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OMIG AUDIT PROTOCOL
CERTIFIED HOME HEALTH AGENCY (CHHA)
For service dates prior to December 31, 2010
Effective February 14, 2013

Audit protocols assist the Medicaid provider community in developing programs to evaluate compliance with Medicaid requirements under federal and state statutory and regulatory law. Audit protocols are intended solely as guidance in this effort. This guidance does not constitute rulemaking by the New York State Office of the Medicaid Inspector General (OMIG) and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person. Furthermore, nothing in the audit protocols alters any statutory or regulatory requirement. In the event of a conflict between statements in the protocols and either statutory or regulatory requirements, the requirements of the statutes and regulations govern.

A Medicaid provider's legal obligations are determined by the applicable federal and state statutory and regulatory law. Audit protocols do not encompass all the current requirements for payment of Medicaid claims for a particular category of service or provider type and, therefore, are not a substitute for a review of the statutory and regulatory law. The OMIG cannot provide individual advice or counseling, whether medical, legal, or otherwise. If you are seeking specific advice or counseling, you should contact an attorney, a licensed practitioner or professional, a social services agency representative, or an organization in your local community.

Audit protocols are applied to a specific provider or category of service in the course of an audit and involve the OMIG's application of articulated Medicaid agency policy and the exercise of agency discretion.

Audit protocols are amended as necessary. Reasons for amending protocols include, but are not limited to, responding to a hearing decision, litigation decision, or statutory or regulatory change.

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1.	Missing or Insufficient Documentation of Hours/Visits Billed
OMIG Audit Criteria	<p>If there is no chart, the aide failed to document hours of service billed, or professional staff failed to document the visit, that portion of the paid claim that was not documented will be disallowed.</p> <p>The nature of the facts surrounding the missing records and/or claims for services not rendered should be evaluated for additional action.</p>
Regulatory References	<p>18 NYCRR 505.23(e)(1)</p> <p>10 NYCRR 763.7(a)(6)&(7)</p>

2.	Billed For Services In Excess Of Ordered Hours/Visits
OMIG Audit Criteria	<p>If the CHHA billed more hours/nursing or therapy visits than plan of care / medical orders authorized, the paid claim for the hours/visits exceeding the order will be disallowed.</p> <p>If the number of hours on any date of service exceeds the total maximum number of hours per visit on the approved POC (and no supplemental order was obtained) the additional hours will be disallowed.</p> <p>The disallowed service or units of service should be a service that exceeded the ordered plan frequency for the calendar week that is used by the provider. If additional time is necessary, the justification for the extra time must be documented.</p> <p>OMIG will consider exceptional situations, where ordered services were exceeded for good cause (situation must be documented).</p>
Regulatory References	<p>18 NYCRR 505.23(a)(1)(i)&(ii)</p> <p>18 NYCRR 518.3(b)</p> <p>18 NYCRR Section 505.23(a)(3)(i)-(iii)</p> <p>10 NYCRR 763.6(d)</p> <p>MMIS Provider Manual for Home Health Services, Revised February 1992, Section 2</p> <p>NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines, Version 2007-1, Section III and Version 2008-1, Section III</p>

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3.	Billed Medicaid Before Services Were Authorized
OMIG Audit Criteria	<p>If the CHHA began billing before the plan of care was signed by the practitioner, the paid claim will be disallowed.</p> <p>All sampled services that were billed prior to date of the practitioner's signature on the order, which covers the approved and signed POC for the time period of the service, will be disallowed.</p>
Regulatory References	<p>10 NYCRR 763.7(a)(3)(i)-(iii) 10 NYCRR 763.6(d) 10 NYCRR 763.7(c) 18 NYCRR 505.23(a)(3)(i)-(iii) 42 CFR 484.18(b) 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</p>
4.	Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame
OMIG Audit Criteria	<p>If the plan of care/medical orders were signed late, the paid claim will be disallowed. Signed medical orders are required within 30 days of the start of care, a change in the plan of care, or recertification. A disallowance will only be taken if the signature is more than 60 days from the date of the start of care, a change in the plan of care or recertification.</p> <p>If the provider has a system to track orders, has documentation that the system has been utilized, and the provider can document diligent efforts to obtain the signed order, consideration will be given to allowing the claim.</p>
Regulatory References	<p>18 NYCRR Section 505.23(a)(3)(i)-(iii) 10 NYCRR 763.7(a)(3)(i)-(iii) 10 NYCRR 763.7(c) 18 NYCRR 505.23(b)(1) 42 CFR 484.18(b) 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</p>

