



**Office of the
Medicaid Inspector
General**

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

**REVIEW OF HUDSON VALLEY LTHHC PROGRAM
CLAIMS FOR LONG TERM HOME HEALTH CARE
AGENCY HOME HEALTH SERVICES
PAID FROM
APRIL 1, 2010 – DECEMBER 31, 2012**

**Final Audit Report
Audit #: 15-6671**

**Dennis Rosen
Medicaid Inspector General**



**Office of the
Medicaid Inspector
General**

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

August 25, 2016

[REDACTED]
Hudson Valley LTHHC Program
260 Vineyard Avenue
Highland, New York 12528-2343

Re: Final Audit Report
Audit #: 15-6671
Provider ID #: [REDACTED]
NPI #: [REDACTED]

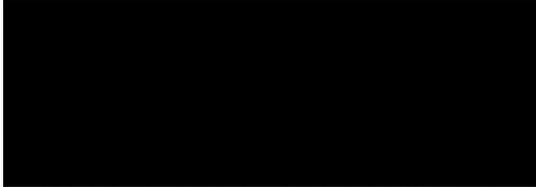
Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report entitled "Review of Hudson Valley LTHHC Program's" (Provider) claims paid for Long Term Home Health Care services from April 1, 2010, through December 31, 2012.

In accordance with Sections 30, 31 and 32 of the New York State Public Health Law, and Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York Parts 504 and 517, OMIG performed an audit of home health services claims paid to Hudson Valley LTHHC Program from April 1, 2010, through December 31, 2012. The audit universe consisted of 53,752 claims totaling \$6,263,774.09. The audit consisted of a random sample of 100 claims with Medicaid payments totaling \$11,567.53 (Attachment A). OMIG shared its proposed findings with Hudson Valley LTHHC Program in the Draft Audit Report dated July 8, 2016. Since you did not respond to our Draft Audit Report dated July 8, 2016, the findings in the Final Audit Report are identical to those in the Draft Audit Report.

The statistical sampling methodology employed in this audit allows for extrapolation of the sample findings to the universe of claims (18 NYCRR Section 519.18). OMIG has determined that the adjusted point estimate of the Medicaid overpayment received by Hudson Valley LTHHC Program is \$176,082. The adjusted lower confidence limit of the amount overpaid is \$2,841 (Attachment B). The enclosed Final Audit Report contains further information about OMIG's audit findings and the calculation of the Medicaid overpayment. 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 adjusted lower confidence limit of \$2,841.

If you have any questions or comments concerning this report, please contact [REDACTED]
[REDACTED] Please refer to audit number
15-6671 in all correspondence.



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

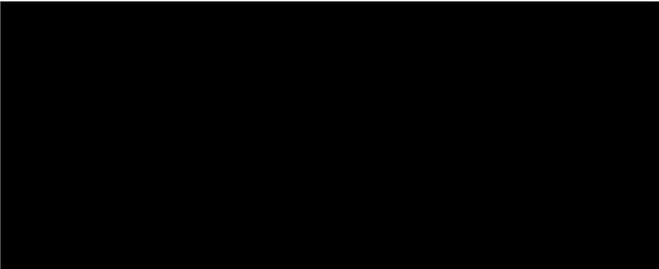


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Mission

The mission of the Office of the Medicaid Inspector General is to enhance 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 while promoting high quality patient care.

Vision

The Office of the Medicaid Inspector General's vision is to be the national leader in promoting and protecting the integrity of the Medicaid program.

Background, Purpose, and Audit Scope

Background

The New York State Department of Health (DOH) is the single state agency responsible for the administration of the Medicaid program. As part of its responsibility as an independent entity within DOH, the Office of the Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assessing provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth in New York Public Health Law, New York Social Services Law, the regulations of DOH (Titles 10, 14 and 18 of the New York Codes Rules and Regulations), DOH's Medicaid Provider Manuals and *Medicaid Update* publications.

Reimbursement under the Medicaid Program is available for medically necessary home health services provided by a public or voluntary non-profit home health agency certified in accordance with the provisions of Article 36 of the Public Health Law. Services provided by a certified home health agency are based on a comprehensive assessment of each patient, a written plan of care, and the written orders of the treating physician, and are generally provided under the supervision of a registered nurse or therapist. The specific standards and criteria for certified home health agency services appear in 42 CFR Part 484, 18 NYCRR Part 505.23 and 10 NYCRR Part 763. MMIS Provider Manuals pertaining to home health services, personal care services, and nursing services also provide programmatic guidance for the provision of home health services.

