



Office of the  
Medicaid Inspector  
General

DENNIS ROSEN  
Medicaid Inspector General

# **Audit of Claims for Assisted Living Program Services**

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**Final Audit Report  
Audit #: 14-2439**

## **The New Falls ALP**

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**Provider ID #: [REDACTED]**



Office of the  
Medicaid Inspector  
General

ANDREW M. CUOMO  
Governor

DENNIS ROSEN  
Medicaid Inspector General

September 20, 2016

[REDACTED]  
The New Falls ALP  
111 Schuyler Street  
Montour Falls, New York 14865

Re: Final Audit Report  
Audit #: 14-2439  
Provider ID #: [REDACTED]

Dear [REDACTED]

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for The New Falls ALP (Provider).

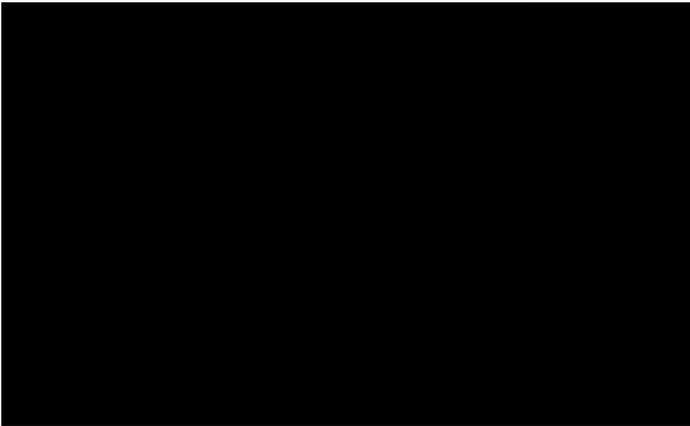
In accordance with Sections 30, 31 and 32 of the New York State Public Health Law, and Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York (NYCRR) Parts 504 and 517, OMIG performed an audit of assisted living program claims paid to the Provider from July 1, 2009, through June 30, 2012. The audit universe consisted of 5,326 claims totaling \$2,397,960.32. The audit consisted of a random sample of 100 claims with Medicaid payments totaling \$42,954.47 (Attachment A).

OMIG has attached the sample detail for the paid claims determined to be in error. This Final Audit Report incorporates consideration of any additional documentation and information presented in the Provider's response to the Draft Audit Report dated July 15, 2016. The adjusted point estimate overpaid is \$293,852. The adjusted lower confidence limit of the amount overpaid is \$119,922. We are 95% certain that the actual amount of the overpayment is greater than the adjusted lower confidence limit. This audit may be settled through repayment of the adjusted lower confidence limit of \$119,922.

If you have any questions or comments concerning this report, please contact [REDACTED]  
[REDACTED] Please refer to audit number 14-2439  
in all correspondence.



Division of Medicaid Audit  
Office of the Medicaid Inspector General



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## Background, Objective, and Audit Scope

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### 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 and 18 of the New York Codes Rules and Regulations), the regulations of the Office of Mental Hygiene (Title 14 of the New York Codes Rules and Regulations), the regulations of the Education Department (Title 8 of the New York Codes Rules and Regulations), DOH's Medicaid Provider Manuals and Medicaid Update publications.

An Assisted Living Program ("ALP") is an entity approved to operate, pursuant to (18 NYCRR 485.6(n)), in adult homes and enriched housing programs. The ALP is established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible residents unrelated to the operator (18 NYCRR 494.2). For each Medicaid enrollee participating in the ALP, a daily rate is paid to the ALP for the provision of nine distinct home care services. No additional fee-for-service billing can be made for these home care services.

Services covered under the daily Medicaid rate and for which no additional separate billing may be made include:

- Title XIX Personal Care Services
- Home Health Aide Services
- Personal Emergency Response Services
- Nursing Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical supplies and equipment not requiring prior approval

Adult Day Health Care

### Objective

The objective of this audit was to assess The New Falls ALP's (Provider) adherence to applicable 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;
- appropriate rate codes were billed for services rendered;
- recipient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with applicable rules and requirements.

