



**Office of the
Medicaid Inspector
General**

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF AIDES AT HOME, INC.
CLAIMS FOR TRAUMATIC BRAIN INJURY SERVICES
PAID FROM
JULY 1, 2003 – JUNE 30, 2008

FINAL AUDIT REPORT
AUDIT #: 09-3737

Dennis Rosen
Medicaid Inspector General

August 25, 2016



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

August 25, 2016

[REDACTED]

Aides at Home, Inc.
29 West Marie Street
Hicksville, New York 11801

Re: Final Audit Report
Audit #: 09-3737
Provider ID #: [REDACTED]

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Aides at Home, Inc." (Provider) paid claims for traumatic brain injury services covering the period July 1, 2003, through June 30, 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 May 19, 2016. The mean point estimate overpaid is \$213,931. The lower confidence limit of the amount overpaid is \$122,527. 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 \$122,527.

[Redacted]

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If the Provider has any questions or comments concerning this final audit report, please contact [Redacted] Please refer to report number 09-3737 in all correspondence.

[Redacted]

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

[Redacted]

OFFICE OF THE MEDICAID INSPECTOR GENERAL

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 July 1, 2003, through June 30, 2008.

SUMMARY OF FINDINGS

We inspected a random sample of 200 services with \$40,886.20 in Medicaid payments. Of the 200 services in our random sample, 27 services had at least one error and did not comply with state requirements. Of the 27 noncompliant services, some contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Partial Service Hours Were Billed Incorrectly	11
TBI Training Not Completed – Home and Community Support Services (HCSS)	10
Missing Documentation of Service	5
Billed More Hours than Authorized in the Service Plan	3
Billed More Hours than Documented	1
Missing/Incomplete Service Plan	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$3,318.56 in sample overpayments with an extrapolated point estimate of \$213,931. The lower confidence limit of the amount overpaid is \$122,527.

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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 July 1, 2003, through June 30, 2008. Our audit universe consisted of 12,893 claims totaling \$2,646,244.74.

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 program;
- ran computer programming application of claims in our data warehouse that identified 12,893 paid traumatic brain injury claims, totaling \$2,646,244.74;
- selected a random sample of 200 services from the population of 12,893 services; and,
- estimated the overpayment paid in the population of 12,893 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 Draft Audit Report dated May 19, 2016. 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 July 1, 2003, through June 30, 2008, identified 27 claims with at least one error, for a total sample overpayment of \$3,318.56 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated May 19, 2016. Appropriate adjustments were made to the findings.

1. 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 11 instances pertaining to 8 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 13, 58, 72, 115, 123, 132, 140, 171, 184, 185 and 191.

2. TBI Training Not Completed – Home and Community Support Services (HCSS)

The HCBS/TBI Waiver Provider Manual states that the individual who provides these services must complete training concerning traumatic brain injury. This training will be provided by the agency employing this individual, and will be completed prior to the provision of the service.

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: developing a written training curriculum to meet the requirements identified in this section, ensuring that individuals providing the training meet the qualifications specified in this section; 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*

In 10 instances pertaining to 6 participants, the services were performed by staff that did not complete the required training. This finding applies to Sample #'s 66, 77, 98, 106, 119, 121, 134, 155, 185 and 190.

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, it 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 5 instances pertaining to 2 participants, services were not documented in the participant’s record. This finding applies to Sample #'s 142, 169, 174, 198 and 199.

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.

42 CFR 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 3 instances pertaining to 2 participants, service hours were billed in excess of those approved in the Service Plan. This finding applies to Sample #'s 119, 134 and 148.

5. 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 DOH-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, Volume 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 1 instance, 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 # 145.

6. Missing/ Incomplete Service Plan

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 Code of Federal Regulations states that:

(b) 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.

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

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

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: “All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that in the care, services and supplies itemized have in fact been furnished; that the amounts listed are 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”

18 NYCRR Section 540.7(a)(8)

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."

