



**Office of the  
Medicaid Inspector  
General**

**STATE OF NEW YORK  
OFFICE OF THE MEDICAID INSPECTOR GENERAL**

**REVIEW OF WILLCARE  
CLAIMS FOR LONG TERM HOME HEALTH CARE  
AGENCY HOME HEALTH SERVICES  
PAID FROM  
JANUARY 1, 2010 – DECEMBER 31, 2012**

**Final Audit Report  
Audit #: 15-2862**

**Dennis Rosen  
Medicaid Inspector General**



Office of the  
Medicaid Inspector  
General

**ANDREW M. CUOMO**  
Governor

**DENNIS ROSEN**  
Medicaid Inspector General

February 17, 2016

[REDACTED]

Willcare Certified Home Health  
700 Corporate Boulevard  
Newburgh, New York 12550

Re: Final Audit Report  
Audit #: 15-2862  
Provider ID #: [REDACTED]  
FEIN: [REDACTED]

Dear [REDACTED]:

Enclosed is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report entitled "Review of Willcare's" (Provider) claims paid for Long Term Home Health Care (LTHHC) services from January 1, 2010, through December 31, 2012.

In accordance with §§ 30, 31 and 32 of the New York State Public Health Law, and Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York Parts 504 and 517, OMIG performed an audit of home health services claims paid to Willcare from January 1, 2010, through December 31, 2012. The audit universe consisted of 28,709 claims totaling \$3,382,164.21. The audit consisted of a random sample of 100 claims with Medicaid payments totaling \$11,151.97 (Attachment A). OMIG shared its proposed findings with Willcare in the Draft Audit Report dated December 23, 2015. Since you did not respond to our Draft Audit Report dated December 23, 2015, the findings in the Final Audit Report are identical to those in the Draft Audit Report.

The statistical sampling methodology employed in this audit allows for extrapolation of the sample findings to the universe of claims (18 NYCRR Section 519.18). OMIG has determined that the adjusted point estimate of the Medicaid overpayment received by Willcare is \$319,519. The adjusted lower confidence limit of the amount overpaid is \$140,531 (Attachment B). The enclosed Final Audit Report contains further information about OMIG's audit findings and the calculation of the Medicaid overpayment. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the lower confidence limit of \$140,531.

If you have any questions or comments concerning this report, please contact [REDACTED]  
[REDACTED] Please refer to audit number  
15-2862 in all correspondence.

Sincerely,

[REDACTED]

Division of Medicaid Audit, Albany Office  
Office of the Medicaid Inspector General

[REDACTED]  
Enclosure

CERTIFIED MAIL # [REDACTED]  
RETURN RECEIPT REQUESTED

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**Mission**

The mission of the Office of the Medicaid Inspector General is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care.

**Vision**

The Office of the Medicaid Inspector General's vision is to be the national leader in promoting and protecting the integrity of the Medicaid program.

## Background, Purpose, and Audit Scope

### Background

The New York State Department of Health (DOH) is the single state agency responsible for the administration of the Medicaid program. As part of its responsibility as an independent entity within DOH, the Office of the Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assessing provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth in New York Public Health Law, New York Social Services Law, the regulations of DOH (Titles 10, 14 and 18 of the New York Codes Rules and Regulations), DOH's Medicaid Provider Manuals and *Medicaid Update* publications.

Reimbursement under the Medicaid Program is available for medically necessary home health services provided by a public or voluntary non-profit home health agency certified in accordance with the provisions of Article 36 of the Public Health Law. Services provided by a certified home health agency are based on a comprehensive assessment of each patient, a written plan of care, and the written orders of the treating physician, and are generally provided under the supervision of a registered nurse or therapist. The specific standards and criteria for certified home health agency services appear in 42 CFR Part 484, 18 NYCRR Part 505.23 and 10 NYCRR Part 763. MMIS Provider Manuals pertaining to home health services, personal care services, and nursing services also provide programmatic guidance for the provision of home health services.

### Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for home health services complied with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- the medical necessity of claimed services was supported by the provider's documentation;
- appropriate rate or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

### Scope

A review of home health service claims paid to Willcare from January 1, 2010, through December 31, 2012, was completed.

The audit universe consisted of 28,709 claims totaling \$3,382,164.21. The audit sample consisted of 100 claims totaling \$11,151.97 (Attachment A).

