New York State Office of the Medicaid Inspector General

Compliance Alert

2011-08

HOME HEALTH CARE'S VERIFICATION ORGANIZATIONS
And
PROVIDER SELF ASSESSMENT TOOL

December 21, 2011

In 2007, the Office of the New York State Comptroller issued an audit report for the five-year period ending April 30, 2006, which identified a substantial risk area for Medicaid fraud and abuse.[1] The report revealed that approximately $5.7 million in overpayments were paid by New York State's medical assistance (Medicaid) program to home health care providers.[2] The Comptroller determined that the source of these overpayments was inappropriate billing for home health services while Medicaid recipients were in the hospital.[3] Subsequently, home health care was identified as an area susceptible to inappropriate billing. Considerable efforts are now underway to reduce that risk in the home health care industry.

On March 31, 2011, Social Services Law Section 2[4] and Section 363-e[5] were amended to require use of a verification organization to conduct pre-claim reviews of Medicaid services and items and to provide exception and conflict report data[6] for the following providers with total Medicaid reimbursements exceeding $15 million per calendar year:[7] certified home health agencies (CHHAs); long term home health care programs (LTHHCPs); and personal care providers.

Purpose of this *Compliance Alert*

The purpose of this *Compliance Alert* is to provide guidance to the above mentioned home health care and personal care providers on the new requirement and to provide a self-assessment tool that providers can use to help them meet their obligation to use a verification organization in their pre-claim review process.

Statutory Obligation:

1 On August 28, 2007, the New York State Office of the State Comptroller issued Report 2006-S-77 entitled, *Department of Health, Medicaid Payments to Home Care Providers While Recipients Were Hospitalized.* It is available on the Office of the State Comptroller's Web site at http://osc.state.ny.us.
2 *Ibid.* at 2.
3 *Ibid.*
4 New York Social Services Law § 2 at subsection 38.
5 New York Social Services Law §363-e which was effective prior to September 27, 2011. On the date of this *Compliance Alert*, there are two Social Services Law sections numbered as 363-e.
6 New York Social Services Law §363-e.
7 New York Social Services Law § 2 at subsection 38(i).

Social Services Law §363-e requires participating providers under New York's Medicaid program[8] to utilize a verification organization to review and verify each service or item within a claim prior to its submission to New York's Department of Health. The verification organization[9] must review the claims that will be submitted by participating providers and declare each service or item to be verified or unverified. For each service or item the verification organization shall capture the following data fields:[10]

1. the identity of the individual providing services or items to the Medicaid recipient;
2. the identity of the Medicaid recipient; and
3. the date, time, duration, location and type of service or item.

Participating providers shall receive and maintain reports from its verification organization which contains data on:

1. verified services or items, including whether a service appeared on a conflict[11] or exception report[12] before verification and how that conflict or exception was resolved; and
2. services or items that were not verified, including conflict and exception report data for the services.

OMIG and the New York State Department of Health developed a list of verification organizations. That list can be accessed through the following link http://www.omig.ny.gov/data/content/view/278/350/

Consequences of Participating Provider's Failure to Comply with Social Services Law §363-e

Participating providers must comply with the new requirements as referenced in this *Compliance Alert*. Failure to utilize a verification organization or failure to take appropriate action upon receipt of a verification organization's conflict or exception report may result in termination of the participating provider's Medicaid contract with the State of New York and/or may result in an audit by OMIG and a recovery of any overpayments that are made.

Self Assessment Tool

To assist providers in assessing and evaluating their compliance with Social Services Law Section 363-e, OMIG has prepared the attached *Assessment Tool – Home Health Care*. Please note that use of the attached Self-Assessment Tool is not required of providers, but it is being offered as a **recommendation** to assist providers in determining whether the statutory and regulatory requirements addressed in this *Compliance Alert* are being met.

Unless specifically requested by OMIG to do so, do not submit the *Self-Assessment Tool – Home Health Care* to OMIG's Bureau of Compliance.

If you have any questions about this *Compliance Alert* of the subject matter of this Compliance Alert, you can contact the Bureau of Compliance at compliance@omig.ny.gov.

Attachment:
HOME HEALTH CARE PROVIDER SELF-ASSESSMENT TOOL -- Pre-Claim Review Process

8 "Participating providers" is defined in Social Services Law §2, subsection 38 (i) to be a certified home health agency, long term home health agency or personal care provider with total Medicaid reimbursements exceeding $15 million per calendar year.

9 "Verification organization" is defined in Social Services §2, subsection 38 (f) to be an entity, operating in a manner consistent with applicable federal and state confidentiality and privacy laws and regulations, which uses electronic means including but not limited to contemporaneous telephone verification or contemporaneous verified electronic data to verify whether a service or item was provided to an eligible Medicaid recipient.

10 The data fields cited are included in the definition of verification organization found in Social Services §2, subsection 38 (f).

11 "Conflict report" is defined in Social Services §2, subsection 38 (h) to be an electronic report containing all of the data fields in Social Services §2, subsection 38 (f) of this subdivision detailing incongruities in services or items between scheduling and/or location of service when compared to a duty roster.

12 "Exception report" is defined in Social Services §2, subsection 38 (g) to be an electronic report containing all the data fields in Social Services §2, subsection 38 (f) of this subdivision for conflicts between services or items on the basis of the identity of the person providing the service or item to the Medicaid recipient, the identity of the Medicaid recipient, and/or time, date, duration or location of the service.

