NEW YORK STATE | Office of the Medicaid Inspector General

FRANK T. WALSH JR.
Acting Medicaid Inspector General

Audit of Claims for Assisted Living Program (ALP) Services

Final Audit Report
Audit #: 19-5931

Valley Residential Services Inc.

Provider ID #: 04196383

Fighting Fraud. Improving Integrity and Quality. Saving Taxpayer Dollars.

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

FRANK T WALSH JR.
Acting Medicaid Inspector General

June 23, 2021

[redacted]
Valley Residential Services Inc.
161 Valley Drive
Herkimer, New York 13350-3736

Re: Final Audit Report
Audit #: 19-5931
Provider ID #: 04196383

Dear [redacted]

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Valley Residential Services Inc (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 504and 517, OMIG performed an audit of assisted living program (ALP) claims paid to the Provider from January 1, 2016, through December 31, 2018. The audit universe consisted of 1,000 claims totaling $1,282,385.34. The audit consisted of a random sample of 100 claims with Medicaid payments totaling $119,906.61 (Attachment A).

The Provider's June 9, 2021 response to OMIG's May 5, 2021 Draft Audit Report stated that the Provider is in agreement with the Draft Audit Report findings. OMIG has attached the sample detail for the paid claims determined to be in error. The adjusted point estimate overpaid is $178,488. The adjusted lower confidence limit of the amount overpaid is $130,776. 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 $130,776.

If you have any questions or comments concerning this report, please contact [redacted] or through email at [redacted]. Please refer to audit number 19-5931 in all correspondence.

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

Attachments
Certified Mail Number: 7011-2970-0002-2621-2682
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.

An Assisted Living Program ("ALP") is an entity approved to operate, pursuant to 18 NYCRR Section 485.6(n), in adult homes and enriched housing programs. The ALP is established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible residents unrelated to the operator 18 NYCRR Section 494.2. For each Medicaid enrollee participating in the ALP, a daily rate is paid to the ALP for the provision of nine distinct home care services. No additional fee-for-service billing can be made for these home care services.

Services covered under the daily Medicaid rate and for which no additional separate billing may be made include:

- Title XIX Personal Care Services
- Home Health Aide Services
- Personal Emergency Response Services
- Nursing Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical supplies and equipment not requiring prior approval
- Adult Day Health Care

Objective

The objective of this audit was to assess Valley Residential Services Inc'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;
- resident 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 assisted living program (ALP) claims paid to the Provider by Medicaid for payment dates included in the period beginning January 1, 2016, and ending December 31, 2018, was completed.

The audit universe consisted of 1,000 claims totaling $1,282,385.34. The audit sample consisted of 100 claims totaling $119,906.61 (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)

Audit Findings

OMIG issued a Draft Audit Report to the Provider on May 5, 2021. The Provider's June 9, 2021 responseto the Draft Audit Report stated that the Provider is in agreement with the Draft Audit Report findings. As a result, the total sample overpayment of $79,777.40 remains unchanged from the sample overpayment cited in the 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 Audit Findings

Error Description	Number of Errors
Missing Required Health Assessment	78
Missing Docmentation of a Tuberculosis Skin Test or Follow-Up	72
Failure to Complete Required In-Service Training for Home Health Aide	62
Failure to Complete Annual Performance Evaluation	28
Missing Certificate of Immunization	23
Missing Entry in the Uniform Assessment System of NY (UAS-NY)	14
Plan of Care Not Updated as Required	5
Failure to Complete Medical Reassessment	5
Missing Medical Evaluation	2
Billed for Services While Inpatient at Another Facility	2

Audit Findings Detail

OMIG's review of Medicaid claims paid to the Provider from January 1, 2016, through December 31, 2018, identified 93 claims with at least one error, for a total sample overpayment of $79,777.40 (Attachment C).

