NEW YORK STATE | Office of the Medicaid Inspector General

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OMIG AUDIT PROTOCOL
NURSING HOME TRANSITION AND DIVERSION WAIVER (NHTD)
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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. No Documentation of Service	
OMIG Audit Criteria	If the record does not document that service was provided, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VII

2. Missing Participant Record	
2.	**Missing Participant Record**
OMIG Audit Criteria	If a participant record is missing, the claim for the sampled date of service associated with the participant record will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VII

3. Billed More Hours than Documented	
OMIG Audit Criteria	Services/units billed in excess of those documented will be disallowed. If the participant record does not support the total units billed, the difference between units billed and the documented units will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) 18 NYCRR § 517.3(b)(1) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VII

4. Missing Service Plan/Revised Service Plan	
OMIG Audit Criteria	If the Initial Service Plan (ISP) or Revised Service Plan (RSP) is missing, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section V

5. Failure to Properly Document Change of Provider	
OMIG Audit Criteria	If the record does not contain the proper documentation for change of provider, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section V

6. Billed Service Not Included in the Service Plan	
OMIG Audit Criteria	If a service is not included in the Initial/Revised Service Plan, or Addendum, then the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

7. Billed More Hours than Authorized in the Service Plan or Addendum	
OMIG Audit Criteria	If the number of service hours billed is greater than the hours specified in the Service Plan or Addendum, then the hours exceeding the plan will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section V

8. Duplicate Billing for Service	
OMIG Audit Criteria	If a service is billed and paid more than once, each additional claim after the initial will be disallowed.
Regulatory References	18 NYCRR § 518.1(c) 18 NYCRR § 504.3(e)

9. Incorrect Rate Code Billed	
OMIG Audit Criteria	If a service was billed with an incorrect rate code, the difference between the correct and incorrect rate codes will be disallowed.
Regulatory References	18 NYCRR § 504.3(h) 18 NYCRR § 518.1(c)

10. Partial Service Hours Billed Incorrectly	
OMIG Audit Criteria	Service of less than one hour should be carried forward to the next service date and combined to accumulate billable time in whole hours. The provider must have an hour of service documented in order to bill. Claims billed that are documented for less than one hour will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

11. Overlapping of Services Not Authorized in Service Plan	
OMIG Audit Criteria	If more than one service is provided during the same time frame, and overlapping services are not authorized in either the Service Plan or the Addendum, then the overlapping claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section V

12. Duration of Service Not Documented	
OMIG Audit Criteria	If the start and/or end time of the service cannot be established from the case note, time record, or any other document used by the provider, the undocumented time will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VII

13. Patient Excess Income (Spend-down) Not applied to Billing 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 § 518.1(c) 18 NYCRR § 360-4.8(c)(1) and (c)(2)(ii) 18 NYCRR § 504.3(e)

14. Failure to Meet Service Coordination Requirements	
OMIG Audit Criteria	The service coordinator (SC) is responsible for: conducting one face-to-face contact with the participant per month, completing an in home visit with the participant every 6 months, coordinating a team meeting every six months and completing the Plan for Protective Oversight. If the above criteria are not met, the claim will be disallowed. **Note:** This finding only applies to sample claims for Service Coordination rate codes 9772, 9773, 9774 and 9775.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Sections V and VI

15. Service Coordination Caseload Exceeds Limit	
OMIG Audit Criteria	A full time SC may not exceed a case load of 20 participants. SCs providing services to NHTD waiver participants on less than a full time basis must limit their caseload proportionately. If the SC exceeds the limit of participants the claim will be disallowed. **Note:** This finding only applies to sample claims for Service Coordination rate codes 9772, 9773, 9774 and 9775.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

16. Nursing Home Transition and Diversion Waiver Service Training Not Completed	
OMIG Audit Criteria	All NHTD waiver service providers are required to complete three training components: Basic Orientation Training, Service Specific Training, and Annual Training. If the staff member providing service has not completed these trainings at the time service is rendered, then all claims provided within that time frame will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VIII

17. Service Performed by Unqualified Service Coordinator	
OMIG Audit Criteria	If the SC does not meet the requirements for qualification of the position (education/experience) at the date of service, all claims provided by the unqualified SC will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

18. Service Performed by Unqualified Community Integration Counseling (CIC) Staff	
OMIG Audit Criteria	If the provided service was performed by staff that did not meet the standards required for the CIC position (education/experience) at the date of service, the claims provided by the unqualified staff will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

19. Service Performed by Unqualified Independent Living Skills Training (ILST) Staff	
OMIG Audit Criteria	If the provided service was performed by staff that did not meet the standards required for the ILST position (education/experience) at the date of service, the claims provided by the unqualified staff will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

