NEW YORK STATE | Office of the Medicaid Inspector General

DENNIS ROSEN
Medicaid Inspector General

Audit of Claims for Long Term Home Health Care Program (LTHHCP) Services

Revised Final Audit Report
Audit #: 16-1022

Hillside Manor Nursing Center

Provider ID #: 01107868
NPI #: 1013090166

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

February 19, 2020

[redacted]
Hillside Manor Nursing Center
18215 Hillside Avenue
Jamaica, New York 11432-4853

Hillside Manor Rehab & Extended Care
18215 Hillside Avenue
Jamaica, New York 11432-4853

Re: Revised Final Audit Report
County Demonstration Project
New York City
Audit #: 16-1022
Provider ID #: 01107868

Dear [redacted]

This is the Office of the Medicaid Inspector General's (OMIG) Revised Final Audit Report for Hillside Manor Nursing Center (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 long term home health care program claims for New York City recipients paid to the Provider from July 1, 2010, through December 31, 2012. The audit universe consisted of 265,221 claims totaling $30,172,730.06. The audit consisted of a random sample of 100 claims with Medicaid payments totaling $11,086.75 (Attachment A).

The OMIG has determined that Hillside Manor Rehab & Extended Care is an affiliate of Hillside Manor Nursing Home as defined in 18 NYCRR 504.1(d)(1) and overpayments may be recouped from Hillside Manor Rehab & Extended Care pursuant to 18 NYCRR 518.6(a).

OMIG has attached the sample detail for the paid claims determined to be in error. Since you did not respond to our Revised Draft Audit Report dated February 6, 2020, the findings in the Revised Final Audit Report are identical to those in the Revised Draft Audit Report. The adjusted point estimate overpaid is $538,617. The adjusted lower confidence limit of the amount overpaid is $14,222. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the adjusted lower confidence limit of $14,222.

If you have any questions or comments concerning this report, please contact [redacted] or through email at [redacted] Please refer to audit number 16-1022 in all correspondence.

[redacted]
Division of Medicaid Audit
Office of the Medicaid Inspector General

Attachments
Certified Mail Number: 7001 0320 0005 1708 2475
Return Receipt Requested
[redacted]

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Background, Objective, and Audit Scope

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.

Reimbursement under the Medicaid Program is available for medically necessary home health services provided by a public or voluntary non-profit home health agency certified in accordance with the provisions of Article 36 of the Public Health Law. Services provided by a certified home health agency are based on a comprehensive assessment of each patient, a written plan of care, and the written orders of the treating physician, and are generally provided under the supervision of a registered nurse or therapist. The specific standards and criteria for certified home health agency services appear in 42 CFR Part 484, 18 NYCRR Section 505.23 and 10 NYCRR Part 763. MMIS Provider Manual for Home Health Services, MMIS Provider Manuals for Personal Care Services, and MMIS Provider Manuals for Nursing Services also provide programmatic guidance for the provision of home health services.

Objective

The objective of this audit was to assess Hillside Manor Nursing Center'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;
- patient 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 long term home health care program services for New York City recipients paid to the Provider by Medicaid for payment dates included in the period beginning July 1, 2010 and ending December 31, 2012 was completed.

The audit universe consisted of 265,221 claims totaling $30,172,730.06. The audit sample consisted of 100 claims totaling $11,086.75 (Attachment A).

Regulations of General Application

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)*

"A certified home health agency must provide home health services in accordance with applicable provisions of the regulations of the Department of Health . . . and with federal regulations governing home health services (42 CFR 440.70 and Part 484)." *18 NYCRR Section 505.23(b)(1)*

"Home care services agency shall mean an organization primarily engaged in arranging and/or providing, directly or through contract arrangement, one or more of the following: nursing services, home health aide services, medical supplies, equipment and appliances, and other therapeutic and related services which may include, but shall not be limited to, physical and occupational therapy, speech pathology, nutritional services, medical social services, personal care services, homemaker services and housekeeper services which may be of a preventive, therapeutic, rehabilitative, health guidance and/or supportive nature to persons at home." *10 NYCRR Section 700.2(a)(6)*

"This part establishes minimum requirements and operating standards for certified home health agencies, long term home health care programs, and AIDS home care programs . . . ."
10 NYCRR Section 763.1

"(a) The governing authority of the agency shall be responsible for the management, operation and evaluation of the agency and shall: (1) ensure compliance of the agency with the applicable federal, state and local statutes, rules and regulations . . . ." *10 NYCRR Section 763.11(a)(1)*

