



Office of the
Medicaid Inspector
General

STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF GENTIVA HEALTH SERVICES, INC.
CLAIMS FOR CERTIFIED HOME HEALTH
AGENCY HOME HEALTH SERVICES
PAID FROM
APRIL 1, 2006 – MARCH 31, 2011

Final Audit Report
Audit #: 11-4936

Dennis Rosen
Acting Medicaid Inspector General



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Acting Medicaid Inspector General

May 8, 2015

[REDACTED]
Gentiva Health Services, Inc.
200 Elwood Davis Road
Liverpool, New York 13088

Re: Final Audit Report
Audit #: 11-4936
Provider ID #: [REDACTED]
FEIN: [REDACTED]
NPI #: [REDACTED]

Dear [REDACTED]:

Enclosed is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report entitled "Review of Gentiva Health Services, Inc." (Provider) claims paid for Certified Home Health Agency (CHHA) home health services from April 1, 2006, through March 31, 2011.

In accordance with §§ 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 Parts 504 and 517, OMIG performed an audit of home health services claims paid to Gentiva Health Services, Inc. from April 1, 2006, through March 31, 2011. The audit universe consisted of 69,175 claims totaling \$7,095,347.54. The audit consisted of a random sample of 200 claims with Medicaid payments totaling \$20,233.11 (Attachment A). OMIG shared its proposed findings with Gentiva Health Services, Inc. in the Draft Audit Report dated December 17, 2014. Any written responses and documentation provided to OMIG in response to the Draft Audit Report have been considered before issuing this report.

The statistical sampling methodology employed in this audit allows for extrapolation of the sample findings to the universe of claims (18 NYCRR Section 519.18). OMIG has determined that the point estimate of the Medicaid overpayment received by Gentiva Health Services, Inc. is \$281,999. The lower confidence limit of the amount overpaid is \$135,863 (Attachment B). The enclosed Final Audit Report contains further information about OMIG's audit findings and the calculation of the Medicaid overpayment. 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 lower confidence limit of \$135,863.

If you have any questions or comments concerning this report, please contact [REDACTED] at [REDACTED] or through email at [REDACTED]. Please refer to audit number 11-4936 in all correspondence.

Sincerely,

[REDACTED]

Division of Medicaid Audit, Syracuse
Office of the Medicaid Inspector General

Enclosure

cc: [REDACTED]

CERTIFIED MAIL #: [REDACTED]
RETURN RECEIPT REQUESTED

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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

The Office of the Medicaid Inspector General's vision is to be the national leader in promoting and protecting the integrity of the Medicaid program.

Background, Purpose, 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, 14 and 18 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 Part 505.23 and 10 NYCRR Part 763. MMIS Provider Manuals pertaining to home health services, personal care services, and nursing services also provide programmatic guidance for the provision of home health services.

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for home health services complied with applicable Federal and State 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;
- the medical necessity of claimed services was supported by the provider's documentation;
- appropriate rate or procedure 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 DOH regulations and the appropriate Provider Manuals.

Audit Scope

A review of home health service claims paid to Gentiva Health Services, Inc. from April 1, 2006, through March 31, 2011, was completed.

The audit universe consisted of 69,175 claims totaling \$7,095,347.54. The audit sample consisted of 200 claims totaling \$20,233.11 (Attachment A).

PROVIDER RIGHTS

18 NYCRR Part 518 regulates the collection of overpayments. Your repayment options are described below. If you decide to repay the lower confidence limit amount of \$135,863, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order 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 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 #: 11-4936
Albany, New York 12237

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. 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%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until the agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
Phone #: [REDACTED]
Fax#: [REDACTED]

If you choose not to settle this audit through repayment of the lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of \$135,863. 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, New York 12204

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

Issues you may raise shall be limited to those issues relating to determinations contained in the Final Audit Report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing the provider has the right to:

- a) request the department to reschedule the hearing (adjournment);
- b) be represented by an attorney, or other representative, or to represent himself/herself;
- c) have an interpreter, at no charge, if the appellant does not speak English or is deaf and cannot afford one (the appellant must advise the department prior to the hearing if an interpreter will be needed);
- d) produce witnesses and present written and/or oral evidence to explain why the action taken was wrong; and
- e) cross-examine witnesses of the department.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

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 and to home health care services. 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)

Part 763 of 10 NYCRR 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 et.seq.