**Audit Scope**

A review of assisted living program claims paid to the Provider by Medicaid for payment dates included in the period beginning July 1, 2009 and ending June 30, 2012 was completed.

The audit universe consisted of 5,326 claims totaling \$2,397,960.32. The audit sample consisted of 100 claims totaling \$42,954.47 (Attachment A).

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## Regulations of General Application

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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. 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)*

## Audit Findings

OMIG issued a Draft Audit Report to the Provider on July 15, 2016. This Final Audit Report incorporates consideration of any additional documentation and information presented in the Provider's response to the Draft Audit Report dated August 17, 2016. A description of each finding, regulations, and the list of samples supporting 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.

### Summary of Audit Findings

<u>Error Description</u>	<u>Number of Errors</u>
Failure to Complete Minimum Training Requirements	24
Missing Certificate of Immunization	15
Failure to Complete Annual Performance Evaluation	12
Missing Service Documentation	3
Missing Plan of Care	2
Missing Interim Assessment	1
Missing Nursing/Functional/Social Assessment	1
Missing/Invalid Signature on Medical Evaluation	1
Missing Patient Review Instrument (PRI)	1
Missing/Invalid Signature on Interim Assessment	1
Failure to Complete Required Health Assessment	1
Missing Documentation of a PPD (Mantoux) Skin Test or Follow-Up	1

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**Audit Findings Detail**

OMIG's review of Medicaid claims paid to the Provider from July 1, 2009, through June 30, 2012, identified 34 claims with at least one error, for a total sample overpayment of \$13,150.74 (Attachment C).

**1. Failure to Complete Minimum Training Requirements**

Regulations require that the provider agency shall ensure that all personnel "receive orientation to the policies and procedures of the agency operation, inservice education necessary to perform his/her responsibilities and continuing programs for development and support. At a minimum, (1) home health aides shall participate in 12 hours of inservice education per year; and (2) personal care aides shall participate in six hours of inservice education per year." 10 NYCRR Section 763.13(l)

Regulations require that the Medicaid provider agrees "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years . . . all records necessary to disclose the nature and extent of services furnished...." 18 NYCRR Section 504.3(a)

Regulations require that all providers who are paid in accordance with the rates, fees and schedules established by the department must prepare and maintain contemporaneous records demonstrating their right to receive payment under the Medicaid program. Records necessary to disclose the nature and extent of services rendered and medical necessity therefor must be kept by the provider for a period of six years from the date upon which care, supplies or services were rendered or billed, whichever is later. 18 NYCRR Section 517.3(b)(1)

Regulations also require that bills for medical care, services and supplies contain a certification that such records as are necessary to disclose fully the services provided to Individuals under the New York State Medicaid program will be kept for a period of not less than six years. These records must be furnished to the Department upon request. 18 NYCRR Section 540.7(a)(8)

For 24 claims pertaining to 20 residents, the personal care aide providing our sampled services did not complete the basic training requirements. This finding applies to Sample #'s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, and 25.

**2. Missing Certificate of Immunization**

Regulations require that the "health status of all new personnel is assessed prior to assuming patient care duties. The assessment shall be of sufficient scope to ensure that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. The agency shall require the following of all personnel prior to assuming patient care duties: (1) a certificate of immunization against rubella. . . (2) a certificate of immunization against measles for all personnel born on or after January 1, 1957. . . ." 10 NYCRR Section 763.13(c)

Regulations require that "a record of all tests, examinations, health assessments and immunizations required by this section is maintained for all personnel who have direct patient contact."  
*10 NYCRR Section 763.13(e)*

"The agency shall ensure for all personnel that . . . that personnel records include, as appropriate, records of professional licenses and registrations; verifications of employment history and qualifications for the duties assigned; signed and dated applications for employment; records of physical examinations and health status assessments; performance evaluations; dates of employment, resignations, dismissals, and other pertinent data..."  
*10 NYCRR Section 763.13(h)*

For 15 claims pertaining to 14 residents, there was no record that the individual providing our sampled services received the required immunizations. This finding applies to Sample #'s 1, 4, 6, 7, 8, 9, 10, 11, 12, 13, 17, 19, 21, 24, and 25.