1. Missing Required Health Assessment

Regulations state, "that the health status of all new personnel is assessed prior to assuming patient care duties. The assessment shall be of sufficient scope to ensure that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. 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)(1) and (2)*

Regulations state, "that the health status of all personnel be reassessed as frequently as necessary, but no less than annually, to ensure that personnel are free from health impairments which pose potential risk to patients or personnel or which may interfere with the performance of duties." *10 NYCRR Section 763.13(d)*

Regulations state, "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)*

Regulations state, "The agency shall ensure for all personnel 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)*

Regulations state, "The governing authority or operator shall ensure for all health care personnel: . . . (d) that a record of the following tests, examinations or other required documentation is maintained for all personnel who have direct patient contact: . . . (5) an annual, or more frequent if necessary, health status assessment to assure that all personnel are free from any health impairment that is of potential risk to the patient, family or to employees or that may interfere with the performance of duties; and . . ." *10 NYCRR Section 766.11(d)(5)*

On 78 claims in 879 instances pertaining to 43 residents, there was no documentation that the individual with direct patient contact for our sampled claim(s) received the required health assessment. This finding applies to Sample #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 28, 29, 30, 32, 33, 34, 36, 38, 39, 42, 44, 45, 46, 47, 48, 50, 51, 52, 53, 55, 56, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 76, 78, 80, 81, 84, 85, 87, 88, 90, 91, 92, 93, 94, 96, 97 and 98.

2. **Missing Documentation of Tuberculosis Skin Test or Follow-up**

Regulations state, "(c) that the health status of all new personnel is assessed prior to assuming patient care duties. The assessment shall be of sufficient scope to ensure that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient...(4) 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. Positive findings shall require appropriate clinical follow-up but no repeat tuberculin skin test or blood assay. The agency shall develop and implement policies regarding follow-up of positive test results . . ."

10 NYCRR Section 763.13(c)(4)

Regulations state, "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)

Regulations state, "The agency shall ensure for all personnel 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)

Regulations state, "The governing authority or operator shall ensure for all health care personnel: . . . (d) that a record of the following tests, examinations or other required documentation is maintained for all personnel who have direct patient contact: . . . (4) 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. Positive findings shall require appropriate clinical follow-up but no repeat tuberculin skin test or blood assay. The agency shall develop and implement policies regarding follow-up of positive test results; . . ."

10 NYCRR Section 766.11(d)(4)

On 72 claims in 845 instances pertaining to 43 residents, there was no documentation that the individual with direct patient contact for our sampled claim(s) had the required Tuberculosis test or follow up. This finding applies to Sample #s 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 28, 29, 30, 33, 34, 36, 38, 39, 42, 43, 44, 46, 48, 50, 51, 52, 53, 55, 56, 58, 59, 60, 61, 62, 63, 65, 66, 67, 68, 69, 70, 71, 73, 74, 76, 78, 80, 81, 84, 87, 88, 90, 91, 92, 93, 94, 96, 97 and 98.

3. **Failure to Complete Required In-Service Training for Home Health Aide**

Regulations State, "(h) that personnel records include, as appropriate, records of professional licenses and registrations; verifications of employment history and qualifications for the duties assigned...and other pertinent data . . ." *10 NYCRR Section 763.13(h)*

Regulations state, "(l) . . . receive orientation to the policies and procedures of the agency operation, inservice education necessary to perform his/her responsibilities and continuing programs for development and support. At a minimum: (1) home health aides shall participate in 12 hours of inservice education per year." *10 NYCRR Section 763.13(l)(1)*

Regulations state, "(i) that all personnel receive orientation to the policies and procedures of the home care services agency operation and inservice education necessary to perform his/her responsibilities. At a minimum: (1) home health aides must participate in 12 hours of inservice education per year; and . . ." *10 NYCRR Section 766.11(i)(1)*

On 62 claims in 1,578 instances pertaining to 34 residents, the home health aide providing our sampled claim(s) did not have documentation of a completed in-service training. This finding applies to Sample #s 1, 2, 3, 4, 5, 6, 8, 10, 11, 15, 16, 21, 22, 24, 25, 26, 28, 29, 30, 32, 34, 35, 37, 38, 39, 41, 43, 44, 47, 48, 49, 50, 54, 55, 56, 57, 58, 62, 64, 68, 69, 70, 72, 74, 75, 76, 79, 80, 81, 82, 83, 86, 87, 88, 89, 90, 92, 93, 96, 97, 98 and 99.