"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)

AUDIT FINDINGS

OMIG's detailed findings appear in the following pages. A description of each finding, supporting regulations, and the list of samples with 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.

This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated December 17, 2014. The attached Bridge Schedule (Attachment D) indicates any changes to the findings as a result of your response.

SUMMARY OF EXTRAPOLATED FINDINGS

<u>Error Description</u>	<u>Number of Errors</u>
Billed Medicaid Before Services Were Authorized	5
Missing or Insufficient Documentation of Hours/Visits Billed	3
Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame	3
Missing Plan of Care/Order	2
Billed for Services in Excess of Ordered Hours/Visits	1
Comprehensive Assessment Not Documented/Late	1

AUDIT FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from April 1, 2006, through March 31, 2011, identified 11 claims with at least one error, for a total sample overpayment of \$815.32 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated December 17, 2014. Appropriate adjustments were made to the findings.

1. Billed Medicaid Before Services Were Authorized

Regulations state: "The agency shall maintain a confidential clinical record for each patient admitted to care or accepted for service to include:...medical orders and nurses diagnoses...signed by the authorized practitioner within 30 days after admission to the agency, or prior to billing, whichever is sooner; 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 renewed by the authorized practitioner as frequently as indicated by the patient's condition but at least every 62 days..."
10 NYCRR Section 763.7(a)(3)(i)-(iii)

Regulations state: "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)

Regulations state: "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)

Regulations also state: "Home health services mean the following services *when prescribed by a physician* and provided to an MA recipient in his or her home...nursing services . . .physical therapy, occupational therapy, or speech pathology and audiology services; and home health aide services. . . ."
18 NYCRR Section 505.23(a)(3)(i)-(iii)

Regulations state: "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 the case-mix assignment; or a discharge and return to the same HHA during the 60-day episode. Agency professional staff promptly alerts the physician to any changes that suggest a need to alter the plan of care."
42 CFR Section 484.18(b)

The Home Health Manual states: "Any such service provided [by a certified home health agency] 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, Section III and Version 2008-1, Section III*

In 5 instances pertaining to 5 patients, Medicaid was billed prior to the date of the signed order. This finding applies to Sample #'s 37, 90, 130, 149, and 195.

2. Missing or Insufficient Documentation of Hours/Visits Billed

"The department will pay providers for 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: . . .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; [and] 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 3 instances pertaining to 2 patients, 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 #'s 10, 177, and 196.

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

Regulations state: "Home health services mean the following services *when prescribed by a physician* and provided to an MA recipient in his or her home...nursing services...physical therapy, occupational therapy, or speech pathology and audiology services; and home health aide services. . . ."

18 NYCRR Section 505.23(a)(3)(i)-(iii)

Regulations state: "The agency shall maintain a confidential clinical record for each patient admitted to care or accepted for service to include:...medical orders and nurses diagnoses...signed by the authorized practitioner within 30 days after admission to the agency, or prior to billing, whichever is sooner; 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 renewed by the authorized practitioner as indicated by the patient's condition but at least every 62 days..."

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

Regulations state: "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)

Regulations state: "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)

Regulations state: "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 alerts the physician to any changes that suggest a need to alter the plan of care."

42 CFR Section 484.18(b)

The Home Health Manual states: "Any such service provided [by a certified home health agency] 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, Section III and Version 2008-1, Section III*

In 3 instances pertaining to 3 patients, 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 #'s 37, 119, and 195.