**PROVIDER RIGHTS**

18 NYCRR Part 518 regulates the collection of overpayments. Your repayment options are described below. If you decide to repay the adjusted lower confidence limit amount of \$140,531, one of the following repayment options must be selected within 20 days from the date of this letter:

**OPTION #1:** Make full payment by check or money order within 20 days of the date of the Final Audit Report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
File #15-2862  
Albany, New York 12237

**OPTION #2:** Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final audit report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until the agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

Bureau of Collections Management  
New York State Office of the Medicaid Inspector General  
800 North Pearl Street  
Albany, New York 12204

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the adjusted point estimate of \$319,519. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel  
Office of Counsel  
New York State Office of the Medicaid Inspector General  
800 North Pearl Street  
Albany, New York 12204

Questions regarding the request for a hearing should be directed to Office of Counsel, at [REDACTED]

Issues you may raise shall be limited to those issues relating to determinations contained in the Final Audit Report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing the provider has the right to:

- a) request the department to reschedule the hearing (adjournment);
- b) be represented by an attorney, or other representative, or to represent himself/herself;
- c) have an interpreter, at no charge, if the appellant does not speak English or is deaf and cannot afford one (the appellant must advise the department prior to the hearing if an interpreter will be needed);
- d) produce witnesses and present written and/or oral evidence to explain why the action taken was wrong; and
- e) cross-examine witnesses of the department.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

**REGULATIONS OF GENERAL APPLICATION**

Each audit finding is supported by relevant regulations, policy statements and manuals. In addition, the audit findings in this audit are supported by regulations of general application to the Medicaid Program and to home health care services. These regulations are provided below.

"By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."  
*18 NYCRR Section 504.3*

"Fee-for-service providers. (1) All providers . . . must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor . . . must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department . . . for audit and review."  
*18 NYCRR Section 517.3(b)*

"All bills for medical care, services and supplies shall contain: (1) patient name, case number and date of service; (2) itemization of the volume and specific types of care, services and supplies provided (including for a physician, his final diagnosis, and for drugs, the prescription filled); (3) the unit price and total cost of the care, services and supplies provided; . . . and (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing; . . . that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment; . . . and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided . . . ."  
*18 NYCRR Section 540.7(a)(1)-(3) and (8)*

"An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake."  
*18 NYCRR Section 518.1(c)*

“Vendor payments for medical care and other items of medical assistance shall not be made unless such care or other items of assistance have been furnished on the basis of the appropriate authorization prescribed by the rules of the board and regulations of the department.”

*18 NYCRR Section 540.1*

“The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim.”

*18 NYCRR Section 518.3(a)*

“The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished....”

*18 NYCRR Section 518.3(b)*

“Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client’s medical record.”

*18 NYCRR Section 518.3(b)*

“A certified home health agency must provide home health services in accordance with applicable provisions of the regulations of the Department of Health...and with federal regulations governing home health services (42 CFR 440.70 and Part 484).”

*18 NYCRR Section 505.23(b)(1)*

“Home care services agency shall mean an organization primarily engaged in arranging and/or providing, directly or through contract arrangement, one or more of the following: nursing services, home health aide services, medical supplies, equipment and appliances, and other therapeutic and related services which may include, but shall not be limited to, physical and occupational therapy, speech pathology, nutritional services, medical social services, personal care services, homemaker services and housekeeper services which may be of a preventive, therapeutic, rehabilitative, health guidance and/or supportive nature to persons at home.”

*10 NYCRR Section 700.2(a)(6)*

Part 763 of 10 NYCRR establishes minimum requirements and operating standards for certified home health agencies, long term home health care programs, and AIDS home care programs.

*10 NYCRR Section 763.1 et.seq.*

“The governing authority of the agency shall be responsible for the management, operation and evaluation of the agency and shall: (1) ensure compliance of the agency with the applicable federal, state and local statutes, rules and regulations....”

*10 NYCRR Section 763.11(a)(1)*

“‘Certified home health agency’ means a home care services agency which possesses a valid certificate of approval issued pursuant to the provisions of this article, or a residential health care facility or hospital possessing a valid operating certificate issued under article twenty-eight of this chapter which is authorized under section thirty-six hundred ten of this article to provide a long term home health care program. Such an agency, facility, or hospital must be qualified to participate as a home health agency under the provisions of titles XVIII and XIX of the federal Social Security Act . . . .”

*New York State Public Health Law § 3602.3*

“Long term home health care program shall mean a coordinated plan of care and services provided at home to invalid, infirm or disabled persons who are medically eligible for placement in a hospital or residential health care facility, and who would require such placement. . . .”

*10 NYCRR 700.2(a)(8)*

“(i) AIDS home care program means a coordinated plan of care and services provided at home to persons who are medically eligible for placement in a hospital or residential health care facility and who: (a) are diagnosed by a physician as having acquired immune deficiency syndrome (AIDS); or (b) are deemed by a physician, within his judgment, to be infected with the etiologic agent of acquired immune deficiency syndrome, and who have an illness, infirmity or disability which can be reasonably ascertained to be associated with such infection.

Such program shall be provided by a long term home health care program specifically authorized pursuant to article 36 of the Public Health Law to provide an AIDS home care program; or an AIDS center, as defined in Part 405 of this Title, specifically authorized pursuant to article 36 of the Public Health Law to provide an AIDS home care program. Such program shall be provided in the person's home or in the home of a responsible relative, other responsible adult, adult care facilities specifically approved to admit or retain residents for such program, or in other residential settings as approved by the commissioner in conjunction with the Commissioner of Social Services. Such program shall provide services, including but not limited to the full complement of health, social and environmental services provided by long term home health care programs in accordance with regulations promulgated by the commissioner. Such programs shall also provide such other services as required by the commissioner to assure appropriate care at home for persons eligible under such program.

