



**Office of the  
Medicaid Inspector  
General**

NEW YORK STATE  
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF LONG ISLAND HEAD INJURY ASSOCIATES  
CLAIMS FOR TRAUMATIC BRAIN INJURY SERVICES  
PAID FROM  
JANUARY 1, 2006 – DECEMBER 31, 2008

FINAL AUDIT REPORT  
AUDIT #: 09-1579

Dennis Rosen  
Medicaid Inspector General

April 13, 2016



Office of the  
Medicaid Inspector  
General

ANDREW M. CUOMO  
Governor

DENNIS ROSEN  
Medicaid Inspector General

April 13, 2016

[REDACTED]  
[REDACTED]  
Long Island Head Injury Associates  
300 Kennedy Drive  
Hauppauge, New York 11788

Re: Final Audit Report  
Audit #: 09-1579  
Provider ID #: [REDACTED]

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Long Island Head Injury Associates" (Provider) paid claims for traumatic brain injury services covering the period January 1, 2006, through December 31, 2008.

In the attached final audit report, the OMIG has detailed our scope, procedures, laws, regulations, rules and policies, sampling technique, findings, provider rights, and statistical analysis.

The OMIG has attached the sample detail for the paid claims determined to be in error. This final audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report dated November 19, 2015. The mean point estimate overpaid is \$363,423. The lower confidence limit of the amount overpaid is \$174,686. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the lower confidence limit of \$174,686.

[REDACTED]

Page 2  
April 13, 2016

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED] Please refer to report number 09-1579 in all correspondence.

Sincerely,

[REDACTED]

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

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

## **OFFICE OF THE MEDICAID INSPECTOR GENERAL**

[www.omig.ny.gov](http://www.omig.ny.gov)

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds.

### **DIVISION OF MEDICAID AUDIT**

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to assess compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to assess the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

### **DIVISION OF MEDICAID INVESTIGATIONS**

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

### **DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION**

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

### **OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL**

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and state governments jointly fund and administer the Medicaid program. In New York State, the Department of Health (DOH) administers the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

The Home and Community Based Services Waiver for Traumatic Brain Injury (HCBS/TBI) is a federally approved New York State Department of Health (Department) program to make thirteen different services, not included in the State's Medicaid Plan, available to persons with traumatic brain injury who meet certain eligibility criteria. The services focus on the community repatriation of New York State TBI individuals who reside in high cost institutionalized settings, and the avoidance of institutional placement for those who are at significant risk. The waiver is funded under the Medicaid Program and the costs are shared by the Federal, State and local governments.

HCBS/TBI services may be provided by not-for-profit or proprietary health and human service agencies. Providers of services must be approved by the Department for participation in the waiver, sign a contract agreement with the Department, and meet the standards established for each waiver service. Services provided by a HCBS/TBI provider are based on a written service plan for each participant that is developed with the waiver participant ( or designated advocate ) and a service coordinator selected by the participant. All plans are approved by the Department.

A HCBS/TBI Waiver provider is generally subject to Title XIX of the Federal Social Security Act and Article 27-CC of the New York State Public Health Law. The specific standards and criteria for HCBS/TBI waiver services are outlined in the Department HCBS/TBI Provider Manual, the related MMIS Manual, various administrative directives issued by the Department, and the contractual agreement with the department for the HCBS/TBI Waiver.

### **PURPOSE AND SCOPE**

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for traumatic brain injury services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to traumatic brain injury claims, this audit covered services paid by Medicaid from January 1, 2006, through December 31, 2008.

### **SUMMARY OF FINDINGS**

We inspected a random sample of 200 services with \$28,405.69 in Medicaid payments. Of the 200 services in our random sample, 18 services had at least one error and did not comply with state requirements. Of the 18 noncompliant services, none contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Billed More Hours than Documented	8
Partial Service Hours Were Billed Incorrectly	5
Missing Documentation of Service	2
Billed More Hours than Authorized in the Service Plan	2
TBI Training Not Completed – Community Integration Counseling (CIC)	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$1,113.36 in sample overpayments with an extrapolated point estimate of \$363,423. The lower confidence limit of the amount overpaid is \$174,686.

## TABLE OF CONTENTS

	<u>PAGE</u>
INTRODUCTION .....	
Background	
Medicaid Program	1
New York State's Medicaid Program	1
New York State's Traumatic Brain Injury Program	1
Purpose, Scope, and Methodology	
Purpose	2
Scope	2
Methodology	2-3
LAWS, REGULATIONS, RULES AND POLICIES .....	4-5
AUDIT FINDINGS.....	6
AUDIT FINDINGS DETAIL .....	7-14
PROVIDER RIGHTS.....	15-16
REMITTANCE ADVICE	
ATTACHMENTS:	
A – SAMPLE DESIGN	
B – SAMPLE RESULTS AND ESTIMATES	
C – DETAILED AUDIT FINDINGS	
D – BRIDGE SCHEDULE	

## **INTRODUCTION**

### **BACKGROUND**

#### **Medicaid Program**

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

#### **New York State's Medicaid Program**

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including traumatic brain injury service claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

#### **New York State's Traumatic Brain Injury Program**

The Home and Community Based Services Waiver for Traumatic Brain Injury (HCBS/TBI) is a federally approved New York State Department of Health (Department) program to make thirteen different services, not included in the State's Medicaid Plan, available to persons with traumatic brain injury who meet certain eligibility criteria. The services focus on the community repatriation of New York State TBI individuals who reside in high cost institutionalized settings, and the avoidance of institutional placement for those who are at significant risk. The waiver is funded under the Medicaid Program and the costs are shared by the Federal, State and local governments.