"'Certified home health agency' means a home care services agency which possesses a valid certificate of approval issued pursuant to the provisions of this article, or a residential health care facility or hospital possessing a valid operating certificate issued under article twenty-eight of this chapter which is authorized under section thirty-six hundred ten of this article to provide a long term home health care program. Such an agency, facility, or hospital must be qualified to participate as a home health agency under the provisions of titles XVIII and XIX of the federal Social Security Act . . ."
NY Public Health Law Section 3602.3

"Long term home health care program shall mean a coordinated plan of care and services provided at home to invalid, infirm or disabled persons who are medically eligible for placement in a hospital or residential health care facility, and who would require such placement . . . ."
10 NYCRR Section 700.2(a)(8)

"(i) AIDS home care program means a coordinated plan of care and services provided at home to persons who are medically eligible for placement in a hospital or residential health care facility and who: (a) are diagnosed by a physician as having acquired immune deficiency syndrome (AIDS); or (b) are deemed by a physician, within his judgment, to be infected with the etiologic agent of acquired immune deficiency syndrome, and who have an illness, infirmity or disability which can be reasonably

ascertained to be associated with such infection. Such program shall be provided by a long term home health care program specifically authorized pursuant to article 36 of the Public Health Law to provide an AIDS home care program; or an AIDS center, as defined in Part 405 of this Title, specifically authorized pursuant to article 36 of the Public Health Law to provide an AIDS home care program. Such program shall be provided in the person's home or in the home of a responsible relative, other responsible adult, adult care facilities specifically approved to admit or retain residents for such program, or in other residential settings as approved by the commissioner in conjunction with the Commissioner of Social Services. Such program shall provide services, including but not limited to the full complement of health, social and environmental services provided by long term home health care programs in accordance with regulations promulgated by the commissioner. Such programs shall also provide such other services as required by the commissioner to assure appropriate care at home for persons eligible under such program. (ii) A long term home health care program that does not obtain authorization to provide an AIDS home care program shall not be precluded from providing services within its existing authority to patients who are diagnosed as having AIDS, or are deemed by a physician, within his judgment, to be infected with the etiologic agent of acquired immune deficiency syndrome, and who have an illness, infirmity or disability which can be reasonably ascertained to be associated with such infection."

10 NYCRR Section 700.2(a)(26)(i)&(ii)

"The New York State Department of Social Services issued an Administrative Directive to the districts on December 30, 1983. This Administrative Directive sets forth LTHHCP requirements, program policies, and procedures to be followed statewide."

Department of Social Services 83 ADM-74, December 30, 1983

Audit Findings

OMIG issued a Revised Draft Audit Report to the Provider on February 6, 2020. Since there was no response to the Revised Draft Audit Report, the total sample overpayment of $2,912.59 remains unchanged from the sample overpayment cited in the Revised Draft Audit Report. 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 Extrapolated Findings

Error Description	Number of Errors
Billed for Services in Excess of Ordered Hours/Visits	1
Missing or Insufficient Documentation of Hours/Visits Billed	1
Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame	1

Extrapolated Findings Detail

OMIG's review of Medicaid claims paid to the Provider from July 1, 2010, through December 31, 2012, identified 3 claims with at least one error, for a total sample overpayment of $202.06 (Attachment C).

1. Billed for Services in Excess of Ordered Hours/Visits

"It is the policy of the department to pay for home health services under the medical assistance (MA) program only when; (i) the services are medically necessary."
18 NYCRR Section 505.23(a)(1)(i)

". . . 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)*

"(2) Home health services mean the following services when prescribed by a physician and provided to an MA recipient in his or her home . . . (i) nursing services . . . (ii) physical therapy, occupational therapy, or speech pathology and audiology services; and (iii) home health aide services. . . ." *18 NYCRR Section 505.23(a)(2)(i)-(iii)*

"Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency and duration of such services." *10 NYCRR Section 763.6(d)*

"Any such service provided to a Recipient must be ordered by his/her physician as part of a written plan of care. . . ."
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

"In addition to the actual provision of services, LTHHCP providers have management responsibilities. These responsibilities include . . . Obtaining necessary physician orders . . . Notifying the local social services districts the first working day following the noting of a change in the patient's condition and concerning any changes in the authorized summary of services. Seeking prior authorization for any service change which exceeds by 10% or more the 75% cap for the patient . . . ." *Department of Social Services 83 ADM-74, December 30, 1983 Section I, paragraph K. 2 and 7*

"The client's physician must indicate that care in the home setting is appropriate for the client and must provide orders for treatment, medication and services."
MMIS Provider Manual, Long Term Home Health Care Program Services, Section 2, February 1992

In 1 instance, billed home care services exceeded the maximum frequency of visits or number of hours or services specified on the authorized practitioner's order. The portion of the sampled claim exceeding the order will be disallowed. This finding applies to Sample # 29.

