

OMIG Payment Audits and Compliance Program Requirements:

Recent Developments and Strategies to Minimize Risk



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What's on the Agenda?

- Overview of the OMIG audit process
- Recent developments in OMIG audits
- Audit risk mitigation strategies
- Compliance Program Requirements and Best Practices
- Preparing for a Compliance Program Review

A close-up photograph of a hand holding a blue pencil, poised to write on a document. The document features a table with multiple columns and rows of data, including numbers and small circular markers. In the background, another person's hand is visible, holding a pen, suggesting a collaborative or instructional setting. The overall scene is brightly lit, with a warm, yellowish glow in the upper right corner.

The OMIG Audit Process

OMIG and its Role in the Medicaid Program

- Independent office within the Department of Health
- Formed to consolidate Medicaid fraud detection, prevention and recovery functions in a single office
- Responsibilities include, among others:
 - Receive and investigate FWA complaints
 - Pursue enforcement actions against person engaged in FWA or unacceptable practices (referral, exclusion, recoveries)
 - Audits
 - Monitor and oversee provider compliance programs, conduct compliance program reviews
 - Administer the Medicaid self-disclosure program

(N.Y. Public Health Law § § 30, 31; N.Y. Social Services Law § 363-d)

OMIG Audit Process

- Types of audits:
 - Desk Audits (e.g. date of death audits)
 - Field Audits (e.g. payment audits)
 - Recovery Audit Contractor
 - Third Party Liability