HCBS/TBI services may be provided by not-for-profit or proprietary health and human service agencies. Providers of services must be approved by the Department for participation in the waiver, sign a contract agreement with the Department, and meet the standards established for each waiver service. Services provided by a HCBS/TBI provider are based on a written service plan for each participant that is developed with the waiver participant ( or designated advocate ) and a service coordinator selected by the participant. All plans are approved by the Department.

A HCBS/TBI Waiver provider is generally subject to Title XIX of the Federal Social Security Act and Article 27-CC of the New York State Public Health Law. The specific standards and criteria for HCBS/TBI waiver services are outlined in the Department HCBS/TBI Provider Manual, the related MMIS Manual, various administrative directives issued by the Department, and the contractual agreement with the department for the HCBS/TBI Waiver.

## **PURPOSE, SCOPE, AND METHODOLOGY**

### **Purpose**

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for traumatic brain injury services complied with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

### **Scope**

Our audit period covered payments to the Provider for traumatic brain injury services paid by Medicaid from January 1, 2006, through December 31, 2008. Our audit universe consisted of 65,284 claims totaling \$8,842,562.88.

During our audit, we did not review the overall internal control structure of the Provider. Rather, we limited our internal control review to the objective of our audit.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with the Provider's management personnel to gain an understanding of the traumatic brain injury services program;
- ran computer programming application of claims in our data warehouse that identified 65,284 paid traumatic brain injury service claims, totaling \$8,842,562.88;
- selected a random sample of 200 services from the population of 65,284 services; and,
- estimated the overpayment paid in the population of 65,284 services.

For each sample selection we inspected, as available, the following:

- Medicaid electronic claim information
- Patient record, including, but not limited to:
  - Notice of Decisions (NOD)
  - Initial/Revised Service Plans (ISP/RSP)
  - Individual Service Report (ISR)
  - Documentation of TBI Service – case notes, activity sheets, or care reports
  - Training certificates and attendance sheets
  - Provider staff list with signatures

- Any additional documentation deemed by the Provider necessary to substantiate the Medicaid paid claim

## LAWS, REGULATIONS, RULES AND POLICIES

The following are applicable Laws, Regulations, Rules and Policies of the Medicaid program referenced when conducting this audit:

- Departments of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, Title 18 NYCRR Section 540.6.
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."  
*18 NYCRR Section 504.3*

Regulations state: "Fee-for-service providers. (1) All providers ... must prepare and maintain contemporaneous records demonstrating their right to receive payment . . . All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor ... must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department ... for audit and review."  
*18 NYCRR Section 517.3(b)*

Regulations require that bills for medical care, services and supplies contain patient name, case number and date of service; itemization of the volume and specific types of care, services and supplies provided; the unit price and total cost of the care, services and supplies provided; and a dated certification by the provider that the care, services and supplies itemized have been in fact furnished; that the amounts listed are in fact due and owing; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may

be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided.

*18 NYCRR Section 540.7(a)(1)-(3) and (8)*

Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake."

*18 NYCRR Section 518.1(c)*

Regulations state: "Vendor payments for medical care and other items of medical assistance shall not be made unless such care or other items of assistance have been furnished on the basis of the appropriate authorization prescribed by the rules of the board and regulations of the department."

*18 NYCRR Section 540.1*

Regulations state: "The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim."

*18 NYCRR Section 518.3(a)*

Regulations state: "The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished...."

*18 NYCRR Section 518.3(b)*

Regulations state: "Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record."

*18 NYCRR Section 518.3(b)*

## **AUDIT FINDINGS**

This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated November 19, 2015. The attached Bridge Schedule (Attachment D) indicates any changes to the findings as a result of your response.

## AUDIT FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2006, through December 31, 2008, identified 18 claims with at least one error, for a total sample overpayment of \$1,113.36 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated November 19, 2015. Appropriate adjustments were made to the findings.

### 1. Billed More Hours than Documented

The Social Security Act states that:

(a) A State plan for medical assistance must—

27. provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the state agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request.

*Social Security Act Section 1902(a)(27) of the Act, 42 U.S.C. 1396(a)(27)*

The CMS State Medicaid Manual states:

Statement of Policy – Federal financial participation (FFP) is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.

*CMS State Medicaid Manual Section 2497.1*

Regulations require that the Medicaid provider agrees, "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date of care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health . . ." and "to comply with the rules, regulations and official directives of the Department."

