OMIG AUDIT PROTOCOL
CERTIFIED HOME HEALTH AGENCY (CHHA)
FOR SERVICE DATES PRIOR TO APRIL 1, 2012

Revised April 22, 2016

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 Billed
OMIG Audit Criteria	If there is no chart, the aide failed to document hours of service billed, or professional staff failed to document the visit, that portion of the paid claim that was not documented 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	**For services prior to 11/17/2010,** 18 NYCRR Section 505.23(e)(1) **For services 11/17/2010 and after**, 18 NYCRR Section 505.23(c)(1) 10 NYCRR Section 763.7(a)(6)&(7)

2.	Billed For Services In Excess Of Ordered Hours/Visits
OMIG Audit Criteria	If the CHHA billed more hours/nursing or therapy visits than plan of care (POC) / medical orders authorized, the paid claim for 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. The disallowed service or units of service should be a service that exceeded the ordered plan frequency for the calendar week that is used by the provider. If additional time is necessary, the justification for the extra time must be documented. **Note:** OMIG will consider exceptional situations, where ordered services were exceeded for good cause (situation must be documented).
Regulatory References	18 NYCRR Section 505.23(a)(1)(i) 18 NYCRR Section 518.3(b) **For services prior to 11/17/2010,** 18 NYCRR Section 505.23(a)(3)(i)-(iii) **For services 11/17/2010 and after**, 18 NYCRR Section 505.23(a)(2)(i)-(iii) 10 NYCRR Section 763.6(d) MMIS Provider Manual for Home Health Services, Revised February 1992, Section 2 NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines, Version 2007-1, Section III Version 2008-1, Section III Version 2012-1, Section III

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3.	**Billed Medicaid Before Services Were Authorized**
OMIG Audit Criteria	If the CHHA began billing before the plan of care (POC) was signed by the practitioner, the paid claim will be disallowed. All sampled services that were billed prior to date of the practitioner's signature on the order, which covers the approved and signed POC for the time period of the service, will be disallowed.
Regulatory References	10 NYCRR Section 763.7(a)(3)(i)-(iii) 10 NYCRR Section 763.6(d) 10 NYCRR Section 763.7(c) **For services prior to 11/17/2010,** 18 NYCRR Section 505.23(a)(3)(i)-(iii) **For services 11/17/2010 and after**, 18 NYCRR Section 505.23(a)(2)(i)-(iii) 42 CFR Section 484.18(b) MMIS Provider Manual for Home Health Services, Revised February 1992, Section 2 NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines, Version 2007-1, Section III Version 2008-1, Section III Version 2012-1, Section III

4.	**Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame**
OMIG Audit Criteria	If the plan of care (POC)/medical orders were signed late, the paid claim will be disallowed. Signed medical orders are required within 30 days of the start of care or a change in the POC. A disallowance will only be taken if the medical order is not signed by the practitioner within 60 days from the date of the start of care or a change in the POC. **Note:** If the provider has a system to track orders, has documentation that the system has been utilized, and can document diligent efforts to obtain the signed order, consideration will be given to allowing the claim.
Regulatory References	**For services prior to 11/17/2010,** 18 NYCRR Section 505.23(a)(3)(i)-(iii) **For services 11/17/2010 and after**, 18 NYCRR Section 505.23(a)(2)(i)-(iii) 10 NYCRR Section 763.7(a)(3)(i)-(iii) 10 NYCRR Section 763.7(c) 42 CFR Section 484.18(b) MMIS Provider Manual for Home Health Services, Revised February 1992, Section 2 NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines, Version 2007-1, Section III Version 2008-1, Section III Version 2012-1, Section III

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5.	**Plan of Care/Orders Not Signed by an Authorized Practitioner**
OMIG Audit Criteria	If the practitioner was not authorized to sign the plan of care/medical orders, the paid claim will be disallowed.
Regulatory References	18 NYCRR Section 540.1 **For services prior to 11/17/2010,** 18 NYCRR Section 505.23(a)(3)(i)-(iii) **For services 11/17/2010 and after**, 18 NYCRR Section 505.23(a)(2)(i)-(iii) 10 NYCRR Section 763.5 10 NYCRR Section 763.7(a)(3)(i)-(iii) 10 NYCRR Section 763.7(c) 42 CFR Section 484.18 MMIS Provider Manual for Home Health Services, Revised February 1992, Section 2 NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines, Version 2007-1, Section III Version 2008-1, Section III Version 2012-1, Section III