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5.	Plan of Care/Orders Not Signed by an Authorized Practitioner
OMIG Audit Criteria	If the practitioner was not authorized to sign the plan of care/medical orders, the paid claim will be disallowed.
Regulatory References	18 NYCRR 540.1 18 NYCRR Section 505.23(a)(3)(i)-(iii) 18 NYCRR 505.2(a)(1)(i)(a) 10 NYCRR 763.5 10 NYCRR 763.7(a)(3)(i)-(iii) 10 NYCRR 763.7(c) 42 CFR 484.18 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
6.	Initial Assessment Not Documented/Late
OMIG Audit Criteria	If there is no initial assessment in the record for the relevant date of service, or the assessment is late, the paid claim will be disallowed. A CHHA must conduct an initial assessment visit to determine the immediate care and support needs of the patient.
Regulatory References	10 NYCRR 763.5(a)(1)&(2) 10 NYCRR 763.5(b) 10 NYCRR 763.5(b)(3) 10 NYCRR 763.7(a)(6) 10 NYCRR 763.7(c) 18 NYCRR 505.23(b)(1) 42 CFR 484.55(a)(1) 42 CFR 484.55(a)(2)

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7.	Initial Assessment Does Not Meet the Required Standards
OMIG Audit Criteria	<p>Nursing staff will review the initial assessment and the record, pertinent to the date of service, to determine if the standards set forth in the regulations were met.</p> <p>The assessment performed during the initial visit (prior to admission) must indicate that the patient's health and supportive needs could safely and adequately be met at home and that the patient's condition required the services of the agency. If the initial assessment does not meet the required standards, the paid claim will be disallowed.</p>
Regulatory References	<p>10 NYCRR 763.5 10 NYCRR 763.5(a)(1)&(2) 10 NYCRR 763.5(b)(1)(i)-(iv) 10 NYCRR 763.5(b)(3) 10 NYCRR 763.7(a)(6) 10 NYCRR 763.7(c) 18 NYCRR 505.23(b)(1) 42 CFR 484.55(a)(1) 42 CFR 484.55(a)(2)</p>
8.	Comprehensive Assessment Not Documented/Late
OMIG Audit Criteria	<p>If there is no comprehensive assessment in the record for the relevant date of service or the comprehensive assessment was late, the paid claim will be disallowed.</p> <p>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.</p> <p>The comprehensive assessment must be updated and revised (including Outcome and Assessment Information Set (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.</p>
Regulatory References	<p>10 NYCRR 763.6(a) 18 NYCRR 505.2(a)(1)(i)(a) 42 CFR 484.55(b)(1) 42 CFR 484.55(d)(1)(i)-(iii) 10 NYCRR 763.7(a)(4) 10 NYCRR 763.7(c)</p>

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9.	Comprehensive Assessment Does Not Meet the Standards Set Forth in New York's Regulations
OMIG Audit Criteria	Nursing staff will review the comprehensive assessment and the record, pertinent to the date of service to determine if the standards set forth in New York's regulations were met. A comprehensive patient assessment must be completed and address the patient's medical, social, mental health, and environmental needs. If the assessment does not meet the required standards, the paid claim will be disallowed.
Regulatory References	18 NYCRR 505.23(a)(1)(i)&(ii) 10 NYCRR 763.6(a) 10 NYCRR 763.6(b)