*18 NYCRR Section 504.3(a) and (i)*

Regulations state: "Fee-for-service providers. (1) All providers, who are not paid at rates or fees approved by the State Director of the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply, must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Medicaid Fraud Control Unit or the New

York State Department of Health for audit and review. This limitation does not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs an audit.”

*18 NYCRR Section 517.3(b)(1) and(2)*

The HCBS Provider Agreement states: Keep any records necessary to disclose the type and extent of services furnished to recipients and on request, furnish to DOH, its designees, the Secretary of the U.S. Department of Health and Human Services or the State Medicaid Fraud Control Unit, information regarding these services and payments claimed under Title XIX.

*NYS Department of Health-HCBS Provider Agreement,  
June 2008, Section I*

The DOH Medicaid Update states: “all Medicaid claims for reimbursement must be supported with a record of services provided. At a minimum, this should include: the participant’s name; the date of service; the start and end time of each session; a description of the activities performed during the session; and the participant’s service plan goals that are being worked and the participant’s progress toward attaining those goals.”

*DOH Medicaid Update January 2005, Vol. 20, No. 1*

The HCBS/TBI Waiver Provider Manual states: An individualized written Service Plan will be developed for each waiver participant receiving services under the provision of the HCBS/TBI waiver. Individualized Service Plans are the key to the provision of HCBS/TBI waiver services. No service will be reimbursed if it is not included in the Service Plan.

*HCBS/TBI Waiver Provider Manual, Section IV*

The Traumatic Brain Injury Program Manual states: “Record keeping to document Medicaid billing is required of all Medicaid providers. The need to maintain the necessary records is discussed in the Provider Agreement, the eMedNY Provider Manual and in this Program Manual. It is the responsibility of the provider to have clear and accurate documentation to support all Medicaid claims.”

*Traumatic Brain Injury Program Manual,  
June 2006, Section VII*

The Traumatic Brain Injury Program Manual states: “The provider must document each encounter with the participant as required by Medicaid for reimbursement. Documentation must include the date, location, time and a description of the activities, which are related to the goals established in the Detailed Plan. This information must be recorded as soon as possible after each contact and reviewed for completeness each month. All records must be maintained for seven years following termination of services to a participant.”

*Traumatic Brain Injury Program Manual,  
June 2006, Section VII*

The Traumatic Brain Injury Program Manual states: “Record keeping documenting Medicaid billing is required of all Medicaid providers. The need to maintain the necessary records is discussed in the Provider Agreement, the eMedNY Provider Manual and this program Manual. It is the responsibility of the provider to have clear and accurate documentation to support all Medicaid claims.”

*Traumatic Brain Injury Program Manual,  
April 2009, Section VII*

In 8 instances pertaining to 8 participants, the number of service hours billed exceeded the number of hours provided as documented in the Agency's records. The amount of time billed that exceeded the documented time of service was disallowed. This finding applies to Sample #'s 63, 88, 93, 109, 110, 127, 141 and 185.

## **2. Partial Service Hours Were Billed Incorrectly**

Regulations require that the Medicaid provider agrees, "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date of care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health . . ." and "to comply with the rules, regulations and official directives of the Department."

*18 NYCRR Section 504.3(a) and (i)*

The HCBS/TBI Waiver Provider Manual states: "All HCBS/TBI Waiver Services must be documented in the Service Plan, and provided by individuals or agencies approved as a provider of this waiver service by the State Department of Social Services. The services will be reimbursed on an hourly basis".

*HCBS/TBI Waiver Provider Manual, Section V*

The HCBS/TBI Waiver Provider Manual states that, "Independent Living Skills Training and Development are services individually designed to improve the ability of the waiver participant to live as independently as possible in the community. . . . This service will be reimbursed on an hourly basis."

*HCBS/TBI Waiver Provider Manual, Section V*

The HCBS/TBI Waiver Provider Manual states that, "Home and Community Support Services are individually designed support services essential for the waiver participant's health and welfare. . . . This service will be reimbursed on an hourly basis".

*HCBS/TBI Waiver Provider Manual, Section V*

The January 2005 Medicaid Update states that, ". . .service of less than one hour should be carried forward to the next service date and combined to accumulate billable time in whole hours. This practice should be fully documented.

*DOH Medicaid Update January 2005, Volume 20, No. 1*

The Traumatic Brain Injury Program Manual states: "Due to cognitive, physical or behavioral limitations related to a traumatic brain injury (e.g. short term memory, low frustration level, etc.), a participant may benefit from services in shorter intervals than the billable unit of service. In these situations, units of service may be accumulated in 15-minute intervals and billed when a full billable unit has been provided. The provider is responsible for maintaining sufficient documentation to verify the dates and times for services provided."

*Traumatic Brain Injury Program Manual,  
June 2006, Section VI*

The Traumatic Brain Injury Program Manual also states: "Due to cognitive, physical or behavioral limitations related to a traumatic brain injury (e.g. short term memory, low frustration level, etc.), a participant may benefit from services in shorter intervals than the billable unit of service. In these situations, units of service may be accumulated in 15-minute intervals and billed when a full billable unit has been provided. The provider is responsible for maintaining sufficient documentation to verify the dates and times for services provided."