18 NYCRR Section 517.3(b)(1)

Regulations state that 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)(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 DOH-HCBS Provider Agreement, June 2008, Section I*

The MMIS Manual states: "An individualized written Service Plan must be developed for each waiver participant. . . The written plan must identify the waiver service(s) to be furnished; the amount, frequency and duration of each service; and the provider(s) who will furnish each service. . . No waiver service will be reimbursed if not included in the written Service Plan. . . All Service Plans must be reviewed by a Regional Resource Development Specialist (RRDS). The Service Plan must be reviewed at least every six months." *HCBS/TBI Waiver Manual, Policy Guidelines, Version 2005-1, Section II*

The HCBS/TBI Provider Manual states: "Each Service Plan will include an assessment of the individual to determine 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."

HCBS/TBI Waiver Provider Manual, Section IV

The Traumatic Brain Injury Program Manual states that the Initial Service Plan (ISP) is due within 60 calendar days from Service Coordinator selection. The ISP is approved for six months. The Revised Service Plan (RSP) is required at least every six months.

Traumatic Brain Injury Program Manual, June 2006, Section V

The Traumatic Brain Injury Program Manual states that the ISP is used when an individual is applying to become a waiver participant. It is the primary component of the Application Packet and is due to the RRDC within 60 calendar days from Service Coordinator selection. *Traumatic Brain Injury Program Manual, April 2009, Section V*

In 1 instance, the Initial/Revised Service Plan was missing or incomplete in the participant's record. This finding applies to Sample # 58.

Repayment Options

In accordance with 18 NYCRR Part 518, which regulates the collection of overpayments, your repayment options are described below.

Option #1: Make a 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** with the audit number included and be sent with the attached remittance advice to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
Audit # 09-3737
Albany, New York 12237

Option #2: Enter into a repayment agreement with OMIG. 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%. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

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

Should you fail to select a payment option above, OMIG, in its discretion, may use any remedy allowed by law to collect the amount due. Pursuant to the State Finance Law §18(5), a collection fee equal to twenty two percent (22%) of the amount due, including interest, may be added to the amount owed. OMIG's remedies may include, without limitation, filing this Final Audit Report as the final administrative determination for purposes of obtaining a judgment lien pursuant to §145-a of the New York State Social Services Law; withholding Medicaid payments otherwise payable to the provider or its affiliates pursuant to 18 NYCRR 518.6; and imposing a sanction, pursuant to 18 NYCRR 515.2, against a provider who fails to reimburse the department for overpayments discovered by this audit.

Hearing Rights

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 OMIG would seek and defend the point estimate of \$213,931. 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]

In accordance with 18 NYCRR 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply along with your hearing request a signed authorization permitting that person to represent you at the hearing; you may call witnesses and present documentary evidence on your behalf.

For a full listing of hearing rights please see 18 NYCRR Part 519.

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

NAME AND ADDRESS OF AUDITEE

[REDACTED]
Aides at Home, Inc.
29 West Marie Street
Hicksville, New York 11801

PROVIDER ID # [REDACTED]

AUDIT # 09-3737

AUDIT

TYPE

PROVIDER
 RATE
 PART B
 OTHER:

AMOUNT DUE: \$122,527

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 # 09-3737
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN

The sample design used for Audit #09-3737 was as follows:

- Universe - Medicaid claims for traumatic brain injury services paid during the period July 1, 2003, through June 30, 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 July 1, 2003, through June 30, 2008.
- Sample Unit - The sample unit is a Medicaid claim paid during the period July 1, 2003, through June 30, 2008.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 200 services.