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for home health 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;
- the medical necessity of claimed services was supported by the provider's documentation;
- 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

A review of home health service claims paid to Hudson Valley LTHHC Program from April 1, 2010, through December 31, 2012, was completed.

The audit universe consisted of 53,752 claims totaling \$6,263,774.09. The audit sample consisted of 100 claims totaling \$11,567.53 (Attachment A).

REGULATIONS OF GENERAL APPLICATION

Each audit finding is supported by relevant regulations, policy statements and manuals. In addition, the audit findings in this audit are supported by regulations of general application to the Medicaid Program and to home health care services. These regulations are provided below.

"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

"Fee-for-service providers. (1) All providers . . . 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 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)

"All bills for medical care, services and supplies shall contain: (1) patient name, case number and date of service; (2) itemization of the volume and specific types of care, services and supplies provided (including for a physician, his final diagnosis, and for drugs, the prescription filled); (3) the unit price and total cost of the care, services and supplies provided; . . . and (8) a dated certification by the provider that 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; . . . 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)

"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)

"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

"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)

"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)

"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)

"A certified home health agency must provide home health services in accordance with applicable provisions of the regulations of the Department of Health...and with federal regulations governing home health services (42 CFR 440.70 and Part 484)."

18 NYCRR Section 505.23(b)(1)

"Home care services agency shall mean an organization primarily engaged in arranging and/or providing, directly or through contract arrangement, one or more of the following: nursing services, home health aide services, medical supplies, equipment and appliances, and other therapeutic and related services which may include, but shall not be limited to, physical and occupational therapy, speech pathology, nutritional services, medical social services, personal care services, homemaker services and housekeeper services which may be of a preventive, therapeutic, rehabilitative, health guidance and/or supportive nature to persons at home."

10 NYCRR Section 700.2(a)(6)

Part 763 of 10 NYCRR establishes minimum requirements and operating standards for certified home health agencies, long term home health care programs, and AIDS home care programs.

10 NYCRR Section 763.1 et.seq.

"The governing authority of the agency shall be responsible for the management, operation and evaluation of the agency and shall: (1) ensure compliance of the agency with the applicable federal, state and local statutes, rules and regulations...."

10 NYCRR Section 763.11(a)(1)

"'Certified home health agency' means a home care services agency which possesses a valid certificate of approval issued pursuant to the provisions of this article, or a residential health care facility or hospital possessing a valid operating certificate issued under article twenty-eight of this chapter which is authorized under section thirty-six hundred ten of this article to provide a long term home health care program. Such an agency, facility, or hospital must be qualified to participate as a home health agency under the provisions of titles XVIII and XIX of the federal Social Security Act"

New York State Public Health Law Section 3602.3

"Long term home health care program shall mean a coordinated plan of care and services provided at home to invalid, infirm or disabled persons who are medically eligible for placement in a hospital or residential health care facility, and who would require such placement. . . ."

10 NYCRR Section 700.2(a)(8)

“(i) AIDS home care program means a coordinated plan of care and services provided at home to persons who are medically eligible for placement in a hospital or residential health care facility and who: (a) are diagnosed by a physician as having acquired immune deficiency syndrome (AIDS); or (b) are deemed by a physician, within his judgment, to be infected with the etiologic agent of acquired immune deficiency syndrome, and who have an illness, infirmity or disability which can be reasonably ascertained to be associated with such infection.

Such program shall be provided by a long term home health care program specifically authorized pursuant to article 36 of the Public Health Law to provide an AIDS home care program; or an AIDS center, as defined in Part 405 of this Title, specifically authorized pursuant to article 36 of the Public Health Law to provide an AIDS home care program. Such program shall be provided in the person's home or in the home of a responsible relative, other responsible adult, adult care facilities specifically approved to admit or retain residents for such program, or in other residential settings as approved by the commissioner in conjunction with the Commissioner of Social Services. Such program shall provide services, including but not limited to the full complement of health, social and environmental services provided by long term home health care programs in accordance with regulations promulgated by the commissioner. Such programs shall also provide such other services as required by the commissioner to assure appropriate care at home for persons eligible under such program.