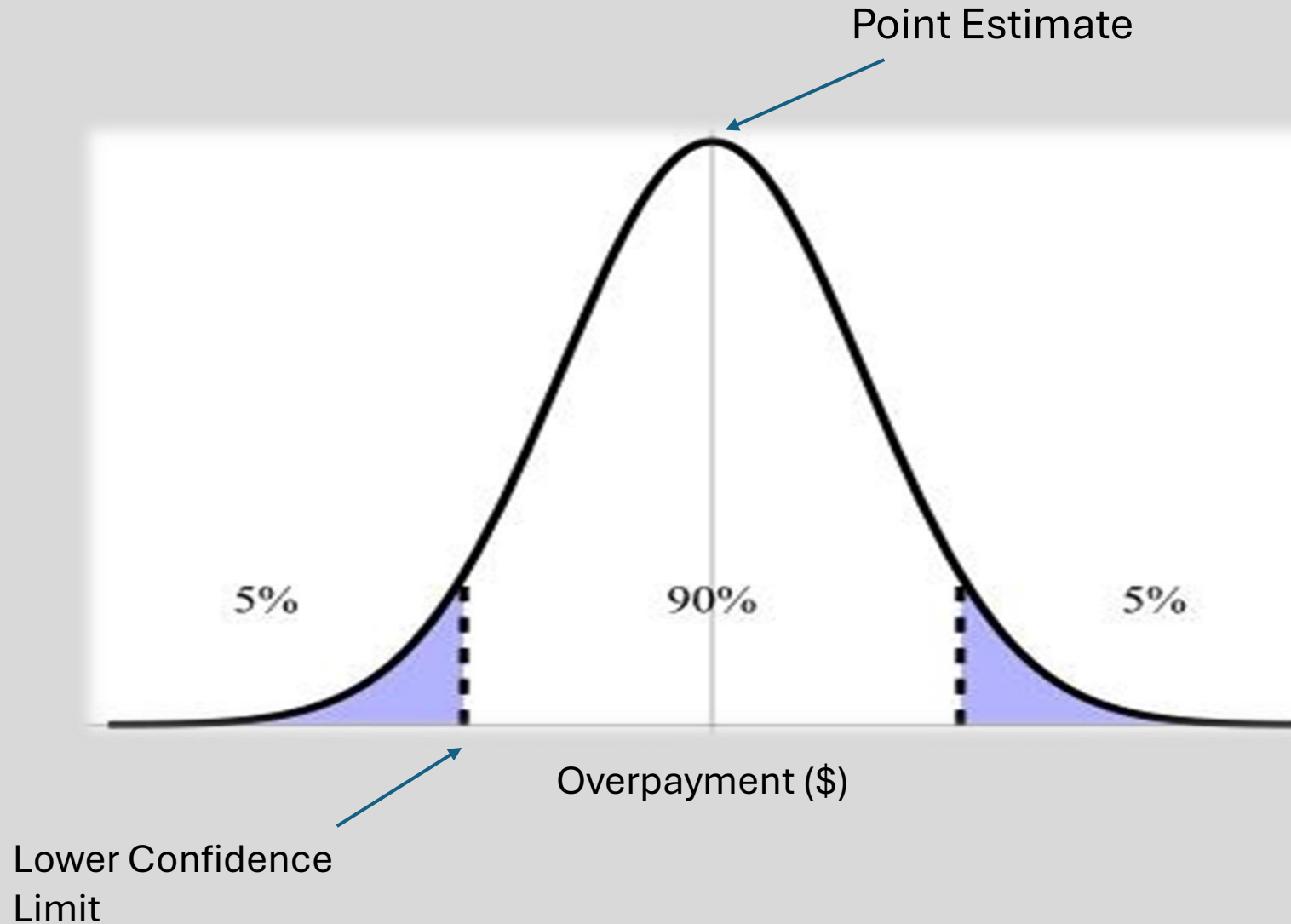
OMIG Payment Audit Process

- Letter notifying provider of audit and scheduling entrance conference
- Review of documentation of sample claims
- Exit conference – preliminary findings presented
- Draft Audit Report – provider has 30 days to respond with **all documentation and legal arguments**
- Final Audit Report issued by OMIG
- Administrative Hearing – **limited to issues and documents raised by provider in response to Draft Audit Report**
- Article 78 proceeding

OMIG Payment Audit Process

- Audit time-period typically three years – all paid claims during period are included in audit
- OMIG selects sample of 100 paid claims from audit time period
- In-depth review of service documentation, required orders, authorizations and assessments, and related personnel files
- Findings for sample of 100 claims extrapolated to the universe of claims to calculate overpayment owed
 - Lower confidence limit – amount by which OMIG will settle the audit if provider accepts results and does not request an administrative hearing
 - Point estimate – the estimate of the true overpayment based on the sample

OMIG Payment Audits - Extrapolation



Common Issues in Home Care Payment Audits

Patient record missing

Plan of Care/Medical Orders:

- Missing
- Signature issues (missing, untimely, not dated)
- Fails to address current needs
- Missing review/update

Assessments:

- Missing or untimely
- Does not meet required standards
- Missing review/update

Service Documentation:

- Missing or insufficient documentation
- # of units billed > authorized
- Services predate authorization
- Services inconsistent with POC or authorization
- Services billed not included in POC
- Medical need for services or hours not documented

Common Issues in Home Care Payment Audits

Staffing/Supervision Related Issues:

- Missing/untimely/inadequate supervision
- Missing orientation visit
- Missing CHRC
- Minimum training standards not met
- In-service training
- Health assessments
- PPD
- Personnel record missing
- Performance evaluations
- Excluded provider issues

Claims Related Issues:

- Failure to maximize TPL
- Duplicative of other services
- Incorrect rate code
- Improper rounding of service unit
- Incorrect practitioner listed
- Spend down not applied

General Trends in OMIG Audits

- Continued extrapolation of technical and ministerial violations
- Changing settlement landscape and its implications
- Increased emphasis on linkage between audits and compliance programs
- New issues emerging around electronic records

Looking Forward: OMIG's Revised Audit Protocols



OMIG Revisions to Audit Protocols

- Part of general overhaul of OMIG audit protocols
- Intent is more regular updates to audit protocols
- Revisions generally addressing:
 - Audit approach for COVID-19 years
 - Telehealth and advances in technology
 - Inclusion of changes to law and more recent agency directives and guidance
 - New protocols for provider types and services
 - Expansion of scope and substance of review of key instruments