### **3. Failure to Complete Annual Performance Evaluation**

"The agency shall ensure for all personnel . . . that personnel records include, as appropriate, records of professional licenses and registrations; verifications of employment history and qualifications for the duties assigned; signed and dated applications for employment; records of physical examinations and health status assessments; performance evaluations; dates of employment, resignations, dismissals, and other pertinent data..."  
*10 NYCRR Section 763.13(h)*

For 12 claims pertaining to 12 residents, there was no documentation that an annual performance evaluation was completed for the individual providing our sampled services. This finding applies to Sample #'s 1, 3, 4, 5, 12, 13, 16, 17, 18, 19, 22, and 23.

### **4. Missing Service Documentation**

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)*

Regulations state: "Appropriate services must be provided to or arranged for an eligible individual only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conduct by an assisted living program, or if the assisted living program itself is not an approved long-term home health care program or certified home health agency, by an assisted living program and a long-term home health care program or certified home health agency."  
*18 NYCRR Section 494.4(b)*

Regulations require that the Medicaid provider agrees "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years . . . all records necessary to disclose the nature and extent of services furnished. . . ."  
*18 NYCRR Section 504.3(a)*

Payment for assisted living program services (1) The MA program will pay an assisted living program for services provided to eligible MA recipients who are assisted living program residents at a capitated rate of payment established in accordance with the regulations of the Department of Health, based upon assessments of the recipients conducted pursuant to section 494.4 of this Title. Such capitated rate of payment is payment in full for the following MA services provided to MA recipients:

- (i) adult day health care provided in a program approved by the Department of Health;
- (ii) home health aide services;
- (iii) medical supplies and equipment not requiring prior approval pursuant to this Title;
- (iv) nursing services;
- (v) personal care services;
- (vi) personal emergency response services; and
- (vii) physical therapy, speech therapy, and occupational therapy.

*18 NYCRR Section 505.35(h)*

“(b)(1) All providers, who are not paid at rates or fees approved by the State Director or the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, 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, including any prescription or fiscal order for the service or supply, 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.”

*18 NYCRR Section 517.3(b)(1)*

For 3 claims pertaining to 3 residents, the record did not include service documentation for our date of service. This finding applies to Sample #'s 29, 52, and 69.

## 5. Missing Plan of Care

Regulations state: “The governing authority or operator shall ensure that... (b) a plan of care is established for each patient based on a professional assessment of the patient’s needs and includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential.”

*10 NYCRR Section 766.3(b)*

Regulations state: “The governing authority or operator shall ensure that...(d) the plan of care is reviewed and revised as frequently as necessary to reflect the changing care needs of the patient, but no less frequently than every six months.”

*10 NYCRR Section 766.3(d)*

Regulations state: “Appropriate services must be provided to or arranged for an eligible individual only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conduct by an assisted living program, or if the assisted living program itself is not an approved long-term home health care program or certified home health agency, by an assisted living program and a long-term home health care program or certified home health agency.”

*18 NYCRR Section 494.4(b)*

By enrolling in the Medicaid program, the provider agrees “to (a) prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program 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. . . and to furnish such records upon request, to the Department..." *18 NYCRR Section 504.3(a)*

Statute states: (iii) Appropriate services shall be provided to an eligible person only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an assisted living program, either directly or through contract with a long term Home health care program or certified home health agency. A reassessment shall be conducted as frequently as is required to respond to changes in the resident's condition and ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months. No person shall be admitted to or retained in an assisted living program unless the person can be safely and adequately cared for with the provision of services determined by such assessment or reassessment.

*NYS SSL 461-L(2) (d)(iii)*

Regulations state: "(a) The agency shall maintain a confidential record for each patient admitted to care to include... (4) an individualized plan of care..." *10 NYCRR 766.6(a)(4)*

For 2 claims pertaining to 2 residents, the record did not include a Plan of Care for our date of service. This finding applies to Sample #'s 47 and 99.