2. Missing or Insufficient Documentation of Hours/Visits Billed

"The department will pay providers of home health services for home health services provided under this section at rates established by the Commissioner of Health and approved by the

Division of Budget; however, no payment will be made unless the claim for payment is supported by documentation of the time spent providing services to each recipient."

18 NYCRR Section 505.23(e)(1)

"The agency shall maintain a confidential clinical record for each patient admitted to care or accepted for service to include: (6) signed and dated progress notes, following each patient contact by each professional person providing care, which shall include a summary of patient status and response to plan of care and, if applicable, contacts with family, informal supports and other community resources, and a brief summary of care provided at the termination of each service; (7) observations and reports made to the registered professional nurse, licensed practical nurse or supervising therapist by the home health aide or personal care aide, including activity sheets." *10 NYCRR Section 763.7(a)(6)&(7)*

In 1 instance, the documentation to support the claim was either missing or did not fully support the claim. In cases where the documentation provided supported part of the claim, only that portion of the claim that was not supported will be disallowed. This finding applies to Sample # 68.

3. **Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame**

"Home health services mean the following services when prescribed by a physician and provided to an MA recipient in his or her home . . . (i) nursing services . . . (ii) physical therapy, occupational therapy, or speech pathology and audiology services; and (iii) home health aide services . . . ." *18 NYCRR Section 505.23(a)(2)(i)-(iii)*

"The agency shall maintain a confidential clinical record for each patient admitted to care or accepted for service to include: . . . (3) medical orders and nursing diagnoses . . . (i) signed by the authorized practitioner within 30 days after admission to the agency, or prior to billing, whichever is sooner; (ii) signed by the authorized practitioner within 30 days after issuance of any change in medical orders or prior to billing, whichever is sooner, to include all written and oral changes and changes made by telephone by such practitioner; and (iii) renewed by the authorized practitioner as indicated by the patient's condition but at least every 60 days . . ."

10 NYCRR Section 763.7(a)(3)(i)-(iii)

"Each patient's clinical records shall be kept securely for not less than six years after discharge from the agency and made available to the department upon request. In the case of minors, records are to be kept for not less than six years after discharge, or three years after they reach majority (18 years), whichever is the longer period." *10 NYCRR Section 763.7(c)*

"The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in case-mix assignment; or a discharge and return to the same HHA during the 60-day episode. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care." *42 CFR Section 484.18(b)*

Medicaid policy states: "Any such service provided to a Recipient must be ordered by his/her physician as part of a written plan of care . . . ."

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

"The NYS Department of Social Services administrative directive dated December 30, 1983 advises that the LTHHCP nurse representative will be directly responsible for and/or assure via the nursing plan of care, that the physician's orders are carried out, that the care is documented, and that the medical orders are renewed every sixty days. The LTHHCP provider has management responsibilities that include obtaining necessary physician orders."

Department of Social Services 83 ADM-74, December 30, 1983, Section III

"The client's physician must indicate that care in the home setting is appropriate for the client and must provide orders for treatment, medication and services."

MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992

In 1 instance, the order was not signed within the required time frame. There was no signed order in effect for the sampled date of service. The practitioner's renewal of the order occurred after the certification period pertaining to the date of service. This finding applies to Sample # 73.

Summary of Not Extrapolated Findings

Error Description	Number of Errors
Home Assessment Abstract Not Documented/Late/Incomplete	23
DMS-1 Not Documented/Late/Incomplete	11
Ordering Practitioner Conflicts with Claim Practitioner	1
Missing Personnel Record	1
DMS-1 Not Prepared by a Licensed and Registered Nurse or Physician	1
Missing Certificate of Immunization	1
Failure to Conduct Required Criminal History Check	1
Failure to Complete Required In-Service Training (PCA)	1
Failure to Complete Annual Performance Evaluation	1

Not Extrapolated Findings Detail

OMIG's review of Medicaid claims paid to the Provider from July 1, 2010, through December 31, 2012, identified 26 claims with at least one error, for a total sample overpayment of $2,710.53 (Attachment C-1). The findings below are not included in the extrapolation calculation.

