicaid**
OMIG Audit Criteria	The spend-down amount should be applied beginning with the first service rendered in the month, and each service thereafter until the spend-down is exhausted. Each sampled claim subject to spend-down application billed to Medicaid before the spend-down is met will be disallowed. The CHHA provider will include the dollar amount of the spend-down for one month on the interim claim that is submitted. At the end of the 60-day episode of care, the provider will notate the individual's spend-down for the entire episode on the final adjusted claim, the timing of the services will determine whether two months of spend-down or three months of spend-down have been covered by the CHHA services. There should be a letter from the local department of social services noting the amount that the recipient is responsible for paying and that the provider is responsible for collecting. **Note**: This finding only applies where the relevant county has assigned responsibility for the spend-down to the provider and the sampled claim must be impacted by the spend-down.
Regulatory References	18 NYCRR § 360-4.8(c)(1) 18 NYCRR § 360-4.8(c)(2)(ii) Episodic Payment System for CHHAs – Spend-Down Questions and Answers, March 27, 2012

13.	Failure to Use the Correct Discharge Code
OMIG Audit Criteria	The record, which may include the discharge summary and/or other supporting documentation, will be reviewed to determine if the correct discharge code was entered onto the claim. If the discharge code entered results in an inappropriate full payment for the episode, the paid claim with be partially disallowed. The amount paid will be pro-rated on a daily basis. Failure of the provider to adjust a claim when the patient is readmitted to home care within 60 days of the start of care will also result in a pro-rated disallowance. Also, full payment is not available for those claims in which the client/recipient is admitted to a long-term care program (including nursing homes, LTHHCP, ALP or Managed Long Term Care) within 60 days of the start of care. Providers are instructed not to use certain codes which trigger full payment in these circumstances.
Regulatory References	10 NYCRR § 86-1.44(a) 10 NYCRR § 86-1.44(h)(4)(i)(1)-(4) 10 NYCRR § 763.7(a)(10) NYS Medicaid Program Home Health Manual, Policy Guidelines, Version 2012-1, Section I Episodic Payment System for CHHAs - Billing Guidelines; updated as of April 9, 2013

14.	Failure to Use the Correct Revenue Code
OMIG Audit Criteria	The record, including the discharge summary and/or other supporting documentation, will be reviewed to determine if the correct/appropriate revenue codes were entered onto the claimed services. Claims previously billed as outlier claims may be reduced to a standard episodic payment or those claims previously reimbursed at the standard episodic payment may be reduce to a low utilization claim.
Regulatory References	NY Public Health Law § 3614(13)(a) 10 NYCRR § 86-1.44(d) 10 NYCRR § 86-1.44(e)(1) Episodic Payment System for CHHAs - Billing Guidelines; updated as of April 9, 2013 Episodic Payment System for CHHAs– Updated Q & A – Claims and Billing; March 27, 2012

15.	**Failure to Conduct Required Criminal History Check**
OMIG Audit Criteria	The record will be reviewed to determine if the CHHA or its contractor initiated a background check within the specified time frames and provided appropriate monitoring of the aide while waiting for the results of the background check. (This pertains to services provided by an employee hired or used after 9/1/06). If the criminal history check requirement has not been completed, the claim will be disallowed.
Regulatory References	10 NYCRR § 402.9(a)(1) & (2) 10 NYCRR § 402.1(a) 10 NYCRR § 402.6(a) 10 NYCRR § 763.13(h)

16.	**Minimum Training Standards Not Met for the Home Health Aide**
OMIG Audit Criteria	If the CHHA or CHHA contract employee did not meet minimum training requirements when services were rendered, the claim will be disallowed. The record must contain a certification of completion from a Department of Health or State Education Department approved training program.
Regulatory References	10 NYCRR § 700.2(b)(9) 10 NYCRR § 763.13(h) 18 NYCRR § 504.1(c) DOH Dear Administrator Letter DAL: DHCBC 06-02 Issued April 13, 2006 42 CFR § 484.4

17.	**Failure to Complete Required In-Service Training**
OMIG Audit Criteria	The record will be reviewed to determine if CHHA or CHHA contract employee completed minimum in-service education requirements. If the employee did not complete the in-service requirements, the claim will be disallowed. **Note:** The criteria for the one-year period for completion of the in-service training that is used by the provider will be considered the base year for each aide under review. An additional 120 days will be allowed beyond the 12 months preceding the date of service before a disallowance will be taken.
Regulatory References	10 NYCRR § 763.13(l)(1) 10 NYCRR § 763.13(h)

18.	Missing Certificate of Immunization
OMIG Audit Criteria	The record will be reviewed to determine if the required certification of immunizations was documented for the CHHA or CHHA contract employee. If the required documentation of the certification of immunizations is not provided, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.13(c) 10 NYCRR § 763.13(e) 10 NYCRR § 763.13(h)

19.	Failure to Complete Required Health Assessment
OMIG Audit Criteria	The record will be reviewed to determine if the annual health assessment of a CHHA or CHHA contract employee was documented within the required time frame. If the documentation of a health assessment performed within the required time frame is not provided, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.13(c) 10 NYCRR § 763.13(d) 10 NYCRR § 763.13(e) 10 NYCRR § 763.13(h)

20.	Missing Documentation of a Tuberculosis Test or Follow-up
OMIG Audit Criteria	The record will be reviewed to determine if a CHHA or CHHA contract employee received a complete tuberculosis test within the required time frame. If the documentation of a yearly tuberculosis test, or the required follow-up, is not in the personnel file of the individual who has direct patient contact, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.13(c)(4) 10 NYCRR § 763.13(e) 10 NYCRR § 763.13(h)

21.	Failure to Complete Annual Performance Evaluation
OMIG Audit Criteria	The record will be reviewed to determine if annual evaluation of the performance and effectiveness of CHHA or CHHA contract employee was conducted within the required time frame. If documentation of the annual performance evaluation completed within the required time frame is not provided, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.13(k) 10 NYCRR § 763.13(h)

22.	Missing Personnel Record(s)
OMIG Audit Criteria	If the personnel record for the CHHA or CHHA contract employee providing the sampled services is missing, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.13(h)