

## Home Health Providers and Verification Organizations Questions/Comments and Answers

| # | Question/Comment  | Answer   |
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| 1 | The legislation speaks to “provider”, please develop covered provider threshold based on Provider ID, not FEIN.   | OMIG will make this adjustment.  |
| 2 | Please limit the applicability of the requirements to home health aide and personal care services claims – and not to claims for professional or other services.  | OMIG will make this adjustment to the initial requirements. Note that these claims will still be used as part of the covered provider threshold.   |
| 3 | On page 1, paragraph 3 under the “covered providers” section – can you please clarify that “capitated payments” includes payments under the forthcoming episodic reimbursement system (which DOH confirmed and announced to providers in a webinar last week will be in place by April 1). Note that your current compliance document language says “Capitated payments <i>and</i> claims made to Managed Care Organizations are not included in calculations for determining covered providers.” This clearly distinguishes between and includes both managed care payments and <i>other</i> capitated payments, of which episodic payments are a form. Again, remember, a claim under episodic payment is not per hour or per visit or per service; as a capitation payment, an episodic payment is a single, capitated payment for a 60 day <i>period of care</i> , an “episode” of care, and is not tied to individual services or comprised of claims for individual services. It is an aggregate, capitated payment. Can I ask that you please clarify in paragraph 3 that the reference to “capitation” includes “episodic” payments as well as other periodic payments to managed long term care plans or other care coordination models. | The Episodic Payment System (EPS) will continue to use the Fee For Service claim methodology with some minor changes. In addition, though each claim is not individually priced, the controls implemented through the project are still essential to properly account for utilization, outlier payments and future rate analysis. As a result, EPS are not considered to be a capitated payment and are included in the project scope. |
| 4 | On page 5, item #3, re the VO’s need to “ensure” caregiver credentials, including “exclusion” lists – Can you please clarify that “ensure” means the VO ensures that the CHHA and LHCSA have in place procedures to verify credentials, including the exclusion lists, and not that OMIG is not requiring the VO to directly and duplicatively perform these checks? (otherwise it is just repeating steps and will be an administrative nightmare.)  | As a neutral, third party, it is the VO’s job to ensure that it’s done – the VO does not need to actually perform the tasks as long as they are verifiably performed. Optimally, the checks should be automated with periodic rechecks (as opposed to once and done).  |
| 5 | First and primarily, we had asked, based on the extensive description of the detailed checks and verification systems that are already in place, if OMIG would consider a process whereby such providers with such mechanisms for claim verification and conflict/exception resolution could be deemed or attested to be in compliance with the new mandate (say subject to audit) without having to duplicate the process and expense through the new, separately mandated VO procedure. If OMIG agrees to this request, then I assume you would have to revise your compliance communication and specifically your implementation duty timeline for providers in reflection of such a change.   | The legislation has a clear expectation that the role of the VO includes a check between claims and conflicts and exceptions. Therefore, it is essential that the originating Electronic Visit Verification (EVV) data (and any subsequent exception resolution data ) is used to perform the required checks before the claims are generated on behalf of the covered provider.   |
| 6 | Every time we have met, I have reviewed and emphasized the massive changes, including claims/information system changes, currently affecting home care providers. Last week we received confirmation from DOH that the new episodic payment system will be in place by April 1, also confirming that there will be a need for providers to gear up between now and then for this entirely new method of Medicaid billing and case coding. Also, just two days ago, DOH posted extensive guidelines for “Care Coordination Models” that will require LTHHCPs primarily, but also some CHHAs, to be completely steeped in activity to either massively ramp up their  | We understand that there are numerous challenges to meeting the MRT-sponsored changes to the program. OMIG is committed to setting an aggressive pace to the implementation while at the same time, making allowance for real-world limitations. In recognition of the varied effects of these requirements on covered providers, we will be requesting an implementation schedule from each covered provider’s                        |

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|   | <p>programs to conform to these new guidelines or attempt to realign their businesses and operations as contractors to managed care. The CCM guidelines, coupled with the highly compressed timetable (again, between now and April 1) for mandatory patient enrollment in to managed long term care or CCMs, are causing huge instability and upheaval in all of these provider agencies and in the system as a whole. In recognition of these and the additional changes being instituted to these agencies, (including the OMIG TPL mandate), it would be of immeasurable help if OMIG were to further extend the timeline and dates for the steps that providers must complete for implementation. We of course have otherwise appealed to OMIG for the straight suspension of the new preclaim/VO mandate, pending implementation of managed long term care, episodic payment and Care Coordination Model changes, since, as we have argued, the preclaim review mandate is not really relevant in the new capitated payment environment. HCA urges OMIG's continued consideration of request. However, in the meantime, HCA asks that OMIG further consider a recalculation of the compliance timetables to accommodate implementation, in full consideration of all of the issues raised here and otherwise affecting the field.</p>  | <p>chosen Verification Organization. These submissions will be reviewed with an understanding that each implementation is unique.</p>  |
| 7 | <p>We are very concerned that EVV systems are not appropriate for the Consumer Directed Personal Assistance Program (CDPAP).</p> <p>As you are aware, in CDPAP, the consumer receiving the services, or their Designated Representative (DR), is the supervisor of the attendant. This is an extremely important distinction from other home care programs that are agency-run. According to regulations promulgated earlier this year (18 NYCRR §505.28), the consumer in CDPAP is responsible for the following (§505.28(g)):</p> <ul style="list-style-type: none"> <li>• Selecting and terminating the assistants employment;</li> <li>• Training, supervising and scheduling each assistant;</li> <li>• Attesting to the accuracy of each consumer directed personal assistant's time sheets;</li> <li>• Transmitting the consumer directed personal assistant's time sheets to the fiscal intermediary according to its procedures; and</li> <li>• Arranging and scheduling substitute coverage when a consumer directed personal assistant is temporarily unavailable for any reason.</li> </ul> <p>Subsection (i)(2) of the regulations clearly state that "Fiscal intermediaries are not responsible for fulfilling responsibilities of the consumer or, if applicable, the consumer's designated representative." As we discussed, in accordance with state regulations, the Fiscal Intermediary does not have access to the schedules for the attendants in CDPAP and therefore does not have a reference to verify if the schedule is being carried out correctly.</p> <p>There are additional challenges that make CDPAP an unlikely candidate for successful</p> | <p>There are a range of special considerations for CDPAP that should receive additional thought prior to any mandate of the project's control. For initial implementation, CDPAP claims will be exempted from Covered Provider calculations.</p> |

