NEW YORK STATE | Office of the Medicaid Inspector General

OMIG AUDIT PROTOCOL
LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)
FOR SERVICE DATES PRIOR TO DECEMBER 31, 2013

Revised 02/15/2017

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
LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)
FOR SERVICE DATES PRIOR TO DECEMBER 31, 2013

Revised 02/15/2017

1. Missing or Insufficient Documentation of Hours/Visits Billed	
OMIG Audit Criteria	If there is no chart, the aide failed to document hours of service billed, or professional staff failed to document the visit, that portion of the claim that was not documented will be disallowed. **Note:** The nature of the facts surrounding the missing records and/or claims for services not rendered should be evaluated for additional action.
Regulatory References	**For services prior to 11/17/2010,** 18 NYCRR § 505.23(e)(1) **For services 11/17/2010 and after**, 18 NYCRR § 505.23(c)(1) 10 NYCRR § 763.7(a)(6) & (7)

2. Billed for Services in Excess of Ordered Hours/Visits	
OMIG Audit Criteria	If the Long Term Home Health Agency (LTHHA) billed more hours/nursing or therapy visits than plan of care (POC) / medical orders authorized, the claim for the hours/visits exceeding the order will be disallowed. If the number of hours on any date of service exceeds the total maximum number of hours per visit on the approved POC (and no supplemental order was obtained), the additional hours will be disallowed. The disallowed service or units of service should be a service that exceeded the ordered plan frequency for the calendar week that is used by the provider. If additional time is necessary, the justification for the extra time must be documented. **Note:** OMIG will consider exceptional situations, where ordered services were exceeded for good cause (situation must be documented).
Regulatory References	18 NYCRR § 505.23(a)(1)(i) 18 NYCRR § 518.3(b) **For services prior to 11/17/2010,** 18 NYCRR § 505.23(a)(3)(i)-(iii) **For services 11/17/2010 and after**, 18 NYCRR § 505.23(a)(2)(i)-(iii) 10 NYCRR § 763.6(d) NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines, Version 2007-1 et seq., Section III Department of Social Services 83 ADM-74, December 30, 1983 MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992, Section 2

3. Billed Medicaid Before Services Were Authorized	
OMIG Audit Criteria	If the LTHHA began billing before the plan of care (POC) was signed by the practitioner, the claim will be disallowed. All sampled services that were billed prior to date of the practitioner's signature on the order, which covers the approved and signed POC for the time period of the service, will be disallowed.
Regulatory References	10 NYCRR § 763.7(a)(3)(i)-(iii) 10 NYCRR § 763.6(d) 10 NYCRR § 763.7(c) **For services prior to 11/17/2010,** 18 NYCRR § 505.23(a)(3)(i)-(iii) **For services 11/17/2010 and after**, 18 NYCRR § 505.23(a)(2)(i)-(iii) 42 CFR § 484.18(b) NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines, Version 2007-1 et seq., Section III Long Term Home Health Care Program Reference Manual, June 2006, Chapter 5 Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Section V Department of Social Services 83 ADM-74, December 30, 1983 MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992, Section 2

4. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame	
OMIG Audit Criteria	If the plan of care (POC) / medical orders were signed late, the claim will be disallowed. Signed medical orders are required within 30 days of the start of care or a change in the POC. A disallowance will only be taken if the medical order is not signed by the practitioner within 60 days from the date of the start of care or a change in the POC. **Note:** If the provider has a system to track orders, has documentation that the system has been utilized, and can document diligent efforts to obtain the signed order, consideration will be given to allowing the claim.
Regulatory References	**For services prior to 11/17/2010,** 18 NYCRR § 505.23(a)(3)(i)-(iii) **For services 11/17/2010 and after**, 18 NYCRR § 505.23(a)(2)(i)-(iii) 10 NYCRR § 763.7(a)(3)(i)-(iii) 10 NYCRR § 763.7(c) 42 CFR § 484.18(b) NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines, Version 2007-1 et seq., Section III Department of Social Services 83 ADM-74, December 30, 1983 MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992, Section 2

5. Plan of Care/Orders Not Signed by an Authorized Practitioner	
OMIG Audit Criteria	If the practitioner was not authorized to sign the plan of care / medical orders, the claim will be disallowed.
Regulatory References	18 NYCRR § 540.1 **For services prior to 11/17/2010,** 18 NYCRR § 505.23(a)(3)(i)-(iii) **For services 11/17/2010 and after**, 18 NYCRR § 505.23(a)(2)(i)-(iii) 10 NYCRR § 763.5 10 NYCRR § 763.7(a)(3)(i)-(iii) 10 NYCRR § 763.7(c) 42 CFR § 484.18 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 et seq., Section III