6.	**Initial Assessment Not Documented/Late**
OMIG Audit Criteria	A CHHA must conduct an initial assessment visit to determine the immediate care and support needs of the patient. If there is no initial assessment in the record for the relevant date of service, or the initial assessment is not completed prior to the relevant date of service, the paid claim will be disallowed. **Note**: The initial patient visit shall be made within 24 hours of receipt and acceptance of a community referral or return home from institutional placement, unless: the patient's authorized practitioner orders otherwise, or there is written documentation that the patient or family refuses such a visit.
Regulatory References	10 NYCRR Section 763.5(a)(1)&(2) 10 NYCRR Section 763.5(b) 10 NYCRR Section 763.5(b)(3) 10 NYCRR Section 763.7(a)(4) 10 NYCRR Section 763.7(c) 42 CFR Section 484.55(a)(1) 42 CFR Section 484.55(a)(2)

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7.	**Initial Assessment Does Not Meet the Required Standards**
OMIG Audit Criteria	Nursing staff will review the initial assessment and the record, pertinent to the date of service, to determine if the standards set forth in the regulations were met. The assessment performed during the initial visit (prior to admission) must indicate that the patient's health and supportive needs could safely and adequately be met at home and that the patient's condition required the services of the agency. If the initial assessment does not meet the required standards the paid claim will be disallowed.
Regulatory References	10 NYCRR Section 763.5 10 NYCRR Section 763.5(a)(1)&(2) 10 NYCRR Section 763.5(b)(1) 10 NYCRR Section 763.5(b)(3) 10 NYCRR Section 763.7(a)(4) 10 NYCRR Section 763.7(c) 42 CFR Section 484.55(a)(1) 42 CFR Section 484.55(a)(2)

8.	**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. 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 five 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 for the relevant date of service or the comprehensive assessment was late, the paid claim will be disallowed.
Regulatory References	10 NYCRR Section 763.6(a) 42 CFR Section 484.55(b)(1) 42 CFR Section 484.55(d)(1)(i)-(iii) 10 NYCRR Section 763.7(a)(4) 10 NYCRR Section 763.7(c)

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9.	Comprehensive Assessment Does Not Meet the Standards Set Forth in New York's Regulations
OMIG Audit Criteria	Nursing staff will review the comprehensive assessment and the record, pertinent to the date of service, to determine if the standards set forth in New York's regulations were met. A comprehensive patient assessment must be completed and address the patient's medical, social, mental health, and environmental needs. If the assessment does not meet the required standards the paid claim will be disallowed.
Regulatory References	18 NYCRR Section 505.23(a)(1)(i)&(ii) 10 NYCRR Section 763.6(a) 10 NYCRR Section 763.5(b)

10.	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations
OMIG Audit Criteria	Nursing staff will review the comprehensive assessment and the record, pertinent to the date of service, to determine if the standards set forth in the Federal regulations were met. The comprehensive assessment must be patient specific and: accurately reflect the patient's status; include information to demonstrate the patient's progress toward achievement of desired outcomes; identify continuing need for home care; meet the medical, nursing, rehabilitative, social and discharge planning needs; incorporate the current version of the Outcome and Assessment Information Set (OASIS) items; include a review of all medications; and be completed by the appropriate discipline. If the assessment does not meet the required standards the paid claim will be disallowed.
Regulatory References	42 CFR Section 484.55 42 CFR Section 484.55(b)(1) 42 CFR Section 484.55(b)(2) 42 CFR Section 484.55(b)(3) 42 CFR Section 484.55(c) 42 CFR Section 484.55(e)

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11.	**Failed to Update the Comprehensive Assessment**
OMIG Audit Criteria	Nursing staff will review the record, pertinent to the date of service, to determine if the applicable assessment was performed. The comprehensive assessment must be updated and revised (including the OASIS instrument) as frequently as the patient's condition warrants. If the comprehensive assessment has not been updated as required, the paid claim will be disallowed.
Regulatory References	42 CFR Section 484.55(d)(1)(i)-(iii) 42 CFR Section 484.55(d)(2)&(3)