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|    | <p>implementation of an EVV system. These challenges include:</p> <ul style="list-style-type: none"> <li>• Consumers starting and/or finishing shifts in the community, not at the consumers residence with a land line phone</li> <li>• The opportunity for fraud if an attendant's cellular phone is registered as an acceptable call-in number for a given consumer</li> <li>• Short term increases in hours authorized by Social Services Districts in cases of consumer sickness or broken equipment that necessitates additional hours of assistance</li> </ul> <p>When a telephony system was implemented in Monroe County, we also experienced difficulties due to language barriers. The system often rejected people with significant accents. Individuals speaking certain languages (e.g. Somali) were entirely exempted from using the system. Deaf individuals were also excused from the system because the system was predicated on the ability to hear and speak. This example highlights that well intentioned fraud prevention measures, when implemented, do not always provide the intended result.</p> |   |
| 8  | On point 14, could you explain or define matching service. We provide home care(PCA) and all billing is for that service and that service only. All authorizations are for home care.  | This was an error, it should read “matching visit”.   |
| 9  | 2) What do you mean by provider installation and the filing of a compliance summary? Please define.  | It is recognized that each provider may have a unique set of systems which are integrated to meet the project requirements. In some cases, the Verification Organization may only provide and/or be directly responsible for a portion of the systems. In addition to the attestation, the Verification Organization must describe the full systems that are in place and how they meet the project requirements. |
| 10 | We are a Consumer-Directed Agency and not a traditional home care agency. Although we only have approximately 20% of our consumers who verify the visits electronically, because of the nature of consumer-directed, we do not know in advance the schedule of the personal assistant. Can you provide any guidance when only a small percentage of our population is using the electronic verifications?  | See answer #7. In addition, at such time that CDPAP is considered, allowance will made for program differences that don't conform to program requirements (e.g., scheduling).   |
| 11 | Could you also please explain Number 2 - “a VO must ensure that all care givers are properly registered, credentialed and matched ...”? What does it mean to be properly registered and credentialed?  | Registered means registered in the State DOH HHA/PCA registry. Credentialed means that all required training has been taken and is current, matching means matching with state sanction/exclusion lists.  |
| 12 | Number 4 – we do not have access to the plan of care, therefore, we cannot determine/verify that the services were consistent with the plan of care. How can we address this?  | Likely another accommodation for special features of the CDPAP.   |
| 13 | Number 6 – a claim is submitted for each hour worked. The exception reports are generated the following month, therefore, I am not sure how we can determine if a claim that was submitted is associated with a conflict. Please note, that all conflicts are investigated and the proper corrected  | At such time that CDPAP is covered, it would be the Verification Organization’s responsibility to ensure that the automated checks for conflict and exception occur prior to  |

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|    | action is taken, which includes collection of overpayment, if applicable.   | submission of a claim.   |
| 14 | Numbers 13 and 15 – as indicated above, because of the nature of consumer-directed, we do not know the scheduled hours or who will be working for the consumer in advance. Under consumer-direction, the consumer hires, fires, and trains the personal assistance. In addition, the consumer will give the personal assistant their work schedule daily. Please advise on how we can adapt this requirement to consumer-directed agencies.   | Covered by previous answers (special accommodations for CDPAP rules).  |
| 15 | <p><b><u>Redundant Process</u></b></p> <ul style="list-style-type: none"> <li>We currently contract with over thirty (30) different LHCSAs to provide HHA services to our patients. We do not directly employ the HHAs. All of these contracted LHCSAs have, for some time, utilized a time and attendance verification system. As explained in great detail at our meeting, these systems require each HHA to call a dedicated number from the patient’s phone at the time of arrival, and the HHA is then required to call again at the time of departure and enters all of the tasks completed during the shift. The LHCSAs monitor this closely, and if there is some exception or anomaly in this reporting, then an exception report is generated. By way of example, if there is no call-in or out time, if the HHA does not call-in within 15 minutes of the start of his/her schedule, or if the time recorded is more or less than scheduled by the LHCSA, an exception report is generated. The exception must then be worked manually, and many steps are involved, before the LHCSA would verify the visit and release it to the CHHA for the CHHA to process for billing. The LHCSA that employs the HHA manage all of the exceptions – not the contracting CHHA. However, we provide our contracted LHCSAs with very explicit guidelines as to how to resolve these exceptions and what documentation needs to be maintained.</li> </ul> <p>For instance, under our current processes, in the event there is no call-in or call-out time entered by the HHA, the LHCSA must: (i) call the patient to confirm the presence of the HHA in the home and identify extenuating circumstances for the failure to call, (ii) require the HHA to complete a paper duty sheet and obtain patient signature, and (iii) manually note in the system that the HHA attendance has been verified.</p> <p>The need to provide all of the call-in and call-out data, the exception reports, and any process associated with resolving those exception reports, which may involve thousands of exceptions each day, will create a huge amount of redundant effort, with limited additional value, at great cost in time and dollars.</p> <ul style="list-style-type: none"> <li>With regard to resolving “conflicts” (which we understand to mean when one person is reporting being in two places at once), the proposal does not address such conflicts in a</li> </ul> | <ul style="list-style-type: none"> <li>As noted in number 5, the legislation has a clear expectation that the role of the VO includes a check between claims and conflicts and exceptions. Therefore, it is essential that the originating Electronic Visit Verification (EVV) data (and any subsequent exception resolution data ) is used to perform the required checks prior to generating claims on behalf of the covered provider.</li> </ul> <p>Based on the process description you provide, it is likely that the LHCSAs can continue to do the processes they currently perform. I.e., if they clear exceptions that occur in the systems provided by their Electronic Visit Verification (EVV) system, that data can then be passed the the CHHA’s Verification Organization vendor which can verify the prescribed checks were performed prior to preparation or submission of a claim.</p> <p>The vendors are cognizant of these requirements and prepared to meet them and provide the necessary access to the data through automated means.</p> <ul style="list-style-type: none"> <li>In the initial implementation, it is recognized that we will only detect conflicts that occur amongst the</li> </ul> |