6. LTHHA Failed to Notify the Local Department of Social Services of Admission of a Patient Under Alternate Entry	
OMIG Audit Criteria	If the LTHHA fails to properly notify the LDSS when a patient is admitted under alternate entry, the claim will be disallowed.
Regulatory References	Department of Social Services 83 ADM-74, December 30, 1983 MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992 Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2 Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Section II

7. DMS-1 Not Documented/Late/Incomplete	
OMIG Audit Criteria	If there is no DMS-1 in the record for the relevant date of service, the DMS-1 was late, or the DMS-1 was incomplete, the claim will be disallowed. **Note:** The DMS-1 comprising the date of service must be completed within 120 days of the prior DMS-1. Effective 9/1/10, completion must be within 180 days of the prior DMS-1. The date of completion is established by comparing the dated signatures on the respective DMS-1s. **Note:** All items on the DMS-1 must be completed with the exception of items 13-16 and a predictor score must be calculated. A predictor score is not required for children 12 and under.
Regulatory References	10 NYCRR § 763.7(b) 18 NYCRR § 505.21(b)(2)(viii) 18 NYCRR § 505.21(b)(8)(i) Department of Social Services 83 ADM-74, December 30, 1983 MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992 Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2 Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Section II NYS DOH 11 OLTC/ ADM-1

8. DMS-1 Not Prepared by a Licensed and Registered Nurse or Physician	
OMIG Audit Criteria	If the DMS-1 comprising the date of service is not prepared by a licensed and registered professional nurse or physician, the claim will be disallowed. A licensed practical nurse (LPN) cannot complete the DMS-1.
Regulatory References	10 NYCRR § 763.5(b) 10 NYCRR § 763.7(b) Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2 Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Section II Department of Social Services 83 ADM-74, December 30, 1983

9. Home Assessment Abstract Not Documented/Late/Incomplete	
OMIG Audit Criteria	If there is no Home Assessment Abstract (HAA) for the relevant date of service, the HAA was late, or the HAA was incomplete, the claim will be disallowed. **Note:** The HAA comprising the date of service must be completed within 120 days of the prior HAA. Effective 9/1/10, completion must be within 180 days of the prior HAA. The date of completion is established by comparing the dated signatures on the respective HAAs. **Note:** Items 12, 13 and 14 A-C must be completed; these items are the sole responsibility of the LTHHA and do not require county input. Under alternate entry, the LTHHA must complete the initial HAA in its entirety.
Regulatory References	10 NYCRR § 763.7(b) 18 NYCRR § 505.21(b)(2)(ii) 18 NYCRR § 505.21(b)(8)(i) 18 NYCRR § 505.21(b)(2)(viii) Department of Social Services 83 ADM-74, December 30, 1983 MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992 Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2 Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Section II NYS DOH 11 OLTC/ ADM-1

10. Home Assessment Abstract is Not Prepared by a Licensed and Registered Nurse	
OMIG Audit Criteria	If the HAA comprising the date of service is not prepared by a licensed and registered professional nurse (RN), the claim will be disallowed. A LPN cannot complete the HAA. The RN is responsible for completion of items 12, 13 and 14 A-C.
Regulatory References	18 NYCRR § 505.21(b)(8)(i) Department of Social Services 83 ADM-74, December 30, 1983 Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2 Long Term Home Health Care Program Medicaid Waiver Program Manual May 2012, Section II Long Term Home Health Care Program Reference Manual, June 2006, Appendix B Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Appendix B

11. No Physician Override for Low Predictor Score	
OMIG Audit Criteria	If the provider does not submit a physician's override for a low DMS-1 predictor score, the claim will be disallowed. **Note:** Overrides are required if a patient does not meet the minimum predictor score of 60 and requires LTHHA services, or the patient scores less than 180 and requires skilled nursing facility level of services. The override can only be authorized by a licensed and registered physician.
Regulatory References	Department of Social Services 83 ADM-74, December 30, 1983 NYS DOH Letter to LTHHA Administrator, August 13, 2008 MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992 Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2 Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Section II

