NEW YORK STATE | Office of the Medicaid Inspector General

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OMIG AUDIT PROTOCOL
LICENSED HOME CARE SERVICES AGENCY (LHCSA) FOR PRIVATE DUTY NURSING

07/24/2019

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.

OMIG AUDIT PROTOCOL – LICENSED HOME CARE SERVICES AGENCY (LHCSA) FOR PRIVATE DUTY NURSING
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1.	Missing or Insufficient Documentation of Hours Billed
OMIG Audit Criteria	If there is no clinical record, or the nurse failed to document the care/service provided for the hours of service billed, that portion of the claim that was not documented will be disallowed.
Regulatory References	10 NYCRR § 766.2(a)(2) 10 NYCRR § 766.6(a)(5) 10 NYCRR § 766.6(b) and (c)

2.	Incorrect Procedure Code Billed
OMIG Audit Criteria	If the claim was billed with an incorrect procedure code, the difference between the correct and incorrect procedure code amount will be disallowed.
Regulatory References	18 NYCRR § 505.8(g)(3) 18 NYCRR § 504.3(e) 18 NYCRR § 504.3(h) NYS Medicaid Program, Private Duty Nursing Manual, Policy Guidelines, Version 2012-1, Section III Version 2016-1, Section IV 18 NYCRR § 518.1(c) 18 NYCRR § 540.7(a)(8)

3.	Missing Medical Orders/Plan of Care
OMIG Audit Criteria	If the medical orders/plan of care is not in the record for the relevant date of service, the claim will be disallowed.
Regulatory References	18 NYCRR § 505.8(f) 10 NYCRR § 766.4(a)-(c) 10 NYCRR § 766.6(a)(2) and (5)

4.	Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame
OMIG Audit Criteria	Signed medical orders are required within 12 months of the start of care, a change in the medical orders/plan of care, or renewal. If the medical orders/plan of care was signed late, the claim will be disallowed.
Regulatory References	18 NYCRR § 505.8(f) 10 NYCRR § 766.4(a)-(c) 10 NYCRR § 766.4(d)(1) and (2) 10 NYCRR § 766.6(a)(2) 10 NYCRR § 766.6(a)(5) 10 NYCRR § 766.6(b) and (c)

5.	Medical Orders/Plan of Care Not Signed by an Authorized Practitioner
OMIG Audit Criteria	If the practitioner was not authorized to sign the medical orders/plan of care, the claim will be disallowed.
Regulatory References	18 NYCRR § 505.8(f) 10 NYCRR § 766.4(a)-(c) 18 NYCRR § 540.1

6.	Billed For Services In Excess Of Ordered Hours
OMIG Audit Criteria	If the licensed agency billed more hours than medical orders/plan of care authorized, the claim for the hours exceeding the order will be disallowed.
Regulatory References	10 NYCRR § 85.33(f) 18 NYCRR § 505.8(f) 10 NYCRR § 766.3(b) 10 NYCRR § 766.4(a) 10 NYCRR § 766.4(d) 18 NYCRR § 540.1 18 NYCRR § 518.3(b) **Note:** If the number of hours on any date of service exceeds the total maximum number of hours per day on the approved medical orders (and no supplemental order was obtained), the additional hours will be disallowed.

7.	Nurse Providing Service Was Not Licensed
OMIG Audit Criteria	If the nurse(s) providing service on the date of service was not licensed and registered to practice nursing in the State of New York, the claim will be disallowed.
Regulatory References	10 NYCRR § 85.33(b)(1) 18 NYCRR § 505.8(b)(1) 42 CFR § 440.80(a) 10 NYCRR § 766.11(g)

8.	Excluded Individual Providing Service
OMIG Audit Criteria	If the nurse providing service was suspended, terminated, excluded, or the individual providing service is ineligible to participate in the Medicaid Program on the date of service, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.1(b)(1) 18 NYCRR § 504.7(d)(1) 18 NYCRR § 515.5(a) 18 NYCRR § 515.5(c) 18 NYCRR § 515.5(e) NYS DOH Medicaid Update, April 2010, Vol. 26, No. 6

9.	Billed for Services Performed by Another Provider/Entity
OMIG Audit Criteria	If the services billed by the agency are duplicative, i.e., already paid for by Medicaid or by another entity, the claim will be disallowed. Specific case circumstance will be evaluated through review of the record. **Note:** Guidance will be sought from the appropriate program division as needed. Relevant program regulations will be cited as appropriate.
Regulatory References	18 NYCRR § 505.23(a)(1)(i)

10.	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.
Regulatory References	18 NYCRR § 360-4.8(c)(1) 18 NYCRR § 360-4.8(c)(2)(ii) 18 NYCRR § 504.3(e) 18 NYCRR § 518.1(c) **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.

11.	Failed to Maximize Third-Party 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 overpaid Medicaid amount will be disallowed.
Regulatory References	18 NYCRR § 540.6(e)(1) and (2) 18 NYCRR § 360-7.2 NYS Medicaid Program, Information for all Providers, General Policy, Versions 2011-1 & 2, Section I

12.	Failure to Complete Annual Performance Evaluation
OMIG Audit Criteria	The record will be reviewed to determine if an annual evaluation of the performance and effectiveness of agency personnel was conducted within the required time frame. If the provider did not provide documentation of the completion of an annual performance evaluation of personnel within the required time frame, the claim will be disallowed.
Regulatory References	10 NYCRR § 766.11(k)

13.	Missing Certificate of Immunization
OMIG Audit Criteria	The record will be reviewed to determine if the required certification of immunizations was documented for the licensed agency employee. If the provider did not provide documentation of the required certification of immunizations, the claim will be disallowed.
Regulatory References	10 NYCRR § 766.11(d)(1)(2)(3)

14.	Missing Documentation of a Tuberculosis Test or Follow-up
OMIG Audit Criteria	If documentation of a yearly tuberculosis test, or the required follow-up, is not in the personnel file of the individual who has direct patient contact, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.13(c)(4) 10 NYCRR § 763.13(e) 10 NYCRR § 763.13(h) 10 NYCRR § 766.11(d)(4)

15.	Failure to Complete Required Health Assessment
OMIG Audit Criteria	The record will be reviewed to determine if the annual health assessment of a licensed agency employee was documented within the required time frame. If the provider does not provide documentation of a health assessment within the required time frame, the claim will be disallowed.
Regulatory References	10 NYCRR § 766.11(d)(5)