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|    | <p>meaningful way as these Verification Organizations are not able to share information with each other. As such, a Verification Organization would not have access to all of the claims submitted and, therefore, the majority of the “conflicts” would continue to be identified by Medicaid post-payment. Even if they could share information, which we understand that they cannot, they would need to obtain the time schedules for each HHA in order to make correct determinations as to whether conflicts exist.</p> <ul style="list-style-type: none"> <li>• There is a clear lack of necessity for another outside Verification Organization to conduct pre-claim reviews particularly as the State seeks to implement Medicaid Reform Team proposals with regard to a Prospective Payment System (where claims are not paid on a per service basis).</li> <li>• Consequently, we request that home care agencies be deemed to have met the new requirements if they currently contract with, or require its LHCSAs to contract with, organizations that conduct similar activities.</li> </ul> | <p>collective clients of a single Verification Organization. In time, as Verification Organizations send data to the NYS Medicaid Warehouse, we will be able to detect, though still post-payment, conflicts across providers.</p> <ul style="list-style-type: none"> <li>• As indicated, the Verification Organization can “piggyback” on the work performed at the LHCSA and use it to verify the cross-check requirements.</li> <li>• As explained, a VO will be required; however, there should be no redundancy and the relevant vendors are aware of the interaction requirements between the CHHAs and LHCSAs.</li> </ul> |
| 16 | <p><b><u>Professional Visits</u></b></p> <p>We request that the OMIG make it clear that these requirements only apply to HHA services. The proposed model is based solely on how HHA services are delivered. Such a model is not applicable to the delivery of professional services as professional visits are not ordered or scheduled in the same prescriptive manner as HHA visits. As such, OMIG’s proposal does not account for such differences and the Verification Organization would not be able to use the same verification procedures utilized for HHA services.</p>  | <p>As indicated in #2, we will remove the requirement for professional services for the initial implementation.</p>  |
| 17 | <p><b><u>Sanction Checks</u></b></p> <p>If the CHHAs and LHCSAs currently perform credentialing, background checks and monthly sanction checks pursuant to applicable regulations and their contracts with the CHHAs, we do not think that the Verifications Organizations should also be required to do these checks. Again, this would be duplicative. We request that OMIG clarify its expectations with respect to this requirement.</p>   | <p>See #4.</p>   |
| 18 | <p><b><u>90 Day Billing Requirement</u></b></p> <p>We would request that the OMIG clarify its expectations for the time frame within which a Verification Organization has to verify claims, and whether OMIG is willing to expand the 90 day window within which providers have to submit claims to Medicaid to account for this additional process. We anticipate that these processes, at least during the first year of its implementation, may cause substantial delays.</p>  | <p>As established in #15, we believe that through the activities and checks already being performed by the LHCSAs and the ability of the vendors to automate the processes, there should be no additional delay nor need for expansion of the claim submission window.</p>   |
| 19 | <p><b><u>Move to PPS</u></b></p>   |  |

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|    | <p>Our understanding is that these requirements only apply to providers who submit Fee-for-Service (FFS) claims. As you are aware, and as discussed in great detail at our meeting, beginning in April 2012, CHHAs will begin to receive episodic payments under a prospective payment system and will no longer be allowed to submit FFS bills. As such, starting in just a few months, CHHAs will no longer be required to utilize these Verification Organizations. We also understand that it is very likely that by April 1, 2012, the Long Term Home Health Care Program will also shift to some form of a capitated payment arrangement and also will no longer receive FFS reimbursement. Given this situation, there will be very few HHA services that are provided, other than a small amount to mothers and children, which will continue to be paid under a FFS arrangement.</p>   | See #3.   |
| 20 | <p><b><u>Verification Organization Diagram Clarification</u></b></p> <p>We request that the OMIG provide clarification with respect to the diagram entitled “Verification Organization Diagram.” We are unable to understand the type of information expected to flow and the actual flow of information to and from the CHHA, and/or to and from the LHCSA to the Verification Organization proposed in the diagram.</p>   | <p>The diagram is necessarily vague due to the variation of provider implementations and inter-relationships. We recommend that a conversation first occur with a selected Verification Organization vendor and then any specific questions can be addressed by OMIG. If additional detail is necessary to facilitate a choice of VO, we can schedule a more detailed, provider-specific discussion.</p>            |
| 21 | <p><b><u>Timing</u></b></p> <ul style="list-style-type: none"> <li>• If any type of Verification Organization process is to be implemented, we strongly urge that providers be given substantial lead time before they are required to comply, and perhaps, include a grace-period to work out any kinks. To date, there are no final requirements and no identified qualifying vendors. Providers are going to need to build appropriate interfaces and operational protocols to meet any requirements, and this requires substantial time, effort and resources.</li> <li>• Home care providers are facing substantial legislative and regulatory changes, such as the move to PPS, mandatory enrollment in MLTCs, the transition of home attendant patients to Medicaid Managed Care, and providers are preparing for these changes. Given that there remains tremendous uncertainty in the home care industry, we ask that the OMIG coordinate closely with DOH to ensure that home care providers are not overburdened with duplicative and what may be deemed to be unnecessary demands.</li> </ul> | <p>We agree. Once the providers select a VO, the first deliverable to OMIG will be the submission of an implementation plan by the VO. This process will allow a customized plan for each provider which accounts for any special challenges or issues in their implementation.</p> <p>All program requirements and feedback are (and will be) shared with DOH prior to the issuance of any final requirements.</p> |
| 22 | <p>I am formally responding to your request for comments on the attached draft of NYS Medicaid’s requirement for homecare providers to use a Verification Organization to verify service provision to a client receiving Medicaid reimbursable services. I am submitting these comments based on</p>  |   |