*Traumatic Brain Injury Program Manual,  
April 2009, Section VI*

In 5 instances pertaining to 5 participants, partial service hours of the waiver services were rounded up to the next whole hour, rather than carried forward to the next service date. This finding applies to Sample #'s 16, 23, 52, 107 and 181.

### **3. Missing Documentation of Service**

The Social Security Act states that:

(a) A State plan for medical assistance must—

27. provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the state agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request.

*Social Security Act Section 1902(a)(27) of the Act, 42 U.S.C. 1396(a)(27)*

The CMS State Medicaid Manual states:

Statement of Policy – Federal financial participation (FFP) is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.

*CMS State Medicaid Manual Section 2497.1*

Medicaid policy states that providers are reminded that all Medicaid claims for reimbursement must be supported with a record of the services provided. At a minimum, this should include:

- the participant's name;
- the date of service;
- the start and end time of each session;
- a description of the activities performed during the session; and
- the participant's service plan goals that are being worked on and the participant's progress toward attaining those goals

*DOH Medicaid Update January 2005, Volume 20, No. 1*

Regulations require that the Medicaid provider agrees, "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date of care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy

Attorney General for Medicaid Fraud Control and the New York State Department of Health . . .” and “to comply with the rules, regulations and official directives of the Department.”

*18 NYCRR Section 504.3(a) and (i)*

The HCBS Provider Agreement states: Keep any records necessary to disclose the type and extent of services furnished to recipients and on request, furnish to DOH, its designees, the Secretary of the U.S. Department of Health and Human Services or the State Medicaid Fraud Control Unit, information regarding these services and payments claimed under Title XIX.

*NYS DOH-HCBS Provider Agreement,  
June 2008, Section I*

The HCBS/TBI Waiver Provider Manual states: Providers of HCBS/TBI waiver services, other than Service Coordinators, shall maintain adequate records which include: a detailed plan describing for each HCBS/TBI waiver service the expected outcomes, method or type of intervention planned and frequency and intensity of the provision of service, billing records, any contacts with the Service Coordinator, and any contacts with the waiver providers.

*HCBS/TBI Waiver Provider Manual, Section VI*

The Traumatic Brain Injury Program Manual states: “Record keeping to document Medicaid billing is required of all Medicaid providers. The need to maintain the necessary records is discussed in the Provider Agreement, the eMedNY Provider Manual and in this Program Manual. It is the responsibility of the provider to have clear and accurate documentation to support all Medicaid claims.”

*Traumatic Brain Injury Program Manual,  
June 2006, Section VII*

The Traumatic Brain Injury Program Manual states: “The provider must document each encounter with the participant as required by Medicaid for reimbursement. Documentation must include the date, location, time and a description of the activities, which are related to the goals established in the Detailed Plan. This information must be recorded as soon as possible after each contact and reviewed for completeness each month. All records must be maintained for seven years following termination of services to a participant.”

*Traumatic Brain Injury Program Manual,  
June 2006, Section VII*

The Traumatic Brain Injury Program Manual states: “Record keeping documenting Medicaid billing is required of all Medicaid providers. The need to maintain the necessary records is discussed in the Provider Agreement, the eMedNY Provider Manual and this program Manual. It is the responsibility of the provider to have clear and accurate documentation to support all Medicaid claims.”

*Traumatic Brain Injury Program Manual,  
April 2009, Section VII*

The Traumatic Brain Injury Program Manual states: “The provider must document each encounter with the participant as required by Medicaid for reimbursement. Documentation must include the date, location, time and a description of the activities, which are related to the goals established in the Detailed Plan. This information must be recorded as soon as possible after each contact and reviewed for completeness each month. All records must be maintained for seven years following termination of services to a participant.”

*Traumatic Brain Injury Program Manual,  
April 2009, Section VII*

In 2 instances pertaining to 2 participants, services were not documented in the participant's record. This finding applies to Sample #'s 124 and 131.

#### **4. Billed More Hours than Authorized in the Service Plan**

The CMS State Medicaid Manual states:

Statement of Policy – Federal financial participation (FFP) is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.

*CMS State Medicaid Manual Section 2497.1*

The CMS State Medicaid Manual also states:

Plan of Care – Explain in detail how the statutory requirements (§ 1915(c)(1) and (4)) for an individual written plan of care will be met:

- Include in the plan of care an assessment of the individual to determine the services needed to prevent institutionalization.

NOTE: The term "assessment" means an examination of an individual who has been determined (through an evaluation) to meet the level of care requirements for participation in a waiver, to determine what waiver services are needed to prevent institutionalization or whether waiver services constitute an acceptable alternative to institutional care.

- Describe the content of the plan of care and make clear that it includes the medical and other services to be given, their frequency, and the type of provider to furnish them.

NOTE: FFP is not available for waiver services which are furnished without a written plan of care.

Include in the waiver request a description of the qualifications of the individuals who will be responsible for developing the individual plan of care and specify the type of provider that will develop the plan of care.

*CMS State Medicaid Manual Section 4442.6*

The Code of Federal Regulations states that:

(a) If the agency furnishes home and community-based services, as defined in §440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must—

(1) Provide that the services are furnished –

- (i) Under a written plan of care subject to approval by the Medicaid agency.