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Pre-Claim Review Process

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Directions on completing the Compliance Program Assessment Tool:

If the answer is yes to a question on the attached Tool, complete the "yes" box and provide a description of what supports that response in the "Evidence of Compliance" column. The Evidence of Compliance description will provide a cross reference to the provider as to where the evidence supporting the "yes" response can be located. For example, if the provider responds, "yes," that the verification organization utilizes contemporaneous phone verification, contemporaneous electronic data, or other electronic means to verify the provision of a service or good to Medicaid recipients (see 2.1 on the attached Tool), the provider should state what the verification organization uses.

If the answer is no to a question, complete the "no" box and consider what action (if any) should be taken to address the "no" response or document the rationale for the "no" response.

Please note that on the Assessment form when an asterisk is used, it denotes the question is based upon a specific statutory requirement.

New York State Office of the Medicaid Inspector General
Medicaid Compliance Program
Assessment Tool—Home Health Care
2011-2012

Name of Medicaid Provider: _____
Medicaid Provider ID #: _____
Federal ID #: _____
Person Completing Assessment: _____ Title: _____
Telephone #: _____
Date Assessment Completed: _____
Assessment Period: _____

(1) Is the Medicaid provider a participating provider?

	Description	Yes	No	Explanation or action required
1.1	Do the Medicaid provider's total Medicaid reimbursements for personal care, certified home health agency and long term home health care program services, in the aggregate, exceed $15 million per calendar year?			In calculating if the provider exceeds the $15 million threshold, the provider does not need to consider Medicaid reimbursements for Consumer Directed Personal Care Assistance services, Home and Community Health Services or hospice services.
	If the answer to 1.1 is no, then the provider may not meet the definition of "participating provider" under Social Services Law § 2, 38(i).			Provider may not need to complete the remainder of the Self Assessment form if the answer is no. If the answer is yes, the provider should complete the Self-Assessment form.
1.2	Is the Medicaid provider a personal care services provider?			
1.3	Is the Medicaid provider a certified home health agency, as defined in 10 NYCRR § 700.2(7)?			
1.4	Does the provider operate a long term home health care program, as defined in 10 NYCRR § 700.2(8)?			
	If the answer to 1.1 is no or the answer to 1.2, 1.3, and 1.4 is no, then the provider does not meet the definition of "participating provider" under Social Services Law § 2, 38(i).			Provider may not need to complete the remainder of the Self-Assessment form if the answer is no. If the answer is yes to <u>both</u> the $15 million threshold <u>and</u> the applicable provider type, the provider should complete the Self-Assessment form.

(2) Does the Medicaid provider utilize a verification organization as required by Social Services Law Sections 2 and 363-e?

	Description	Yes	No	Explanation or action required
2.1 *	Does the verification organization utilize contemporaneous phone verification, contemporaneous electronic data, or other electronic means to verify the provision of			Please detail.

	a service or item to Medicaid recipients?			
2.2 *	Does the verification organization comply with state and federal confidentiality and privacy laws and regulations?			Identify confirmation method(s).
2.3 *	Does the verification organization capture the identity of the individual providing home health services or items to the Medicaid recipient?			Identify confirmation method(s).
2.4 *	Does the verification organization capture the identity of the Medicaid recipient?			Identify confirmation method(s).
2.5 *	Does the verification organization capture the date the home health service or item was delivered to the Medicaid recipient?			Identify confirmation method(s).
2.6 *	Does the verification organization capture the time and/or duration that the home health service or item was delivered to the Medicaid recipient?			Identify confirmation method(s).
2.7 *	Does the verification organization capture the location the home health service or item was delivered to the Medicaid recipient?			Identify confirmation method(s).
2.8 *	Does the verification organization capture the type of home health service or item delivered to the Medicaid recipient?			Identify confirmation method(s).

(3) Preclaim Review.

	Description	**Yes**	**No**	**Explanation or action required**
3.1 *	Does the verification organization review and verify every claim for home health services or items prior to the home health care provider's claim submission?			Identify confirmation method(s).
3.2 *	Does the verification organization make a determination for each service or item that it is verified or unverified?			Identify confirmation method(s).
3.3	Does the Medicaid provider have systems and processes in place to follow up if a service or item is deemed unverified?			
3.4 *	Does the verification organization provide the Medicaid provider with a report of its determinations?			

3.5 *	Do the verification organization reports indicate whether a service or item appears on a conflict or exception report, whether the good or service is verified or unverified?			
3.6 *	If the verification organization reports that a service or item appears on a conflict or exception report, does the Medicaid provider have systems and processes in place to resolve that conflict or exception?			Explain the process.
3.7 *	Does the Medicaid provider have a policy and procedure in place to maintain records of the verification organization's reports for a period of six years?			

(4) Exception and Conflicts Reports.

	Description	**Yes**	**No**	**Explanation or action required**
4.1 *	Does the Medicaid provider maintain exception and conflict reports?			
4.2 *	When an exception or conflict report shows that inconsistent records exist of a caregiver's hours, does the Medicaid provider have systems and processes in place to investigate?			
4.3 *	When an exception or conflict report shows that inconsistent records exist of a caregiver's hours, does the Medicaid provider maintain a record demonstrating that the good or service was actually rendered?			
4.4	When an exception or conflict report shows that an inconsistent record exists of a caregiver's hours, or services, does the Medicaid provider hold the questioned claims and not submit them for payment?			
4.5	Does the Medicaid provider have a system or process in place to self-disclose any overpayment to OMIG when an exception or conflict report shows that an inconsistent record of a caregiver's hours, and the claims have already been submitted for payment?			
4.6	If the Medicaid provider receives an Edit 00760 denial, does the provider have systems and processes in place to review the specific billing(s) of service(s) or good(s)?			