12.	**Missing Plan of Care/Order**
OMIG Audit Criteria	If there is no plan of care/medical order in the record for the relevant date of service, the paid claim will be disallowed.
Regulatory References	10 NYCRR Section 763.6(b) 10 NYCRR Section 763.7(a)(5) 10 NYCRR Section 763.7(a)(3)(i)-(iii) 10 NYCRR Section 763.6(d) 10 NYCRR Section 763.7(c) 42 CFR Section 484.18 42 CFR Section 484.18(b) 42 CFR Section 484.18(c) MMIS Provider Manual for Home Health Services, Revised February 1992, Section 2 NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines, Version 2007-1, Section III Version 2008-1, Section III Version 2012-1, Section III

13.	Plan of Care Does Not Adequately Address Patient Needs
OMIG Audit Criteria	Nursing staff will review the plan of care (POC) and the record, pertinent to the date of service, to determine if the POC addresses the patient's current health and safety needs. If the POC fails to address the patient's current health and safety needs, the paid claim will be disallowed.
Regulatory References	10 NYCRR Section 763.3(a) 10 NYCRR Section 763.11(a)(2)(ii) 10 NYCRR Section 763.6(b)(1)-(4) 10 NYCRR Section 763.6(c) 10 NYCRR Section 763.6(d) 42 CFR Section 484.18 42 CFR Section 484.18(a) 42 CFR Section 484.18(c)

14.	Failed to Review/Update the Plan of Care
OMIG Audit Criteria	Nursing staff will review the plan of care (POC) and the record, pertinent to the date of service, to determine if the POC was reviewed/updated as required by the regulations. The POC must be reviewed and updated as frequently as the patient's condition warrants but no later than every 62 days. The record must contain written documentation that the authorized practitioner was notified of any significant changes that may require an update to the POC. If the provider failed to review/update the POC when required, the paid claim will be disallowed.
Regulatory References	10 NYCRR Section 763.6(e)(1)&(2) 10 NYCRR Section 763.7(a)(3(ii) 10 NYCRR Section 763.6(c) 10 NYCRR Section 763.6(d) 42 CFR Section 484.30(a) 42 CFR Section 484.18(b) 42 CFR Section 484.18(c) 42 CFR Section 484.14(g)

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15.	Failed to Provide Services as Required by the Plan of Care/Medical Orders
OMIG Audit Criteria	If the record shows the services billed by the CHHA are not consistent with the ordered services or plan of care, the difference between the paid claim and the services ordered will be disallowed.
Regulatory References	**For services prior to 11/17/2010,** 18 NYCRR Section 505.23(a)(3)(i)-(iii) **For services 11/17/2010 and after**, 18 NYCRR Section 505.23(a)(2)(i)-(iii) 10 NYCRR Section 763.6(c) 10 NYCRR Section 763.7(a)(5)-(7) 42 CFR Section 484.18 42 CFR Section 484.18(c) MMIS Provider Manual for Home Health Services, Revised February 1992, Section 2 NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines, Version 2007-1, Section III Version 2008-1, Section III Version 2012-1, Section III

16.	Billed for Performance of Tasks/Services Not Ordered
OMIG Audit Criteria	If the CHHA billed for tasks/services that were not included in the plan of care/medical orders, the claim will be disallowed.
Regulatory References	18 NYCRR Section 540.1 **For services prior to 11/17/2010,** 18 NYCRR Section 505.23(a)(3)(i)-(iii) **For services 11/17/2010 and after**, 18 NYCRR Section 505.23(a)(2)(i)-(iii) 10 NYCRR Section 763.6(c) 10 NYCRR Section 763.6(d) 10 NYCRR Section 763.7(a)(3)(i)-(iii) 42 CFR Section 484.18 42 CFR Section 484.18(a) 42 CFR Section 484.18(b) 42 CFR Section 484.18(c) MMIS Provider Manual for Home Health Services, Revised February 1992, Section 2 NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines, Version 2007-1, Section III Version 2008-1, Section III Version 2012-1, Section III