(ii) A long term home health care program that does not obtain authorization to provide an AIDS home care program shall not be precluded from providing services within its existing authority to patients who are diagnosed as having AIDS, or are deemed by a physician, within his judgment, to be infected with the etiologic agent of acquired immune deficiency syndrome, and who have an illness, infirmity or disability which can be reasonably ascertained to be associated with such infection.”

10 NYCRR Section 700.2(a)(26)(i) & (ii)

The New York State Department of Social Services issued an Administrative Directive to the districts on December 30, 1983. This Administrative Directive sets forth LTHHCP requirements, program policies, and procedures to be followed statewide.

Department of Social Services 83 ADM-74, December 30, 1983

AUDIT FINDINGS

OMIG's detailed findings appear in the following pages. A description of each finding, supporting regulations, and the list of samples with each finding, appear below. Each sample may contain more than one error, and may be listed in more than one category of finding. A sample may only be disallowed once in an audit, however, each sample is subject to disallowance based on a single error.

This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated July 8, 2016. Since you did not respond to the Draft Audit Report, the findings remain the same.

SUMMARY OF FINDINGS

<u>Error Description</u>	<u>Number of Errors</u>
DMS-1 Not Documented/Late/Incomplete	21
Home Assessment Abstract Not Documented/Late/Incomplete	20
Billed for Services in Excess of Ordered Hours/Visits	5

AUDIT FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from April 1, 2010, through December 31, 2012, identified 25 claims with at least one error, for a total sample overpayment of \$2,373.28 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated July 8, 2016. Since you did not respond to the Draft Audit Report, the findings remain the same.

1. DMS-1 Not Documented/Late/Incomplete

"In addition to meeting the clinical record requirements of subdivision (a) of this section, clinical records for long term home health care programs and AIDS home care programs shall include an evaluation of the medical, mental health, social and environmental needs of the patient, on forms prescribed by the commissioner, which shows that the patient is medically eligible for placement in a hospital or residential health care facility were this program not available."

10 NYCRR Section 763.7(b)

"The commissioner must prescribe the forms on which the assessment will be made."

18 NYCRR Section 505.21(b)(2)(viii)

"No single authorization for LTHHCP or AHCP services may exceed four months. (i) A reassessment must be performed at least every 120 days . . ."

18 NYCRR Section 505.21(b)(8) and (b)(8)(i)

The NYS Department of Social Services Administrative Directive dated December 30, 1983 advises that a medical assessment is the initial assessment process. The medical assessment is accomplished by completion and scoring of the DMS-1 or its successor. The DMS-1 is also the tool that is used as an indicator for need for SNF or HRF placement. If the person is currently in his own home or the home of a relative or responsible adult, the DMS-1 or its successor will most often be completed by the LTHHCP nurse representative or by the patient's physician. After the initial medical and home assessments, development of the summary of service requirements and implementation of the plan of care, there will be a complete reassessment done every 120 days for each patient. Therefore, no single authorization for Long Term Home Health Care Program services may exceed 120 days.

Department of Social Services 83 ADM-74, December 30, 1983

"The following conditions must be met in order for a client to receive the services of a LTHHCP: . . . A client must be assessed as medically eligible for placement in a skilled nursing or health related facility. The assessment must be completed by a physician or a registered professional nurse on forms approved by the Commissioner of Health (the DMS-1 or its successor)."

*MMIS Provider Manual for Long Term Home Health Care Program Services,
February 1992*

"A registered nurse must complete the *New York State Long Term Care Placement Form Medical Assessment Abstract* (otherwise known as the DMS-1). The DMS-1 is an instrument used to evaluate an individual's current medical condition. . . ."

*Long Term Home Health Care Program Reference Manual, June 2006
Chapter 2*

"A registered nurse (RN), or physician, must complete the DMS-1 to evaluate an individual's current medical condition..."

*Long Term Home Health Care Program Medicaid Waiver Program Manual, May, 2012
Section II*

"The RN must ensure that the reassessment is done within 120 days and is responsible for revising the nursing goals, updating the Plan of Care, and completing the DMS-1 form."

*Long Term Home Health Care Program Reference Manual, June 2006
Chapter 2*

"A complete reassessment, including re-evaluation of the participant's current health, medical, nursing, social, environmental, and rehabilitative needs, must be conducted no later than 180 days from the individual's previous assessment. No single authorization for LTHHCP participation may exceed 180 days."