1. **Home Assessment Abstract Not Documented/ Late/Incomplete**

"In addition to meeting the clinical record requirements of subdivision (a) of this section, clinical records for long term home health care programs and AIDS home care programs shall include an evaluation of the medical, mental health, social and environmental needs of the patient, on forms prescribed by the commissioner, which shows that the patient is medically eligible for placement in a hospital or residential health care facility were this program not available."
10 NYCRR Section 763.7(b)

"(2) If a person . . . desires to remain and is deemed by his or her physician able to remain in his/her own home . . . the social services district must authorize a home assessment of the appropriateness of the LTHHCP or AHCP services. The assessment must include, in addition to the physician's recommendation, an evaluation of the social and environmental needs of the person. . . . (ii) . . . and must be performed by the person's physician, a representative of the social services district, and a representative of the LTHHCP or AHCP that will provide services to the person." *18 NYCRR Section 505.21(b)(2)(ii)*

"(8) No single authorization for LTHHCP or AHCP services may exceed four months. (i) A reassessment must be performed at least every 120 days . . ."
18 NYCRR Section 505.21(b)(8)(i)

"The commissioner must prescribe the forms on which the assessment will be made."
18 NYCRR Section 505.21(b)(2)(viii)

"The NYS Department of Social Services administrative directive dated December 30, 1983 advises that the home assessment is done in order to determine how, and if, the patient's total health and social care needs, as well as those prescribed by the physician, can be met in the home environment. The home assessment is accomplished by completion of the Home Assessment Abstract (or its successor) by the nurse representative of the LTHHCP and the professional caseworker from the LDSS. If a joint assessment cannot be made the LTHHCP representative performs a preliminary assessment; based on this assessment the LTHHCP representative develops a proposed summary of service requirements. The summary of service requirements is a listing of the types, frequency and amounts of services which will be necessary to maintain the patient at home. This listing can be found on the Home Assessment Abstract. The summary of service requirements should represent all the services-medical, nursing, social work, therapies, health aide, personal care, homemaking, housekeeping, drugs, and all other support services. It shall be the responsibility of the LTHHCP nurse representative to assure that the orders are written clearly and concisely and reflected on page 4 of the Home Assessment Abstract. The representative of the LTHHCP will be a registered professional nurse. The LTHHCP nurse representative establishes goals for the patient and methodology for achieving these goals by a practical nursing plan which clearly outlines the nursing, home health aide and personal care services and other therapeutic and supportive modalities. The plan outlines the methodology of approach and practical applications. The goals should be well-defined, measurable and updated and re-evaluated at each reassessment period (120 days)

and whenever indicated. There will be a "complete" reassessment done every 120 days for each patient. No single authorization for LTHHCP services may exceed 120 days."

Department of Social Services 83 ADM-74, December 30, 1983

"Home Assessment This assessment determines if and how the client's total health, social and environmental care needs can be met at home. It is accomplished by completion of the Home Assessment Abstract (HAA) or its successor . . ."

MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992

"Each patient will be reassessed every 120 days . . . The tool for the periodic reassessment and any resultant change in service requirements will be the DMS-1 or its successor and the Home Assessment Abstract or its successor."

MMIS Provider Manual for Long Term Home Health Care Program Services, Revised February 1992

"The Long Term Home Health Care Program Reference Manual (Manual) advises that the Home Assessment Abstract (otherwise known as the HAA or DSS 3139) is a tool used to determine whether the individual's total health and social care needs can be met in the home environment. The Summary of Service Requirements and Plan of Care are developed from the abstract. In items 12 and 13 of the HAA, a registered nurse (RN) from the provider agency records all clinical information regarding the individual's health status. The RN is responsible for assessing the home with regard to safety and ease of activities of daily living and records that information Item 12. The nurse must assess the recovery potential anticipated for the individual, and records the result in Item 13. The RN must also assess individual abilities in the activities of daily living (such as bathing, dressing and grooming) and records the results in Item 14. The RN must ensure that the reassessment is done within 120 days and is responsible for revising the nursing goals and updating the Plan of Care."

Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2

"In addition, at least once every 180 days, a reassessment of the participant must be conducted by the LTHHCP agency RN and the LDSS staff to verify the participant's eligibility for the LTHHCP waiver program and determine whether the participant's POC needs to be modified based upon the results of the reassessment of the participant's condition."

Long Term Home Health Care Program Medical Waiver Program Manual, May 2012, Section II

"The waiver renewal implements legislation enacted in June 2010 to extend the reassessment time frame from every 120 days to every 180 days, or more frequently when a participant's service needs change. LDSS staff were instructed to phase-in the new policy effective September 1, 2010, as participants' existing 120 day authorizations expired and subsequent reassessments could then be authorized for 180 days." *NYS DOH11 OLTC/ ADM-1*

In 23 instances pertaining to 20 patients, the Home Assessment Abstract was not completed within the regulatory time frame. This finding applies to Sample #s 2, 3, 6, 8, 10, 13, 18, 26, 27, 30, 42, 45, 54, 65, 69, 71, 76, 82, 93, 94, 95, 96, and 98.

2. **DMS-1 Not Documented/Late/Incomplete**

"In addition to meeting the clinical record requirements of subdivision (a) of this section, clinical records for long term home health care programs and AIDS home care programs shall include an evaluation of the medical, mental health, social and environmental needs of the patient, on forms prescribed by the Commissioner, which shows that the patient is medically eligible for placement in a hospital or residential health care facility were this program not available."

10 NYCRR Section 763.7(b)

"The commissioner must prescribe the forms on which the assessment will be made."

18 NYCRR Section 505.21(b)(2)(viii)

"(8) No single authorization for LTHHCP or AHCP services may exceed four months. (i) A reassessment must be performed at least every 120 days . . ."

18 NYCRR Section 505.21(b)(8)(i)

"The NYS Department of Social Services Administrative Directive dated December 30, 1983 advises that a medical assessment is the initial assessment process. The medical assessment is accomplished by completion and scoring of the DMS-1 or its successor. The DMS-1 is also the tool that is used as an indicator for need for SNF or HRF placement. If the person is currently in his own home or the home of a relative or responsible adult, the DMS-1 or its successor will most often be completed by the LTHHCP nurse representative or by the patient's physician. After the initial medical and home assessments, development of the summary of service requirements and implementation of the plan of care, there will be a complete reassessment done every 120 days for each patient. Therefore, no single authorization for Long Term Home Health Care Program services may exceed 120 days."

Department of Social Services 83 ADM-74, December 30, 1983

"The following conditions must be met in order for a client to receive the services of a LTHHCP: . . . A client must be assessed as medically eligible for placement in a skilled nursing or health related facility. The assessment must be completed by a physician or a registered professional nurse on forms approved by the Commissioner of Health (the DMS-1 or its successor)." *MMIS Provider Manual for Long Term Home Health Care Program Services, February 1992*

"A registered nurse must complete the New York State Long Term Care Placement Form Medical Assessment Abstract (otherwise known as the DMS-1). The DMS-1 is an instrument used to evaluate an individual's current medical condition . . . ."

Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2

"A registered nurse (RN), or physician, must complete the DMS-1 to evaluate an individual's current medical condition . . ."

Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012 Section II

"The RN must ensure that the reassessment is done within 120 days and is responsible for revising the nursing goals, updating the Plan of Care, and completing the DMS-1 form."

Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2

"A complete reassessment, including re-evaluation of the participant's current health, medical, nursing, social, environmental, and rehabilitative needs, must be conducted no later than 180 days from the individual's previous assessment. No single authorization for LTHHCP participation may exceed 180 days."

Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Section II

"The waiver renewal implements legislation enacted in June 2010 to extend the reassessment time frame from every 120 days to every 180 days, or more frequently when a participant's service needs change. LDSS staff were instructed to phase-in the new policy effective September 1, 2010, as participants' existing 120 day authorizations expired and subsequent reassessments could then be authorized for 180 days." *NYS DOH 11 OLTC/ ADM-1*

In 11 instances pertaining to 10 patients, the DMS-1 was not completed within the regulatory time frame. This finding applies to Sample #s 6, 8, 18, 26, 30, 45, 69, 71, 76, 82, and 94.