4. Missing Plan of Care/Order

Regulations state: "A plan of care shall be developed within 10 days of admission to the agency and approved by the patient based on the comprehensive interdisciplinary patient assessment. . . ."

10 NYCRR Section 763.6(b)-(e)

Regulations state: "The agency shall maintain a confidential record for each patient admitted to care or accepted for service to include...the individualized plan of care..."

10 NYCRR Section 763.7(a)(5)

Regulations state: "The agency shall maintain a confidential clinical record for each patient admitted to care or accepted for service to include:...medical orders and nurses diagnoses...signed by the authorized practitioner within 30 days after admission to the agency, or prior to billing, whichever is sooner; 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 renewed by the authorized practitioner as indicated by the patient's condition but at least every 62 days..."

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

Regulations state: "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)

Regulations state: "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)

Regulations state: "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)

Regulations state: "Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing and social needs can be met adequately by the agency in the patient's place of residence. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine."

42 CFR Section 484.18

Regulations state: "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 the 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)

Regulations state: "Drugs and treatments are administered by agency staff only as ordered by the physician...Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist...responsible for furnishing and supervising the ordered services..."

42 CFR Section 484.18(c)

The Home Health Manual states: "Any such service provided [by a certified home health agency] 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, Section III and Version 2008-1, Section III*

In 2 instances pertaining to 2 patients, the applicable plan of care/order was missing from the provider's records. This finding applies to Sample #'s 149 and 166.

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

Regulations state: "It is the policy of the department to pay for home health services under the medical assistance program only when the services are medically necessary."

18 NYCRR Section 505.23(a)(1)(i)&(ii)

Regulations state: "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)

Regulations state: "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)(3)(i)-(iii)

Regulations state: "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)

The Home Health Manual states: "Any such service provided [by a certified home health agency] 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, Section III and Version 2008-1, Section III*

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 applies to Sample # 173.

6. Comprehensive Assessment Not Documented/Late

Regulations state: "A comprehensive interdisciplinary patient assessment shall be completed, involving, as appropriate, a representative of each service needed, the patient, the patient's family or legally designated representative and patient's authorized practitioner. Such assessment shall address, at a minimum, the medical, social, mental health and environmental needs of the patient."

10 NYCRR Section 763.6(a)

Regulations state: "Physicians [providing care under the medical assistance program] shall be licensed and currently registered by the New York State Education Department...[and shall] hold[] a valid operating certificate from the New York State Department of Health..."

18 NYCRR Section 505.2(a)(1)(i)(a)

Regulations state: "The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care."

42 CFR Section 484.55(b)(1)

Regulations state: "The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than – the last five days of every 60 days beginning with the start-of-care date, unless there is a beneficiary elected transfer; significant change in condition resulting in a new case-mix assignment; or discharge and return to the same HHA during the 60-day episode..."

42 CFR Section 484.55(d)(1)(i)-(iii)

Regulations state: "The agency shall maintain a confidential record for each patient admitted to care or accepted for service to include...the comprehensive interdisciplinary patient assessment."

10 NYCRR Section 763.7(a)(4)

Regulations state: "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)

In 1 instance, the comprehensive assessment for our sampled date of service was not completed within the required time frame. This applies to Sample # 130.

SAMPLE DESIGN

The sample design used for Audit #: 11-4936 was as follows:

- Universe - Medicaid claims for home health agency services paid during the period April 1, 2006, through March 31, 2011.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of Provider claims for home health agency services paid during the period April 1, 2006, through March 31, 2011.
- Sample Unit - The sample unit is a Medicaid claim paid during the period April 1, 2006, through March 31, 2011.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 200 claims.