(ii) A long term home health care program that does not obtain authorization to provide an AIDS home care program shall not be precluded from providing services within its existing authority to patients who are diagnosed as having AIDS, or are deemed by a physician, within his judgment, to be infected with the etiologic agent of acquired immune deficiency syndrome, and who have an illness, infirmity or disability which can be reasonably ascertained to be associated with such infection.”

*10 NYCRR 700.2(a)(26)(i)& (ii)*

The New York State Department of Social Services issued an Administrative Directive to the districts on December 30, 1983. This Administrative Directive sets forth LTHHCP requirements, program policies, and procedures to be followed statewide.

*Department of Social Services 83 ADM-74, December 30, 1983*

### AUDIT FINDINGS

OMIG's detailed findings appear in the following pages. A description of each finding, supporting regulations, and the list of samples with each finding, appear below. Each sample may contain more than one error, and may be listed in more than one category of finding. A sample may only be disallowed once in an audit, however, each sample is subject to disallowance based on a single error.

This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated December 23, 2015. Since you did not respond to the Draft Audit Report, the findings remain the same.

### SUMMARY OF FINDINGS

<u>Error Description</u>	<u>Number of Errors</u>
DMS-1 Not Documented/Late/Incomplete	12
Home Assessment Abstract Not Documented/Late/Incomplete	12
Billed for Services in Excess of Ordered Hours/Visits	7
Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame	4
Billed Medicaid Before Services Were Authorized	2
Patient Excess Income ("Spend Down") Not Applied Prior to Billing Medicaid	1
Ordering Practitioner Conflicts with Claim Practitioner	1

## AUDIT FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2010, through December 31, 2012, identified 21 claims with at least one error, for a total sample overpayment of \$2,294.17 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated December 23, 2015. Appropriate adjustments were made to the findings.

### 1. DMS-1 Not Documented/Late/Incomplete

"In addition to meeting the clinical record requirements of subdivision (a) of this section, clinical records for long term home health care programs and AIDS home care programs shall include an evaluation of the medical, mental health, social and environmental needs of the patient, on forms prescribed by the commissioner, which shows that the patient is medically eligible for placement in a hospital or residential health care facility were this program not available."

*10 NYCRR Section 763.7(b)*

"The commissioner must prescribe the forms on which the assessment will be made."

*18 NYCRR Section 505.21(b)(2)(viii)*

"No single authorization for LTHHCP or AHCP services may exceed four months. (i) A reassessment must be performed at least every 120 days . . ."

*18 NYCRR Section 505.21(b)(8) and (b)(8)(i)*

The NYS Department of Social Services Administrative Directive dated December 30, 1983 advises that a medical assessment is the initial assessment process. The medical assessment is accomplished by completion and scoring of the DMS-1 or its successor. The DMS-1 is also the tool that is used as an indicator for need for SNF or HRF placement. If the person is currently in his own home or the home of a relative or responsible adult, the DMS-1 or its successor will most often be completed by the LTHHCP nurse representative or by the patient's physician. After the initial medical and home assessments, development of the summary of service requirements and implementation of the plan of care, there will be a complete reassessment done every 120 days for each patient. Therefore, no single authorization for Long Term Home Health Care Program services may exceed 120 days.

*Department of Social Services 83 ADM-74, December 30, 1983*

"The following conditions must be met in order for a client to receive the services of a LTHHCP: . . . A client must be assessed as medically eligible for placement in a skilled nursing or health related facility. The assessment must be completed by a physician or a registered professional nurse on forms approved by the Commissioner of Health (the DMS-1 or its successor)."

*MMIS Provider Manual for Long Term Home Health Care Program Services,  
February 1992*

"A registered nurse must complete the *New York State Long Term Care Placement Form Medical Assessment Abstract* (otherwise known as the DMS-1). The DMS-1 is an instrument used to evaluate an individual's current medical condition. . . ."

*Long Term Home Health Care Program Reference Manual, June 2006  
Chapter 2*

"A registered nurse (RN), or physician, must complete the DMS-1 to evaluate an individual's current medical condition..."

*Long Term Home Health Care Program Medicaid Waiver Program Manual, May, 2012  
Section II*

"The RN must ensure that the reassessment is done within 120 days and is responsible for revising the nursing goals, updating the Plan of Care, and completing the DMS-1 form."

*Long Term Home Health Care Program Reference Manual, June 2006  
Chapter 2*

"A complete reassessment, including re-evaluation of the participant's current health, medical, nursing, social, environmental, and rehabilitative needs, must be conducted no later than 180 days from the individual's previous assessment. No single authorization for LTHHCP participation may exceed 180 days."