AUDIT PROTOCOLS

Department of Health (DOH) Project Type	For Service Dates	Published Date	Targeted Next Publication
Assisted Living Program (ALP) Protocol	01/01/2013 - 10/31/2025	12/26/2025	Pending
Certified Home Health Agency (CHHA) Episodic Payment Protocol	05/02/2012 – 07/12/2017	03/19/2019	2026
Certified Home Health Agency (CHHA) Protocol	-	06/26/2018	2027
Consumer Directed Personal Assistance Program Protocol	-	12/09/2020	2027
Dental Protocol	10/01/2012 - 07/02/2025	08/05/2025	Pending
Diagnostic & Treatment Center (DTC) Services Protocol	01/01/2018 - 02/05/2023	11/25/2024	2027
Durable Medical Equipment Protocol	04/01/2013 - 05/15/2025	08/20/2025	Pending
Early Intervention (EI) Program Protocol	04/06/2016 - 10/18/2021	03/30/2023	2027
Health Home (Adults) Protocol	01/09/2014 - 08/21/2025	04/01/2026	Pending
Hospice Protocol	08/31/2016 - 02/17/2026	03/24/2026	Pending
Hospital Outpatient Department (OPD) Emergency Room/Clinic Protocol	09/14/2015 - 03/31/2025	04/11/2025	2027
Hospital Outpatient Department (OPD) - Laboratory Protocol	09/14/2015 - 03/31/2025	04/11/2025	2027
Hospital Outpatient Department Ordered Ambulatory Services - Other Than Laboratory Protocol	09/14/2015 - 03/31/2025	04/11/2025	2027
Independent Provider for Private Duty Nursing Protocol	01/01/2018 - 05/05/2025	08/05/2025	Pending
Licensed Home Care Services Agency (LHCSA) for Private Duty Nursing Protocol	01/01/2018 - 05/05/2025	08/05/2025	Pending
Nursing Home Transition and Diversion Waiver (NHTD) Protocol	01/01/2013 - 06/02/2025	12/17/2025	Pending
Personal Care Aides (PCA) Protocol	-	12/05/2018	2027
Pharmacy Protocol	01/01/2015 - 12/31/2019	05/24/2022	Q4 2026
Preschool & School Supportive Health Services Programs Protocol	-	02/11/2016	2027
Transportation Ambulette Protocol	03/15/2016 - 03/31/2025	06/18/2025	2027
Transportation Taxi/Livery Protocol	03/15/2016 - 03/31/2025	06/18/2025	2027
Traumatic Brain Injury (TBI) Protocol	-	03/09/2018	2027

OMIG Revisions to Audit Protocols

OMIG website now lists issue date and next targeted update/publication date

OMIG's Revised Audit Protocols – Preliminary Takeaways

- Covid-Era Audits

General approach: Services provided and billed in accordance with COVID-19 PHE guidance will not be subject to disallowance, provided all other programmatic and billing requirements not altered or waived by the PHE guidance were met.

Audit protocols specify the applicable COVID PHE guidance to be considered.

OMIG Audit Protocols – COVID Era Audits

OMIG AUDIT PROTOCOL Licensed Home Care Services Agency (LHCSA) for Private Duty Nursing

(For Service Dates 01/01/2018 through 05/05/25)

Public Health Emergency (PHE)

During the PHE, services provided and billed in accordance with COVID-19 PHE guidance issued by the NYS Department of Health (DOH) and pertaining to Private Duty Nursing services will not be subject to disallowance if all other requirements not specifically addressed in the guidance were met. The "Medicaid Changes to Private Duty Nursing (PDN) Policy" guidance was effective as the date of the notice, March 28, 2020, and shall remain in effect for the remainder of the disaster emergency declared by Executive Order No. 202.

This includes the following guidance:

Agency	Guidance Title	Date Issued	Date Expired
DOH	Medicaid Changes to Private Duty Nursing (PDN) Policy PDN Services Over 16 hours (Policy Manual 16.3 E) PDN Administrative Approval – Reduced documentation (PDN Manual 6.0) Change Request for Addition of Non–School Hours (PDN Policy Manual Section 9.4)	3/28/2020	5/11/2023

The Federal Government announced that the PHE expired at the end of the day on May 11, 2023. After the date the PHE ended, the flexibilities afforded providers regarding minimum billing standards and documentation requirements also ended, unless otherwise specified by DOH through formal regulatory waivers.

