NEW YORK STATE | Office of the Medicaid Inspector General

OMIG AUDIT PROTOCOL – HOSPICE
FOR SERVICE DATES PRIOR TO 8/31/2016

03/14/2019

Audit protocols assist the Medicaid provider community in developing programs to evaluate compliance with Medicaid requirements under federal and state statutory and regulatory law. Audit protocols are intended solely as guidance in this effort. This guidance does not constitute rulemaking by the New York State Office of the Medicaid Inspector General (OMIG) and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person. Furthermore, nothing in the audit protocols alters any statutory or regulatory requirement and the absence of any statutory or regulatory requirement from a protocol does not preclude OMIG from enforcing the requirement. In the event of a conflict between statements in the protocols and either statutory or regulatory requirements, the requirements of the statutes and regulations govern.

A Medicaid provider's legal obligations are determined by the applicable federal and state statutory and regulatory law. Audit protocols do not encompass all the current requirements for payment of Medicaid claims for a particular category of service or provider type and, therefore, are not a substitute for a review of the statutory and regulatory law. OMIG cannot provide individual advice or counseling, whether medical, legal, or otherwise. If you are seeking specific advice or counseling, you should contact an attorney, a licensed practitioner or professional, a social services agency representative, or an organization in your local community.

Audit protocols are applied to a specific provider type or category of service in the course of an audit and involve OMIG's application of articulated Medicaid agency policy and the exercise of agency discretion. Audit protocols are used as a guide in the course of an audit to evaluate a provider's compliance with Medicaid requirements and to determine the propriety of Medicaid expended funds. In this effort, OMIG will review and consider any relevant contemporaneous documentation maintained and available in the provider's records to substantiate a claim.

OMIG, consistent with state and federal law, can pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the medical assistance program. Furthermore, audit protocols do not limit or diminish OMIG's authority to recover improperly expended Medicaid funds and OMIG may amend audit protocols as necessary to address identified issues of non-compliance. Additional reasons for amending protocols include, but are not limited to, responding to a hearing decision, litigation decision, or statutory or regulatory change.

1.	**Missing Patient / Family Record**
OMIG Audit Criteria	If the patient or family record is incomplete or unavailable for review, the claim associated with the patient or family record will be disallowed.
Regulatory References	10 NYCRR § 794.3 (b) 10 NYCRR § 794.3 (e) 18 NYCRR § 504.3 (a) 18 NYCRR § 517.3 (b)(1) 18 NYCRR § 540.7 (a)(8) 42 CFR § 418.104 (a)(1)-(7) 42 CFR § 418.104 (b) 42 CFR § 418.104 (d)

2.	**Physician Admission Certification or Recertification of Terminal Illness is Missing**
OMIG Audit Criteria	If the physician initial certification or recertification is missing or incomplete, the claim will be disallowed.
Regulatory References	10 NYCRR § 794.3 (b)(5) 18 NYCRR § 504.3 (a) 42 CFR § 418.22(a)(1-3) 42 CFR § 418.102 (b) 42 CFR § 418.102 (c) 42 CFR § 418.104 (a)(5) 42 CFR § 418.104 (d)

3.	**Certification or Recertification of Terminal Illness Not Obtained Within Required Timeframe**
OMIG Audit Criteria	If the provider did not obtain the written certification before submitting a claim for payment, the claim prior to the certification being obtained will be disallowed.
Regulatory References	42 CFR § 418.22(a)(2) and (3)

4.	**Informed Consent or Notice of Election Missing**
OMIG Audit Criteria	If the Informed Consent or Notice of Election voluntarily electing hospice is missing or incomplete, the claim will be disallowed.
Regulatory References	10 NYCRR § 793.6 (c)(3) 10 NYCRR § 794.3 (b)(2) 42 CFR § 418.24 (b) 42 CFR § 418.104 (a)(2) 42 CFR § 418.104 (d) New York State Medicaid Program, Hospice Program, Policy Guidelines, Version 2008-1, Section I

5.	Initial Assessment Was Not Completed Within 48 Hours of Election to Hospice
OMIG Audit Criteria	If the initial assessment was not completed by a registered nurse within 48 hours after the election of hospice care, the claim for services provided after 48 hours from the election of hospice care and until completion of the initial assessment, will be disallowed.
Regulatory References	42 CFR § 418.54 (a)