10.	Comprehensive Assessment Does Not Meet the Standards Set Forth in the Federal Regulations
OMIG Audit Criteria	<p>Nursing staff will review the comprehensive assessment and the record, pertinent to the date of service, to determine if the standards set forth in the Federal regulations were met.</p> <p>The comprehensive assessment must be patient specific and: accurately reflect the patient's status; include information to demonstrate the patient's progress toward achievement of desired outcomes; identify continuing need for home care; meet the medical, nursing, rehabilitative, social and discharge planning needs; incorporate the current version of the Outcome and Assessment Information Set (OASIS) items; include a review of all medications; and be completed by the appropriate discipline. If the assessment does not meet the required standards, the paid claim will be disallowed.</p>
Regulatory References	18 NYCRR 505.23(b)(1) 42 CFR 484.55 42 CFR 484.55(b)(1) 42 CFR 484.55(b)(2) 42 CFR 484.55(b)(3) 42 CFR 484.55(c) 42 CFR 484.55(e)

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11.	Failed to Update the Comprehensive Assessment
OMIG Audit Criteria	Nursing staff will review the record, pertinent to the date of service, to determine if the applicable assessment was performed. The comprehensive assessment must be updated and revised (including the OASIS instrument) as frequently as the patient's condition warrants. If the comprehensive assessment has not been updated as required, the paid claim will be disallowed.
Regulatory References	18 NYCRR 505.23(b)(1) 42 CFR 484.55(d)(1)(i)-(iii) 42 CFR 484.55(d)(2)&(3)

12.	Missing Plan of Care/Order
OMIG Audit Criteria	If there is no plan of care/medical order in the record for the relevant date of service, the paid claim will be disallowed.
Regulatory References	10 NYCRR 763.6(b)-(e) 10 NYCRR 763.7(a)(5) 10 NYCRR 763.7(a)(3)(i)-(iii) 10 NYCRR 763.6(d) 10 NYCRR 763.7(c) 18 NYCRR 505.23(b)(1) 42 CFR 484.18 42 CFR 484.18(b) 42 CFR 484.18(c) 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

13.	Plan of Care Does Not Adequately Address Patient Needs
OMIG Audit Criteria	Nursing staff will review the plan of care and the record, pertinent to the date of service, to determine if the plan of care addresses the patient's current health and safety needs. If the plan of care fails to address the patient's current health and safety needs, the paid claim will be disallowed.
Regulatory References	10 NYCRR 763.3(a) 10 NYCRR 763.11(a)(1)&(2)(ii) 10 NYCRR 763.6(b)(1)-(4) 10 NYCRR 763.6(c) 10 NYCRR 763.6(d) 18 NYCRR 505.23(b)(1) 42 CFR 484.18 42 CFR 484.18(a) 42 CFR 484.18(c)

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14.	Failed to Review/Update the Plan of Care
OMIG Audit Criteria	Nursing staff will review the plan of care and the record, pertinent to the date of service, to determine if the plan of care was reviewed/updated as required by the regulations. The plan of care must be reviewed and updated as frequently as the patient's condition warrants but no later than every 62 days. The record must contain written documentation that the authorized practitioner was notified of any significant changes that may require an update to the plan of care. If the provider failed to review/update the plan of care when required, the paid claim will be disallowed.
Regulatory References	10 NYCRR 763.6(e)(1)&(2) 10 NYCRR 763.7(a)(3)(i)-(iii) 10 NYCRR 763.7(c) 10 NYCRR 763.6(d) 18 NYCRR 505.23(b)(1) 42 CFR 484.30(a) 42 CFR 484.18(b) 42 CFR 484.18(c) 42 CFR 484.14(g)

15.	Failed to Provide Services as Required by the Plan of Care/Medical Orders
OMIG Audit Criteria	If the record shows the services billed by the CHHA are not consistent with the ordered services or plan of care, the difference between the paid claim and the services ordered will be disallowed.
Regulatory References	18 NYCRR 505.23(a)(3)(i-iii) 10 NYCRR 763.6(c) 10 NYCRR 763.7(a)(5)-(7) 18 NYCRR 505.23(b)(1) 42 CFR 484.18 42 CFR 484.18(c) 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