3. **Ordering Practitioner Conflicts with Claim Practitioner**

". . . the 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), (f), (h) and (i)

"Effective 90 days after the release of this Medicaid Update . . . . . ordering provider information fields on all home health care claims . . . The ordering provider should identify the practitioner who actually ordered the services being billed. Inaccurate information . . . may result in future audit disallowances. Full compliance with this requirement will enable the State to verify the licensing of ordering practitioners and identify practitioners excluded or suspended from Medicare/Medicaid." *NYS DOH Medicaid Update, May 2009, Vol. 25, No. 6*

"Enter the NPI of the provider ordering the services . . . . A facility ID cannot be used for the referring/ordering provider. In those instance(s) where an order or referral was made by a facility, the ID of the practitioner at the facility must be used. When providing services to a member who is restricted to a primary physician or facility, the NPI of the member's primary physician must be entered in this field. The ID of the facility cannot be used."

NYS Medicaid Provider Manual for Home Health – UB-04 Billing Guidelines, Version 2010-1, Section 2.4.2

NYS Medicaid General Billing Guidelines Institutional, Version 2011-01, Section 2.4.2

In 1 instance, the ordering practitioner included on the claim differed from the ordering practitioner who signed the order. This finding applies to Sample # 88.

4. **Missing Personnel Record**

"(h) that personnel records include, as appropriate, records of professional licenses and registrations; verifications of employment history and qualifications for 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)*

In 1 instance, the provider failed to produce a personnel file for the individual providing the sampled service. This finding applies to Sample # 70.

5. **DMS-1 Not Prepared by a Licensed and Registered Nurse or Physician**

"A patient shall be admitted to the agency after an assessment, using a form prescribed or approved by the department, is performed during the initial patient visit, which indicates that the patient's health and supportive needs can be met safely and adequately at home and that the patient's condition requires the services of the agency." *10 NYCRR Section 763.5(b)*

"In addition to meeting the clinical record requirements of subdivision (a) of this section, clinical records for long term home health care programs and AIDS home care programs shall include an evaluation of the medical, mental health, social and environmental needs of the patient, on forms prescribed by the commissioner, which shows that the patient is medically eligible for placement in a hospital or residential health care facility were this program not available." *10 NYCRR Section 763.7(b)*

"A registered nurse must complete the New York State Long Term Care Placement Form Medical Assessment Abstract (otherwise known as the DMS-1). The DMS-1 is an instrument used to evaluate an individual's current medical condition . . . ."
Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2

"A registered nurse (RN), or physician, must complete the DMS-1 to evaluate an individual's current medical condition . . ."
Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Section II

"The RN must ensure that the reassessment is done within 120 days and is responsible for revising the nursing goals, updating the Plan of Care, and completing the DMS-1 form."
Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2

"A complete reassessment, including re-evaluation of the participant's current health, medical, nursing, social, environmental, and rehabilitative needs, must be conducted no later than 180 days from the individual's previous assessment. No single authorization for LTHHCP participation may exceed 180 days."
Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Section II

"New York State Long Term Care Placement Form Medical Assessment Abstract (DMS-1) . . . is completed and signed by the provider RN."
Long Term Home Health Care Program Reference Manual, June 2006, Chapter 2

"New York State Long Term Care Placement Form Medical Abstract (DMS-1) . . . is completed and signed by the LTHHCP agency RN."
Long Term Home Health Care Program Medicaid Waiver Program Manual, May 2012, Section II

"The NYS Department of Social Services Administrative Directive dated December 30, 1983 advises that a medical assessment is the initial assessment process. The medical assessment is accomplished by completion and scoring of the DMS-1 or its successor. The DMS-1 is also the tool that is used as an indicator for need for SNF or HRF placement. If the person is currently in his own home or the home of a relative or responsible adult, the DMS-1 or its successor will most often be completed by the LTHHCP nurse representative or by the patient's physician. After the initial medical and home assessments, development of the summary of service requirements and implementation of the plan of care, there will be a complete reassessment done every 120 days for each patient. Therefore, no single authorization for Long Term Home Health Care Program services may exceed 120 days."

Department of Social Services 83 ADM-74, December 30, 1983

In 1 instance, the DMS-1 was not prepared by a licensed and registered nurse or physician. This finding applies to Sample # 10.

6. **Missing Certificate of Immunization**

"(c) 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 . . . (2) a certificate of immunization against measles for all personnel born on or after January 1, 1957. . . ."

10 NYCRR Section 763.13(c)

"(e) 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)

"(h) 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, provided that all documentation and information pertaining to an employee's medical condition or health status, including such records of physical examinations and health status assessments shall be maintained separate and apart from the non-medical personnel record information and shall be afforded the same confidential treatment given patient medical records . . ." *10 NYCRR Section 763.13(h)*

In 1 instance, there was no record that the individual providing the sampled services received the required immunizations. This finding applies to Sample # 80.

