



**Office of the
Medicaid Inspector
General**

STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF GENTIVA HEALTH SERVICES
CLAIMS FOR CERTIFIED HOME HEALTH
AGENCY HOME HEALTH SERVICES
PAID FROM
OCTOBER 1, 2003 – DECEMBER 31, 2005

Final Audit Report
Audit #: 09-5205

Dennis Rosen
Medicaid Inspector General



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

June 22, 2015

[REDACTED]
[REDACTED]

Gentiva Health Services
888 Veteran's Memorial Highway, Ste. 210
Hauppauge, New York 11788

Re: Final Audit Report
Audit #: 09-5205
Provider ID #: [REDACTED]
FEIN: [REDACTED]
NPI #: [REDACTED]

Dear [REDACTED]:

Enclosed is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report entitled "Review of Gentiva Health Services" (Provider) claims paid for Certified Home Health Agency (CHHA) home health services from October 1, 2003, through December 31, 2005.

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 Gentiva Health Services from October 1, 2003, through December 31, 2005. The audit universe consisted of 24,723 claims totaling \$3,299,633.83. The audit consisted of a random sample of 100 claims with Medicaid payments totaling \$13,061.14 (Attachment A). OMIG shared its proposed findings with Gentiva Health Services in the Draft Audit Report dated September 10, 2014. Any written responses and documentation provided to OMIG in response to the Draft Audit Report have been considered before issuing this 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 point estimate of the Medicaid overpayment received by Gentiva Health Services is \$312,608. The lower confidence limit of the amount overpaid is \$135,954 (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 \$135,954.

If you have any questions or comments concerning this report, please contact [REDACTED] at [REDACTED] or through email at [REDACTED]. Please refer to audit number 09-5205 in all correspondence.

Sincerely,

[REDACTED]

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

[REDACTED]

Enclosure

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

cc:

[REDACTED]

Table of Contents

	Page
Background	5
Purpose	5
Audit Scope	5
Provider Rights	6-7
Regulations of General Application	8-9
Audit Findings	10-16
Attachments:	
A – Sample Design	
B – Sample Results and Estimates	
C – Detailed Audit Findings – Extrapolated	
D – Bridge Schedule	

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 Gentiva Health Services from October 1, 2003, through December 31, 2005, was completed.

The audit universe consisted of 24,723 claims totaling \$3,299,633.83. The audit sample consisted of 100 claims totaling \$13,061.14 (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 lower confidence limit amount of \$135,954, 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 #09-5205
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
Phone #: [REDACTED]
Fax#: [REDACTED]

If you choose not to settle this audit through repayment of the lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of \$312,608. 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)

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 September 10, 2014. The attached Bridge Schedule indicates any changes to the findings.

SUMMARY OF EXTRAPOLATED FINDINGS

<u>Error Description</u>	<u>Number of Errors</u>
Missing or Insufficient Documentation of Hours/Visits Billed	6
Comprehensive Assessment Not Documented/Late	5
Supervision Visit Not Performed Within Required Time Frame	3
Failed to Maximize Third Party/Medicare Benefit	2
Missing Plan of Care/Order	1
Billed for Services in Excess of Ordered Hours/Visits	1

EXTRAPOLATED FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from October 1, 2003, through December 31, 2005, identified 10 claims with at least one error, for a total sample overpayment of \$1,264.44 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated September 10, 2014. Appropriate adjustments were made to the findings.

1. Missing or Insufficient Documentation of Hours/Visits Billed

"The department will pay providers of home health services for home health services provided under this section at rates established by the Commissioner of Health and approved by the Division of Budget; however, no payment will be made unless the claim for payment is supported by documentation of the time spent providing services to each recipient."

18 NYCRR Section 505.23(e)(1)

"The agency shall maintain a confidential clinical record for each patient admitted to care or accepted for service to include: . . . signed and dated progress notes, following each patient contact by each professional person providing care, which shall include a summary of patient status and response to plan of care and, if applicable, contacts with family, informal supports and other community resources, and a brief summary of care provided at the termination of each service; [and] observations and reports made to the registered professional nurse, licensed practical nurse or supervising therapist by the home health aide or personal care aide, including activity sheets; . . ."