4. Failure to Complete Annual Performance Evaluation

Regulations state, "The agency shall ensure for all personnel . . . 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)*

Regulations state, "(5) At a minimum the operator shall maintain: (vii) staff records, including personnel procedures, job descriptions, staffing schedules and payment records." *18 NYCRR Section 487.10(d)(5)(vii)*

Regulations state, "(4) At a minimum, the operator must maintain: (vii) staff records, including personnel procedures, job descriptions, staffing schedules and payment records; *18 NYCRR Section 488.10(d)(4)(vii)*

On 28 claims in 152 instances pertaining to 23 residents, there was no documentation that an annual performance evaluation was completed for the individual providing services for our sampled claim(s). This finding applies to Sample #s 7, 9, 12, 14, 17, 18, 20, 23, 33, 36, 42, 45, 51, 52, 53, 59, 60, 61, 63, 65, 66, 67, 71, 73, 78, 85, 91 and 94.

5. Missing Certificate of Immunization

Regulations state, "that the health status of all new personnel is assessed prior to assuming patient care duties. The assessment shall be of sufficient scope to ensure that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. 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)(1) and (2)*

Regulations state, "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)*

Regulations state, "The governing authority or operator shall ensure for all health care personnel: . . . (d) that a record of the following tests, examinations or other required documentation is maintained for all personnel who have direct patient contact: . . . (1) a certificate of immunization against rubella which means: (i) a document prepared by a physician, physician assistant, specialist assistant, nurse practitioner, licensed midwife or a laboratory possessing a laboratory permit issued pursuant to Part 58 of this Title, demonstrating serologic evidence of rubella antibodies; (ii) a document indicating one dose of live virus rubella vaccine was administered on or after the age of 12 months, showing the product administered and the date of administration, and prepared by the health practitioner who administered the immunization; or (iii) a copy of the document described in subparagraph (i) or (ii) of this paragraph which comes from a previous employer or the school which the individual attended as a student; (2) a certificate of immunization against measles for all personnel born on or after January 1, 1957, which means: (i) a document prepared by a physician, physician assistant, specialist assistant, nurse practitioner, licensed midwife or a laboratory possessing a laboratory permit issued pursuant to Part 58 of this Title, demonstrating serologic evidence of measles antibodies; (ii) a document indicating two doses of live virus measles vaccine were administered with the first dose administered on or after the age of 12 months and the second dose administered more than 30 days after the first dose but after 15 months of age showing the product administered and the date of administration, and prepared by the health practitioner who administered the immunization; (iii) a document indicating a diagnosis of the person as having had measles disease prepared by the physician, physician assistant, specialist assistant, licensed midwife or nurse practitioner who diagnosed the person's measles; or (iv) a copy of the document described in subparagraph (i), (ii) or (iii) of this paragraph which comes from a previous employer or the school which the person attended as a student; (3) a written statement, if applicable, from any licensed physician, physician assistant, specialist assistant, licensed midwife or nurse practitioner, which certifies that immunization with measles and/or rubella vaccine may be detrimental to the person's health. The requirements of paragraphs (1) and (2) of this subdivision relating to measles and/or rubella immunization shall be inapplicable until such immunization is found no longer to be detrimental to such person's health. The nature and duration of the medical exemption must be stated in the individual's personnel record and must be in accordance with generally accepted medical standards (for example, the recommendations of the American Academy of Pediatrics and the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services); . . . (6) 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 current influenza season, pursuant to section 2.59 of this Title."

10 NYCRR Section 766.11(d)(1-3) & (6)

On 23 claims in 128 instances pertaining to 20 residents, there was no record that the individual with direct patient contact for our sampled claim(s) received the required immunizations. This finding applies to Sample #s 1, 8, 22, 26, 30, 35, 37, 41, 47, 48, 49, 50, 56, 57, 75, 79, 82, 83, 87, 89, 92, 98 and 99.

6. **Missing Entry in the Uniform Assessment System for NY (UAS-NY)**

Regulations state, "(a) The agency shall maintain a confidential record for each patient admitted to care to include . . . (3) nursing assessments conducted to provide services."

10 NYCRR Section 766.6(a)(3)

Regulations state, "By enrolling the provider agrees: (i) to comply with the rules, regulations, and official directives of the department." *18 NYCRR Section 504.3(i)*

Medicaid policy states: "The UAS-NY will be used in the following Medicaid programs: Adult Day Health Care, Assisted Living Program, Care at Home I and II, Managed Long Term Care (PACE, MAP, MLTC), Long Term Home Health Care, Personal Care, Consumer Directed Personal Care, Nursing Home Transition and Diversion Waiver, and Traumatic Brain Injury Waiver." *NYS DOH Medicaid Update, February 2013, Vol. 29, No. 3*

On 14 claims in 145 instances pertaining to 14 residents, the record did not include an entry in the UAS NY System for our claim. This finding applies to Sample #s 4, 14, 21, 35, 39, 46, 56, 57, 60, 65, 76, 82, 88 and 89.