*Long Term Home Health Care Program Medicaid Waiver Program Manual, May, 2012  
Section II*

The waiver renewal implements legislation enacted in June 2010 to extend the reassessment time frame from every 120 days to every 180 days, or more frequently when a participant's service needs change. LDSS staff were instructed to phase-in the new policy effective September 1, 2010, as participants' existing 120 day authorizations expired and subsequent reassessments could then be authorized for 180 days.

11 OLTC/ ADM-1

In 12 instances pertaining to 11 patients, the DMS-1 was not completed within the regulatory time frame. This finding applies to Sample #'s 11, 27, 28, 38, 55, 61, 65, 74, 76, 83, 89 and 96.

## **2. Home Assessment Abstract Not Documented/Late/Incomplete**

"In addition to meeting the clinical record requirements of subdivision (a) of this section, clinical records for long term home health care programs and AIDS home care programs shall include an evaluation of the medical, mental health, social and environmental needs of the patient, on forms prescribed by the commissioner, which shows that the patient is medically eligible for placement in a hospital or residential health care facility were this program not available."

*10 NYCRR Section 763.7(b)*

"If a person . . . desires to remain and is deemed by his or her physician able to remain in his/her own home . . . the social services district must authorize a home assessment of the appropriateness of the LTHHCP or AHCP services. The assessment must include, in addition to the physician's recommendation, an evaluation of the social and environmental needs of the person. . . . (ii) . . . and must be performed by the person's physician, a representative of the social services district, and a representative of the LTHHCP or AHCP that will provide services to the person."

*18 NYCRR Section 505.21(b)(2)& (b)(2)(ii)*

"No single authorization for LTHHCP or AHCP services may exceed four months. (i) A reassessment must be performed at least every 120 days . . ."

*18 NYCRR Section 505.21(b)(8)& (b)(8)(i)*

"The commissioner must prescribe the forms on which the assessment will be made."

*18 NYCRR Section 505.21(b)(2)(viii)*

The NYS Department of Social Services administrative directive dated December 30, 1983 advises that the home assessment is done in order to determine how, and if, the patient's total health and social care needs, as well as those prescribed by the physician, can be met in the home environment. The home assessment is accomplished by completion of the Home Assessment Abstract (or its successor) by the nurse representative of the LTHHCP and the professional caseworker from the LDSS. If a joint assessment cannot be made the LTHHCP representative performs a preliminary assessment; based on this assessment the LTHHCP representative develops a proposed summary of service requirements. The summary of service requirements is a listing of the types, frequency and amounts of services which will be necessary to maintain the patient at home. This listing can be found on the Home Assessment Abstract. The summary of service requirements should represent all the services-medical, nursing, social work, therapies, health aide, personal care, homemaking, housekeeping, drugs, and all other support services. It shall be the responsibility of the LTHHCP nurse representative to assure that the orders are written clearly and concisely and reflected on page 4 of the Home Assessment Abstract. The representative of the LTHHCP will be a registered professional nurse. The LTHHCP nurse representative establishes goals for the patient and methodology for achieving these goals by a practical nursing plan which clearly outlines the nursing, home health aide and personal care services and other therapeutic and supportive modalities. The plan outlines the methodology of approach and practical applications. The goals should be well-defined, measurable and updated and re-evaluated at each reassessment period (120 days) and whenever indicated. There will be a "complete" reassessment done every 120 days for each patient. No single authorization for LTHHCP services may exceed 120 days.

*Department of Social Services 83 ADM-74, December 30, 1983*

"Home Assessment This assessment determines if and how the client's total health, social and environmental care needs can be met at home. It is accomplished by completion of the Home Assessment Abstract (HAA) or its successor . . ."

*MMIS Provider Manual for Long Term Home Health Care Program Services,  
Revised February 1992*

"Each patient will be reassessed every 120 days . . . The tool for the periodic reassessment and any resultant change in service requirements will be the DMS-1 or its successor and the Home Assessment Abstract or its successor."

*MMIS Provider Manual for Long Term Home Health Care Program Services,  
Revised February 1992*

The Long Term Home Health Care Program Reference Manual (Manual) advises that the Home Assessment Abstract (otherwise known as the HAA or DSS 3139) is a tool used to determine whether the individual's total health and social care needs can be met in the home environment. The Summary of Service Requirements and Plan of Care are developed from the abstract. In items 12 and 13 of the HAA, a registered nurse (RN) from the provider agency records all clinical information regarding the individual's health status. The RN is responsible for assessing the home with regard to safety and ease of activities of daily living and records that information Item 12. The nurse must assess the recovery potential anticipated for the individual, and records the result in Item 13. The RN must also assess individual abilities in the activities of daily living (such as bathing, dressing and grooming) and records the results in Item 14. The RN must ensure that the reassessment is done within 120 days and is responsible for revising the nursing goals and updating the Plan of Care.

*Long Term Home Health Care Program Reference Manual, June 2006  
Chapter 2*

“In addition, at least once every 180 days, a reassessment of the participant must be conducted by the LTHHCP agency RN and the LDSS staff to verify the participant’s eligibility for the LTHHCP waiver program and determine whether the participant’s POC needs to be modified based upon the results of the reassessment of the participant’s condition.”