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17.	**Medical Need for Tasks/Services Not Documented in the Record**
OMIG Audit Criteria	Nursing staff will review the record, pertinent to the date of service, to determine if the patient's medical need for authorized tasks or services was documented as required by the regulations. If the medical need for the authorized tasks or services is not supported by the case record documentation, the paid claim will be disallowed.
Regulatory References	18 NYCRR Section 518.3(b) 18 NYCRR Section 505.23(a)(1)(i)

18.	**Medical Need for Hours Billed Not Documented in the Record**
OMIG Audit Criteria	Nursing staff will review the record, pertinent to the date of service, to determine if the patient's medical need for hours billed was documented as required by the regulations. The time spent providing services to the patient must be supported by the documentation in the record. If the medical need for the hours billed was not documented in the record, the paid claim will be disallowed.
Regulatory References	18 NYCRR Section 518.3(b) 18 NYCRR Section 505.23(a)(1)(i) **For services prior to 11/17/2010,** 18 NYCRR Section 505.23(e)(1) **For services 11/17/2010 and after**, 18 NYCRR Section 505.23(c)(1)

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19.	**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 paid claim 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 on-site visit has not occurred within the two weeks prior to the date of service, the paid claim will be disallowed. 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 prior to the date of services, the paid claim will be disallowed. .
Regulatory References	**For services prior to 11/17/2010,** 18 NYCRR Section 505.23(a)(3) & (3)(iii) **For services 11/17/2010 and after**, 18 NYCRR Section 505.23(a)(2) & (2)(iii) 10 NYCRR Section 763.7(a)(6) 10 NYCRR Section 763.7(c) 42 CFR Section 484.36(d)(1)&(2) 42 CFR Section 484.36(d)(3)

20.	**Failed to Meet the Standard of Supervision Required**
OMIG Audit Criteria	Nursing staff will review the record, pertinent to the date of service, to determine if the provider met the standards for home health aide supervision as required by the regulations. If the provider failed to meet the required standards of supervision, the paid claim will be disallowed.
Regulatory References	10 NYCRR Section 763.4(h)(1)-(7)(i)-(iii) 10 NYCRR Section 763.7(a)(6) 10 NYCRR Section 763.7(c) 42 CFR Section 484.36(c)(1) 42 CFR Section 484.36(d)(1)&(2) 42 CFR Section 484.36(d)(3) 42 CFR Section 484.30(a)

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21.	**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. Medicare will generally cover either part-time or intermittent home health aide services or skilled nursing services as long as they are furnished, (combined) less than 8 hours each day and up to 28 hours per week. Where Medicare has paid for a full episode of skilled care, OMIG will assume that included in this episode is coverage for up to 8 hours each day or up to 28 hours per week unless the CHHA can provide documentation otherwise. OMIG will assume that home health aide hours for services, which are incidental to a Medicare paid visit, are included in the episode covered by Medicare up to the maximum hours. When it is determined that a sample service was covered or reimbursed by third party insurance in whole or in part, the amount MA incorrectly paid will be disallowed. **Note**: Any service to a Medicare 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 Section 360-7.2 18 NYCRR Section 540.6(e)(1)&(2) 18 NYCRR Section 540.6(e)(3)(i)-(v) **For services prior to 11/17/2010,** 18 NYCRR Section 505.23(e)(2) & (2)(ii) **For services 11/17/2010 and after**, 18 NYCRR Section 505.23(c)(2) & (2)(ii) SSA Section1861(m)(1), (4) and (7) 42 CFR Section 409.45(b)(1),(3)(i) and(4) Medicare Benefit Policy Manual, Chapter 7 Home Health Services, Section 50.2 NYS Medicaid Program Information for All Providers, General Policy, Version 2004-1,Section I, Version 2006-1, Section I Versions 2008-1 & 2, Section II Versions 2010-1 & 2, Section II Versions 2012-1 & 2, Section II

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22.	**Billed for Services Performed by Another Provider/Entity**
OMIG Audit Criteria	If the services billed by the CHHA are duplicative, i.e., already paid for by Medicaid or by another entity, the paid claim will be disallowed. Specific case circumstances will be evaluated through 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 Section 505.23(a)(1)(i)