Attachment B

SAMPLE RESULTS AND ESTIMATES**Audit Statistics**

Universe Size	69,175
Sample Size	200
Sample Value	\$ 20,233.11
Sample Overpayments	\$ 815.32
Net Financial Error Rate	4.03%
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments for Extrapolation Purposes	\$ 815.32
Sample Size	200
Mean Dollars in Error for Extrapolation Purposes	\$ 4.0766
Universe Size	69,175
Point Estimate of Total Dollars	\$ 281,999
Lower Confidence Limit	\$ 135,863

OFFICE OF THE MEDICAID INSPECTOR GENERAL
GENTIVA HEALTH SERVICES, INC.
REVIEW OF CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES
PROJECT NUMBER: 11-4936
REVIEW PERIOD: 4/1/2006 - 3/31/2011

Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS					
		Billed	Derived	Paid	Derived		1. Billed Medicaid Before Services Were Authorized	2. Missing or Insufficient Documentation of Hours/Visits Billed	3. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame	4. Missing Plan of Care/Order	5. Billed for Services in Excess of Ordered Hours/Visits	6. Comprehensive Assessment Not Documented/Late
26	03/30/07	2620	2620	\$ 61.95	\$ 61.95	-						
27	02/19/09	2650	2650	106.65	106.65	-						
28	08/13/09	2650	2650	106.65	106.65	-						
29	10/11/06	2620	2620	133.64	133.64	-						
30	09/08/06	2650	2650	101.75	101.75	-						
31	09/18/07	2620	2620	124.16	124.16	-						
32	08/13/06	2620	2620	133.64	133.64	-						
33	05/11/08	2620	2620	134.22	134.22	-						
34	07/13/07	2499	2499	216.40	216.40	-						
35	05/19/06	2499	2499	17.64	17.64	-						
36	05/16/06	2620	2620	124.10	124.10	-						
37	07/13/07	2620	-	62.08	-	62.08	X		X			
38	07/01/06	2620	2620	133.64	133.64	-						
39	07/23/10	2650	2650	106.65	106.65	-						
40	10/25/06	2620	2620	66.82	66.82	-						
41	03/13/07	2620	2620	123.90	123.90	-						
42	01/04/08	2650	2650	107.41	107.41	-						
43	11/01/08	2620	2620	134.22	134.22	-						
44	04/23/06	2620	2620	124.10	124.10	-						
45	01/17/07	2620	2620	61.95	61.95	-						
46	01/18/07	2620	2620	61.95	61.95	-						
47	02/26/07	2620	2620	123.90	123.90	-						
48	06/18/08	2650	2650	103.83	103.83	-						
49	06/13/07	2620	2620	60.33	60.33	-						
50	11/27/07	2620	2620	62.08	62.08	-						

OFFICE OF THE MEDICAID INSPECTOR GENERAL
GENTIVA HEALTH SERVICES, INC.
REVIEW OF CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES
PROJECT NUMBER: 11-4936
REVIEW PERIOD: 4/1/2006 - 3/31/2011

Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS 1. Billed Medicaid Before Services Were Authorized 2. Missing or Insufficient Documentation of Hours/Visits Billed 3. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame 4. Missing Plan of Care/Order 5. Billed for Services in Excess of Ordered Hours/Visits 6. Comprehensive Assessment Not Documented/Late						
		Billed	Derived	Paid	Derived								
51	08/29/07	2650	2650	\$ 102.54	\$ 102.54	\$ -							
52	02/16/08	2620	2620	138.88	138.88	-							
53	05/26/07	2620	2620	120.66	120.66	-							
54	06/17/09	2620	2620	87.37	87.37	-							
55	04/01/06	2620	2620	62.05	62.05	-							
56	09/13/06	2620	2620	66.82	66.82	-							
57	06/16/08	2620	2620	134.22	134.22	-							
58	02/07/08	2620	2620	69.44	69.44	-							
59	02/19/08	2620	2620	69.44	69.44	-							
60	03/01/11	2620	2620	87.37	87.37	-							
61	09/15/06	2620	2620	66.82	66.82	-							
62	10/22/06	2620	2620	66.82	66.82	-							
63	05/24/07	2620	2620	60.33	60.33	-							
64	11/09/07	2620	2620	62.08	62.08	-							
65	12/08/07	2620	2620	62.08	62.08	-							
66	04/03/09	2650	2650	106.65	106.65	-							
67	09/05/07	2499	2499	216.40	216.40	-							
68	01/10/07	2620	2620	61.95	61.95	-							
69	04/24/07	2620	2620	120.66	120.66	-							
70	08/13/07	2620	2620	124.16	124.16	-							
71	08/19/06	2620	2620	66.82	66.82	-							
72	12/04/08	2620	2620	134.22	134.22	-							
73	12/17/08	2620	2620	134.22	134.22	-							
74	12/12/06	2620	2620	133.64	133.64	-							
75	07/14/09	2620	2620	87.37	87.37	-							