## 6. Missing Interim Assessment

Regulations state that "[a]n operator shall not admit an individual before a determination has been made that the facility program can support the physical and social needs of the resident." *18 NYCRR Section 487.4(d)*

Regulations further state that "[s]uch a determination shall be based upon: (1) receipt and consideration of a medical evaluation..." *18 NYCRR Section 487.4(e)(1)*

Regulations also require that "[e]ach medical evaluation (DSS- 3122 or an approved substitute) shall be a written, and signed report from a physician which includes:

- (1) the date of examination, significant medical history and current conditions, known allergies, the prescribed medication regimen, including information on the applicant's ability to self-administer medications, recommendations for diet, exercise, recreation, frequency of medical examinations and assistance needed in the activities of daily living;
- (2) a statement that the resident is not medically or mentally unsuited for care in the facility;
- (3) a statement that the resident does not require placement in a hospital or residential health care facility; and
- (4) a statement that the physician has physically examined the resident within 30 days prior to the date of admission or, for required annual evaluations, within 30 days prior to the date of the report." *18 NYCRR Section 487.4(f)*

Regulations state: "Appropriate services must be provided to or arranged for an eligible individual only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an assisted living program, or if the assisted living program itself is not an approved long-term home health care program or certified home health

agency, by an assisted living program and a long-term home health care program or certified home health agency." *18 NYCRR Section 494.4(b)*

(g) A reassessment of the resident must be conducted no later than 45 days after the date of admission of the resident. In addition, reassessments must be conducted as frequently as required to respond to changes in the resident's condition and to ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months." *18 NYCRR Section 494.4(g)*

Regulations state: "Appropriate services shall be provided to an eligible person only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an assisted living program, either directly or through contract with a long term Home health care program or certified home health agency. A reassessment shall be conducted as frequently as is required to respond to changes in the resident's condition and ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months. No person shall be admitted to or retained in an assisted living program unless the person can be safely and adequately cared for with the provision of services determined by such assessment or reassessment."

*NYS SSL 461-L(2) (d)(iii)*

For 1 claim, the record did not include a Medical Evaluation for our date of service. This finding applies to Sample # 91.

## 7. Missing Nursing/Functional/Social Assessment

Regulations state that "(a) The agency shall maintain a confidential record for each patient admitted to care to include... (3) nursing assessments conducted to provide services...."

*10 NYCRR Section 766.6(a)(3)*

Regulations state as follows:

"(e) Before an operator admits an individual to an assisted living program, a determination must be made that the assisted living program can support the physical, supervisory and psychosocial needs of the resident.

(f) The determination referred to in subdivision (e) of this section must be based on:

- (1) a medical evaluation conducted within 30 days prior to the date of admission;
- (2) an interview between the administrator or a designee responsible for admission and retention decisions and the resident and resident's representative(s), if any;
- (3) a preassessment screening, a nursing assessment, and an assessment of the individual's social and functional needs and an assessment of the ability of the program to meet those needs. These assessments will be conducted by the operator and, if required, by a certified home health agency or a long-term home health care program; and
- (4) a mental health evaluation if a proposed resident has a known history of chronic mental disability, or if the medical evaluation or resident interview or any assessment suggests that such a disability exists. This evaluation will be conducted by a psychiatrist, physician, nurse, psychologist or social worker who has experience in the assessment and treatment of mental illness.

(g) A reassessment of the resident must be conducted no later than 45 days after the date of admission of the resident. In addition, reassessments must be conducted as frequently as

required to respond to changes in the resident's condition and to ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months." *18 NYCRR Section 494.4(e)-(g)*

Regulations require that the Medicaid provider agrees "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years . . . all records necessary to disclose the nature and extent of services furnished. . . ." *18 NYCRR Section 504.3(a)*

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)*

For 1 claim, the record did not include a Nursing/Functional/Social Assessment for our date of service. This finding applies to Sample # 64.