23.	**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 will be disallowed.
Regulatory References	**For services prior to 11/17/2010,** 18 NYCRR Section 505.23(e)(1) **For services 11/17/2010 and after**, 18 NYCRR Section 505.23(c)(1) 18 NYCRR Section 504.3(e),(f),(h) and (i) **For services 1/1/2010 and after**, 10 NYCRR Section 86-1.13(b) **For services prior to 1/1/2010**, 10 NYCRR Section 86-1.46(b) DOH *Medicaid Update*, May 2007, Vol. 23, No. 5

24.	**Incorrect Rounding of a Service Unit**
OMIG Audit Criteria	If the CHHA billed for more hours than allowed by failing to follow rounding instructions in the NYS Medicaid Home Health Manual, the difference between the appropriate claim and the paid claim will be disallowed.
Regulatory References	**For services prior to 11/17/2010,** 18 NYCRR Section 505.23(e)(1) **For services 11/17/2010 and after**, 18 NYCRR Section 505.23(c)(1) 18 NYCRR Section 504.3(e),(f),(h) and (i) NYS Medicaid Provider Manual for Home Health – UB-92 Billing Guidelines, Version 2004-1, Section II NYS Medicaid Provider Manual for Home Health – UB-04 Billing Guidelines, Version 2007-1, Section II Versions 2008-1, 2 & 3, Section II Versions 2009-1 & 2, Section II Version 2010-1, Section 2.4.2 Version 2011-1, Section 2.3.1

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25.	**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 paid claim will be disallowed. **Note:** This finding only applies to claims with dates of service paid after the May 2009 Medicaid Update takes effect.
Regulatory References	18 NYCRR Section 504.3(e),(f),(h) and (i) DOH *Medicaid Update*, May 2009, Vol. 25, No. 6 NYS Medicaid Provider Manual for Home Health – UB-04 Billing Guidelines, Version 2007-1, Section II Versions 2008-1, 2 & 3, Section II Versions 2009-1 & 2, Section II Version 2010-1, Section 2.4.2

26.	**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. **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 Section 360-4.8(c)(1) 18 NYCRR Section 360-4.8(c)(2)(ii) NYS Medicaid Provider Manual for Home Health – UB-92 Billing Guidelines, Version 2004-1, Section II NYS Medicaid Provider Manual for Home Health – UB-04 Billing Guidelines, Version 2007-1, Section II Versions 2008-1, 2 & 3, Section II Versions 2009-1 & 2, Section II Version 2010-1, Section 2.4.2 Version 2011-1, Section 2.3.1

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27.	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 paid claim will be disallowed.
Regulatory References	10 NYCRR Section 402.9(a)(1)&(2) 10 NYCRR Section 402.1(a) 10 NYCRR Section 402.6(a) 10 NYCRR Section 763.13(h)

28.	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 paid 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 Section 700.2(b)(9) 10 NYCRR Section 763.13(h) 18 NYCRR Section 504.1(c) DOH Dear Administrative Letter DAL: DHCBC 06-02 Issued April 13, 2006 42 CFR Section 484.4

29.	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 paid 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 Section 763.13(l)(1) 10 NYCRR Section 763.13(h)

30.	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 paid claim will be disallowed.
Regulatory References	10 NYCRR Section 763.13(c) 10 NYCRR Section 763.13(e) 10 NYCRR Section 763.13(h)

31.	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 paid claim will be disallowed.
Regulatory References	10 NYCRR Section 763.13(c) 10 NYCRR Section 763.13(d) 10 NYCRR Section 763.13(e) 10 NYCRR Section 763.13(h)

32.	Missing Documentation of a PPD (Mantoux) Skin Test or Follow-up
OMIG Audit Criteria	The record will be reviewed to determine if a CHHA or CHHA contract employee received a complete PPD skin test within the required time frame. If the documentation of a complete PPD skin test given within the required time frame is not provided, the paid claim will be disallowed.
Regulatory References	10 NYCRR Section 763.13(c)(4) 10 NYCRR Section 763.13(e) 10 NYCRR Section 763.13(h)

33.	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 paid claim will be disallowed.
Regulatory References	10 NYCRR Section 763.13(h)

34.	**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 paid claim will be disallowed.
Regulatory References	10 NYCRR Section 763.13(k) 10 NYCRR Section 763.13(h)

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by the 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.