SAMPLE RESULTS AND ESTIMATES

Universe Size	12,893
Sample Size	200
Sample Value	\$ 40,886.20
Sample Overpayments	\$ 3,318.56
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	\$ 3,318.56
Sample Size	200
Mean Dollars in Error for Extrapolation Purposes	\$ 16.5928
Universe Size	12,893
Point Estimate of Total Dollars	\$ 213,931
Lower Confidence Limit	\$ 122,527

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 AIDES AT HOME, INC.
 REVIEW OF TRAUMATIC BRAIN INJURY SERVICES
 PROJECT NUMBER: 09-3737
 REVIEW PERIOD: 07/01/03 - 06/30/08

Sample Number	Date of Service	Rate Code		Amount		Overpayment	DETAILED AUDIT FINDINGS 1. Partial Service Hours Were Billed Incorrectly 2. TBI Training Not Completed - Home and Community Support Services (HCSS) 3. Missing Documentation of Service 4. Billed More Hours than Authorized in the Service Plan 5. Billed More Hours than Documented 6. Missing/Incomplete Service Plan						
		Billed	Derived	Paid	Derived								
51	03/07/06	9863	9863	\$ 141.60	\$ 141.60	\$ -							
52	03/13/06	9863	9863	159.30	159.30	-							
53	03/14/06	9863	9863	371.70	371.70	-							
54	03/17/06	9863	9863	194.70	194.70	-							
55	03/16/06	9863	9863	141.60	141.60	-							
56	03/22/06	9863	9863	230.10	230.10	-							
57	04/01/06	9863	9863	123.90	123.90	-							
58	03/29/06	9863		177.00	-	177.00	X						X
59	04/11/06	9863	9863	371.70	371.70	-							
60	04/25/06	9863	9863	389.40	389.40	-							
61	04/28/06	9863	9863	212.40	212.40	-							
62	05/12/06	9863	9863	53.10	53.10	-							
63	10/25/05	9863	9863	354.00	354.00	-							
64	12/01/05	9863	9863	371.70	371.70	-							
65	01/09/06	9863	9863	318.60	318.60	-							
66	01/26/06	9863	9863	371.70	265.50	106.20		X					
67	05/01/06	9863	9863	141.60	141.60	-							
68	05/02/06	9863	9863	159.30	159.30	-							
69	05/17/06	9863	9863	35.40	35.40	-							
70	05/21/06	9863	9863	106.20	106.20	-							
71	05/23/06	9863	9863	70.80	70.80	-							
72	04/11/06	9863	9863	371.70	354.00	17.70	X						
73	06/01/06	9863	9863	194.70	194.70	-							
74	06/17/06	9863	9863	424.80	424.80	-							
75	07/08/06	9863	9863	424.80	424.80	-							

OFFICE OF THE MEDICAID INSPECTOR GENERAL
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76	07/08/06	9863	9863	\$ 212.40	\$ 212.40	\$ -						
77	07/01/06	9863	9863	424.80	354.00	70.80		X				
78	07/04/06	9863	9863	424.80	424.80	-						
79	07/07/06	9863	9863	194.70	194.70	-						
80	07/05/06	9863	9863	283.20	283.20	-						
81	07/10/06	9863	9863	212.40	212.40	-						
82	07/22/06	9863	9863	212.40	212.40	-						
83	07/31/06	9863	9863	177.00	177.00	-						
84	08/04/06	9863	9863	35.40	35.40	-						
85	08/10/06	9863	9863	53.10	53.10	-						
86	08/16/06	9863	9863	247.80	247.80	-						
87	08/21/06	9863	9863	35.40	35.40	-						
88	08/25/06	9863	9863	247.80	247.80	-						
89	09/01/06	9863	9863	283.20	283.20	-						
90	08/28/06	9863	9863	53.10	53.10	-						
91	09/06/06	9863	9863	141.60	141.60	-						
92	09/10/06	9863	9863	212.40	212.40	-						
93	08/30/06	9863	9863	53.10	53.10	-						
94	09/14/06	9863	9863	53.10	53.10	-						
95	09/18/06	9863	9863	106.20	106.20	-						
96	09/28/06	9863	9863	212.40	212.40	-						
97	09/29/06	9863	9863	70.80	70.80	-						
98	10/06/06	9863		35.40	-	35.40		X				
99	10/02/06	9863	9863	177.00	177.00	-						
100	10/07/06	9863	9863	424.80	424.80	-						