OFFICE OF THE MEDICAID INSPECTOR GENERAL
GENTIVA HEALTH SERVICES, INC.
REVIEW OF CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES
PROJECT NUMBER: 11-4936
REVIEW PERIOD: 4/1/2006 - 3/31/2011

Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS 1. Billed Medicaid Before Services Were Authorized 2. Missing or Insufficient Documentation of Hours/Visits Billed 3. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame 4. Missing Plan of Care/Order 5. Billed for Services in Excess of Ordered Hours/Visits 6. Comprehensive Assessment Not Documented/Late					
		Billed	Derived	Paid	Derived							
101	09/10/06	2620	2620	\$ 200.46	\$ 200.46	\$ -						
102	12/08/08	2620	2620	67.11	67.11	-						
103	08/04/06	2620	2620	133.64	133.64	-						
104	06/18/08	2620	2620	67.11	67.11	-						
105	07/08/06	2650	2650	101.75	101.75	-						
106	10/03/06	2620	2620	66.82	66.82	-						
107	05/18/06	2620	2620	62.05	62.05	-						
108	07/12/08	2620	2620	67.11	67.11	-						
109	06/29/06	2620	2620	66.82	66.82	-						
110	03/05/07	2620	2620	61.95	61.95	-						
111	07/20/09	2620	2620	174.74	174.74	-						
112	11/25/07	2620	2620	124.16	124.16	-						
113	09/20/06	2620	2620	133.64	133.64	-						
114	12/26/07	2620	2620	124.16	124.16	-						
115	05/01/09	2499	2499	21.08	21.08	-						
116	03/16/08	2620	2620	138.88	138.88	-						
117	08/18/08	2620	2620	67.11	67.11	-						
118	11/27/08	2620	2620	67.11	67.11	-						
119	01/06/08	2620	-	138.88	-	138.88			X			
120	07/13/09	2620	2620	174.74	174.74	-						
121	09/19/06	2620	2620	66.82	66.82	-						
122	09/01/06	2620	2620	66.82	66.82	-						
123	03/12/07	2620	2620	61.95	61.95	-						
124	09/14/07	2620	2620	124.16	124.16	-						
125	08/04/06	2620	2620	66.82	66.82	-						

OFFICE OF THE MEDICAID INSPECTOR GENERAL
GENTIVA HEALTH SERVICES, INC.
REVIEW OF CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES
PROJECT NUMBER: 11-4936
REVIEW PERIOD: 4/1/2006 - 3/31/2011

Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS						
		Billed	Derived	Paid	Derived		1. Billed Medicaid Before Services Were Authorized	2. Missing or Insufficient Documentation of Hours/Visits Billed	3. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame	4. Missing Plan of Care/Order	5. Billed for Services in Excess of Ordered Hours/Visits	6. Comprehensive Assessment Not Documented/Late	
126	07/03/08	2620	2620	\$ 134.22	\$ 134.22	\$ -							
127	04/01/06	2620	2620	124.10	124.10	-							
128	05/11/07	2620	2620	60.33	60.33	-							
129	05/11/09	2650	2650	106.65	106.65	-							
130	02/13/07	2499	-	32.40	-	32.40	X						X
131	05/03/06	2499	2499	176.40	176.40	-							
132	07/31/06	2620	2620	133.64	133.64	-							
133	04/09/08	2620	2620	134.22	134.22	-							
134	06/05/09	2620	2620	174.74	174.74	-							
135	05/08/07	2620	2620	60.33	60.33	-							
136	07/23/08	2620	2620	134.22	134.22	-							
137	07/21/10	2650	2650	106.65	106.65	-							
138	06/19/08	2620	2620	67.11	67.11	-							
139	11/12/09	2650	2650	106.65	106.65	-							
140	01/05/07	2650	2650	102.33	102.33	-							
141	07/23/08	2650	2650	103.83	103.83	-							
142	03/30/08	2620	2620	138.88	138.88	-							
143	10/05/06	2620	2620	66.82	66.82	-							
144	08/15/07	2620	2620	124.16	124.16	-							
145	07/17/08	2620	2620	134.22	134.22	-							
146	10/18/07	2620	2620	186.24	186.24	-							
147	07/23/08	2499	2499	214.80	214.80	-							
148	12/01/10	2620	2620	87.37	87.37	-							
149	10/30/09	2620	-	87.37	-	87.37	X			X			
150	07/31/07	2620	2620	62.08	62.08	-							

OFFICE OF THE MEDICAID INSPECTOR GENERAL
GENTIVA HEALTH SERVICES, INC.
REVIEW OF CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES
PROJECT NUMBER: 11-4936
REVIEW PERIOD: 4/1/2006 - 3/31/2011

Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS 1. Billed Medicaid Before Services Were Authorized 2. Missing or Insufficient Documentation of Hours/Visits Billed 3. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame 4. Missing Plan of Care/Order 5. Billed for Services in Excess of Ordered Hours/Visits 6. Comprehensive Assessment Not Documented/Late						
		Billed	Derived	Paid	Derived								
151	12/29/06	2499	2499	\$ 38.00	\$ 38.00	\$ -							
152	02/03/08	2620	2620	138.88	138.88	-							
153	08/05/06	2620	2620	133.64	133.64	-							
154	03/20/06	2620	2620	62.05	62.05	-							
155	04/25/07	2650	2650	99.66	99.66	-							
156	04/20/06	2620	2620	62.05	62.05	-							
157	10/23/10	2650	2650	106.65	106.65	-							
158	10/04/10	2620	2620	174.74	174.74	-							
159	08/10/06	2620	2620	66.82	66.82	-							
160	07/03/06	2499	2499	9.50	9.50	-							
161	03/20/09	2620	2620	87.37	87.37	-							
162	07/31/06	2620	2620	66.82	66.82	-							
163	11/06/06	2620	2620	66.82	66.82	-							
164	07/20/06	2620	2620	66.82	66.82	-							
165	07/06/10	2650	2650	106.65	106.65	-							
166	02/03/06	2620	-	62.05	-	62.05					X		
167	08/03/06	2620	2620	66.82	66.82	-							
168	04/22/10	2620	2620	87.37	87.37	-							
169	09/13/07	2499	2499	43.28	43.28	-							
170	03/15/07	2620	2620	61.95	61.95	-							
171	08/15/06	2620	2620	66.82	66.82	-							
172	07/28/06	2620	2620	133.64	133.64	-							
173	10/09/10	2620	2620	174.74	87.37	87.37						X	
174	01/04/10	2620	2620	174.74	174.74	-							
175	04/13/09	2620	2620	174.74	174.74	-							

OFFICE OF THE MEDICAID INSPECTOR GENERAL
GENTIVA HEALTH SERVICES, INC.
REVIEW OF CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES
PROJECT NUMBER: 11-4936
REVIEW PERIOD: 4/1/2006 - 3/31/2011

Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS					
		Billed	Derived	Paid	Derived		1. Billed Medicaid Before Services Were Authorized	2. Missing or Insufficient Documentation of Hours/Visits Billed	3. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame	4. Missing Plan of Care/Order	5. Billed for Services in Excess of Ordered Hours/Visits	6. Comprehensive Assessment Not Documented/Late
176	08/21/07	2650	2650	\$ 102.54	\$ 102.54	\$ -						
177	03/04/09	2620	2620	262.11	174.74	87.37		X				
178	01/06/07	2620	2620	123.90	123.90	-						
179	10/23/09	2650	2650	106.65	106.65	-						
180	02/23/10	2620	2620	87.37	87.37	-						
181	08/15/06	2620	2620	133.64	133.64	-						
182	12/14/06	2620	2620	133.64	133.64	-						
183	01/12/10	2620	2620	174.74	174.74	-						
184	12/23/08	2620	2620	67.11	67.11	-						
185	05/14/06	2620	2620	62.05	62.05	-						
186	11/29/08	2499	2499	21.48	21.48	-						
187	08/27/09	2620	2620	87.37	87.37	-						
188	06/02/08	2620	2620	67.11	67.11	-						
189	01/03/08	2620	2620	138.88	138.88	-						
190	01/20/08	2620	2620	69.44	69.44	-						
191	10/23/06	2620	2620	66.82	66.82	-						
192	07/15/07	2620	2620	62.08	62.08	-						
193	04/09/07	2620	2620	60.33	60.33	-						
194	02/24/09	2499	2499	42.16	42.16	-						
195	11/30/09	2620	-	87.37	-	87.37	X		X			
196	08/06/07	2499	-	43.28	-	43.28		X				
197	01/22/09	2650	2650	106.65	106.65	-						
198	12/19/07	2620	2620	62.08	62.08	-						
199	04/22/08	2650	2650	103.83	103.83	-						
200	12/05/07	2620	2620	62.08	62.08	-						
Totals				\$ 20,233.11	\$ 19,417.79	\$ 815.32	5	3	3	2	1	1

FINAL DISPOSITION FOR SAMPLED SELECTIONS CHANGED FROM DRAFT TO FINAL AUDIT REPORT

GENTIVA HEALTH SERVICES, INC.
 CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES AUDIT
 AUDIT #: 11-4936
 AUDIT PERIOD: 04/01/06 - 03/31/11

BRIDGE SCHEDULE

SAMPLE #	FINDING	DRAFT REPORT AMOUNT DISALLOWED	FINAL REPORT AMOUNT DISALLOWED	CHANGE
3	Missing or Insufficient Information of Hours/Visits Billed	\$102.33	\$0.00	(\$102.33)
35	Missing or Insufficient Information of Hours/Visits Billed	\$17.64	\$0.00	(\$17.64)
157	Billed Medicaid Before Services Were Authorized	\$106.65	\$0.00	(\$106.65)
172	Billed for Services in Excess of Ordered Hours/Visits	\$66.82	\$0.00	(\$66.82)
197	Missing or Insufficient Information of Hours/Visits Billed	\$106.65	\$0.00	(\$106.65)
TOTALS		<u>\$400.09</u>	<u>\$0.00</u>	<u>(\$400.09)</u>

Note: The adjustments shown above only reflect those that were revised as a result of the provider's response. All other financial adjustments remain the same as shown in the Draft Audit Report.

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

NAME AND ADDRESS OF AUDITEE

Gentiva Health Services, Inc.
200 Elwood Davis Road
Liverpool, New York 13088

PROVIDER ID #: [REDACTED]

AUDIT #: 11-4936

AMOUNT DUE: \$135,863

AUDIT

TYPE

PROVIDER
 RATE
 PART B
 OTHER:

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 check to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File #: 11-4936
Albany, New York 12237

Thank you for your cooperation.