7. **Failure to Conduct Required Criminal History Check**

"(1) Each provider shall establish, maintain, and keep current, a record of: (i) a roster of current employees who were reviewed pursuant to this Part and a list of their staffing assignments; such roster shall be submitted by April 1st of each year or upon written request of the Department in a form and format specified by the Commissioner; (ii) the names of each person for whom a request for a criminal history information was submitted to the Department; (iii) for each such name recorded pursuant to subparagraph (ii) of this paragraph, a copy of the signed informed consent form required pursuant to section 402.5 of this Part; (iv) and the results of the criminal

history record check and determination of the department with regard to the employment; and (v) for certified home health care agencies, licensed home care services agencies or long term home health care programs licensed or certified under article 36 of the Public Health Law, the onsite supervision and alternate week contacts made for assessment of temporary employees as set forth in section 402.4(b)(2)(ii) of this Title. (2) Such record shall be maintained in a manner that ensures the security of the information contained therein, but which also assures the Department of immediate and unrestricted access to such information upon its request, for the purpose of monitoring compliance with this Part." *10 NYCRR Section 402.9(a)(1)&(2)*

"Chapter 769 of the Laws of 2005 and amended by Chapters 331 and 673 of the Laws of 2006, imposed the requirement for review of the criminal history record of certain prospective employees of . . . certified home health agencies, . . . who are hired or used on or after September 1, 2006 and who provide direct care or supervision to patients . . ."
10 NYCRR Section 402.1(a)

"The provider shall ensure the submission of a request for a criminal history check for each prospective employee . . . . ." *10 NYCRR Section 402.6(a)*

"(h) 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)*

In 1 instance, the provider did not initiate the required criminal history check for the employee providing the sampled service. This finding applies to Sample # 69.

8. **Failure to Complete Required In-Service Training (PCA)**

"(l) . . . At a minimum: . . . (2) personal care aides shall participate in six hours of in-service education per year; . . ." *10 NYCRR Section 763.13(l)(2)*

"(h) 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)*

In 1 instance, there was no documentation that the personal care aide providing the sampled services received the required in-service training. This finding applies to Sample # 69.

9. **Failure to Complete Annual Performance Evaluation**

"(k) that an annual assessment of the performance and effectiveness of each person is conducted and documented in writing, including at least one home visit to observe performance if the person provides services in the home . . ." *10 NYCRR Section 763.13(k)*

"(h) that personnel records include, as appropriate, records of professional licenses and registrations; verifications of employment history and qualifications for 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)*

In 1 instance, there was no documentation that an annual performance evaluation was completed for the individual providing the sampled services. This finding applies to Sample # 69.

Repayment Options

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 Revised 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 # 16-1022
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 Revised 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 Section 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 Revised Final Audit Report as the final administrative determination for purposes of obtaining a judgment lien pursuant to Section 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 Section 518.6; and imposing a sanction, pursuant to 18 NYCRR Section 515.2, against a provider who fails to reimburse the department for overpayments discovered by this audit.

Hearing Rights

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 $538,617. 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

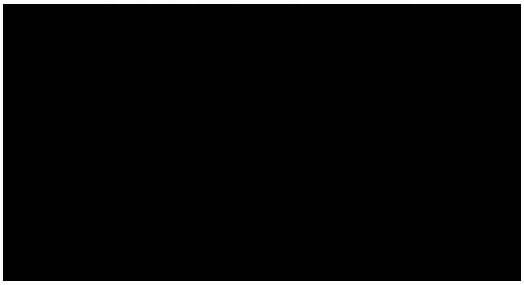
Questions regarding the request for a hearing should be directed to Office of Counsel, at [redacted]

In accordance with 18 NYCRR Section 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.

Contact Information



Office Address:

New York State
Office of the Medicaid Inspector General
Division of Medicaid Audit
800 North Pearl Street
Albany, New York 12204

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.

NEW YORK STATE | Office of the Medicaid Inspector General

REMITTANCE ADVICE

[redacted]
Hillside Manor Nursing Center
18811 Hillside Avenue
Hollis, New York 11423-1935

Provider ID #: 01107868

Audit #: 16-1022

Amount Due: $14,222

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 #16-1022
Albany, New York 12237