*Long Term Home Health Care Program Medical Waiver Program Manual, May 2012  
Section II*

The waiver renewal implements legislation enacted in June 2010 to extend the reassessment time frame from every 120 days to every 180 days, or more frequently when a participant’s service needs change. LDSS staff were instructed to phase-in the new policy effective September 1, 2010, as participants’ existing 120 day authorizations expired and subsequent reassessments could then be authorized for 180 days.

11 OLTC/ ADM-1

In 12 instances pertaining to 11 patients, the Home Assessment Abstract was not completed within the regulatory time frame. This finding applies to Sample #'s 11, 27, 28, 38, 55, 61, 65, 74, 76, 83, 89 and 96.

**3. Billed for Services in Excess of Ordered Hours/Visits**

Regulations state: “It is the policy of the department to pay for home health services under the medical assistance program only when the services are medically necessary.”  
*18 NYCRR Section 505.23(a)(1)(i)&(ii)*

Regulations state: “Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client’s medical record.”  
*18 NYCRR Section 518.3(b)*

**For services prior to 11/17/2010**

Regulations state: “Home health services mean the following services when prescribed by a physician and provided to an MA recipient in his or her home . . . (i) nursing services . . . (ii) physical therapy, occupational therapy, or speech pathology and audiology services; and (iii) home health aide services. . . .”

*18 NYCRR Section 505.23(a)(3)(i)-(iii)*

**For services 11/17/2010 and after**

Regulations state: “Home health services mean the following services when prescribed by a physician and provided to an MA recipient in his or her home . . . (i) nursing services . . . (ii) physical therapy, occupational therapy, or speech pathology and audiology services; and (iii) home health aide services. . . .”

*18 NYCRR Section 505.23(a)(2)(i)-(iii)*

Regulations state: “Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency and duration of such services. . . .”

*10 NYCRR Section 763.6(d)*

The Home Health Manual states: "Any such service provided [by a certified home health agency] to a Recipient must be ordered by his/her physician as part of a written plan of care...".

*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*

The Department of Social Services administrative directive dated December 30, 1983 states, "In addition to the actual provision of services, LTHHCP providers have management responsibilities. These responsibilities include . . . Obtaining necessary physician orders . . . Notifying the local social services districts the first working day following the noting of a change in the patient's condition and concerning any changes in the authorized summary of services. Seeking prior authorization for any service change which exceeds by 10% or more the 75% cap for the patient. . . ."

*Department of Social Services 83 ADM-74, December 30, 1983  
Section I, paragraph K. 2 and 7*

"The client's physician must indicate that care in the home setting is appropriate for the client and must provide orders for treatment, medication and services."

*Medicaid Management Information System Provider Manual  
Long Term Home Health Care Program Services, February 1992*

In 7 instances pertaining to 5 patients, billed home care services exceeded the maximum frequency of visits or number of hours or services specified on the authorized practitioner's order. The portion of the sampled claim exceeding the order will be disallowed. This finding applies to Sample #'s 7, 8, 16, 26, 64, 73 and 76.

#### **4. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame**

##### **For services prior to 11/17/2010**

Regulations state: "Home health services mean the following services *when prescribed by a physician* and provided to an MA recipient in his or her home...nursing services...physical therapy, occupational therapy, or speech pathology and audiology services; and home health aide services. . . ."

*18 NYCRR Section 505.23(a)(3)(i)-(iii)*

##### **For services 11/17/2010 and after**

Regulations state: "Home health services mean the following services *when prescribed by a physician* and provided to an MA recipient in his or her home...nursing services...physical therapy, occupational therapy, or speech pathology and audiology services; and home health aide services. . . ."

*18 NYCRR Section 505.23(a)(2)(i)-(iii)*

Regulations state: "The agency shall maintain a confidential clinical record for each patient admitted to care or accepted for service to include:...medical orders and nurses diagnoses...signed by the authorized practitioner within 30 days after admission to the agency, or prior to billing, whichever is sooner; signed by the authorized practitioner within 30 days after issuance of any change in medical orders or prior to billing, whichever is sooner, to include all written and oral changes and changes made by telephone by such practitioner; and renewed by the authorized practitioner as indicated by the patient's condition but at least every 62 days..."

*10 NYCRR Section 763.7(a)(3)(i)-(iii)*

Regulations state: "Each patient's clinical records shall be kept securely for not less than six years after discharge from the agency and made available to the department upon request. In the case of minors, records are to be kept for not less than six years after discharge, or three years after they reach majority (18 years), whichever is the longer period."

*10 NYCRR Section 763.7(c)*

Regulations state: "A certified home health agency must provide home health services in accordance with applicable provisions of the regulations of the Department of Health and with federal regulations governing home health services (42 CFR 440.70 and Part 484)."

*18 NYCRR Section 505.23(b)(1)*

Regulations state: "The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in case-mix assignment; or a discharge and return to the same HHA during the 60-day episode. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care."