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|   | <p>significant observations I have gathered as a current user of a verification organization. I am just as passionate in ensuring that tax dollars are utilized for ethical, moral and productive purposes. Therefore my comments to this draft will also include suggestions as to how Verification Organizations could develop or improve their software to maximize its fraud detection and fraud prevention mechanisms. The following are my comments:</p> <ol style="list-style-type: none"> <li>1. A few recipients of home based Medicaid services <u>do not</u> have a digital landline telephone that can be used as an effective tool to completely record an electronic attendance verification data. When a worker departs from a case assignment he/she calls the designated 1800 number to clock out. The telephony system directs a worker to key in numbers that represents the tasks that they have completed during their work shift before they are instructed to finally key in his/her social security number to complete his/her “clock out” information. A Non digital telephone can only capture information that verifies that a call was made from a client’s registered telephone number. Because of the inability of the caller to further key in data to attain a full “clock out” entry, the limited data recorded by the software turns up in the Agency’s “Exception Report”.</li> </ol> <p>Recommendation: The VO must develop a software that will allow the caller to have the option to “key in” the information requested or to speak/verbalize the information requested. This way data required for a full attendance verification entry could be captured even using a non digital telephone system.</p> <ol style="list-style-type: none"> <li>2. A few recipients of home based Medicaid services refuse to allow the worker to use their landline telephone system to “clock in” or “clock out” their respective workers arrival and departure from the client’s home. Although we homecare vendors implement random attendance verification calls and/or unannounced visits to randomly selected clients, it does not provide us an accurate basis to conclude that the worker arrived and departed from the client’s home as per client’s scheduled service authorization.</li> </ol> <p>The same situation applies to clients who have no landline telephones at all. These clients refuse to have a landline telephone installed because of the cost to install and maintain it. Clients convey that they have limited income and cannot afford any landline telephones.</p> <p>Recommendations:</p> <p>For this first instance, clients when processed and prior to being approved for Medicaid entitlements must be required to sign off on a document that mandates them to permit the use of a landline telephone unit for workers to electronically record their attendance on the case.</p> | <ul style="list-style-type: none"> <li>• Suggestion shared with vendors via this document.</li> <li>• We definitely realize there will be exceptions due to 'phone issues' at the client's home. Note too that some vendors offer additional solutions beyond</li> </ul> |

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|   | <p>For the second instance, clients who have no landline telephone must be provided a landline by Medicaid or insurance provider is authorized to receive home based services. The telephone is a safety and lifeline tool which can mandated similar to PERS, (Personal Emergency Response System). For some reason despite the ads for LIFELINE (free phone) from Verizon, clients still refuse to access this free service.</p> <p>3. The use of GPS was mentioned as a tool that can be used for attendance verification. I find this very appropriate for clients who refuse the use of their telephones, clients with no telephones, and clients with n on digital phones. When GPS was introduced as a “stand alone” verification tool, our current VO did not agree to accept attendance information from them to be integrated in our payroll system. We can only surmise the reasons to be that of business monopoly, (where our current VO can similarly develop a GPS system that can be integrated in its current VO software) or incompatibility of software programs used by two different verification providers.</p> <p>Recommendation: All VOs must be required to develop a GPS system to cater to the three different categories of clients who may not have the appropriate tool for electronic attendance verification.</p> <p>4. Conflict of hours report with our current VO becomes available to us a month after the conflict has occurred. It used to be available after three months. Because of the lapse in the availability of the conflict of hours report, delays contribute to a decreased opportunity to detect and prevent fraud as well as recover loss of government funds.</p> <p>Recommendation: VOs must be required to provide conflict of hours report within one week, (which may be set as the maximum time frame) for the homecare employer to be alerted. This way the employer can immediately investigate and adopt corrective measures to detect and prevent fraud. VOs could develop a system similar to the “Positive Pay” mechanism that we currently have with our banks where we get electronic alerts when an unusual check transaction is drawn against our bank accounts.</p> <p>5. The expectation for the VO to gather additional information to support an exception report may be unrealistic. They have no direct contact or rapport with the client and the worker to secure the documents. We ourselves have difficulty securing supporting documentation from our clients to substantiate payroll payment for a time sheet.</p> <p>Recommendation: NYS Medicaid must provide a list of acceptable documentation to manually verify a worker’s attendance in the home. Based on the acceptable list of documentation, universal forms that are user friendly could be developed for internal control</p> | <p>telephony.</p> <ul style="list-style-type: none"> <li>• We also believe that GPS-based system have some advantages. As price points hopefully drop and usage adoption occurs, this could be a future requirement. But it also is an acceptable way to meet the initial requirements today.</li> <li>• Conflict and exception report availability will need to be expedited to real-time (or something close) to avoid undue delays on claiming.</li> <li>• The VO’s responsibility is to ensure that the systems and processes ensure that exceptions are caught and</li> </ul> |

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|    | <p>purposes.</p> <p>Noting the current budget climate that we are all in at the present time, standard pricing, (similar to Verizon, Cable vision, etc.) for the services provided by VOs must be established and regulated by the NYS Medicaid Inspector General. <u>There is currently an existing monopoly in the provision of database providers here in New York City. We the homecare vendors are held hostage in negotiating a fair price and a price that our current budget can support. If NYS is requiring us to comply with this requirement, we need the budget to pay for the database services and also a staffing pattern that will oversee the effective use of this verification tool.</u></p>  | <p>properly resolved. It is assumed that in most cases, this will be done with automated controls and role-based entry by staff of the client.</p> <ul style="list-style-type: none"> <li>There are no plans to regulate pricing; however, we do hope that the multi-vendor approach increases competition, innovation and systems interaction.</li> </ul> |
| 23 | How will the VO integrate its systems with the provider in order to verify the services provided?   | This is variable based on each provider implementation. In general, where a VO does not control the full spectrum of systems, they need to review the systems to ensure that all of the checks are in place, persistent and can't be circumvented.   |
| 24 | How will this integration be paid for? Will DOH reimburse us for the associated cost?   | The implementation is considered a cost of participating in the NYS Medicaid program. It is hoped that for agencies already employing a vendor to meet HRA's longstanding rules, that there will be minimal additional costs. Providers are encouraged to share their experiences in this area to keep us abreast of the market conditions.                |
| 25 | How will the VO process affect the 90 day billing requirements when there are exceptions that require further investigation and follow up? Will DOH and OMIG recognize any associated delays in claims submission as a valid excuse under the regulations for not billing within 90 days? Will the VO be required to issue its reports on a sufficiently timely basis so as to ensure that the provider has enough time to review and if necessary investigate any reported exceptions and still satisfy the 90-day rule? Will the regulations or enforcement of the the 90-day rule be modified or relaxed in light of this additional layer of review being performed by an organization that is, after all, "outside of the control of the provider". 18 NYCRR 540.6(a)(1).? | See #18.   |
| 26 | How will services be verified for the Para-professional vendors that are not using the time in and out electronic system? Will those vendors be required to adopt an electronic system? If unable to do so within a certain time frame would the agency have to discontinue the contract with those vendors?  | See #2.  |
| 27 | Will the patient signature on the paper voucher or on the laptop be sufficient to verify the visits made by the professional staff? Will the agency be required to implement a time in and out electronic system for verification of visits by the professional staff? How will we verify visits?   | See #2.  |
| 28 | What is the expected implementation time frame and date?  | We expect to have providers choose a VO by mid-January. By mid-February, VO's will be expected to submit an implementation plan and schedule for each of their clients (providers).  |