OFFICE OF THE MEDICAID INSPECTOR GENERAL
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101	10/14/06	9863	9863	\$ 123.90	\$ 123.90	\$ -						
102	10/26/06	9863	9863	194.70	194.70	-						
103	10/17/06	9863	9863	194.70	194.70	-						
104	10/27/06	9863	9863	106.20	106.20	-						
105	11/02/06	9863	9863	212.40	212.40	-						
106	11/01/06	9863	9863	35.40	-	35.40		X				
107	11/19/06	9863	9863	106.20	106.20	-						
108	11/19/06	9863	9863	230.10	230.10	-						
109	11/26/06	9863	9863	230.10	230.10	-						
110	12/01/06	9863	9863	53.10	53.10	-						
111	12/12/06	9863	9863	371.70	371.70	-						
112	12/15/06	9863	9863	70.80	70.80	-						
113	12/17/06	9863	9863	141.60	141.60	-						
114	12/20/06	9863	9863	212.40	212.40	-						
115	12/25/06	9863	9863	212.40	194.70	17.70	X					
116	01/12/07	9863	9863	389.40	389.40	-						
117	01/19/07	9863	9863	106.20	106.20	-						
118	01/31/07	9863	9863	212.40	212.40	-						
119	02/11/07	9863	9863	424.80	212.40	212.40		X		X		
120	02/08/07	9863	9863	177.00	177.00	-						
121	02/17/07	9863	9863	424.80	212.40	212.40		X				
122	02/16/07	9863	9863	106.20	106.20	-						
123	03/15/07	9863	9863	88.50	70.80	17.70	X					
124	03/16/07	9863	9863	177.00	177.00	-						
125	03/29/07	9863	9863	424.80	424.80	-						

OFFICE OF THE MEDICAID INSPECTOR GENERAL
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PROJECT NUMBER: 09-3737
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Sample Number	Date of Service	Rate Code		Amount			DETAILED AUDIT FINDINGS					
		Billed	Derived	Paid	Derived	Overpayment	1. Partial Service Hours Were Billed Incorrectly	2. TBI Training Not Completed - Home and Community Support Services (HCSS)	3. Missing Documentation of Service	4. Billed More Hours than Authorized in the Service Plan	5. Billed More Hours than Documented	6. Missing/Incomplete Service Plan
126	03/28/07	9863	9863	\$ 53.10	\$ 53.10	\$ -						
127	04/03/07	9863	9863	135.38	135.38	-						
128	04/03/07	9863	9863	96.70	96.70	-						
129	04/10/07	9863	9863	464.16	464.16	-						
130	04/09/07	9863	9863	116.04	116.04	-						
131	04/17/07	9863	9863	38.68	38.68	-						
132	04/30/07	9863	9863	135.38	116.04	19.34	X					
133	04/02/07	9863	9863	77.36	77.36	-						
134	05/02/07	9863		77.36	-	77.36		X		X		
135	05/07/07	9863	9863	77.36	77.36	-						
136	05/11/07	9863	9863	232.08	232.08	-						
137	05/10/07	9863	9863	58.02	58.02	-						
138	05/14/07	9863	9863	154.72	154.72	-						
139	05/21/07	9863	9863	77.36	77.36	-						
140	05/21/07	9863	9863	135.38	116.04	19.34	X					
141	05/22/07	9863	9863	77.36	77.36	-						
142	05/21/07	9863		232.08	-	232.08			X			
143	04/25/07	9863	9863	116.04	116.04	-						
144	05/26/07	9863	9863	270.76	270.76	-						
145	05/29/07	9863	9863	116.04	96.70	19.34					X	
146	06/08/07	9863	9863	232.08	232.08	-						
147	06/08/07	9863	9863	232.08	232.08	-						
148	06/07/07	9863		77.36	-	77.36			X			
149	06/08/07	9863	9863	154.72	154.72	-						
150	06/02/07	9863	9863	270.76	270.76	-						