20. Service Performed by Unqualified Behavioral Specialist	
OMIG Audit Criteria	If the provided service was performed by staff that did not meet the standards required for the Behavioral Specialist position (education/experience) at the date of service, the claims provided by the unqualified staff will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

21. Service Performed by Unqualified Peer Mentor	
OMIG Audit Criteria	If the provided service was performed by staff that did not meet the standards required for Peer Mentoring at the date of service, the claims provided by the unqualified staff will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

22. Service Performed by Unqualified Respite Staff	
OMIG Audit Criteria	Respite Service staff must meet the same standards and qualifications as the direct care providers of Home and Community Support Services (HCSS). If services were performed by staff that did not meet the standards required for the HCSS position, then the claims provided by the unqualified staff will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

23. Service Performed by Unqualified Structured Day Program Staff	
OMIG Audit Criteria	If the provided service was performed by staff that did not meet the standards required for the Structured Day Program position, the claims provided by the unqualified staff will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

24. Service Performed by Unqualified HCSS Staff	
OMIG Audit Criteria	HCSS staff must successfully complete a 40 hour training program for Level II Personal Care Aide (PCA) or PCA Alternate Competency Demonstration equivalency testing that is approved by the Department of Health. If services were performed by staff that did not meet the standards required for the HCSS position, then the claims provided by the unqualified staff will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

25. Failure to Complete Required Annual HCSS In-Service Training	
OMIG Audit Criteria	If services were performed by HCSS staff that did not receive six hours of in-service education per year, the claims will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) 10 NYCRR § 763.13(1) 10 NYCRR § 766.11(i)(2) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

26. Failure to Complete Health Requirements	
OMIG Audit Criteria	Services provided by HCSS staff that failed to complete health requirements will be disallowed. All health requirements that are specified in 10 NYCRR 766.11 must be met inclusive of the following: • Health status assessment at time of hire, (prior to assuming patient care duties) or annual health status assessment (whichever pertains to the sampled claim). • Certificate of immunization against rubella and a certificate of immunization against measles (for all personnel born on or after January 1, 1957). • Record of either tuberculin skin test or Food and Drug Administration (FDA) approved blood assay for the detection of latent tuberculosis infection, prior to assuming patient care duties and no less than every year thereafter for negative findings (whichever pertains to the sampled claim). • **For dates of service after 7/31/2013**: documentation of vaccination against influenza, or wearing of a surgical or procedure mask during the influenza season, for personnel who have not received the influenza vaccine for the influenza season.
Regulatory References	18 NYCRR § 504.3(i) 10 NYCRR § 766.11(c) and (d)(1)(2)(4)(5)(6) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI NYS Education Department, Office of the Professions, Nursing Guide to Practice, page 37 NYS Education Department, Office of the Professions, Nursing Practice Alerts and Guidelines, PPD Protocol, June 30, 2009

27. Missing Nursing Supervision Visit	
OMIG Audit Criteria	HCSS must be provided under the direction and supervision of a Registered Professional Nurse (RN). The RN must conduct an initial home visit on the day and time HCSS staff begins providing services to the participant. Claims will be disallowed if the record does not include documentation of RN's participation in the initial home visit.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

28. Nursing Supervision Visit Reimbursed for Unbillable Services	
OMIG Audit Criteria	Nursing Supervision visits made on the day HCSS begin and visits to re-evaluate the participant for the continued need for HCSS are billable visits. If the claim is for a Nursing Supervision Visit for supervision or on-the-job training of the HCSS staff the visit is not billable and will be disallowed. **Note:** This finding only applies to sample claims for Nursing Supervision rate code 9799.
Regulatory References	18 NYCRR § 504.3(i) Nursing Home Transition and Diversion Medicaid Waiver, Program Manual 2008, Section VI

29. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame	
OMIG Audit Criteria	If the medical order was signed late, the paid claim will be disallowed. Signed medical orders are required within 30 calendar days after the authorized practitioner conducts a medical examination of the patient. If the medical order is not reviewed and revised at least every six months, the claim will be disallowed (except where an authorized practitioner, as part of an authorization, orders personal care services for up to one year for a Medicaid Patient). If the medical order for personal care services exceeds six months, the claim will be disallowed.
Regulatory Reference	18 NYCRR § 505.14(b)(3)(i)(a)(1) 10 NYCRR § 766.4(c) 10 NYCRR 763.7(a)(3)

30. Missing Documentation of Required Criminal History Check	
OMIG Audit Criteria	The record will be reviewed to determine if the provider or its contractor has documentation of 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 after 9/1/06). If the criminal history check requirement has not been completed, the paid claim will be disallowed.
Regulatory Reference	10 NYCRR § 402.9(a)(1)&(2) 10 NYCRR § 402.1(a) 10 NYCRR § 402.6(a) 10 NYCRR § 763.13(h)