#### **8. Missing/Invalid Signature on Medical Evaluation**

The Medical Evaluation can be signed by a Nurse Practitioner or a Physician's Assistant but is not effective until the Physician co-signs the document.

Regulations state that "An operator shall not admit an individual before a determination has been made that the facility program can support the physical and social needs of the resident." *18 NYCRR Section 487.4(d)*

Regulations further state that "[s]uch a determination shall be based upon: (1) receipt and consideration of a medical evaluation." *18 NYCRR Section 487.4(e)(1)*

Regulations also require that "[e]ach medical evaluation (DSS- 3122 or an approved substitute) shall be a written, and signed report from a physician which includes:

- (1) the date of examination, significant medical history and current conditions, known allergies, the prescribed medication regimen, including information on the applicant's ability to self-administer medications, recommendations for diet, exercise, recreation, frequency of medical examinations and assistance needed in the activities of daily living;
- (2) a statement that the resident is not medically or mentally unsuited for care in the facility;
- (3) a statement that the resident does not require placement in a hospital or residential health care facility; and
- (4) a statement that the physician has physically examined the resident within 30 days prior to the date of admission or, for required annual evaluations, within 30 days prior to the date of the report." *18 NYCRR Section 487.4(f)*

Regulations state: "Appropriate services must be provided to or arranged for an eligible individual only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an assisted living program, or if the assisted living program itself is not an approved long-term home health care program or certified home health

agency, by an assisted living program and a long-term home health care program or certified home health agency.”  
*18 NYCRR Section 494.4(b)*

For 1 claim, the patient's medical record did not illustrate a visit for the date of service listed on the Medical Evaluation. This finding applies to Sample # 81.

#### 9. Missing Patient Review Instrument (PRI)

Residential health care facilities patient assessment for certified rates. (a) For the purpose of determining reimbursement rates effective January 1, 1986 and thereafter, for governmental payments, each residential health care facility shall, on an annual basis or more often as determined by the department pursuant to this Subpart, assess all patients to determine case mix intensity using the patient review criteria and standards promulgated and published by the department (Patient Review Instrument (PRI) and instructions: patient review instrument) and specified in subdivision (i) of this section.  
*10 NYCRR Section 86-2.30*

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 PRI score is used to determine the RUG category that is used to reimburse the ALP for services provided to residents enrolled in the ALP. A true and accurate representation of the resident must be reflected on the PRI and substantiated in the medical record to support the Medicaid payment. Fiscal penalties will be assessed to providers for the inappropriate practice of claiming services not provided to or needed by ALP residents.  
*18 NYCRR Section 515.2*

Providers are reminded that they are responsible for ensuring that assessments are completed accurately and reflect the needs of the resident being evaluated for admission to or for continued stay in the ALP. Lack of appropriate documentation to support the assigned RUG grouping and subsequent payment may result in fiscal penalties being assessed.”  
*DAL HCBS 08-02, January 23, 2008*

The Purpose of the Patient Review Instrument (PRI) is a "pre-admission review to a Residential Health Care Facility (RHCF) from the hospital and community based residences and facilities, such as personal dwelling, domiciliary care facility/adult home and congregate housing”.

*Instructions Form DOH-694*

Regulations state that "(a) The agency shall maintain a confidential record for each patient admitted to care to include... (3) nursing assessments conducted to provide services....”

*10 NYCRR Section 766.6(a)(3)*

For 1 claim, the record did not include a PRI for our date of service. This finding applies to Sample # 98.

**10. Missing/Invalid Signature on Interim Assessment**

Regulations state that "An operator shall not admit an individual before a determination has been made that the facility program can support the physical and social needs of the resident."  
*18 NYCRR Section 487.4(d)*

Regulations further state that "[s]uch a determination shall be based upon: (1) receipt and consideration of a medical evaluation."  
*18 NYCRR Section 487.4(e)(1)*

Regulations also require that "[e]ach medical evaluation (DSS-3122 or an approved substitute) shall be a written, and signed report from a physician which includes:

- (1) the date of examination, significant medical history and current conditions, known allergies, the prescribed medication regimen, including information on the applicant's ability to self-administer medications, recommendations for diet, exercise, recreation, frequency of medical examinations and assistance needed in the activities of daily living;
- (2) a statement that the resident is not medically or mentally unsuited for care in the facility;
- (3) a statement that the resident does not require placement in a hospital or residential health care facility; and
- (4) a statement that the physician has physically examined the resident within 30 days prior to the date of admission or, for required annual evaluations, within 30 days prior to the date of the report."  
*18 NYCRR Section 487.4(f)*

Regulations state: "Appropriate services must be provided to or arranged for an eligible individual only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an assisted living program, or if the assisted living program itself is not an approved long-term home health care program or certified home health agency, by an assisted living program and a long-term home health care program or certified home health agency."  
*18 NYCRR Section 494.4(b)*

Statute states: (iii) Appropriate services shall be provided to an eligible person only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an assisted living program, either directly or through contract with a long term home health care program or certified home health agency. A reassessment shall be conducted as frequently as is required to respond to changes in the resident's condition and ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months. No person shall be admitted to or retained in an assisted living program unless the person can be safely and adequately cared for with the provision of services determined by such assessment or reassessment.

*NYS SSL 461-L(2)(d)(iii)*

(g) A reassessment of the resident must be conducted no later than 45 days after the date of admission of the resident. In addition, reassessments must be conducted as frequently as required to respond to changes in the resident's condition and to ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months."  
*18 NYCRR Section 494.4(g)*

For 1 claim, the record did not contain an Interim Assessment as required because the Medical Evaluation is over six months old for our date of service. This finding applies to Sample # 8.

**11. Failure to Complete Required Health Assessment**

Regulations require that the agency ensure "... that the health status of all new personnel is assessed prior to assuming patient care duties. . . . The agency shall require the following of all personnel prior to assuming patient care duties: (1) a certificate of immunization against rubella. . . and "(2) a certificate of immunization against measles for all personnel born on or after January 1, 1957. . . ."

*10 NYCRR Section 763.13(c)*

Regulations state "that the health status of all personnel be reassessed as frequently as necessary, but no less than annually, to ensure that personnel are free from health impairments which pose potential risk to patients or personnel or which may interfere with the performance of duties..."

*10 NYCRR Section 763.13(d)*

Regulations state "that the health status of all personnel be reassessed as frequently as necessary, but no less than annually, to ensure that personnel are free from health impairments which pose potential risk to patients or personnel or which may interfere with the performance of duties..."

*10 NYCRR Section 763.13(e)*

"The agency shall ensure for all personnel that . . . that personnel records include, as appropriate, records of professional licenses and registrations; verifications of employment history and qualifications for the duties assigned; signed and dated applications for employment; records of physical examinations and health status assessments; performance evaluations; dates of employment, resignations, dismissals, and other pertinent data..."

*10 NYCRR Section 763.13(h)*

For 1 claim, there was no documentation that the individual providing our sampled services received the required health assessment. This finding applies to Sample # 16.

**12. Missing Documentation of a PPD (Mantoux) Skin Test or Follow-up**

Regulations state that "ppd (Mantoux) skin test for tuberculosis prior to assuming patient care duties and no less than every year thereafter for negative findings. Positive findings shall require appropriate clinical follow-up but no repeat skin test. The agency shall develop and implement policies regarding follow-up of positive test results...."

*10 NYCRR Section 763.13(c)(4)*

Regulations state that "a record of all tests, examinations, health assessments and immunizations required by this section is maintained for all personnel who have direct patient contact;

*10 NYCRR Section 763.13(e)*

"The agency shall ensure for all personnel that . . . that personnel records include, as appropriate, records of professional licenses and registrations; verifications of employment history and qualifications for the duties assigned; signed and dated applications for employment; records of physical examinations and health status assessments; performance evaluations; dates of employment, resignations, dismissals, and other pertinent data..."

*10 NYCRR Section 763.13(h)*

For 1 claim, there was no documentation that the individual providing our sampled services had the required PPD (Mantoux) test or follow up. This finding applies to Sample # 16.