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| 29 | What will be the time frame allowed to integrate the provider system and the VO?  | This can vary for each provider. OMIG will review each implementation plan for reasonableness.  |
| 30 | Our main concern is almost 80% of our Medicaid billing is in a county which has specifically stated we are not to use any AT&L systems. We are unsure how to handle this situation since it seems the VO requirements are specifically based on a telephony or GPS based time and attendance system.  | The requirement is a state law and must be followed by covered providers; however, counties do have the ability to set additional requirements. In cases where this project and county requirements are in conflict or redundant, we will work with the county to pursue compatible requirements. |
| 31 | Additionally, two of the draft requirements read as follows: “13. VOs must ensure that each visit that occurs is scheduled” and “15. VOs must create an exception for late/missed services (tolerances to be decided)” More than 50% of our weekly hours are CDPAP. These requirements would be difficult to enforced for this population. We do not schedule these cases, they are scheduled by the consumers. I have attached a copy of the DOH regulations for the CDPAP program. Subset G, beginning on page 14, outlines the consumers responsibilities. Among them is scheduling of the Personal Assistant. | See #7.   |
| 32 | I am concerned that the definition of such terms as “properly resolved” and or “tolerances to be decided” be determined by individuals experienced in home health care.   | Resolution remains in the hands of the experts, the system must capture the identity of the person resolving it and the reasons. The tolerance will definitely be based on best practices from the health community and in consultation with DOH program staff.                                   |
| 33 | Also, the document references a website with “additional ... resources related to these regulations”. However, I did not find any resources that would help a provider pay for the implementation of these regulations.   | There is currently no additional information on the web site beyond the initial draft requirements document. As the program evolves additional information, such as this Q&A document can be posted.  |
| 34 | Under the covered providers section: This requirement will apply to Provider ID’s which, in aggregate, directly submit Fee for Service Claims in the following Categories of Service:<br>Question: fee for service will not exist for CHHA providers beyond April, 1 2011 for Medicaid recipients, will this requirement change or be altered to reflect the new payment system?  | See #3.   |
| 35 | Question: We had Medicaid revenues last year of an amount greater than 15 million to necessitate this mandate, the law/language states 15 million in reimbursements on a calendar year basis. With the change from fee-for-service to prospective payment system and the mandatory enrollment of individuals into other Care settings/plans. W do not anticipate having 15 million in reimbursements for calendar year 2012, would this mandate still apply?  | Normally, we would recalculate as each calendar year’s data closes and becomes available; however, we are cognizant of the changes which are occurring and will be monitoring billing levels and will consider accommodations and adjustments where appropriate.                                  |
| 36 | Question: Who or Whom is paying for this external verification organization?  | See # 24.   |
| 37 | The new regulation requires that each EVV exception is documented. The question is what is the definition of an exception. For example, which one of the following scenarios would be defined as an exception where the schedule is 8am – 12pm:<br><br><b>Scenario 1:</b>   |   |

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|    | <p>EVV verification in: No EVV verification out: No<br/>Supervisor enters the time in manually<br/><i>Suggestion:</i> exception</p> <p><b>Scenario 2:</b><br/>EVV verification in: No EVV verification out: 12:00<br/>Supervisor enters the time in manually<br/><i>Suggestion:</i> exception</p> <p><b>Scenario 3:</b><br/>EVV verification in: 7:45, EVV verification out: 12:15<br/>Supervisor changes the hours to: 8am-12pm (this would be done for payroll or overlap reasons)<br/><i>Suggestion:</i> not an exception as the original EVV verification matches the requirement. The changes are due to other operational reasons. I'm a bit torn on this one.</p> <p><b>Scenario 4:</b><br/>EVV verification in: 8:15, EVV verification out: 12:15<br/>Supervisor changes the hours to: 8am-12pm</p> <p><i>Suggestion:</i> not an exception as the original EVV verification matches the requirement. The changes are due to other operational reasons.</p> | <p>Agreed</p> <p>Agreed</p> <p>This scenario highlights a need for an additional requirement; namely, that the billing duration cannot exceed the duration of what is scheduled. With that change noted, it would be the provider's choice as to whether a separate exception is generated (as long as the billing is adjusted).</p> <p>Agreed (assuming the 15 minutes is within the tolerance for a late visit exception).</p>   |
| 38 | <p>The scenarios below are related to changes to updating of tasks (i.e. duties) (it is not clear if the regulation includes those changes in the definition of an exception)</p> <p><u>Scenario 1:</u><br/>EVV verification in: 08:00, EVV verification out: 1200, no duties entered<br/>Supervisor enters duties based on conversation with the caregiver.<br/><i>Suggestion:</i> Exception</p> <p><u>Scenario 2:</u><br/>EVV verification in: 08:00, EVV verification out: 1200, personal care and other duties entered.<br/>Supervisor updates one of the custodial tasks (e.g. laundry, went shopping with the patient, prepared snack...)<br/><i>Suggestion:</i> No. As those are non critical tasks. Those should be reviewed by DOH during audits</p>  | <p>The requirements indicate that the scheduled service must be consistent with the plan of care and has had proper authorization and sign-off. This was left at a relatively high level due to differences in sophistication in mapping duties to plan of care. This is an area where we will want to bring some standardization in time. Answers below are good faith answers in the theme of good or best practices.</p> <p>Agreed.</p> <p>Agreed as long as the full set of duties are consistent with the</p> |