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OMIG AUDIT PROTOCOL
Nursing Home Transition and Diversion Waiver (NHTD)
(For Service Dates 01/01/2013 through 06/02/2025)

Public Health Emergency (PHE)

Services provided and billed in accordance with COVID-19 PHE guidance issued by the NYS Department of Health (DOH) and Centers for Medicare and Medicaid Services (CMS) will not be subject to disallowance, provided all other programmatic and billing requirements not altered or waived by the PHE guidance were met.

This includes the following guidance:

Agency	Guidance Title	Date Issued
NYSDOH	Appendix K: Emergency Preparedness Response and COVID-19 Addendum, NY.0444.R02.12	11/22/22
NYSDOH	Appendix K: Emergency Preparedness Response and COVID-19 Addendum, NY.0444.R02.10	09/26/22
NYSDOH	Appendix K: Emergency Preparedness Response and COVID-19 Addendum, NY.0444.R02.09	07/12/22
NYSDOH	Appendix K: Emergency Preparedness Response and COVID-19 Addendum, NY.0444.R02.07	03/29/22
NYSDOH	DAL: DHCBS 21-11	08/23/21
NYSDOH	DAL: DHCBS 21-09	07/23/21
NYSDOH	Appendix K: Emergency Preparedness Response and COVID-19 Addendum, NY.0444.R02.06	02/08/21
NYSDOH	DAL: DHCBS 21-02	01/21/21
NYSDOH	DAL: DHCBS 20-11	11/23/20
NYSDOH	DAL: DHCBS 20-10	10/13/20
NYSDOH	Appendix K: Emergency Preparedness Response and COVID-19 Addendum, NY.0444.R02.04	08/24/20
NYSDOH	Updated COVID-19 Guidance for the Authorization of Community Based Long-Term Services and Supports Covered by Medicaid	04/08/20
NYSDOH	Appendix K: Emergency Preparedness Response and COVID-19 Addendum, NY.0444.R02.02	04/07/20
NYSDOH	COVID-19 Guidance for Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) 1915 (c) Medicaid Waiver Providers	03/20/20

The Federal Government announced that the PHE expired at the end of the day on May 11, 2023. On the date the PHE ended, the flexibilities afforded providers regarding minimum billing standards and documentation requirements also ended, unless otherwise specified by DOH through formal regulatory waivers.

The background is a blurred image of a financial document. It features a line graph with a blue line showing fluctuations. There are handwritten numbers in blue ink, including '2.5' on the left and '2.47' on the right. A pen is visible in the top right corner, and the overall image has a soft, out-of-focus aesthetic.

Risk Mitigation: What can I
do to mitigate audit risk and
minimize recoupment?

What can I do during the audit?

- Successful responses are typically “in the weeds” of regulatory landscape and supporting documentation
- Use the exit conference as an opportunity to ask questions and clarify basis of findings
- Communication and cooperation with auditors
- Address apparent interpretation issues early
- Response to draft audit report should be comprehensive and include all evidentiary and legal arguments, with supporting documentation
- Carefully consider pros and cons of requesting an administrative hearing



What can I do before an audit?

The most effective way to prevent against recoupment is to:

- (1) Adopt and maintain an effective compliance program.
- (2) Focus compliance program activities on issues and areas considered “high risk”.
- (3) Self-disclose issues proactively when they are identified.

OMIG Compliance Program Requirements and Best Practices



The Compliance Program Requirement

New York Social Services Law (“SOS”) Section 363-d

“The legislature finds that medical assistance providers may be able to detect and correct payment and billing mistakes and fraud if required to develop and implement compliance programs. It is the purpose of such programs to organize provider resources to resolve payment discrepancies and detect inaccurate billings, among other things, as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences.” N.Y. SOS § 363-d(1).