*42CFR Section 441.301(b)(1)(i)*

The HCBS Waiver Provider Manual states: Each Service Plan will include an assessment of the individual to determine the services needed to prevent institutionalization. The written plan will contain the type of waiver services to be furnished, the amount, frequency and duration of each service, and the provider who will furnish each service. The plan will also describe supports provided by informal caregivers, such as family or neighbors, as well as services provided under the State Medicaid Plan, and other Federal and State funded services. Waiver services will be used only when these other sources of support and services have been fully utilized.

*HCBS/TBI Waiver Provider Manual, Section IV*

The Traumatic Brain Injury Program Manual states: "The Addendum to the Service Plan is needed when there is an existing Notice of Decision and only a minor change is needed in the amount, type, or mix of waiver services (e.g. a participant wishes to increase/decrease the amount of time at a Structured Day Program).

When an Addendum to the Service Plan is approved, a new Notice of Decision will not be issued and the six month approval period on the current Notice of Decision remains in effect.

The waiver is a prior approval program. No services can be provided without written prior approval from the RRDS [Regional Resource Development Specialists]. Services provided without RRDS approval are not eligible for reimbursement."

*Traumatic Brain Injury Program Manual,  
June 2006, Section V*

The Traumatic Brain Injury Program Manual states: "Only those services which are provided by a DOH approved provider and included in the Service Plan will be reimbursed. "

*Traumatic Brain Injury Program Manual,  
April 2009, Section VI*

In 2 instances pertaining to 2 participants, service hours were billed in excess of those approved in the Service Plan. This finding applies to Sample #'s 102 and 164.

#### **5. TBI Training Not Completed – Community Integration Counseling (CIC)**

The HCBS/TBI Waiver Provider Manual states: Community Integration Counseling may be provided by any not for profit or proprietary health and human services agency, such as a licensed or certified home health care agency, a hospital, nursing facility, or diagnostic and treatment center. Self-employed individuals meeting the standards described may also provide this service.

This service will be provided by a:(1) Licensed Psychologist; (2) Person with a Master of Social Work; (3) Certified Rehabilitation Counselor; (4) Person with a Master of Psychology; or (5) Psychiatrist.

Each of these individuals shall have, at a minimum, two (2) years' experience in providing adjustment related counseling to individuals with traumatic brain injuries and their families.

*HCBS/TBI Waiver Provider Manual, Section V*

The Traumatic Brain Injury Program Manual states that there are three components of required training for Waiver Service providers: (1) Basic Orientation Training, (2) Service Specific Training, and (3) Annual Training. An approved provider agency is responsible for: providing Basic Orientation Training and the appropriate Service Specific Training to all waiver providers prior to any unsupervised contact with a waiver participant; providing required annual training to all service providers; and documenting all training in the employee file, including all related TBI training, seminars and conferences attended, whether offered by the provider or other entities.

*Traumatic Brain Injury Program Manual,  
June 2006, Section VIII*

The Traumatic Brain Injury Program Manual states that there are three components of required training for Waiver Service providers: (1) Basic Orientation Training, (2) Service Specific Training, and (3) Annual Training. An approved provider agency is responsible for: providing Basic Orientation Training and the appropriate Service Specific Training to all waiver providers prior to any unsupervised contact with a waiver participant; providing required annual training to all service providers; and documenting all training in the employee file, including all related TBI training, seminars and conferences attended,

whether offered by the provider or other entities.

*Traumatic Brain Injury Program Manual,  
April 2009, Section VIII*

In 1 instance, the services were performed by staff that did not complete the required training for a Community Integration Counseling provider. This finding applies to Sample # 43.

## PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the lower confidence limit amount of \$174,686, one of the following repayment options must be selected within 20 days from the date of this letter:

**OPTION #1:** Make full payment by check or money order within 20 days of the date of the final audit report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
File #09-1579  
Albany, New York 12237

**OPTION #2:** Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final audit report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until the agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

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

If you choose not to settle this audit through repayment of the lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of \$363,423. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel  
Office of Counsel  
New York State Office of the Medicaid Inspector General  
800 North Pearl Street  
Albany, NY 12204

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

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

At the hearing you have the right to:

- a) be represented by an attorney or other representative, or to represent yourself;
- b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
- c) cross examine witnesses of the Department of Health and/or the OMIG.

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

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

NAME AND ADDRESS OF AUDITEE

PROVIDER ID # [REDACTED]

[REDACTED]  
Long Island Head Injury Associates  
300 Kennedy Drive  
Hauppauge, New York 11788

AUDIT #09-1579

AUDIT

PROVIDER

RATE

PART B

TYPE

OTHER:

AMOUNT DUE: \$174,686

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
File #09-1579  
Albany, New York 12237

*Thank you for your cooperation.*

## **SAMPLE DESIGN**

The sample design used for Audit #09-1579 was as follows:

- Universe - Medicaid claims for traumatic brain injury services paid during the period January 1, 2006, through December 31, 2008.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for traumatic brain injury services paid during the period January 1, 2006, through December 31, 2008.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2006, through December 31, 2008.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 200 services.