*42 CFR Section 484.18(b)*

The Home Health Manual states: "Any such service provided [by a certified home health agency] to a Recipient must be ordered by his/her physician as part of a written plan of care. . . ."

*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*

The NYS Department of Social Services administrative directive dated December 30, 1983 advises that the LTHHCP nurse representative will be directly responsible for and/or assure via the nursing plan of care, that the physician's orders are carried out, that the care is documented, and that the medical orders are renewed every sixty days. The LTHHCP provider has management responsibilities that include obtaining necessary physician orders.

*Department of Social Services 83 ADM-74, December 30, 1983  
Section III*

"The client's physician must indicate that care in the home setting is appropriate for the client and must provide orders for treatment, medication and services."

*MMIS Provider Manual for Long Term Home Health Care Program Services,  
Revised February 1992*

In 4 instances pertaining to 4 patients, the order was not signed within the required time frame. There was no signed order in effect for the sampled date of service. The practitioner's renewal of the order occurred after the certification period pertaining to the date of service. This finding applies to Sample #'s 19, 34, 73 and 76.

#### 5. Billed Medicaid Before Services Were Authorized

Regulations state: "The agency shall maintain a confidential clinical record for each patient admitted to care or accepted for service to include:...medical orders and nurses diagnoses...signed by the authorized practitioner within 30 days after admission to the agency, or prior to billing, whichever is sooner; signed by the authorized practitioner within 30 days after issuance of any change in medical orders or prior to billing, whichever is sooner, to include all written and oral changes and changes made by telephone by such practitioner; and renewed by the authorized practitioner as frequently as indicated by the patient's condition but at least every 62 days..."

*10 NYCRR Section 763.7(a)(3)(i)-(iii)*

Regulations state: "Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency and duration of such services."

*10 NYCRR Section 763.6(d)*

Regulations state: "Each patient's clinical records shall be kept securely for not less than six years after discharge from the agency and made available to the department upon request. In the case of minors, records are to be kept for not less than six years after discharge, or three years after they reach majority (18 years), whichever is the longer period."

*10 NYCRR Section 763.7(c)*

#### **For services 11/17/2010 and after**

Regulations also state: "Home health services mean the following services *when prescribed by a physician* and provided to an MA recipient in his or her home...nursing services . . .physical therapy, occupational therapy, or speech pathology and audiology services; and home health aide services. . . ."

*18 NYCRR Section 505.23(a)(2)(i)-(iii)*

Regulations state: "The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60-day episode. Agency professional staff promptly alerts the physician to any changes that suggest a need to alter the plan of care."

*42 CFR Section 484.18(b)*

The Home Health Manual states: "Any such service provided [by a certified home health agency] to a Recipient must be ordered by his/her physician as part of a written plan of care. . . ."

*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*

"The LTHHCP provider obtains necessary physician orders . . ."

*Long Term Home Health Care Program Reference Manual, June 2006  
Chapter 5*

"The LTHHCP agency Registered Nurse (RN) must obtain necessary physician orders."

*Long Term Home Health Care Program Medicaid Waiver Program Manual, May, 2012  
Section V*

The Department of Social Services administrative directive dated December 30, 1983 states, "In addition to the actual provision of services, LTHHCP providers have management responsibilities. These responsibilities include . . . Obtaining necessary physician orders . . . Notifying the local social services districts the first working day following the noting of a change in the patient's condition and concerning any changes in the authorized summary of services."

*Department of Social Services 83 ADM-74, December 30, 1983  
Section IV, paragraph K, 2 and 7*

"The client's physician must indicate that care in the home setting is appropriate for the client and must provide orders for treatment, medication and services."

*MMIS Provider Manual for Long Term Home Health Care Program Services,  
Revised February 1992*

In 2 instances pertaining to 1 patient, Medicaid was billed prior to the date of the signed order. This finding applies to Sample #'s 7 and 76.

#### 6. Patient Excess Income ("Spend Down") Not Applied Prior to Billing Medicaid

Regulations state: "If an otherwise eligible MA applicant's or recipient's net available income exceeds the appropriate income standard, he or she will be eligible for MA only after incurring medical expenses equal to or greater than the amount of excess income, provided such medical expenses are not subject to payment by a third party other than another public program of the State or any of its political subdivisions. Once deduction of incurred medical expenses reduces income to the income standard, the MA applicant or recipient is eligible for MA; however, no MA payment will be made for those incurred medical expenses used to establish eligibility."

*18 NYCRR Section 360-4.8(c)(1)*

Regulations state: "To be eligible for MA coverage of all medical care, . . . the applicant/recipient must incur medical expenses in the month equal to or greater than the amount of his/her excess monthly income."

*18 NYCRR Section 360-4.8(c)(2)(ii)*

The NYS Medicaid Home Health Manual's general billing guidelines state: "Some patients of Home Health services do not become eligible for Medicaid until they pay an overage or monthly amount (spend-down) toward the cost of their medical care. The billing manual instructs the provider to enter code 31 in the value codes section to indicate the patient's spend-down participation."