Requirements of SOS § 363-d implemented through OMIG regulations

New York Budget for Fiscal Year 2021 included several changes to N.Y. SOS § 363-d intended to strengthen Medicaid program integrity provisions

Part 521-1 – Medicaid Compliance Programs

Elements of a Medicaid Compliance Program:

1. Written Policies and Procedures
2. Compliance Officer
3. Compliance Committee
4. Training and Education
5. Lines of Communication
6. Disciplinary Standards
7. Auditing and Monitoring
8. Systems for Responding to Compliance Issues



The Keys to Success: Incorporating High Risk Issues into Compliance Activities

- System of due date reminders accessible to supervisors, compliance officer and billing
 - Pre-claim submission review
 - Do not bill if compliance issues exist
- Compliance processes and procedures for reviewing and verifying accuracy and completeness of key documents
- Training includes substantive content on high-risk issues
- Internal audits focused on OMIG audit protocol topics
- Self-disclose and return payments where issues identified after payment received

The Keys to Success: Focus on Record Retention

- Record retention and storage
 - Organization and access to paper records
 - Refiling/misfiling of records
- Robust back-up systems for electronic records
 - Do not rely on potential mitigation by OMIG
- Suspension of record destruction processes upon receipt of notice of audit
 - Include personnel records and payroll/timesheet records
- Think about record retention issues when significant turnover occurs or in the event of a sale of the business or change in management
- Discharged patients' records are still subject to audit! Make sure record retention is equally as robust for discharged patients.
 - Create clear directories of file location
 - Consider electronic scan/backup



Effective Compliance Program Definition

- A compliance program adopted and implemented by the required provider that, at a minimum, satisfies the requirements of this SubPart and that is designed to be compatible with the provider's characteristics (i.e., size, complexity, resources, and culture), which shall mean that it:
 - (i) is well-integrated into the company's operations and supported by the highest levels of the organization, including the chief executive, senior management, and the governing body;
 - (ii) promotes adherence to the required provider's legal and ethical obligations; and
 - (iii) is reasonably designed and implemented to prevent, detect, and correct non-compliance with MA program requirements, including fraud, waste, and abuse most likely to occur for the required provider's risk areas and organizational experience.

(18 NYCRR 521-1.2(b)(3))

What does OMIG look for when doing a compliance program review?

1. Documentation of activities is key

- a. Records of Investigations / Corrective Actions
- b. Compliance reports to governing body
- c. Charter, meeting minutes, agendas of compliance committee
- d. Annual review of compliance program
- e. Record of implementation and review / revision dates for P&Ps
- f. Governing body's assessment of adequacy of CCO resources and time

2. Compliance Plan language comports with Part 521-1 requirements

What does OMIG look for when doing a compliance program review?

1. Compliance Work Plan, Training Plan and Audit Work Plan

- a) Work Plan covers required topics
- b) Training Plan and evidence of completion
- c) Audit Work Plan covers all risk areas

2. Focus on contractors

- a. Contract requirements (right to terminate)
- b. Contractor training
- c. Exclusion checks – who is responsible, how do you monitor completion?

Involvement and oversight by governing body

1. Governing body responsible for overseeing and monitoring implementation of compliance program and ensuring that CCO has adequate time, resources and authority to carry out functions.
2. CCO Quarterly Reporting to Governing Body
 - a. Evidence that the CCO reported directly to the governing body members (written reports or governing body meeting agendas, minutes, and excerpts that describe reports by the CCO).
 - b. Established method for governing body members to directly ask the CCO questions.
3. Governing Body and CEO role in overseeing and holding compliance committee accountable
 - a. Consider member attendance, participation and contribution in performance plan and compensation evaluation
 - b. CO periodic reports to the board assessing Compliance Committee performance and attendance
 - c. Oversee Compliance Committee Risk Assessment process

Role and authority of compliance officer

- Stature, authority, independence, access and resources
- Continued concern over conflicts created by dual roles and reporting relationship
- Strong advocacy for compliance officer's sole responsibility being compliance

“[T]he compliance officer should not lead or report to the entity’s legal or financial functions, and should not provide the entity with legal or financial advice or supervise anyone who does.”

OIG’s General Compliance Program Guidance (November 2023)

Incentives and Disincentives

- Do performance incentives inadvertently disincentivize compliance and/or incentivize inappropriate behavior?
- Requesting or requiring personnel to bring concerns to managers/supervisors first can deter reporting
- Incentives designed to reward:
 - Achievement of compliance goals for a specific department or position description
 - Achievements that reduce compliance risk
 - Performance of compliance activities outside of one's job description

Self-Disclosures as an Indicator of Effectiveness

- Affordable Care act and Part 521-3 – providers must report and return overpayments within 60 days of identification
- No issues? = Compliance Program is Ineffective.