**SAMPLE RESULTS AND ESTIMATES**

Universe Size	65,284
Sample Size	200
Sample Value	\$ 28,405.69
Sample Overpayments	\$ 1,113.36
Confidence Level	90%

**Extrapolation of Sample Findings**

Sample Overpayments	\$ 1,113.36
Sample Size	200
Mean Dollars in Error for Extrapolation Purposes	\$ 5.5668
Universe Size	65,284
Point Estimate of Total Dollars	\$ 363,423
Lower Confidence Limit	\$ 174,686

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
LONG ISLAND HEAD INJURY ASSOCIATES  
REVIEW OF TRAUMATIC BRAIN INJURY SERVICES  
PROJECT NUMBER: 09-1579  
REVIEW PERIOD: 1/1/2006-12/31/2008

Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS 1. Billed More Hours than Documented 2. Partial Service Hours than Documented Incorrectly 3. Missing Documentation of Service 4. Billed More Hours than Authorized in the Service Plan 5. TBI Training Not Completed - Community Integration Counseling (CIC)				
		Billed	Derived	Billed	Derived						
1	04/01/07	9851	9851	\$ 497.19	\$ 497.19	\$ -					
2	11/21/06	9860	9860	48.00	48.00	-					
3	03/01/06	9851	9851	350.00	350.00	-					
4	10/22/08	9870	9870	110.85	110.85	-					
5	05/11/06	9863	9863	53.10	53.10	-					
6	02/05/07	9863	9863	70.80	70.80	-					
7	05/30/08	9863	9863	154.72	154.72	-					
8	10/01/07	9851	9851	497.19	497.19	-					
9	03/29/07	9870	9870	62.40	62.40	-					
10	07/06/06	9861	9861	64.00	64.00	-					
11	03/14/06	9870	9870	78.00	78.00	-					
12	11/30/07	9861	9861	363.64	363.64	-					
13	05/09/06	9870	9870	31.20	31.20	-					
14	03/24/08	9870	9870	133.02	133.02	-					
15	09/01/06	9851	9851	350.00	350.00	-					
16	01/05/06	9870	9870	93.60	89.70	3.90		X			
17	01/25/06	9858	9858	96.00	96.00	-					
18	06/13/08	9870	9870	88.68	88.68	-					
19	03/31/06	9863	9863	35.40	35.40	-					
20	05/02/08	9870	9870	133.02	133.02	-					
21	09/28/07	9870	9870	110.85	110.85	-					
22	07/18/06	9870	9870	78.00	78.00	-					
23	03/05/08	9858	9858	90.92	79.56	11.36		X			
24	05/16/08	9870	9870	133.02	133.02	-					
25	03/19/06	9863	9863	177.00	177.00	-					

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		Billed	Derived	Billed	Derived						
26	01/28/05	9870	9870	\$ 78.00	\$ 78.00	\$ -					
27	09/28/06	9870	9870	93.60	93.60	-					
28	03/30/06	9863	9863	247.80	247.80	-					
29	03/30/06	9870	9870	93.60	93.60	-					
30	02/03/07	9863	9863	212.40	212.40	-					
31	01/02/07	9863	9863	53.10	53.10	-					
32	05/03/07	9870	9870	133.02	133.02	-					
33	05/04/07	9870	9870	133.02	133.02	-					
34	04/19/07	9863	9863	154.72	154.72	-					
35	01/19/06	9861	9861	64.00	64.00	-					
36	02/23/06	9870	9870	93.60	93.60	-					
37	04/10/07	9863	9863	212.74	212.74	-					
38	02/11/07	9863	9863	141.60	141.60	-					
39	06/14/07	9870	9870	133.02	133.02	-					
40	09/29/08	9870	9870	133.02	133.02	-					
41	05/09/06	9870	9870	93.60	93.60	-					
42	12/20/06	9870	9870	93.60	93.60	-					
43	11/29/06	9861		64.00	-	64.00					X
44	12/17/07	9870	9870	133.02	133.02	-					
45	06/27/08	9870	9870	110.85	110.85	-					
46	03/19/08	9870	9870	133.02	133.02	-					
47	04/27/06	9860	9860	96.00	96.00	-					
48	07/31/07	9858	9858	90.92	90.92	-					
49	10/24/06	9860	9860	96.00	96.00	-					
50	07/08/05	9870	9870	78.00	78.00	-					