10 NYCRR Section 763.7(a)(6)&(7)

In 6 instances pertaining to 4 patients, the documentation to support the claim was either missing or did not fully support the claim. In cases where the documentation provided supported part of the claim, only that portion of the claim that was not supported will be disallowed. This finding applies to Sample #'s 41, 53, 64, 85, 86 and 87.

2. Comprehensive Assessment Not Documented/Late

Regulations state: "A comprehensive interdisciplinary patient assessment shall be completed, involving, as appropriate, a representative of each service needed, the patient, the patient's family or legally designated representative and patient's authorized practitioner. Such assessment shall address, at a minimum, the medical, social, mental health and environmental needs of the patient."

10 NYCRR Section 763.6(a)

Regulations state: "Physicians [providing care under the medical assistance program] shall be licensed and currently registered by the New York State Education Department...[and shall] hold[] a valid operating certificate from the New York State Department of Health..."

18 NYCRR Section 505.2(a)(1)(i)(a)

Regulations state: "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."

42 CFR Section 484.55(b)(1)

Regulations state: "The comprehensive assessment must be updated and revised (including the administration of the 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..."

42 CFR Section 484.55(d)(1)(i)-(iii)

Regulations state: "The agency shall maintain a confidential record for each patient admitted to care or accepted for service to include...the comprehensive interdisciplinary patient assessment."

10 NYCRR Section 763.7(a)(4)

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)

In 5 instances pertaining to 3 patients, the comprehensive assessment for our sampled date of service was not completed within the required time frame. This finding applies to Sample #'s 53, 64, 85, 86 and 87.

3. Supervision Visit Not Performed Within Required Time Frame

Regulations define home health aide services as, ". . . the following services when prescribed by a physician and provided to an MA recipient in his or her home...home health aide services, as defined in the regulations of the Department of Health . . . and is supervised by a registered professional nurse from a certified home health agency or a therapist, in accordance with the regulations of the Department of Health."

18 NYCRR Section 505.23(a)(3)& (a)(3)(iii)

Regulations state: "The agency shall maintain a confidential clinical record for each patient admitted to care or accepted for service to include...signed and dated progress notes, following each patient contact by each professional person providing care..."

10 NYCRR Section 763.7(a)(6)

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: "If the patient receives skilled nursing care...a registered nurse must perform a supervisory visit...to the patient's home no less frequently than every two weeks. If the patient is not receiving skilled nursing care, [the supervisory visit to patient's home] may be provided by the appropriate therapist."
42 CFR Section 484.36(d)(1)&(2)

Regulations state: "If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 60 days; each supervisory visit must occur while the home health aide is providing patient care."
42 CFR Section 484.36(d)(3)

In 3 instances pertaining to 2 patients, a home health aide supervision visit was not made within the regulatory time frame. This finding applies to Sample #'s 64, 81 and 85.

4. Failed to Maximize Third Party/Medicare Benefit

Regulations state: "MA program as payment source of last resort: Where a third party, such as a health insurer or responsible person, has a legal liability to pay for MA-covered services on behalf of a recipient, the department or social services district will pay only the amount by which the MA reimbursement rate for the services exceeds the amount of the third party liability. The department or social services district will also pay if the third party payment will not be made within a reasonable time. The department or social services district will seek reimbursement for any payments for care and services it makes for which a third party is legally responsible. They will seek reimbursement to the extent of the third party's legal liability unless the amount reasonably expected to be recovered is less than the cost of making the recovery."
18 NYCRR Section 360-7.2

Regulations state: "As a condition of payment, all providers of medical assistance must take reasonable measures to ascertain the legal liability of third parties to pay for medical care and services. No claim for reimbursement shall be submitted unless the provider has: investigated to find third-party resources in the same manner and to the same extent as the provider would to ascertain the existence of third-party resources for individuals for whom reimbursement is not available under the medical assistance program...; and sought reimbursement from liable third parties."
18 NYCRR Section 540.6(e)(1)&(2)

Regulations state: "Each medical assistance provider shall: request the ...recipient or his representatives to inform the provider of any resources available to pay for medical care and services; make claims against all resources ...prior to submission of any claim to the medical assistance program; continue investigation and attempts to recover from potential third-party resources after submission of a claim to the medical assistance program...; if a provider is informed of the potential existence of any third-party resources...investigate the possibility of making a claim to the liable third party and make such claim as is reasonably appropriate; and take any other reasonable measures necessary to assure that no claims are submitted to the medical assistance program that could be submitted to another source of reimbursement."
18 NYCRR Section 540.6(e)(3)(i)-(v)

Regulations state: "Certified home health agencies must maximize Medicare and third-party revenues, in accordance with the requirements of this Title....If an audit demonstrates that a certified home health agency has not implemented good faith efforts to collect Medicare and third-party revenues, the agency may be subject to the recoupment of MA payments for claims which are otherwise payable."
18 NYCRR Section 505.23(e)(2) (ii)

The Social Security Act defines home health services for Medicare as including "part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse", and "part-time or intermittent services of a home health aide". The Act further defines "part-time or intermittent services" as "skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 hours or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week)".