6.	Comprehensive Assessment Was Not Completed Within 5 Calendar Days After the Election to Hospice
OMIG Audit Criteria	If the comprehensive assessment was not completed by the interdisciplinary group and attending physician (if any) within 5 calendar days after the election of hospice, the claim for services provided after 5 days after the election of hospice and until the comprehensive assessment is completed by the interdisciplinary group, will be disallowed.
Regulatory References	42 CFR § 418.54 (b) 10 NYCRR § 794.2 (a)

7.	Comprehensive Assessment Not Timely Updated
OMIG Audit Criteria	If the comprehensive assessment was not updated as needed or at minimum every 15 days, the claim will be disallowed.
Regulatory References	42 CFR § 418.54 (d)

8.	Plan of Care Untimely or Missing
OMIG Audit Criteria	If the plan of care was not completed by the interdisciplinary group and the attending physician (if any) prior to services, or the plan of care is missing, the claim will be disallowed.
Regulatory References	10 NYCRR § 794.2 (a)-(d) 42 CFR § 418.56 (b) 42 CFR § 418.104 (a)(1) 42 CFR § 418.104 (d)

9.	Plan of Care Not Timely Updated
OMIG Audit Criteria	If the interdisciplinary group did not review/revise the plan of care at least every 15 days, the claim for services provided after that 15 days and until the plan of care is reviewed/revised, will be disallowed.
Regulatory References	10 NYCRR § 794.2 (d) 10 NYCRR § 794.3 (b)(7) 42 CFR § 418.56 (d)

10.	**Missing Documentation of Supervision Visit**
OMIG Audit Criteria	If the record fails to document that a registered nurse made an on-site visit to the patient's home to assess the hospice aide's services no less than every 14 days, the claim will be disallowed.
Regulatory References	42 CFR § 418.76 (h)(1)(i) 42 CFR § 418.104 (a)(1) 42 CFR § 418.104 (a)(3) 42 CFR § 418.104 (d)

11.	**Failed to Maximize Third Party/Medicare Benefit**
OMIG Audit Criteria	Medicaid providers must take reasonable measures to determine legal liability to pay for medical care and services. No claim for reimbursement shall be submitted without provider investigation of the existence of such third parties. When it is determined that a sample service was covered or reimbursed by third party insurance in whole or in part, the amount Medicaid incorrectly paid will be disallowed.
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6 (e)(1) and (2) New York State Medicaid Program Information For All Providers, General Policy, Version 2011-2, Section 1

12.	**Patient Excess Income (Spend-down) Not Applied Prior to Billing Medicaid**
OMIG Audit Criteria	The spend-down amount should be applied beginning with the first service rendered in the month and each service thereafter until the spend-down is exhausted. Each sampled claim subject to spend-down application billed to Medicaid before the spend-down is met will be disallowed. **Note:** This finding only applies where the relevant county has assigned responsibility for the spend-down to the provider and the sampled claim must be impacted by the spend-down.
Regulatory References	18 NYCRR § 360-4.8 (c)(1) 18 NYCRR § 360-4.8 (c)(2)(ii)

13.	**Minimum Licensure Requirements Not Met for Hospice Personnel**
OMIG Audit Criteria	If the services were provided by any person, either employed by the provider, or contracted with the hospice provider, who was not licensed/registered as appropriate for the profession or did not meet minimum training requirements when services were rendered, the claim will be disallowed.
Regulatory References	10 NYCRR § 793.5(b)

14.	Inpatient Respite Care Exceeded Five Day Limit
OMIG Audit Criteria	Any claim that exceeds five days of respite care will be downgraded to routine home care starting on the sixth day. The difference between the amount paid for respite care and the proper amount for routine home care will be disallowed from day 6 and after.
Regulatory References	10 NYCRR § 86-6.1 (h) 10 NYCRR § 86-6.2 (a)(1) 42 CRF § 418.204 (b) 42 CFR § 418.302 (e)(5)

15.	Provider Incorrectly Billed Medicaid for Unfurnished Services After the Patient is Deceased
OMIG Audit Criteria	Any claim that is billed after the patient is deceased (date of death), will be disallowed.
Regulatory References	18 NYCRR 504.3(e) 18 NYCRR 504.3(h) 18 NYCRR 504.3(i) 18 NYCRR 518(c)