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Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS				
		Billed	Derived	Billed	Derived		1. Billed More Hours than Documented Incorrectly	2. Partial Service Hours Were Billed	3. Missing Documentation of Service	4. Billed More Hours than Authorized in the Service Plan	5. TBI Training Not Completed - Community Integration Counseling (CIC)
51	04/28/08	9870	9870	\$ 133.02	\$ 133.02	\$ -					
52	02/27/06	9870	9870	15.60	11.70	3.90		X			
53	03/01/07	9851	9851	350.00	350.00	-					
54	09/03/08	9870	9870	88.68	88.68	-					
55	06/13/06	9870	9870	46.80	46.80	-					
56	03/17/06	9863	9863	123.90	123.90	-					
57	10/08/08	9858	9858	90.92	90.92	-					
58	02/22/07	9863	9863	177.00	177.00	-					
59	06/14/05	9870	9870	93.60	93.60	-					
60	08/09/07	9858	9858	318.22	318.22	-					
61	10/17/07	9870	9870	66.51	66.51	-					
62	04/23/07	9863	9863	154.72	154.72	-					
63	04/03/06	9863	9863	141.60	132.75	8.85	X				
64	04/10/07	9870	9870	110.85	110.85	-					
65	12/21/07	9858	9858	45.46	45.46	-					
66	01/17/07	9863	9863	70.80	70.80	-					
67	06/10/06	9863	9863	212.40	212.40	-					
68	03/11/08	9858	9858	181.84	181.84	-					
69	12/01/08	9870	9870	133.02	133.02	-					
70	02/10/06	9863	9863	106.20	106.20	-					
71	01/02/08	9858	9858	136.38	136.38	-					
72	06/21/08	9858	9858	181.84	181.84	-					
73	06/22/06	9870	9870	78.00	78.00	-					
74	11/07/07	9870	9870	133.02	133.02	-					
75	11/01/08	9851	9851	497.19	497.19	-					

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Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	<b>DETAILED AUDIT FINDINGS</b> 1. Billed More Hours than Documented Incorrectly 2. Partial Service Hours Were Billed 3. Missing Documentation of Service 4. Billed More Hours than Authorized in the Service Plan 5. TBI Training Not Completed - Community Integration Counseling (CIC)				
		Billed	Derived	Billed	Derived						
76	05/04/06	9863	9863	\$ 177.00	\$ 177.00	\$ -					
77	09/03/06	9863	9863	106.20	106.20	-					
78	04/19/05	9870	9870	93.60	93.60	-					
79	07/01/08	9851	9851	497.19	497.19	-					
80	12/22/06	9870	9870	93.60	93.60	-					
81	07/09/08	9870	9870	133.02	133.02	-					
82	04/23/07	9870	9870	133.02	133.02	-					
83	11/22/06	9870	9870	93.60	93.60	-					
84	06/29/06	9863	9863	141.60	141.60	-					
85	01/01/08	9851	9851	497.19	497.19	-					
86	04/26/05	9863	9863	123.90	123.90	-					
87	07/05/06	9863	9863	141.60	141.60	-					
88	09/27/06	9863	9863	212.40	141.60	70.80	X				
89	03/25/08	9861	9861	90.91	90.91	-					
90	02/26/08	9870	9870	155.19	155.19	-					
91	04/01/06	9851	9851	350.00	350.00	-					
92	08/20/07	9870	9870	133.02	133.02	-					
93	05/03/06	9863	9863	159.30	88.50	70.80	X				
94	06/30/06	9863	9863	141.60	141.60	-					
95	08/29/08	9870	9870	133.02	133.02	-					
96	10/01/08	9870	9870	155.19	155.19	-					
97	03/10/06	9863	9863	106.20	106.20	-					
98	04/21/05	9863	9863	141.60	141.60	-					
99	05/29/08	9860	9860	136.38	136.38	-					
100	11/02/06	9870	9870	46.80	46.80	-					

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Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS					
		Billed	Derived	Billed	Derived		1. Billed More Hours than Documented Incorrectly	2. Partial Service Hours Were Billed	3. Missing Documentation of Service	4. Billed More Hours than Authorized in the Service Plan	5. TBI Training Not Completed - Community Integration Counseling (CIC)	
101	01/14/08	9870	9870	\$ 133.02	\$ 133.02	\$ -						
102	11/12/06	9863	9863	424.80	212.40	212.40					X	
103	01/24/07	9870	9870	93.60	93.60	-						
104	08/19/06	9863	9863	212.40	212.40	-						
105	05/16/06	9870	9870	78.00	78.00	-						
106	06/01/08	9851	9851	497.19	497.19	-						
107	06/21/06	9870	9870	93.60	89.70	3.90		X				
108	02/01/08	9851	9851	497.19	497.19	-						
109	02/06/06	9870	9870	93.60	62.40	31.20	X					
110	11/28/06	9863	9863	283.20	141.60	141.60	X					
111	03/13/08	9870	9870	110.85	110.85	-						
112	07/20/06	9863	9863	88.50	88.50	-						
113	10/31/08	9870	9870	110.85	110.85	-						
114	05/06/06	9863	9863	123.90	123.90	-						
115	08/09/06	9860	9860	48.00	48.00	-						
116	11/12/08	9870	9870	133.02	133.02	-						
117	10/18/08	9870	9870	88.68	88.68	-						
118	11/17/08	9870	9870	155.19	155.19	-						
119	05/07/07	9863	9863	232.08	232.08	-						
120	06/21/07	9870	9870	110.85	110.85	-						
121	05/31/06	9870	9870	93.60	93.60	-						
122	04/16/07	9870	9870	110.85	110.85	-						
123	09/01/08	9851	9851	497.19	497.19	-						
124	04/18/06	9863		106.20	-	106.20			X			
125	08/30/06	9870	9870	93.60	93.60	-						