## Repayment Options

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In accordance with 18 NYCRR Part 518, which regulates the collection of overpayments, your repayment options are described below.

**Option #1:** Make a 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** with the audit number included 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 # 14-2439  
Albany, New York 12237

**Option #2:** Enter into a repayment agreement with OMIG. 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%. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

New York State  
Office of the Medicaid Inspector General  
Bureau of Collections Management  
800 North Pearl Street  
Albany, New York 12204  
Phone #: [REDACTED]  
Fax #: [REDACTED]

Should you fail to select a payment option above, OMIG, in its discretion, may use any remedy allowed by law to collect the amount due. Pursuant to the State Finance Law §18(5), a collection fee equal to twenty two percent (22%) of the amount due, including interest, may be added to the amount owed. OMIG's remedies may include, without limitation, filing this Final Audit Report as the final administrative determination for purposes of obtaining a judgment lien pursuant to §145-a of the New York State Social Services Law; withholding Medicaid payments otherwise payable to the provider or its affiliates pursuant to 18 NYCRR 518.6; and imposing a sanction, pursuant to 18 NYCRR 515.2, against a provider who fails to reimburse the department for overpayments discovered by this audit.

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## Hearing Rights

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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 OMIG would seek and defend the adjusted point estimate of \$293,852. 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, NY 12204

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

In accordance with 18 NYCRR 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply along with your hearing request a signed authorization permitting that person to represent you at the hearing; you may call witnesses and present documentary evidence on your behalf.

For a full listing of hearing rights please see 18 NYCRR Part 519.

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## Contact Information

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Office Address:

New York State  
Office of the Medicaid Inspector General  
Division of Medicaid Audit  
259 Monroe Avenue, Suite 312  
Rochester, New York 14607

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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

To be the national leader in promoting and protecting the integrity of the Medicaid program.



Office of the  
Medicaid Inspector  
General

## REMITTANCE ADVICE

The New Falls ALP  
111 Schuyler Street  
Montour Falls, New York 14865

Provider ID #: [REDACTED]

Audit #: 14-2439

Amount Due: \$119,922

Audit  
Type

Managed Care

Fee-for-Service

Rate

### 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 the check to:

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
File #14-2439  
Albany, New York 12237

### Sample Design

The sample design used for Audit # 14-2439 was as follows:

- Universe - Medicaid claims for assisted living program services paid during the period July 1, 2009, through June 30, 2012.
- Universe Size – The universe size is 5,326 claims.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of Provider claims for assisted living program services paid during the period July 1, 2009, through June 30, 2012.
- Sample Unit - The sample unit is a Medicaid claim paid during the period July 1, 2009, through June 30, 2012.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 claims.

Sample Results and Estimates

**Audit Statistics**

Universe Size	5,326
Sample Size	100
Sample Value	\$ 42,954.47
Sample Overpayments	\$ 13,150.74
Confidence Level	90%

**Extrapolation of Sample Findings**

Sample Overpayments	\$ 13,150.74
<b>Less Overpayments Not Extrapolated*</b>	<u>(7,779.50)</u>
Sample Overpayments for Extrapolation Purposes	\$ 5,371.24
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	\$ 53.7124
Universe Size	5,326
Point Estimate of Total Dollars	\$ 286,072
<b>Add Overpayments Not Extrapolated*</b>	<u>7,780</u>
Adjusted Point Estimate of Total Dollars	<u>\$ 293,852</u>
Lower Confidence Limit	\$ 112,142
<b>Add Overpayments Not Extrapolated*</b>	<u>7,780</u>
Adjusted Lower Confidence Limit	<u>\$ 119,922</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 - Failure to Complete Minimum Training Requirements**
- **Finding #2 - Missing Certificate of Immunization**
- **Finding #3 - Failure to Complete Annual Performance Evaluation**
- **Finding #11 - Failure to Complete Required Health Assessment**
- **Finding #12 - Missing Documentation of a PPD (Mantoux) Skin Test or Follow-up**

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.

