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|    | <p>but should not be triggering an exception. Each agency should setup their own compliance/corrective action plan to manage those cases.</p> <p><u>Scenario 3:</u><br/>           EVV verification in: 08:00, EVV verification out: 1200<br/>           Caregiver is updating her task sheet electronically after the visit (e.g. next day). This is done via a caregiver portal or via the EVV system (e.g. phone system)<br/> <i>Suggestion:</i> if the tasks are updated within X days then no. If done after X days then yes.</p>  | <p>plan of care.</p> <p>Ideally, the duties should be captured electronically at the time they are performed (esp. since EVV was available in the scenario). It is recommended that any other entry method still be treated as an exception to ensure oversight of the duties being performed and lack of entry at the point of service.</p> |
| 39 | <p><b><u>Exception:</u></b><br/>           In case of multiple updates of an exception would OMIG require that each update should be document or one documentation per record is enough.<br/>           e.g.<br/>           schedule: 8am- 12pm<br/>           Step1: caregiver does not call in. Supervisor calls the caregiver at 8:30am and update the record and document the reason of the exception.<br/>           Step2: Caregiver does not call out. Supervisor calls the caregiver again at 12:15 and update the record.<br/>           Should the supervisor update her existing documentation or create a new one.<br/>           In other words, on the exception report – should this scenario create 2 records or only 1 record?</p> | <p>All exceptions must be resolved. A vendor could create a single exception containing multiple issues or create separate exceptions. In either case, the most important thing is that they are resolved and tracked.</p>   |
| 40 | <p>Currently the conflict reports existing on the market are based on SSN. During our conversations we discussed that this should work based on the caregiver registry number. Please confirm.</p>  | <p>Vendors are encouraged to utilize both numbers as part of their checks in order to optimize the ability to detect matches.</p>  |
| 41 | <p>Some of the DSS requires that any exception (no EVV verification for in or out) should be supported by a paper timesheet. Will the new rules and regulation be applied to all DSS too?</p>   | <p>See #30.</p>  |
| 42 | <p>Which one of the following programs are under this new regulation: CHHA's, Long Term (LTHHCP), Managed long term (MLTC), personal care service programs, consumer direct, Hospice?</p>   | <p>Anything billed under Categories of Service 260, 264 or 388, with the exception of CDPAP. This generally covers CHHA, Personal Care and LTHHCP and excludes Consumer Directed Personal Care, Home and Community Support Services (HCSS) and Hospice. Professional Services are also exempted from EVV for initial implementation.</p>     |
| 43 | <p>The current telephone based EVV are currently allowing the employee to enter any task that is on the plan of care. This results in some confusion. For instance – if the codes of the plan of care change, the caregiver might enter an old duty code or in some instances the caregiver forgets the task code. Would the following telephone based EVV features be accepted by OMIG:</p> <p>1- The system speaks the duties that are on the plan of care. For each task the caregiver can enter yes (performed)/ no (not performed). At the end the caregiver can enter any additional task</p>   | <p>The suggested behaviors are acceptable; however, best practice would still be to elicit the discrete duties performed from the caregiver rather than suggesting them.</p>   |

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|    | <p>2- In case the caregiver completed all the tasks on the plan of care, they can enter 1 code which means that all the tasks have been completed (instead of entering one task at the time)</p> <p>3- After the employee enters all the tasks, the system verifies on the spot the tasks against the plan of care. The system will notify the caregiver in case of any discrepancy and will provide an option for the caregiver to correct the tasks on the spot.</p>                  |   |
| 44 | <p>“A VO must ensure that electronic visit verification is employed.”</p> <p>Should the VO ensure that the agency is using one of the approved EVV software or should it assure that each visit is verified by an EVV entry. If so – what should the policy for patients that don’t have a home phone and the EVV is using telephony or the GPS location doesn’t work in the patient apartment (therefore no verification is possible) and the agency is using an EVV based on GPS?</p> | <p>It is important to differentiate between the VOs, which will be approved, vs. the EVV vendors which may be a layer removed and not directly overseen (e.g., VO employed by CHHA, EVV employed by sub-contracted LHCSA). VOs are encouraged to communicate issues with EVV systems and their vendors and we will assist in the problem resolution.</p> <p>It is recognized that there will always be exceptions. One of OMIG’s operational roles will be to monitor exceptions from a variety of perspectives (e.g., agency, employee) both in frequency as well as the methods and reasons given for resolution.</p> |
| 45 | <p>In case of subcontracting of services– (NY city) – Would the VO be liable for any of the subcontractors EVV or can it rely on the approved list of EVV vendors provided by OMIG/DOH?</p>   | <p>The VO does have a responsibility to ensure the overall concept of operations for their client. Hopefully, the large majority of EVV players are also part of the pool of approved VO's or at least, a component thereof. Where that's not the case, the VO and/or the covered provider would ensure that the contributing EVV from the sub-contract is reliable.</p>  |
| 46 | <p>To what extent should the VO become a repository of information. Should it keep all the exclusion reports and resolutions?</p>   | <p>The VO needs to have a single repository (or a virtual representation of one) which can be accessed and queried by state staff. Once we are operational, a longer term goal will be to create data transport mechanisms so that each VO's data can be further consolidated in the Medicaid Data Warehouse.</p>   |
| 47 | <p>“A VO must ensure that all care givers are properly registered, credentialed and matched against exclusion and sanction lists”</p> <p>Registered – meaning registered with the homecare registry? Currently, there is no interface to the registry. Will DOH provide such interface? If not, how would the VO be able to confirm the</p>   | <p>At least one acceptable approach would be to ensure that each HCA/PCA has a registry number and automate a query and perform a match of the agency data with the result set data. Less sophisticated, but still acceptable, would be to require the number and attest to the agency's business process of</p>  |