OFFICE OF THE MEDICAID INSPECTOR GENERAL
AIDES AT HOME, INC.
REVIEW OF TRAUMATIC BRAIN INJURY SERVICES
PROJECT NUMBER: 09-3737
REVIEW PERIOD: 07/01/03 - 06/30/08

Sample Number	Date of Service	Rate Code		Amount			DETAILED AUDIT FINDINGS					
		Billed	Derived	Paid	Derived	Overpayment	1. Partial Service Hours Were Billed Incorrectly	2. TBI Training Home and Community Services (HCSS) Not Completed -	3. Missing Documentation of Service	4. Billed More Hours than Authorized in the Service Plan	5. Billed More Hours than Documented	6. Missing/Incomplete Service Plan
151	06/15/07	9863	9863	\$ 77.36	\$ 77.36	\$ -						
152	07/05/07	9863	9863	77.36	77.36	-						
153	07/16/07	9863	9863	77.36	77.36	-						
154	07/24/07	9863	9863	58.02	58.02	-						
155	08/05/07	9863	9863	464.16	232.08	232.08		X				
156	08/04/07	9863	9863	464.16	464.16	-						
157	08/16/07	9863	9863	212.74	212.74	-						
158	08/14/07	9863	9863	77.36	77.36	-						
159	08/17/07	9863	9863	58.02	58.02	-						
160	08/28/07	9863	9863	174.06	174.06	-						
161	09/08/07	9863	9863	464.16	464.16	-						
162	09/12/07	9863	9863	464.16	464.16	-						
163	09/23/07	9863	9863	174.06	174.06	-						
164	10/04/07	9863	9863	193.40	193.40	-						
165	10/02/07	9863	9863	77.36	77.36	-						
166	10/10/07	9863	9863	77.36	77.36	-						
167	10/16/07	9863	9863	116.04	116.04	-						
168	10/30/07	9863	9863	58.02	58.02	-						
169	11/02/07	9863		232.08	-	232.08			X			
170	10/22/07	9863	9863	58.02	58.02	-						
171	11/21/07	9863	9863	367.46	348.12	19.34	X					
172	12/09/07	9863	9863	251.42	251.42	-						
173	12/15/07	9863	9863	464.16	464.16	-						
174	12/15/07	9863		232.08	-	232.08			X			
175	12/12/07	9863	9863	212.74	212.74	-						

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

AIDES AT HOME, INC.
 TRAUMATIC BRAIN INJURY SERVICES AUDIT
 AUDIT #09-3737
 AUDIT PERIOD: 7/01/2003 - 6/30/2008

BRIDGE SCHEDULE

SAMPLE #	FINDING	DRAFT REPORT AMOUNT DISALLOWED	FINAL REPORT AMOUNT DISALLOWED	CHANGE
74	Billed More Hours than Authorized in the Service Plan	\$88.50	\$0.00	(\$88.50)
133	TBI Training Not Completed - Home and Community Support Services (HCSS)	\$77.36	\$0.00	(\$77.36)
148	TBI Training Not Completed - Home and Community Support Services (HCSS)	\$77.36	\$0.00	(\$77.36)
148	Billed More Hours than Authorized in the Service Plan	\$0.00	\$77.36	\$77.36
155	Billed More Hours than Authorized in the Service Plan	\$232.08	\$0.00	(\$232.08)
155	TBI Training Not Completed - Home and Community Support Services (HCSS)	\$0.00	\$232.08	\$232.08
163	TBI Training Not Completed - Home and Community Support Services (HCSS)	\$174.06	\$0.00	(\$174.06)
TOTALS		<u>\$649.36</u>	<u>\$309.44</u>	<u>(\$339.92)</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.

Sample's #148 & 155. The findings were reversed based upon additional information provided in response to the Draft Audit Report. However, information was not provided for the additional findings identified in the Draft Audit Report, resulting in no change in the amount disallowed.