12. Initial Assessment Not Documented/Late	
OMIG Audit Criteria	A LTHHA must conduct an initial assessment visit to determine the immediate care and support needs of the patient. If there is no initial assessment in the record for the relevant date of service, or the initial assessment is not completed prior to the relevant date of service, the claim will be disallowed. **Note:** The initial patient visit shall be made within 24 hours of receipt and acceptance of a community referral or return home from institutional placement, unless: the patient's authorized practitioner orders otherwise, or there is written documentation that the patient or family refuses such a visit.
Regulatory References	10 NYCRR § 763.5(a)(1) & (2) 10 NYCRR § 763.5(b) 10 NYCRR § 763.5(b)(3) 10 NYCRR § 763.7(a)(4) 10 NYCRR § 763.7(b) 10 NYCRR § 763.7(c) 18 NYCRR § 505.21(b)(2) 18 NYCRR § 505.21(b)(2)(iii) 18 NYCRR § 505.23(b)(1) 42 CFR § 484.55(a)(1) 42 CFR § 484.55(a)(2) MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992

13. Comprehensive Assessment Not Documented/Late	
OMIG Audit Criteria	The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than five calendar days after the start of care. The comprehensive assessment must be updated and revised (including Outcome and Assessment Information Set (OASIS)) data items 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 LTHHA during the 60 day episode. If there is no comprehensive assessment in the record for the relevant date of service, or the comprehensive assessment was late, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.6(a) 42 CFR § 484.55(b)(1) 42 CFR § 484.55(d)(1)(i)-(iii) 10 NYCRR § 763.7(a)(4) 10 NYCRR § 763.7(c) 42 CFR § 484.20(a)

14. Missing Plan of Care/Order	
OMIG Audit Criteria	If there is no plan of care / medical order in the record for the relevant date of service, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.6(b) 10 NYCRR § 763.7(a)(5) 10 NYCRR § 763.7(a)(3)(i)-(iii) 10 NYCRR § 763.6(d) 10 NYCRR § 763.7(c) 42 CFR § 484.18 42 CFR § 484.18(b) 42 CFR § 484.18(c) Department of Social Services 83 ADM-74, December 30, 1983 MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992 NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines, Version 2007-1 et seq., Section III Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2 Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Section II

15. Supervision Visit of Home Health Aide (HHA) Not Performed Within Required Time Frame	
OMIG Audit Criteria	If the required home health aide supervision visit was not documented within the required time period, the claim will be disallowed. If the patient is receiving skilled services, the RN (or appropriate therapist if the only skilled service is OT, PT, or Speech) must make an on-site visit to the patient's home at least once every two weeks. The home health aide does not need to be present at the time of the on-site visit. If the on-site visit has not occurred within the two weeks prior to the date of service, the claim will be disallowed. If the patient is not authorized to receive skilled services, the RN must make a supervisory visit every 60 days <u>while the home health aide is providing patient care</u>. If the supervisory visit has not occurred within the 60 days prior to the date of services, the claim will be disallowed.
Regulatory References	**For services prior to 11/17/2010,** 18 NYCRR § 505.23(a)(3)(iii) **For services 11/17/2010 and after,** 18 NYCRR § 505.23(a)(2)(iii) 10 NYCRR § 763.7(a)(6) 10 NYCRR § 763.7(c) 42 CFR § 484.36(d)(1) & (2) 42 CFR § 484.36(d)(3)

16. Supervision Visit of Personal Care Aide (PCA) Not Performed Within Required Time Frame	
OMIG Audit Criteria	Nursing supervision visits are required every 90 days. A written report must be prepared following each nursing supervision visit. The claim will be disallowed if there is no documentation of a nursing supervision visit occurring within 120 days prior to the sampled date of service. This only applies in counties where the provider is responsible for conducting the nursing supervision visit and the visit documentation covering the sampled date of service is not available. **<u>Note</u>:** In certain counties, nursing supervision visits may only be required every six months, particularly for PCA level I services. The required frequency of nursing supervision visits should be stated on the plan of care or in the agency's contract with the local social services district.
Regulatory References	18 NYCRR § 505.14(f)(1) 18 NYCRR § 505.14(f)(3)(vi) 18 NYCRR § 505.14(f)(3)(vi)(b) 18 NYCRR § 505.14(f)(3)(vii)

17. 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. **Note:** Medicare will generally cover either part-time or intermittent home health aide services or skilled nursing services as long as they are furnished, (combined) less than eight hours each day and up to 28 hours per week. Where Medicare has paid for a full episode of skilled care, OMIG will assume that included in this episode is coverage for up to eight hours each day or up to 28 hours per week unless the LTHHA can provide documentation otherwise. OMIG will assume that home health aide hours for services, which are incidental to a Medicare paid visit, are included in the episode covered by Medicare up to the maximum hours. Any service to a Medicare eligible patient for which Medicare made no payment will NOT be evaluated for possible Medicare coverage. A statewide sample of these claims is evaluated by OMIG and an outside contractor for possible Medicare eligibility.
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 540.6(e)(1) & (2) 18 NYCRR § 540.6(e)(3)(i)-(v) **For services prior to 11/17/2010,** 18 NYCRR § 505.23(e)(2)(ii) **For services 11/17/2010 and after,** 18 NYCRR § 505.23(c)(2)(ii) SSA § 1861(m)(1), (4) and (7) 42 CFR § 409.45(b)(1), (3)(i) and (4) Medicare Benefit Policy Manual, Chapter 7 Home Health Aide Services, Section 50.2 NYS Medicaid Program Information for All Providers, General Policy, Version 2004-1 et seq., Section I Long Term Home Health Care Program Reference Manual, June 2006, Chapter 4 Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Section IV