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|    | registration?  | checks.   |
| 48 | Matched against exclusion lists – even if the employee is matched against the exclusion/sanction list, in most of the cases a human intervention is required to review and decide if the person found in the exclusion list matches the employee. Is the VO responsible for reviewing the resolution or its only required to assure that the matching process occurred on a monthly basis. In case of wrong doing, would the VO or the agency be liable?                         | Similar to above, the key would be to attest to a process which is in place. Again, some level of automation is also possible and OMIG aids those functions with extracts: <a href="http://www.omig.ny.gov/data/content/view/72/52/">http://www.omig.ny.gov/data/content/view/72/52/</a>  |
| 49 | <p>“A VO must ensure that the recipient has proper authorization, both for enrollment and any utilization limits, that the service scheduled is consistent with the plan of care and has had proper authorization and sign off.”</p> <p>Proper authorization: authorizations are provided by the plan of care which is not always electronic. Does that mean that all plans of care must from now on be electronic?. Without such verification the VO should hold the claim?</p> | As in the previous questions, a verified mix of process and automation is possible. For instance, a supervisor could establish an electronic list of duties from a paper plan of care. From that point, the system could check against the master list of duties. Again, the VO is verifying that the checks and balances are in place. |
| 50 | ‘enrollment’ – do you mean that the VO is responsible to check the eligibility of the patient in the Medicaid plan? Can it rely on the agency internal processes?  | Though the hope is that there is an automated check, review and attestation of business process is acceptable.  |
| 51 | “sign off” – does that mean that the VO is responsible to verify that (in case of a chha) the physician order is signed before the claim can be sent out?  | Yes, but again, business process attestation is acceptable. Long term, we will encourage increasing automation for some of these requirements.  |
| 52 | <p>“A VO must ensure that all required checks are on and cannot be altered or bypassed by the provider”</p> <p>There might be exceptions where the provider wants to release a claim that is ‘stuck’ in the pre-billing. Those are usually exceptions where the agency has (paper) supporting material showing that the claim is compliant. Should that still be permitted?</p>  | The key to exceptions is that there are controls and that personal accountability and rational reasoning are captured (and thereafter maintained) at the point of resolution.   |
| 53 | <p>“A VO must ensure that no claim can be submitted unless there are no exceptions (of those which are required) or any exceptions have been properly resolved.”</p> <p>What are the ‘required’ exceptions?</p>  | All of the other items in that same list (Attachment 2). This was just to emphasize in a more blanket fashion, that exceptions must be resolved.  |
| 54 | <p>“A VO must track all exception resolutions and at a minimum”</p> <p>In the scenario of subcontracting – the VO will reconcile the information from multiple vendors using multiple systems. In such case, can the VO rely on the approved list of EVV vendors for the exception resolution or should it maintain its own database of resolutions?</p>   | Resolution data must be part of the EVV data which is passed to the VO. This is a key area of data that OMIG will monitor.  |
| 55 | “Where a claim is billed in time units, and where the duration of the visit is captured electronically, the billed duration must not exceed the duration of the service as indicated by the electronic time stamps.”   | Exceptional scenarios like this can be handled through training; i.e., where there are extenuating circumstances where an attempt to use EVV would actually cause an incorrect billing, the exception path (non-EVV) should be  |

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|    | What happen in case the employee called in late (assuming that the EVV is telephony based) for some honest reasons (e.g. picked up the patient by the physician, found the patient in distress and had to attend to the patient right away...). In those cases, the agency would want to adjust the hours to reflect the actual time the employee arrived. This would create an 'exception' but would still be billable. Based on this requirement, the agency would not be allowed to change the time and the employee would be under paid (which might in turn create a problem with the department of Labor). | followed.  |
| 56 | <p>“VOs must ensure that each visit that occurs is scheduled.”</p> <p>With skilled services (and some non-skilled services) the care giver doesn't schedule in advance their visits (or at least not with the agency). Its managed based on the frequency of the service (e.g. 3 visits per week) – in those scenario's the visits are not scheduled.</p>  | Professional services will not be subject to the EVV for initial implementation. Where unscheduled non-professional services are allowable, the system can by-pass this check but should still account for overutilization (e.g., disallow a 4 <sup>th</sup> service in a week if only three are allowed).   |
| 57 | <p>“VOs must create an exception when a scheduled visit does not have a matching service.”</p> <p>What is the definition of 'matching service'? the VO won't allow anyway to bill for services not authorized. Is that not redundant?</p>  | Typo, should be a “matching visit”.  |
| 58 | Please Clarify # 5: A VO must ensure that all required checks are on and cannot be altered or bypassed by the provider.  | In the implementations in NY, there are a number where all of the software is installed at the provider's location. Even the ones which are implemented as SaaS (Software as a Service), the provider can often dictate the different checks. This requirement is to ensure that the vendor's implementation eliminates the ability of the provider to turn off a required edit or otherwise change data after processing has been completed.  |
| 59 | Please Clarify # 7: A VO must track all exception resolutions and at a minimum, must capture the identity of the individual attesting to the resolution and capture an explanation for why the exception occurred and why it is a legitimate claim for Medicaid reimbursed services.   | This requirement engenders responsibility on the part of the individual resolving an exception and allows us to query exception clearing behaviors and, upon audit, track back to an individual.   |
| 60 | Please Clarify # 12: VOs must enroll in NYS Medicaid as Service Bureau with a special designation as a VO. Note that it is already a requirement for entities that submit claims to Medicaid on behalf of a provider to enroll.  | Any vendor which submits claims on behalf of a provider is required to enroll as a Service Bureau. A number of companies contemplating the VO role have billing software which create files which the provider then submits. In these cases, the vendor is not acting as a Service Bureau. Independent of the explained connotation of a Service Bureau for billing, we will add a new category of Service Bureaus for Verification Organizations. This formalizes the role and allows controlled communication and requirement setting with the Verification Organizations. |
| 61 | Please Clarify # 16: For each provider installation, the Verification Organization must file a   | This is in recognition of the almost infinite variations and   |