7. Plan of Care not Updated as Required

Regulations state, "(d) The plan of care is reviewed and revised as frequently as necessary to reflect the changing care needs of the patient, but no less frequently than every six months; (1) each review shall be documented in the patient's clinical record; and (2) agency professional personnel shall promptly alert the patient's authorized practitioner and other affected care providers to any significant changes in the patient's condition that indicate a need to alter the plan of care." *10 NYCRR Section 766.3(d)*

Regulations state, "(a) the agency shall maintain a confidential record for each patient admitted to care to include . . . (4) an individualized plan of care." *10 NYCRR 766.6(a)(4)*

Regulations state, "Appropriate services must be provided to or arranged for an eligible individual only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conduct by an assisted living program, or if the assisted living program itself is not an approved long-term home health care program or certified home health agency, by an assisted living program and a long-term home health care program or certified home health agency." *18 NYCRR Section 494.4(b)*

On 5 claims in 32 instances pertaining to 5 residents, the record did not include a plan of care that was updated and reviewed at least every 6 months. This finding applies to Sample #s 17, 21, 60, 69 and 76.

8. Failure to Complete the Medical Reassessment

Regulations state, "(iii) Appropriate services shall be provided to an eligible person only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an assisted living program, either directly or through contract with a long term home health care program or certified home health agency. A reassessment shall be conducted as frequently as is required to respond to changes in the resident's condition and ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months. No person shall be admitted to or retained in an assisted living program unless the person can be safely and adequately cared for with the provision of services determined by such assessment or reassessment."
NYS Social Services Law 461-L(2)(d)(iii)

Regulations state, "Each medical evaluation (DSS-3122 or an approved substitute) shall be a written and signed report from a physician, physician assistant or nurse practitioner which includes: (1) the date of examination, significant medical history and current conditions, known allergies, the prescribed medication regimen, including information on the applicant's ability to self-administer medications, recommendations for diet, exercise, recreation, frequency of medical examinations and assistance needed in the activities of daily living; (2) a statement that the resident is not medically or mentally unsuited for care in the facility; (3) a statement that the resident does not require placement in a hospital or residential health care facility; and (4) a statement that the physician, physician assistant or nurse practitioner has physically examined the resident within 30 days prior to the date of admission or, for required annual evaluations, within 30 days prior to the date of the report." *18 NYCRR Section 487.4(f)*

Regulations state, "(d) An operator must not admit nor retain an individual without a determination being made that the enriched housing program can support the physical and social needs of the resident. Such determination must be based upon: (1) a medical evaluation (DSS-3122 or an approved substitute) written and signed by a physician, physician assistant or nurse practitioner, which includes: . . ." *18 NYCRR Section 488.4(d)(1)*

Regulations state, "By enrolling the provider agrees: (i) to comply with the rules, regulations, and official directives of the department." *18 NYCRR Section 504.3(i)*

Medicaid policy states: "The ALP Medical Evaluation – Interim was approved as an alternate to the more in depth ALP Medical Evaluation (DSS 4449C) for the six month reassessment. During the six month ALP reassessment, the UAS-NY will be updated by the assessor and sent to the resident's physician who will complete the Medical Evaluation form and sign the physician certification." *NYS DOH DAL 14-10: Revised ALP Medical Evaluation*

Regulations state, "(g) . . . reassessments must be conducted as frequently as required to respond to changes in the resident's condition and to ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months." *18 NYCRR Section 494.4(g)*

Medicaid policy states: "The ALP Medical Evaluation (DSS 4449C) and ALP Medical Evaluation – Interim (DSS 4568) must continue to be signed by a physician."
NYS DOH DAL 14-12: Amendment of Sections 487.4 and 488.4 of Title 18 NYCRR and Section 1001.7 of Title 10 NYCRR

On 5 claims in 86 instances pertaining to 4 residents, the record did not include a completed medical reassessment for our date of service. This finding applies to Sample #s 25, 49, 60, 63 and 65.