*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 II*

“LDSS staff determine the amount that the person must spend or incur in medical costs or pay to the district each month in order to be eligible for Medicaid. . . . LTHHCP staff may assist a LTHHCP recipient to document the amounts the recipient spends or incurs in medical costs.”

*Long Term Home Health Care Program Reference Manual  
June 2006, Chapter 6*

“Some recipients of the Long Term Home Health Care Program do not become eligible for Medicaid until they pay an overage or monthly amount (spend-down) toward the cost of their medical care.”

*NYS Medicaid Program Long Term  
Home Health Care Program  
(LTHHCP) UB-04 Billing Guidelines;  
Version 2004-1, Section II  
Version 2007-1, Section II  
Versions 2008-1, 2 & 3, Section II  
Versions 2009-1 & 2, Section II*

In 1 instance, the spend-down that was assigned to the provider was not properly applied to the sampled claim. The difference between the claimed amount and the appropriate claim amount had the spend-down been properly applied will be disallowed. This finding applies to Sample # 4.

## **7. Ordering Practitioner Conflicts with Claim Practitioner**

By enrolling in the Medicaid program, “[T]he provider agrees: (e) to submit claims for payment only for services actually furnished...; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission;... (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department.”

*18 NYCRR Section 504.3(e)-(i)*

The May 2009 DOH Medicaid Update states: “Effective 90 days after the release of this Medicaid Update [providers will be required to complete] ordering provider information fields on all home health care claims... The ordering provider should identify the practitioner who actually ordered the services being billed. Inaccurate information...may result in future audit disallowances. Full compliance with this requirement will enable the State to verify the licensing of ordering practitioners and identify practitioners excluded or suspended from Medicare/Medicaid.”

*DOH Medicaid Update, May 2009,  
Volume 25, Number 6*

**For Services 1/1/10 and after**

Medicaid billing guidelines require providers to report the Ordering/Referring Provider. The guidance instructs the provider to: "Enter the NPI of the provider ordering the services" and further states: "A facility ID cannot be used for the referring/ordering provider. In those instances where an order or referral was made by a facility, the ID of the practitioner at the facility must be used. When providing services to a member who is restricted to a primary physician or facility, the NPI of the member's primary physician must be entered in this field. The ID of the facility cannot be used." The guidance also provides instructions for entering the appropriate NPI.

*NYS Medicaid Provider Manual for Home Health – UB-04 Billing Guidelines,  
Version 2010-1, Section 2*

In 1 instance, the ordering practitioner included on the claim differed from the ordering practitioner who signed the order. This finding applies to Sample # 4.

**SAMPLE DESIGN**

The sample design used for Audit #15-2862 was as follows:

- Universe - Medicaid claims for home health agency services paid during the period January 1, 2010, through December 31, 2012.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of Provider claims for home health agency services paid during the period January 1, 2010, through December 31, 2012.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2010, through December 31, 2012.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 claims.

Attachment B

## SAMPLE RESULTS AND ESTIMATES

Audit Statistics

Universe Size	28,709
Sample Size	100
Sample Value	\$ 11,151.97
Sample Overpayments	\$ 2,294.17
Net Financial Error Rate	20.57%
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	\$ 2,294.17
Less Overpayments Not Extrapolated	\$ (1,185.34)
Sample Overpayments for Extrapolation Purposes	\$ 1,108.83
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	\$ 11.0883
Universe Size	28,709
Point Estimate of Total Dollars	\$ 318,334
Add Overpayments Not Extrapolated	\$ 1,185
Adjusted Point Estimate of Total Dollars	\$ <u>319,519</u>
Lower Confidence Limit	\$ 139,345
Add Overpayments Not Extrapolated	\$ 1,185
Adjusted Lower Confidence Limit	\$ <u>140,531</u>

\* The actual dollar disallowance for the following findings was subtracted from the total sample overpayment and added to the Point Estimate and Lower Confidence Limit:

- Finding #1 – DMS-1 Not Documented/Late/Incomplete
- Finding #2 – Home Assessment Abstract Not Documented/Late/Incomplete
- Finding #7 – Ordering Practitioner Conflicts with Claim Practitioner

The dollar disallowance associated with these findings was not used in the extrapolation. However, this does not apply if an extrapolated finding was also identified for a sampled claim.