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|    | compliance summary of the installation. The installation should describe the products and processes included in the VO solution and should include attestations by representatives of the provider and the VO that all required checks are in place, properly functioning and will be maintained as a condition of continued billing to the Medicaid program as a covered provider.   | customizations that VOs may need to make in order to satisfy each provider's needs. The VO must become familiar enough with the provider's end-to-end concept of operations; EVV, Electronic Medical Records (EMR) and billing, to ensure that the required edits and checks are in place and can't be circumvented by the provider. |
| 62 | We are a software vendor for Home Health, Long Term Health and PCA agencies; however, we do not submit claims to Medicaid on behalf of its providers. Can we enroll with NY Medicaid as a Verification Organization?  | Yes, in the described model you would simply have to ensure that the proper checks were automated and outside of the provider's capability to circumvent. E.g., if you had the EVV and EMR functions, you'd have to make sure that all checks were performed/cleared before transactions were fed to the billing system.             |
| 63 | Can the Verification Organization be the same entity that is used as the software vendor to submit claims to NY Medicaid?   | Yes.   |
| 64 | Is it a conflict of interest to be both their software vendor for claims processing and their Verification Organization.  | No, in fact this model allows for tighter integration between the required checks and billing.   |
| 65 | Is the NYS Medicaid Home Health Verification Organization Project mandated or is it voluntary?  | It is mandated for covered providers.  |
| 66 | When an Exception Report Shows that an inconsistent record exists of a caregiver's hours, is that information to be submitted by the Verification Organization to the NY Medicaid?  | It should be properly dealt with before billing is allowed. It should be available in a repository for NY Medicaid queries and, eventually, should be transferred to a central repository (all VO information consolidated).   |
| 67 | Should all claims be submitted to the Verification Organization before sending to NY Medicaid?  | That is one solution; alternatively, the VO's process can occur "ahead" of the billing function and only pass "clean" transactions on to a separate billing system.  |
| 68 | When a provider has been identified as having a potential conflict/exception will their claims be placed on hold or suspended until resolved?   | Suspended until resolved.  |
| 69 | Will Verification Organizations be liable if the provider fails to review and update records before sending claims to NY Medicaid?  | The Verification Organization needs to take reasonable steps to ensure that the relevant systems don't allow a transaction with one or more exceptions to be billed until a documented resolution to each exception is entered.  |
| 70 | We recommend multiple technologies to address recipients in all locations, including<br>a) Telephony;<br>b) Integrated GPS enabled devices to provide visit verification for recipients without a land line but have cellular service;<br>c) Alternative fixed location tracking device that can be in the recipient's home to provide verification coverage for those recipients who have no land line and no available cell services;<br>d) Uses biometric voice verification that provides accuracy to assure the correct caregiver is | At this time, OMIG only mandates electronic visit verification. Any of the first three technologies are acceptable for this and the fourth is an added, complementary check.   |

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|    | identified.  |   |
| 71 | We also suggest that you do not place any limitations on when data can be entered into the master EVV system.  | Aside from the expectation that EVV data should be gathered at the point of service (or create an exception), this is the case.   |
| 72 | We suggest you add a requirement that the system does not allow caregivers whose credentials are not in order to be scheduled to deliver care.   | Requirement 3 is intended to create this requirement.   |
| 73 | We suggest the EVV technology must have the ability to match the plan of care against the actual service in both real time and retrospectively. The system should prompt the caregiver on the plan of care and ensure plan of care compliance upon check out. The system should be able to accept authorizations and track them against services.  | The requirements indicate that the scheduled service must be consistent with the plan of care and has had proper authorization and sign-off. This was left at a relatively high level due to differences in sophistication in mapping duties to plan of care. This is an area where we will want to bring some standardization in time.   |
| 74 | We suggest that the system must have roles based security and provide a comprehensive audit trail.   | This is embedded in the requirements.   |
| 75 | We suggest you add the system should also provide real time alerts for exceptions against the plan of care and service plan  | See # 73.   |
| 76 | The system should also have voice biometrics to ensure caregiver compliance, as well as a scheduling system that does not allow for conflicting schedules.   | These are good features; however, they are not currently required.  |
| 77 | The system should also provide real time visibility and alerting to service agency   | Not a requirement; however, providers will likely demand real time or near real time since billing must be held until exceptions are cleared.   |
| 78 | <p>Attachment 2, Item 3 – “a VO must ensure that all care givers are properly registered, credentialed and ....”</p> <p>Right now, our company performs verification checks on individuals comparing names to the various exclusion lists. We then identify any potential matches and the providers must then go and perform any additional verifications as we do not have access to their caregiver Social Security Numbers. If a provider ignored the individual’s notification and allowed them to perform a service or if they mark that they have verified the individual, I do not believe the VO would be able to ensure that they individual is properly checked. Also, the information in the requirement is a little vague as it doesn’t specify which list must be checked.</p> <p>Looking at just PCA services, is the VO expected to verify(check) PCA/HHA credentials from the various credentialing databases (Home Care Registry)? If a RN were to perform PCA services, they may not appear in the PCA database but would be able to provide such services. In order to verify the credentials, additional lists would have to be checked and a listing of them would be very helpful. Also, access to such lists in an electronic form (CSV/XLS) would then have to be available for VOs.</p> | <p>Generally speaking, wherever a VO attests to manual processes, there are weaknesses that are not in the direct control of the VO. VO’s will be encouraged to articulate these areas and submit for OMIG approval. Over time, we will hopefully strengthen requirements to gradually remove the weaknesses.</p> <p>OMIG can work with VO’s to ensure these type of exceptions can be worked out. In the case of an RN, a State Education Department license check can be performed.</p> |
| 79 | Attachment 2, Item 4 - A VO must ensure that the recipient has proper authorization...and has  | The intent is for the VO to participate in putting reasonable   |

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|    | <p>had the proper authorization and sign off.<br/>Here, the word “ensure” seems to be a little worrisome. I do not believe it was the intent of this document to imply that the VO should actually perform a third party verification of the MD signatures for MD orders. Also, many times, the authorization is given directly to the provider and the documentation would never make it to the VO (worker’s comp, private insurance, private pay, etc.) I believe the wording should be adjusted in some of the requirements to remove the word “ensure” and have the VO “notify” the provider when a requirement is not being met rather than “ensure” all requirements are met.</p> | <p>controls in place or attesting to same. For example, a good control would be to require a high level entry attesting to the proper authorization which could thereafter be checked.</p> |
| 80 | <p>Attachment 2, Item 5 – A VO must ensure that all required checks are on...<br/>The VO should be provided a list of the required checks so that they guarantee that all the checks are on in order to respond to the ability to become a VO.</p>  | <p>The attachment represents the full list of mandated checks. Additional checks can be put in place through agreement of the provider and the VO.</p>                                     |