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16.	Billed for Performance of Tasks/Services Not Ordered
OMIG Audit Criteria	If the CHHA billed for tasks/services that were not included in the plan of care/medical orders, the services will be disallowed.
Regulatory References	18 NYCRR 540.1 18 NYCRR Section 505.23(a)(3)(i)-(iii) 10 NYCRR 763.6(c) 10 NYCRR 763.7(a)(3)(i)-(iii) 10 NYCRR 763.6(d) 18 NYCRR 505.23(b)(1) 42 CFR 484.18 42 CFR 484.18(a) 42 CFR 484.18(b) 42 CFR 484.18(c) 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
17.	Medical Need for Tasks/Services Not Documented in the Record
OMIG Audit Criteria	Nursing staff will review the record, pertinent to the date of service, to determine if the patient's medical need for authorized tasks or services was documented as required by the regulations. If the medical need for the authorized tasks or services is not supported by the case record documentation, the paid claim will be disallowed.
Regulatory References	18 NYCRR 518.3(b) 18 NYCRR 505.23(a)(1)(i)&(ii)
18.	Medical Need for Hours Billed Not Documented in the Record
OMIG Audit Criteria	Nursing staff will review the record, pertinent to the date of service, to determine if the patient's medical need for hours billed was documented as required by the regulations. The time spent providing services to the patient must be supported by the documentation in the record. If the medical need for the hours billed was not documented in the record, the paid claim will be disallowed.
Regulatory References	18 NYCRR 518.3(b) 18 NYCRR 505.23(a)(1)(i)&(ii) 18 NYCRR Section 505.23(e)(1)

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19.	Supervision Visit Not Performed Within Required Time Frame
OMIG Audit Criteria	<p>If the required home health aide supervision visit was not documented within the required time period, the paid claim will be disallowed.</p> <p>Supervisory visits by an RN or therapist are required by regulations every 14 days if the patient is authorized to receive skilled services. If the supervisory visit has not occurred within the 30 days prior to the date of service, the paid claim will be disallowed.</p> <p>If the patient is not authorized to receive skilled services, the RN must make a supervisory visit every 60 days. If the supervisory visit has not occurred within the 60 days prior to the date of services, the paid claim will be disallowed. With some exceptions, supervisory visits must occur while the home health aide is providing care or the paid claim will be disallowed.</p>
Regulatory References	<p>18 NYCRR 505.23(a)(3)&(a)(3)(iii) 10 NYCRR 763.7(a)(6) 10 NYCRR 763.7(c) 18 NYCRR 505.23(b)(1) 42 CFR 484.36(d)(1)&(2) 42 CFR 484.36(d)(3)</p>

20.	Failed to Meet the Standard of Supervision Required
OMIG Audit Criteria	<p>Nursing staff will review the record, pertinent to the date of service, to determine if the provider met the standards for home health aide supervision as required by the regulations. If the provider failed to meet the required standards of supervision, the paid claim will be disallowed.</p>
Regulatory References	<p>10 NYCRR 763.4(h)(1)-(7)(i)-(iii) 10 NYCRR 763.7(a)(6) 10 NYCRR 763.7(c) 18 NYCRR 505.23(b)(1) 42 CFR 484.36(c) 42 CFR 484.36(d)(1)&(2) 42 CFR 484.36(d)(3) 42 CFR 484.30(a)</p>