“No matter how strong an entity’s commitment to compliance or how effective the policies and procedures, training, and risk assessment, it is inevitable that a compliance officer will receive audit or monitoring results that raise concerns or receive a report through the disclosure program that requires investigating.”

“How an entity responds when it finds a violation resulting in a substantial overpayment or serious misconduct sets apart those that have a strong compliance program from those with a compliance program that is more form than substance.”

Audits, Compliance Programs and Self-Disclosure Obligations are Interrelated

- Risk Areas defined to include “other risk areas that are or should reasonably be identified by the provider through its organizational experience.”
- Definition of “Organizational Experience”:
 - experience, knowledge, skill, practice and understanding
 - internal monitoring and auditing activities
 - any audits, investigations, or reviews; or
 - awareness of any issues it should have reasonably become aware of for its category or categories of service
- When has an overpayment been “identified”?
 - An overpayment is “identified” when a provider has, or should have, through the exercise of reasonable diligence, (i) determined that an overpayment was received, and (ii) quantified the amount of the overpayment.
 - Inadequate or ineffective compliance program => “Should have known”
- Part of provider’s “due diligence is to review the results of the audit and look at past and future periods - not covered by the audit – to identify any overpayments resulting from similar issues.”

OMIG Self-Disclosure Guidance – January 2024
- False Claims Act
 - Reckless disregard/deliberate ignorance standard
 - Failure to timely report and return an overpayment



Provider Self-Disclosure Obligation

- Upon receipt of a Final Audit Report, provider must:
 - Assess potential for additional overpayments outside of audit period
 - Consider inclusion as a risk area in compliance activities
- Effort should be:
 - Led by compliance officer
 - Shared with compliance committee and governing body
 - Documented in compliance program records
- Risks:
 - False Claims Act referral to MFCU
 - Reduced leverage in future audit
 - Compliance Program Review result = compliance program not effective
 - Penalties
 - Exclusion

Self-Disclosure Reminder

Pursuant to 18 NYCRR Sub Part 521-3, any person who has received an overpayment under the NYS Medicaid program is required to report, return, and explain the overpayment through OMIG's Self-Disclosure Program. Providers cannot submit self-disclosures for overpayments currently subject to audit by OMIG. However, you are required to self-disclose any identified overpayments outside the scope of this audit.

After reviewing the findings in this Final Audit Report, the provider should exercise reasonable diligence to identify overpayments in other time periods for issues similar to those identified in this audit. If as a result of your review you determine that you are in receipt of an overpayment, you are required to self-disclose the overpayment to OMIG within 60 days of identification or the date any corresponding cost report is due, if applicable, pursuant to 18 NYCRR 521-3.3. Failure to exercise reasonable diligence to identify any overpayments, and subsequently retaining those overpayments, may result in monetary penalties and/or sanctions, in addition to the recoupment of the overpayment in a future audit or review.

It is recommended that you document any internal audit or review conducted, and the results of such audit or review. If after your review you determine that no overpayment is due, no further action is required. Such documentation may be requested in a future OMIG audit or review, or a compliance program review pursuant to 18 NYCRR Sub Part 521-1.

7-2	18 NYCRR § 521-1.4(h)(1) If the provider had an OMIG audit or investigation, that was finalized during the Review Period and resulted in overpayments, did the provider comply with the requirements of 18 NYCRR § 521-1.4(h)(1)? Yes ____ No ____ N/A ____ (There were no OMIG audits or investigations that were finalized during the Review Period.)	If yes, provide, as "Attachment 7-2," a copy of the following: a. a summary that includes: - OMIG audit or investigation number and final report date; - a description of any related internal audits or investigations of the reason(s) for the identified overpayments; - a description of related plans of correction, including implementation dates; and - any other evidence the provider took prompt action to investigate the reason for identified overpayments in an OMIG audit or investigation to determine what, if any, corrective action was required and promptly implemented such corrective action; and
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Questions?



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