18. Billed for Services Performed by Another Provider/Entity	
OMIG Audit Criteria	If the services billed by the LTHHA are duplicative, i.e. already paid for by Medicaid or by another entity, the claim will be disallowed. Specific case circumstances 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)

19. Incorrect Rate Code Billed	
OMIG Audit Criteria	If the rate code billed is not the correct rate code for the services provided, the difference between the appropriate claim amount and the paid claim amount will be disallowed.
Regulatory References	**For services prior to 11/17/2010,** 18 NYCRR § 505.23(e)(1) **For services 11/17/2010 and after,** 18 NYCRR § 505.23(c)(1) 18 NYCRR § 504.3(e),(f),(h) and (i) **For services prior to 1/1/2010,** 10 NYCRR § 86-1.46(b) **For services 1/1/2010 and after,** 10 NYCRR § 86-1.13(b) NYS DOH *Medicaid Update*, May 2007, Vol. 23, No. 5

20. Incorrect Rounding of a Service Unit	
OMIG Audit Criteria	If the LTHHA billed for more hours than allowed, by failing to follow rounding instructions in the NYS Medicaid Home Health Manual, the difference between the appropriate claim amount and the paid claim amount will be disallowed.
Regulatory References	**For services prior to 11/17/2010,** 18 NYCRR § 505.23(e)(1) **For services 11/17/2010 and after,** 18 NYCRR § 505.23(c)(1) 18 NYCRR § 504.3(e),(f),(h) and (i) NYS Medicaid Provider Manual for Home Health – UB-92 Billing Guidelines, Version 2004-1, Section II NYS Medicaid Provider Manual for Home Health – UB-04 Billing Guidelines, Version 2007-1 et seq., Section II

21. Ordering Practitioner Conflicts With Claim Practitioner	
OMIG Audit Criteria	If the ordering/referring practitioner on the claim differs from the practitioner that ordered the services, the claim will be disallowed. **Note:** This finding only applies to claims with dates of service paid after the May 2009 *Medicaid Update* took effect.
Regulatory References	18 NYCRR § 504.3(e),(f),(h) and (i) NYS DOH *Medicaid Update*, May 2009, Vol. 25, No. 6 NYS Medicaid Provider Manual for Home Health – UB-04 Billing Guidelines, Versions 2009-1 & 2, Section II Version 2010-1, Section 2.4.2 NYS Medicaid General Billing Guidelines Institutional, Version 2011-01, Section 2.4.2

22. 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) NYS Medicaid Provider Manual for Home Health – UB-92 Billing Guidelines, Version 2004-1, Section II NYS Medicaid Provider Manual for Home Health – UB-04 Billing Guidelines, Version 2007-1, Section II Versions 2008-1, 2 & 3, Section II Versions 2009-1 & 2, Section II Version 2010-1, Section 2.4.2 Long Term Home Health Care Program Reference Manual, June 2006, Chapter 6 NYS Medicaid Program Long Term Home Health Care Program (LTHHCP) – UB-92 Billing Guidelines, Version 2004-1, Section II NYS Medicaid Program Long Term Home Health Care Program (LTHHCP) – UB-04 Billing Guidelines, Version 2007-1, Section II Versions 2008-1, 2 & 3, Section II Versions 2009-1 & 2, Section II Version 2010-1, Section 2.4.2

23. Recipient Enrolled in Medicaid Managed Care and the LTHHCP	
OMIG Audit Criteria	If a patient is enrolled in Medicaid Managed Care and a LTHHCP, the agency and county will be notified of the dual enrollment and documentation of disenrollment from Medicaid Managed Care will be requested. If a patient is enrolled in Medicaid Managed Care, the LTHHCP claim will be disallowed.
Regulatory References	18 NYCRR § 360-10.16(a)(1) NYS DOH *Medicaid Update*, February 2007, Vol. 2, No. 2