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21.	Failed To Maximize Third Party/ Medicare Benefit
OMIG Audit Criteria	<p>Medicaid providers must take reasonable measures to determine legal liability to pay for medical care and services. No claim for reimbursement shall be submitted without provider investigation of the existence of such third parties.</p> <p>Medicare will generally cover either part-time or intermittent home health aide services or skilled nursing services as long as they are furnished, (combined) less than 8 hours each day and up to 28 hours per week. Where Medicare has paid for a full episode of skilled care, OMIG will assume that included in this episode is coverage for up to 8 hours each day or up to 28 hours per week unless the CHHA can provide documentation otherwise. OMIG will assume that home health aide hours for services, which are incidental to a Medicare paid visit, are included in the episode covered by Medicare up to the maximum hours.</p> <p>When it is determined that a sample service was covered or reimbursed by third party insurance in whole or in part, the amount MA incorrectly paid will be disallowed.</p> <p>Note: Any service to a Medicare eligible patient for which Medicare made no payment will <u>NOT</u> be evaluated for possible Medicare coverage. A statewide sample of these claims is evaluated by OMIG and an outside contractor for possible Medicare eligibility.</p>
Regulatory References	<p>18 NYCRR 360-7.2 18 NYCRR 540.6(e)(1)&(2) 18 NYCRR 540.6(e)(3)(i)-(v) 18 NYCRR 505.23(e)(2) (ii) 42 CFR 409.45(b)(3)(i); 409.45(b)(1) et.seq.; 409.45(b)(4), and §50.2 Home Health Aide Services (Rev.1, 10-01-03) Chapter 7 Home Health Services, Medicare Benefit Policy Manual (Rev. 142, 04-15-11) NYS Medicaid Program Information for All Providers, General Policy, Version 2004-1, Section I and Version 2006-1, Section I and Version 2008-1, Section I</p>

22.	Billed for Services Performed by Another Provider/Entity
OMIG Audit Criteria	<p>If the services billed by the CHHA are duplicative, i.e., already paid for by Medicaid or by another entity, the paid claim will be disallowed. Specific case circumstances will be evaluated through review of the record.</p> <p>Guidance will be sought from the appropriate program division as needed. Relevant program regulations will be cited as appropriate.</p>
Regulatory References	<p>18 NYCRR 505.23(a)(1) (i)&(ii)</p>

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23.	Incorrect Rate Code Billed
OMIG Audit Criteria	If the rate code billed is not the correct rate code for the services provided, the difference between the appropriate claim amount and the paid claim will be disallowed.
Regulatory References	18 NYCRR 505.23(e)(1) 18 NYCRR 504.3(e)-(i) 10 NYCRR 86-1.13(b) [from 2009 to present] 10 NYCRR 86-1.46(b) [from 1994 to 2009] DOH Medicaid Update, May 2007, Vol. 23, No. 5
24.	Incorrect Rounding of a Service Unit
OMIG Audit Criteria	If the CHHA billed for more hours than allowed by failing to follow rounding instructions in the NYS Medicaid Home Health Manual, the difference between the appropriate claim and the paid claim will be disallowed.
Regulatory References	18 NYCRR Section 505.23(e)(1) 18 NYCRR 504.3(e)-(i) NYS Medicaid Provider Manual for Home Health – UB-92 Billing Guidelines, Version 2004-1, Section II NYS Medicaid Provider Manual for Home Health – UB-04 Billing Guidelines, Version 2007-1, Section II and Version 2008-1, 2 & 3, Section II and Version 2009-1 & 2, Section II and Version 2010-1, Section 2
25.	Ordering Practitioner Conflicts With Claim Practitioner
OMIG Audit Criteria	If the ordering/referring practitioner on the claim differs from the practitioner that ordered the services, the paid claim will be disallowed. (This finding only applies to claims with dates of service paid after the <u>May 2009 Update takes effect.</u>)
Regulatory References	18 NYCRR 504.3(e)-(i) DOH Medicaid Update, May 2009, Volume 25, Number 6 NYS Medicaid Provider Manual for Home Health – UB-04 Billing Guidelines, Version 2009-1 & 2, Section II and Version 2010-1, Section 2