SSA Section 1861(m)(1), (m)(4) and (m)(7)(B)

Regulations state: "To be covered [by Medicare Part A], home health aide services must [] be reasonable and necessary. To be considered reasonable and necessary, [] the reason for the visits must be to provide hands-on personal care to the beneficiary or services that are needed to maintain the beneficiary's health or to facilitate treatment of the beneficiary's illness or injury. [] The home health aide also may perform services incidental to a visit that was for the provision of [personal] care []. For example, these incidental services may include changing bed linens, personal laundry, or preparing a light meal."

42 CFR Section 409.45(b)(3)(i); 409.45(b)(1) et seq.; 409.45(b)(4)

Regulations state: "When a home health aide visits a patient to provide a health related service [], the home health aide may also perform some incidental services which do not meet the definition of a home health aide service (e.g., light cleaning, preparation of a meal, taking out the trash, shopping, etc.). However, the purpose of the visit may not be to provide these incidental services since they are not health related services, but rather are necessary household tasks that must be performed by anyone to maintain a home."

Section 50.2 Home Health Aide Services (Rev. 1, 10-01-03)

Chapter 7 Home Health Services, Medicare Benefit Policy Manual (Rev. 142, 04-15-11)

The NYS Medicaid Program Information for All Providers, General Policy, Version 2004-1, Section I Manual states: "When a Medicaid recipient has other insurance, benefits from that insurance must be utilized first."

The NYS Medicaid Program Information for All Providers, General Policy, Version 2004-1, Section I

The NYS Medicaid Program Information for All Providers, General Policy, Version 2006-1, Section I and Version 2008-1, Section I Manual states: "The Medicaid Program is designed to provide payment for medical care and services only after all other resources available for payments have been exhausted; Medicaid is the payor of last resort..."

NYS Medicaid Program Information for All Providers, General Policy, Version 2006-1, Section I and Version 2008-1, Section I

FOR MEDICARE RELATED SERVICES:

In 1 instance, the provider failed to maximize the existing Medicare benefit for a dual Medicare/Medicaid eligible patient. The Medicare Prospective Payment System (PPS) includes up to 28 hours a week and 8 hours a day in nursing and home health aide services. The provider billed Medicaid for home health aide hours of service that should have been included in the Medicare PPS payment. This finding applies to Sample # 13.

FOR THIRD PARTY RELATED SERVICES:

In 1 instance, the provider failed to maximize the existing Third Party Health Insurance (TPHI) benefit for an eligible patient. The amount of the claim that should have been covered by TPHI and was paid by Medicaid will be disallowed. This finding applies to Sample # 84.

5. Missing Plan of Care/Order

Regulations state: "A plan of care shall be developed within 10 days of admission to the agency and approved by the patient based on the comprehensive interdisciplinary patient assessment..."
10 NYCRR Section 763.6(b)-(e)

Regulations state: "The agency shall maintain a confidential record for each patient admitted to care or accepted for service to include...the individualized plan of care..."
10 NYCRR Section 763.7(a)(5)

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: "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)

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: "Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing and social needs can be met adequately by the agency in the patient's place of residence. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine."
42 CFR Section 484.18

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 alert the physician to any changes that suggest a need to alter the plan of care."

42 CFR Section 484.18(b)

Regulations state: "Drugs and treatments are administered by agency staff only as ordered by the physician...Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist...responsible for furnishing and supervising the ordered services..."

42 CFR Section 484.18(c)

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 and Version 2008-1, Section III*

In 1 instance, the applicable plan of care/order was missing from the provider's records. This finding applies to Sample # 95.

6. 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)

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)

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 and Version 2008-1, Section III*

In 1 instance, 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 # 41.