OFFICE OF THE MEDICAID INSPECTOR GENERAL  
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Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS 1. Billed More Hours than Documented Incorrectly 2. Partial Service Hours Were Billed 3. Missing Documentation of Service 4. Billed More Hours than Authorized in the Service Plan 5. TBI Training Not Completed - Community Integration Counseling (CIC)				
		Billed	Derived	Billed	Derived						
151	09/05/06	9860	9860	\$ 48.00	\$ 48.00	\$ -					
152	03/08/05	9863	9863	106.20	106.20	-					
153	05/12/08	9860	9860	68.19	68.19	-					
154	01/27/08	9863	9863	232.08	232.08	-					
155	12/10/06	9863	9863	212.40	212.40	-					
156	12/13/07	9870	9870	133.02	133.02	-					
157	04/13/06	9863	9863	159.30	159.30	-					
158	10/04/06	9870	9870	93.60	93.60	-					
159	10/25/07	9858	9858	90.92	90.92	-					
160	06/11/07	9860	9860	204.57	204.57	-					
161	05/16/08	9870	9870	133.02	133.02	-					
162	12/21/06	9870	9870	78.00	78.00	-					
163	03/07/08	9870	9870	110.85	110.85	-					
164	05/25/06	9863	9863	106.20	35.40	70.80				X	
165	09/09/06	9863	9863	212.40	212.40	-					
166	04/14/06	9863	9863	70.80	70.80	-					
167	06/26/06	9863	9863	141.60	141.60	-					
168	05/04/07	9870	9870	110.85	110.85	-					
169	02/12/08	9863	9863	154.72	154.72	-					
170	08/30/05	9863	9863	123.90	123.90	-					
171	10/23/08	9858	9858	181.84	181.84	-					
172	07/16/08	9870	9870	88.68	88.68	-					
173	10/19/06	9870	9870	93.60	93.60	-					
174	08/16/07	9870	9870	133.02	133.02	-					
175	05/07/07	9870	9870	110.85	110.85	-					

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Sample Number	Date of Service	Rate Code		Amount		Overpayment Extrapolated	DETAILED AUDIT FINDINGS					
		Billed	Derived	Billed	Derived		1. Billed More Hours than Documented Incorrectly	2. Partial Service Hours Were Billed	3. Missing Documentation of Service the Service Plan	4. Billed More Hours than Authorized in Community Integration Counseling (CIC)	5. TBI Training Not Completed -	
176	01/11/07	9870	9870	\$ 93.60	\$ 93.60	\$ -						
177	07/26/07	9870	9870	133.02	133.02	-						
178	05/31/07	9870	9870	110.85	110.85	-						
179	10/19/07	9870	9870	110.85	110.85	-						
180	01/20/06	9863	9863	88.50	88.50	-						
181	01/05/06	9870	9870	93.60	89.70	3.90		X				
182	10/05/07	9870	9870	133.02	133.02	-						
183	03/21/08	9870	9870	133.02	133.02	-						
184	04/09/08	9861	9861	90.91	90.91	-						
185	10/17/06	9863	9863	141.60	61.95	79.65	X					
186	12/10/07	9870	9870	133.02	133.02	-						
187	10/08/07	9861	9861	90.91	90.91	-						
188	02/02/07	9863	9863	141.60	141.60	-						
189	02/21/08	9870	9870	133.02	133.02	-						
190	01/31/07	9870	9870	46.80	46.80	-						
191	06/30/06	9870	9870	93.60	93.60	-						
192	11/19/07	9870	9870	110.85	110.85	-						
193	02/07/08	9870	9870	66.51	66.51	-						
194	10/20/06	9870	9870	93.60	93.60	-						
195	12/14/05	9870	9870	93.60	93.60	-						
196	10/14/06	9863	9863	141.60	141.60	-						
197	01/02/05	9858	9858	32.00	32.00	-						
198	09/25/07	9870	9870	88.68	88.68	-						
199	10/20/06	9870	9870	93.60	93.60	-						
200	05/03/07	9870	9870	110.85	110.85	-						
<b>Totals</b>				<b>\$ 28,405.69</b>	<b>\$ 27,292.33</b>	<b>\$ 1,113.36</b>	<b>8</b>	<b>5</b>	<b>2</b>	<b>2</b>	<b>1</b>	

ATTACHMENT D

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

LONG ISLAND HEAD INJURY ASSOCIATES  
TRAUMATIC BRAIN INJURY SERVICES AUDIT  
AUDIT #09-1579  
AUDIT PERIOD: 01/01/2006 - 12/31/2008

BRIDGE SCHEDULE

<u>SAMPLE #</u>	<u>FINDING</u>	<u>DRAFT REPORT AMOUNT DISALLOWED</u>	<u>FINAL REPORT AMOUNT DISALLOWED</u>	<u>CHANGE</u>
194	Partial Service Hours Were Billed Incorrectly	\$3.79	\$0.00	(\$3.79)
	<b>TOTALS</b>	<u>\$3.79</u>	<u>\$0.00</u>	<u>(\$3.79)</u>

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