**NEW YORK STATE  
OFFICE OF THE MEDICAID INSPECTOR GENERAL  
REMITTANCE ADVICE**

**NAME AND ADDRESS OF AUDITEE**

**Willcare Certified Home Health  
700 Corporate Boulevard  
Newburgh, New York 12550**

**PROVIDER ID** [REDACTED]

**AUDIT #15-2862**

**AUDIT**

**TYPE**

**PROVIDER**  
 **RATE**  
 **PART B**  
 **OTHER:**

**AMOUNT DUE: \$140,531**

**CHECKLIST**

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

[REDACTED]  
**New York State Department of Health  
Medicaid Financial Management, B.A.M.  
GNARESP Corning Tower, Room 2739  
File #15-2862  
Albany, New York 12237**

*Thank you for your cooperation.*

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
WILLCARE  
REVIEW OF HHC-LONG TERM SERVICES  
PROJECT NUMBER: 15-2862  
REVIEW PERIOD: 1/1/2010 - 12/31/2012

Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS									
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. DHS-1 Not Documented/Late/Incomplete	2. Home Assessment Abstract Not Documented/Late/Incomplete	3. Billed for Services in Excess of Ordered Hours/Visits	4. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame	5. Billed Medicaid Before Services Authorized	6. Patient Excess Income ("Spend Down") Not Applied Prior to Billing Medicaid	7. Ordering Practitioner Conflicts With Claim Practitioner			
1	02/11/11	2681	2681	\$	203.44	\$	203.44	\$	-	\$	-						
2	07/20/12	2681	2681		97.80		97.80		-		-						
3	12/15/11	2681	2681		100.72		100.72		-		-						
4	12/02/11	2681	-		151.08		-	151.08		-						X	X
5	03/09/10	2681	2681		50.42		50.42		-		-						
6	08/29/12	2681	2681		146.70		146.70		-		-						
7	12/27/10	2681	-		151.26		-	151.26		-		X			X		
8	03/24/11	2681	2681		152.58		127.15	25.43		-		X					
9	11/23/11	2681	2681		100.72		100.72		-		-						
10	12/01/09	2681	2681		120.36		120.36		-		-						
11	10/15/12	2681	-		97.80		-	-	97.80	X	X						
12	01/11/12	2621	2621		91.23		91.23		-		-						
13	05/30/12	2621	2621		91.23		91.23		-		-						
14	07/15/11	2681	2681		75.54		75.54		-		-						
15	04/14/11	2681	2681		100.72		100.72		-		-						
16	02/19/10	2681	2681		176.47		100.84	75.63		-		X					
17	09/15/10	2651	2651		97.05		97.05		-		-						
18	07/10/10	2681	2681		100.84		100.84		-		-						
19	09/15/11	2681	-		151.08		-	151.08		-		X					
20	11/03/12	2681	2681		48.90		48.90		-		-						
21	07/12/10	2681	2681		50.42		50.42		-		-						
22	04/12/10	2681	2681		151.26		151.26		-		-						
23	04/06/11	2681	2681		106.99		106.99		-		-						
24	06/30/10	2621	2621		108.94		108.94		-		-						
25	01/28/10	2681	2681		25.21		25.21		-		-						





OFFICE OF THE MEDICAID INSPECTOR GENERAL  
WILLCARE  
REVIEW OF HHC-LONG TERM SERVICES  
PROJECT NUMBER: 15-2862  
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Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS						
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. OMS-1 Not Documented/Late/Incomplete	2. Home Assessment Documented/Late/Incomplete	3. Billing for Services in Excess of Ordered Hours/Visits	4. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame	5. Billed Medicaid Before Services Were Authorized	6. Patient Excess Income ("Spend Down") Not Applied Prior to Billing Medicaid	7. Ordering Practitioner Conflicts With Claim Practitioner
76	10/18/11	2681	-	151.08	\$ -	\$ 151.08	\$ -	X	X	X	X	X		
77	05/09/11	2681	2681	100.72	100.72	-	-							
78	09/04/12	2681	2681	73.35	73.35	-	-							
79	11/10/11	2681	2681	151.08	151.08	-	-							
80	12/06/11	2681	2681	151.08	151.08	-	-							
81	12/31/11	2681	2681	176.26	176.26	-	-							
82	10/20/10	2681	2681	201.68	201.68	-	-							
83	08/12/11	2621	-	113.83	-	-	113.83	X	X					
84	03/20/12	2681	2681	146.70	146.70	-	-							
85	06/17/11	2681	2681	62.93	62.93	-	-							
86	07/19/10	2621	2621	108.94	108.94	-	-							
87	03/10/12	2681	2681	97.80	97.80	-	-							
88	03/01/12	2681	2681	195.60	195.60	-	-							
89	01/03/12	2681	-	122.25	-	-	122.25	X	X					
90	08/24/12	2681	2681	97.80	97.80	-	-							
91	06/13/11	2681	2681	100.72	100.72	-	-							
92	07/28/11	2681	2681	50.36	50.36	-	-							
93	06/01/12	2681	2681	48.90	48.90	-	-							
94	01/13/12	2681	2681	73.35	73.35	-	-							
95	10/12/12	2681	2681	48.90	48.90	-	-							
96	10/03/11	2621	-	113.83	-	-	113.83	X	X					
97	09/01/12	2681	2681	73.35	73.35	-	-							
98	04/06/10	2681	2681	151.26	151.26	-	-							
99	01/04/12	2681	2681	73.35	73.35	-	-							
100	06/23/12	2681	2681	73.35	73.35	-	-							
Totals				\$ 11,151.97	\$ 8,857.80	\$ 1,108.83	\$ 1,185.34	12	12	7	4	2	1	1