24. Failure to Conduct Required Criminal History Check	
OMIG Audit Criteria	The record will be reviewed to determine if the LTHHA or its contractor initiated a background check within the specified time frames and provided appropriate monitoring of the aide while waiting for the results of the background check. (This pertains to services provided by an employee hired or used after 9/1/06). If the criminal history check requirement has not been completed, the claim will be disallowed.
Regulatory References	10 NYCRR § 402.9(a)(1) & (2) 10 NYCRR § 402.1(a) 10 NYCRR § 402.6(a) 10 NYCRR § 763.13(h)

25. Minimum Training Standards Not Met for the Home Health Aide	
OMIG Audit Criteria	If the LTHHA or LTHHA contract employee did not meet minimum training requirements when services were rendered, the claim will be disallowed. **Note:** The record must contain a certification of completion from a Department of Health or State Education Department approved training program.
Regulatory References	10 NYCRR § 700.2(b)(9) 10 NYCRR § 763.13(h) 18 NYCRR § 504.1(c) NYS DOH DAL: DHCBC 06-02, April 13, 2006 42 CFR § 484.4 MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992

26. Minimum Training Standards Not Met for the Personal Care Aide	
OMIG Audit Criteria	If the LTHHA or LTHHA contract employee did not meet minimum training requirements when services were rendered, the claim will be disallowed. **Note:** The record must contain a certification of completion from a Department of Health or State Education Department approved training program.
Regulatory References	18 NYCRR § 504.1(c) 10 NYCRR § 763.13(b)(1) 10 NYCRR § 700.2(b)(14)(iii) 18 NYCRR § 505.14(e)(1) 18 NYCRR § 505.14(e)(7) 10 NYCRR § 763.13(h) NYS DOH DAL: DHCBC 06-02, April 13, 2006

27. Failure to Complete Required In-Service Training (Home Health Aide)	
OMIG Audit Criteria	The record will be reviewed to determine if LTHHA or LTHHA contract employee completed minimum in-service education requirements. If the employee did not complete the in-service requirements, the claim will be disallowed. **Note:** The criteria for the one-year period for completion of the in-service training that is used by the provider will be considered the base year for each aide under review. An additional 120 days will be allowed beyond the 12 months preceding the date of service before a disallowance will be taken.
Regulatory References	10 NYCRR § 763.13(l)(1) 10 NYCRR § 763.13(h)

28. Failure to Complete Required In-Service Training (Personal Care Aide)	
OMIG Audit Criteria	The record will be reviewed to determine if LTHHA or LTHHA contract employee completed minimum in-service education requirements. If the employee did not complete the in-service requirements, the claim will be disallowed. **Note:** The criteria for the one-year period for completion of the in-service training that is used by the provider will be considered the base year for each aide under review. An additional 120 days will be allowed beyond the 12 months preceding the date of service before a disallowance will be taken.
Regulatory References	10 NYCRR § 763.13(l)(2) 10 NYCRR § 763.13(h)

29. Missing Certificate of Immunization	
OMIG Audit Criteria	The record will be reviewed to determine if the required certification of immunizations was–documented for the LTHHA or LTHHA contract employee. If the required documentation of the certification of immunizations is not provided, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.13(c) 10 NYCRR § 763.13(e) 10 NYCRR § 763.13(h)

30. Failure to Complete Required Health Assessment	
OMIG Audit Criteria	The record will be reviewed to determine if the annual health assessment of a LTHHA or LTHHA contract employee was documented within the required time frame. If the documentation of a health assessment performed within the required time frame is not provided, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.13(c) 10 NYCRR § 763.13(d) 10 NYCRR § 763.13(e) 10 NYCRR § 763.13(h)

31. Missing Documentation of a PPD (Mantoux) Skin Test or Follow-up	
OMIG Audit Criteria	The record will be reviewed to determine if a LTHHA or LTHHA contract employee received a complete PPD skin test within the required time frame. If the documentation of a complete PPD skin test given within the required time frame is not provided, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.13(c)(4) 10 NYCRR § 763.13(e) 10 NYCRR § 763.13(h)

32. Missing Personnel Record(s)	
OMIG Audit Criteria	If the personnel record for the LTHHA or LTHHA contract employee providing the sampled service is missing, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.13(h)

33. Failure to Complete Annual Performance Evaluation	
OMIG Audit Criteria	The record will be reviewed to determine if annual evaluation of the performance and effectiveness of LTHHA or LTHHA contract employee was conducted within the required time frame. If documentation of the annual performance evaluation completed within the required time frame is not provided, the claim will be disallowed.
Regulatory References	10 NYCRR § 763.13(k) 10 NYCRR § 763.13(h)