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26.	Patient Excess Income (“Spend down”) Not Applied Prior to Billing Medicaid
OMIG Audit Criteria	<p>If the provider did not apply a client spend-down to a sampled claim, the difference between the paid claim and the correct claim amount (had the spend-down been properly applied) will be disallowed.</p> <p>Note: This finding only applies where the relevant county has assigned responsibility for the spend-down to the provider and the sampled claim must be impacted by the spend-down.</p>
Regulatory References	<p>18 NYCRR Section 360-4.8(c)(1) 18 NYCRR Section 360-4.8(c)(2)(ii) NYS Medicaid Provider Manual for Home Health – UB-92 Billing Guidelines, Version 2004-1, Section II NYS Medicaid Provider Manual for Home Health – UB-04 Billing Guidelines, Version 2007-1, Section II and Version 2008-1, 2 & 3, Section II and Version 2009-1 & 2, Section II and Version 2010-1, Section 2</p>
27.	Failure to Conduct Required Criminal History Check
OMIG Audit Criteria	<p>The record will be reviewed to determine if the CHHA or its contractor initiated a background check within the specified time frames and provided appropriate monitoring of the aide while waiting for the results of the background check. (This pertains to services provided by an employee hired after 9/1/06).</p> <p>If the criminal history check requirement has not been completed, the paid claim will be disallowed.</p>
Regulatory References	<p>10 NYCRR 402.9(a)(1)&(2) 10 NYCRR 402.1(a) 10 NYCRR 402.6(a) 10 NYCRR 763.13(h)</p>

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28.	Minimum Training Standards Not Met for the Home Health Aide
OMIG Audit Criteria	<p>If the CHHA or CHHA contract employee did not meet minimum training requirements when services were rendered, the paid claim will be disallowed.</p> <p>The record must contain a certification of completion from a DOH or SED approved training program.</p>
Regulatory References	<p>10 NYCRR Section 700.2(b)(9) 10 NYCRR 763.13(h) 18 NYCRR 504.1(c) DOH Dear Administrative Letter DAL: DHCBC 06-02 Issued April 13, 2006 42 CFR 484.4</p>
29.	Failure to Complete Required In-Service Training
OMIG Audit Criteria	<p>The record will be reviewed to determine if CHHA or CHHA contract employee completed minimum in-service education requirements. If the employee did not complete the in-service requirements, the paid claim will be disallowed.</p> <p>The criteria for the one year period for completion of the in-service training that is used by the provider will be considered the base year for each aide under review. An additional 120 days will be allowed beyond the 12 months preceding the date of service before a disallowance will be taken.</p>
Regulatory References	<p>10 NYCRR Section 763.13(l) 10 NYCRR 763.13(h)</p>
30.	Missing Certificate of Immunization
OMIG Audit Criteria	<p>The record will be reviewed to determine if the required certification of immunizations was not documented for the CHHA or CHHA contract employee. If the provider does not provide documentation of the required certification of immunizations, the paid claim will be disallowed.</p>
Regulatory References	<p>10 NYCRR Section 763.13(c) 10 NYCRR 763.13(e) 10 NYCRR 763.13(h)</p>

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31.	Failure to Complete Required Health Assessment
OMIG Audit Criteria	The record will be reviewed to determine if the annual health assessment of a CHHA or CHHA contract employee was documented within the required time frame. If the provider does not provide documentation of a health assessment within the required time frame, the paid claim will be disallowed.
Regulatory References	10 NYCRR 763.13(c) 10 NYCRR 763.13(d) 10 NYCRR 763.13(e) 10 NYCRR 763.13(h)

32.	Missing Documentation of a PPD (Mantoux) Skin Test or Follow-up
OMIG Audit Criteria	The record will be reviewed to determine if a CHHA or CHHA contract employee received a complete PPD skin test within the required time frame. If the provider does not provide documentation of a complete PPD skin test within the required time frame, the paid claim will be disallowed.
Regulatory References	10 NYCRR 763.13(c)&(c)(4) 10 NYCRR 763.13(e) 10 NYCRR 763.13(h)

33.	Missing Personnel Record(s)
OMIG Audit Criteria	If the personnel record for the CHHA or CHHA contract employee providing sampled services is missing, the paid claim will be disallowed.
Regulatory References	10 NYCRR 763.13(h) 10 NYCCR 763.5

34.	Failure to Complete Annual Performance Evaluation
OMIG Audit Criteria	The record will be reviewed to determine if annual evaluation of the performance and effectiveness of CHHA or CHHA contract employee was not conducted within the required time frame. If the provider did not provide documentation of the completion of an annual performance evaluation within the required time frame, the paid claim will be disallowed.
Regulatory References	10 NYCRR 763.13(k) 10 NYCRR 763.13(h)

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by the OMIG and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person.