9. <u>Missing Medical Evaluation</u>

Regulations state, "An operator shall not admit an individual before a determination has been made that the facility program can support the physical, psychological and social needs of the resident." *18 NYCRR Section 487.4(d)*

Regulations state, "Such a determination shall be based upon: (1) receipt and consideration of a medical evaluation." *18 NYCRR Section 487.4(e)(1)*

Regulations state, "(a) The agency shall maintain a confidential record for each patient admitted to care to include: . . . (2) medical orders, if applicable; . . ." *10 NYCRR Section 766.6(a)(2)*

Regulations state, "(d) An operator must not admit nor retain an individual without a determination being made that the enriched housing program can support the physical and social needs of the resident. Such determination must be based upon: (1) a medical evaluation (DSS-3122 or an approved substitute) written and signed by a physician, physician assistant or nurse practitioner . . ." *18 NYCRR Section 488.4(d)(1)*

Regulations state, "(e) The following assessments must be conducted whenever a change in a resident's condition warrants and no less than once every 12 months: (1) a medical assessment;" *18 NYCRR Section 488.4(e)(1)*

Regulations state, "Each medical evaluation (DSS-3122 or an approved substitute) shall be a written and signed report from a physician, physician assistant or nurse practitioner which includes: (1) the date of examination, significant medical history and current conditions, known allergies, the prescribed medication regimen, including information on the applicant's ability to self-administer medications, recommendations for diet, exercise, recreation, frequency of medical examinations and assistance needed in the activities of daily living; (2) a statement that the resident is not medically or mentally unsuited for care in the facility; (3) a statement that the resident does not require placement in a hospital or residential health care facility; and (4) a statement that the physician, physician assistant or nurse practitioner has physically examined the resident within 30 days prior to the date of admission or, for required annual evaluations, within 30 days prior to the date of the report." *18 NYCRR Section 487.4(f)*

On 2 claims in 48 instances pertaining to 2 residents, the record did not contain a medical evaluation for our date of service. This finding applies to Sample #s 7 and 88.

10. <u>Billed for Services While Inpatient at Another Facility</u>

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

Regulations state, "The MA program will not make payments for assisted living program services provided to an MA recipient while the recipient is receiving residential health care facility services or in-patient hospital services." *18 NYCRR Section 505.35(h)(7)*

Regulations state, "By enrolling the provider agrees: (i) to comply with the rules, regulations, and official directives of the department." *18 NYCRR Section 504.3(i)*

Medicaid policy states: "Medicaid will only pay for home health aide services in an adult care facility when the need for "total assistance" with tasks is established. Tasks which may be performed by the recipient with assistance already provided by ACF personnel may not be billed separately to Medicaid." *Department of Social Services 92 ADM-15 (March 1992), Vol. 21, No. 4, Office of Medicaid Management*

On 2 claims in 2 instances pertaining to 2 residents, the record included documentation in conflict with an inpatient stay at a different facility for our claim. This finding applies to Sample #s 24 and 32.

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, money order, or OMIG's Online Payment Portal within 20 days of the date of the Final Audit Report.

- The check should be made payable to the New York State Department of Health, should include the audit number on the memo line, and be mailed with the attached remittance advice to:

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]
[redacted]

- If you elect to pay electronically through OMIG's Online Payment Portal, please visit [redacted] or contact OMIG's Bureau of Collections Management by telephone or email, at the above number or address.

Option #2: Enter into a repayment agreement with OMIG. If your repayment terms exceed 90 days from the date of the Final Audit Report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. OMIG's acceptance of a 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, by telephone or email, as provided above.

Should you fail to select a payment option above within 20 days of the date of this Report, OMIG will initiate recoupment by withholding all or a part of your payments otherwise payable, in accordance with 18 NYCRR 518.6. Additionally, OMIG reserves the right to 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.

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 $178,488. 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
221 South Warren Street, Suite 410
Syracuse, New York 13202

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]
Valley Residential Services Inc.
161 Valley Drive
Herkimer, New York 13350-3736

Provider ID #: 04196383

Audit #: 19-5931

Amount Due: $130,776

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:

New York State Office of the Medicaid Inspector General
Bureau of Collections Management
800 North Pearl Street
Albany, New York 12204
[redacted]

If you elect to pay electronically through OMIG's Online Payment Portal, please visit [redacted] or contact OMIG's Bureau of Collections Management by telephone or email, at the above number or address.