SAMPLE DESIGN

The sample design used for Audit #09-5205 was as follows:

- Universe - Medicaid claims for home health agency services paid during the period October 1, 2003, through December 31, 2005.
- 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 October 1, 2003, through December 31, 2005.
- Sample Unit - The sample unit is a Medicaid claim paid during the period October 1, 2003, through December 31, 2005.
- 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	24,723
Sample Size	100
Sample Value	\$ 13,061.14
Sample Overpayments	\$ 1,264.44
Net Financial Error Rate	9.68%
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	\$ 1,264.44
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	\$ 12.6444
Universe Size	24,723
Point Estimate of Total Dollars	\$ 312,608
Lower Confidence Limit	\$ 135,954

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

NAME AND ADDRESS OF AUDITEE

[REDACTED]
Gentiva Health Services
888 Veteran's Memorial Hwy, Ste. 210
Hauppauge, New York 11788

PROVIDER ID # [REDACTED]

AUDIT # 09-5205

AMOUNT DUE: \$135,954

AUDIT

TYPE

PROVIDER

RATE

PART B

OTHER:

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 #09-5205
Albany, New York 12237

Thank you for your cooperation.

OFFICE OF THE MEDICAID INSPECTOR GENERAL
GENTIVA HEALTH SERVICES
REVIEW OF CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES
PROJECT NUMBER: 09-5205
REVIEW PERIOD: 10/1/2003 - 12/31/2005

Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS 1. Missing or Insufficient Documentation of Hours/Visits Billed 2. Comprehensive Assessment Not Documented/Late 3. Supervision Assessment Not Within Required Time Frame 4. Failed to Maximize Third Party/Medicare Benefit 5. Missing Plan of Care/Order 6. Billed for Services in Excess of Ordered Hours/Visits						
		Billed	Derived	Paid	Derived								
1	02/02/05	2610	2610	\$ 41.40	\$ 41.40	-							
2	02/22/05	2610	2610	248.40	248.40	-							
3	02/13/05	2610	2610	248.40	248.40	-							
4	03/16/05	2620	2620	178.50	178.50	-							
5	03/24/05	2610	2610	82.80	82.80	-							
6	03/25/05	2610	2610	82.80	82.80	-							
7	05/19/05	2610	2610	103.50	103.50	-							
8	04/27/05	2610	2610	165.60	165.60	-							
9	05/20/05	2610	2610	41.40	41.40	-							
10	05/27/05	2610	2610	82.80	82.80	-							
11	04/02/05	2620	2620	89.25	89.25	-							
12	06/24/05	2610	2610	186.30	186.30	-							
13	05/02/05	2610	-	41.40	-	41.40					X		
14	07/11/05	2620	2620	89.25	89.25	-							
15	07/23/05	2620	2620	89.25	89.25	-							
16	07/28/05	2610	2610	144.90	144.90	-							
17	08/17/05	2610	2610	165.60	165.60	-							
18	09/09/05	2610	2610	124.20	124.20	-							
19	09/18/05	2620	2620	89.25	89.25	-							
20	09/26/05	2620	2620	178.50	178.50	-							
21	10/25/05	2620	2620	178.50	178.50	-							
22	10/26/05	2610	2610	248.40	248.40	-							
23	09/23/05	2620	2610	89.25	89.25	-							
24	06/29/04	2620	2620	34.63	34.63	-							
25	11/26/05	2620	2620	178.50	178.50	-							

OFFICE OF THE MEDICAID INSPECTOR GENERAL
GENTIVA HEALTH SERVICES
REVIEW OF CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES
PROJECT NUMBER: 09-S205
REVIEW PERIOD: 10/1/2003 - 12/31/2005

Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS					
		Billed	Derived	Paid	Derived		1. Missing or Insufficient Documentation of Hours/Visits Billed	2. Comprehensive Assessment Not Documented/Late	3. Supervision Visit Not Performed Within Required Time Frame	4. Failed to Maximize Third Party/Medicare Benefit	5. Missing Plan of Care/Order	6. Billed for Services In Excess of Ordered Hours/Visits
26	11/27/05	2620	2620	\$ 89.25	\$ 89.25	\$ -						
27	06/10/05	2610	2610	41.40	41.40	-						
28	12/15/05	2620	2620	89.25	89.25	-						
29	09/25/03	2620	2620	175.02	175.02	-						
30	09/24/03	2620	2620	175.02	175.02	-						
31	10/07/03	2620	2620	175.02	175.02	-						
32	10/13/03	2620	2620	175.02	175.02	-						
33	10/21/03	2620	2620	87.51	87.51	-						
34	10/23/03	2620	2620	87.51	87.51	-						
35	10/29/03	2620	2620	87.51	87.51	-						
36	11/07/03	2620	2620	175.02	175.02	-						
37	11/05/03	2620	2620	175.02	175.02	-						
38	11/13/03	2620	2620	87.51	87.51	-						
39	11/01/03	2610	2610	71.52	71.52	-						
40	11/11/03	2610	2610	143.04	143.04	-						
41	12/01/03	2620	2620	262.53	175.02	87.51	X					X
42	12/19/03	2620	2620	87.51	87.51	-						
43	12/18/03	2620	2620	87.51	87.51	-						
44	12/30/03	2620	2620	87.51	87.51	-						
45	01/04/04	2610	2610	21.25	21.25	-						
46	01/16/04	2620	2620	187.26	187.26	-						
47	01/12/04	2610	2610	127.50	127.50	-						
48	01/29/04	2620	2620	187.26	187.26	-						
49	01/26/04	2620	2620	187.26	187.26	-						
50	02/05/04	2620	2620	187.26	187.26	-						

OFFICE OF THE MEDICAID INSPECTOR GENERAL
GENTIVA HEALTH SERVICES
REVIEW OF CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES
PROJECT NUMBER: 09-5205
REVIEW PERIOD: 10/1/2003 - 12/31/2005

Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS					
		Billed	Derived	Paid	Derived		1. Missing or Insufficient Documentation of Hours/Visits Billed	2. Comprehensive Assessment Not Documented/Late	3. Supervision Visit Not Performed Within Required Time Frame	4. Failed to Maximize Third Party/Medicare Benefit	5. Missing Plan of Care/Order	6. Billed for Services in Excess of Ordered Hours/Visits
51	02/04/04	2610	2610	\$ 85.00	\$ 85.00	\$ -						
52	11/21/03	2610	2610	71.52	71.52	-						
53	02/12/04	2620	-	93.63	-	93.63	X	X				
54	02/26/04	2620	2620	93.63	93.63	-						
55	02/25/04	2620	2620	93.63	93.63	-						
56	12/01/03	2610	2610	89.40	89.40	-						
57	04/01/04	2620	2620	187.26	187.26	-						
58	03/29/04	2620	2620	93.63	93.63	-						
59	04/02/04	2620	2620	93.63	93.63	-						
60	04/04/04	2620	2620	187.26	187.26	-						
61	03/29/04	2610	2610	127.50	127.50	-						
62	04/10/04	2620	2620	187.26	187.26	-						
63	03/23/04	2620	2620	93.63	93.63	-						
64	05/20/04	2610	-	233.75	-	233.75	X	X	X			
65	05/18/04	2620	2620	93.63	93.63	-						
66	05/16/04	2620	2620	93.63	93.63	-						
67	05/28/04	2610	2610	170.00	170.00	-						
68	05/27/04	2620	2620	187.26	187.26	-						
69	05/17/04	2610	2610	127.50	127.50	-						
70	05/25/04	2610	2610	85.00	85.00	-						
71	06/04/04	2620	2620	187.26	187.26	-						
72	06/02/04	2610	2610	170.00	170.00	-						
73	06/06/04	2620	2620	187.26	187.26	-						
74	06/08/04	2610	2610	170.00	170.00	-						
75	07/20/04	2620	2620	93.63	93.63	-						

OFFICE OF THE MEDICAID INSPECTOR GENERAL
GENTIVA HEALTH SERVICES
REVIEW OF CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES
PROJECT NUMBER: 09-5205
REVIEW PERIOD: 10/1/2003 - 12/31/2005

Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS						
		Billed	Derived	Paid	Derived		1. Missing or Insufficient Documentation of Hours/Visits Billed	2. Comprehensive Assessment Not Documented/Late	3. Supervision Visit Not Performed Within Required Time Frame	4. Failed to Maximize Third Party/Medicare Benefit	5. Missing Plan of Care/Order	6. Billed for Services in Excess of Ordered Hours/Visits	
76	07/28/04	2620	2620	\$ 187.26	\$ 187.26	\$ -							
77	08/06/04	2620	2620	187.26	187.26	-							
78	05/20/04	2610	2610	42.50	42.50	-							
79	07/15/04	2610	2610	106.25	106.25	-							
80	09/06/04	2620	2620	93.63	93.63	-							
81	09/14/04	2610	-	106.25	-	106.25				X			
82	03/12/04	2610	2610	170.00	170.00	-							
83	05/05/04	2610	2610	255.00	255.00	-							
84	10/05/04	2620	-	93.63	-	93.63					X		
85	10/13/04	2610	-	233.75	-	233.75	X	X	X				
86	10/16/04	2620	-	93.63	-	93.63	X	X					
87	10/12/04	2620	-	93.63	-	93.63	X	X					
88	11/08/04	2610	2610	63.75	63.75	-							
89	11/14/04	2620	2620	93.63	93.63	-							
90	11/13/04	2620	2620	187.26	187.26	-							
91	11/18/04	2620	2620	187.26	187.26	-							
92	04/21/04	2620	2620	93.63	93.63	-							
93	11/23/04	2620	2620	93.63	93.63	-							
94	11/30/04	2610	2610	255.00	255.00	-							
95	12/12/04	2620	-	187.26	-	187.26						X	
96	12/23/04	2620	2620	93.63	93.63	-							
97	12/22/04	2610	2610	63.75	63.75	-							
98	01/05/05	2610	2610	103.50	103.50	-							
99	01/21/05	2620	2620	178.50	178.50	-							
100	02/23/05	2610	2610	41.40	41.40	-							
				\$ 13,061.14	\$ 11,796.70	\$ 1,264.44	6	5	3	2	1	1	

ATTACHMENT D

FINAL DISPOSITION FOR SAMPLED SELECTIONS CHANGED FROM DRAFT TO FINAL AUDIT REPORT

GENTIVA HEALTH SERVICES
 CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES AUDIT
 AUDIT #09-5205
 AUDIT PERIOD: 10/01/03-12/31/05

BRIDGE SCHEDULE

SAMPLE #	FINDING	DRAFT REPORT	FINAL REPORT	CHANGE
		AMOUNT DISALLOWED	AMOUNT DISALLOWED	
2	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$248.40	\$0.00	(\$248.40)
3	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$248.40	\$0.00	(\$248.40)
4	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$178.50	\$0.00	(\$178.50)
5	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$82.80	\$0.00	(\$82.80)
6	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$82.80	\$0.00	(\$82.80)
7	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$103.50	\$0.00	(\$103.50)
8	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$165.60	\$0.00	(\$165.60)
9	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$41.40	\$0.00	(\$41.40)
10	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$82.80	\$0.00	(\$82.80)
11	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$89.25	\$0.00	(\$89.25)
12	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$186.30	\$0.00	(\$186.30)
14	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$89.25	\$0.00	(\$89.25)
16	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$144.90	\$0.00	(\$144.90)
17	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$165.60	\$0.00	(\$165.60)
18	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$124.20	\$0.00	(\$124.20)
20	Missing or Insufficient Documentation of Hours/Visits Billed	\$178.50	\$0.00	(\$178.50)
22	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations	\$248.40	\$0.00	(\$248.40)
23	Missing or Insufficient Documentation of Hours/Visits Billed	\$89.25	\$0.00	(\$89.25)
24	Failed to Provide Services as Required by the Plan of Care/Medical Orders	\$34.63	\$0.00	(\$34.63)
25	Billed for Services in Excess of Ordered Hours/Visits-Primary Finding	\$89.25	\$0.00	(\$89.25)
56	Supervision Visit not Performed within Required Time Frame	\$89.40	\$0.00	(\$89.40)
58	Missing or Insufficient Documentation of Hours/Visits Billed	\$93.63	\$0.00	(\$93.63)
82	Missing Plan of Care	\$170.00	\$0.00	(\$170.00)
83	Missing Plan of Care	\$255.00	\$0.00	(\$255.00)
93	Comprehensive Assessment Not Documented/Late	\$93.63	\$0.00	(\$93.63)
TOTALS		\$3,375.39	\$0.00	(\$3,375.39)

Note: The adjustments shown above reflect those that were revised as a result of the provider's response. The Not Extrapolated (nurse's) Findings have been removed due to a revision of OMIG protocols. All other financial adjustments remain the same as shown in the Draft Audit Report.