*Long Term Home Health Care Program Medicaid Waiver Program Manual, May, 2012
Section II*

The waiver renewal implements legislation enacted in June 2010 to extend the reassessment time frame from every 120 days to every 180 days, or more frequently when a participant's service needs change. LDSS staff were instructed to phase-in the new policy effective September 1, 2010, as participants' existing 120 day authorizations expired and subsequent reassessments could then be authorized for 180 days.

11 OLTC/ ADM-1

In 21 instances pertaining to 20 patients, the DMS-1 was not completed within the regulatory time frame. This finding applies to Sample #'s 8, 9, 10, 11, 13, 19, 33, 40, 45, 47, 50, 53, 54, 57, 60, 67, 69, 85, 90, 97 and 98.

2. Home Assessment Abstract Not Documented/Late/Incomplete

"In addition to meeting the clinical record requirements of subdivision (a) of this section, clinical records for long term home health care programs and AIDS home care programs shall include an evaluation of the medical, mental health, social and environmental needs of the patient, on forms prescribed by the commissioner, which shows that the patient is medically eligible for placement in a hospital or residential health care facility were this program not available."

10 NYCRR Section 763.7(b)

"If a person . . . desires to remain and is deemed by his or her physician able to remain in his/her own home . . . the social services district must authorize a home assessment of the appropriateness of the LTHHCP or AHCP services. The assessment must include, in addition to the physician's recommendation, an evaluation of the social and environmental needs of the person. . . . (ii) . . . and must be performed by the person's physician, a representative of the social services district, and a representative of the LTHHCP or AHCP that will provide services to the person."

18 NYCRR Section 505.21(b)(2)& (b)(2)(ii)

"No single authorization for LTHHCP or AHCP services may exceed four months. (i) A reassessment must be performed at least every 120 days . . ."

18 NYCRR Section 505.21(b)(8)& (b)(8)(i)

"The commissioner must prescribe the forms on which the assessment will be made."

18 NYCRR Section 505.21(b)(2)(viii)

The NYS Department of Social Services administrative directive dated December 30, 1983 advises that the home assessment is done in order to determine how, and if, the patient's total health and social care needs, as well as those prescribed by the physician, can be met in the home environment. The home assessment is accomplished by completion of the Home Assessment Abstract (or its successor) by the nurse representative of the LTHHCP and the professional caseworker from the LDSS. If a joint assessment cannot be made the LTHHCP representative performs a preliminary assessment; based on this assessment the LTHHCP representative develops a proposed summary of service requirements. The summary of service requirements is a listing of the types, frequency and amounts of services which will be necessary to maintain the patient at home. This listing can be found on the Home Assessment Abstract. The summary of service requirements should represent all the services-medical, nursing, social work, therapies, health aide, personal care, homemaking, housekeeping, drugs, and all other support services. It shall be the responsibility of the LTHHCP nurse representative to assure that the orders are written clearly and concisely and reflected on page 4 of the Home Assessment Abstract. The representative of the LTHHCP will be a registered professional nurse. The LTHHCP nurse representative establishes goals for the patient and methodology for achieving these goals by a practical nursing plan which clearly outlines the nursing, home health aide and personal care services and other therapeutic and supportive modalities. The plan outlines the methodology of approach and practical applications. The goals should be well-defined, measurable and updated and re-evaluated at each reassessment period (120 days) and whenever indicated. There will be a "complete" reassessment done every 120 days for each patient. No single authorization for LTHHCP services may exceed 120 days.

Department of Social Services 83 ADM-74, December 30, 1983

"Home Assessment This assessment determines if and how the client's total health, social and environmental care needs can be met at home. It is accomplished by completion of the Home Assessment Abstract (HAA) or its successor . . ."

*MMIS Provider Manual for Long Term Home Health Care Program Services,
Revised February 1992*

"Each patient will be reassessed every 120 days . . . The tool for the periodic reassessment and any resultant change in service requirements will be the DMS-1 or its successor and the Home Assessment Abstract or its successor."

*MMIS Provider Manual for Long Term Home Health Care Program Services,
Revised February 1992*

The Long Term Home Health Care Program Reference Manual (Manual) advises that the Home Assessment Abstract (otherwise known as the HAA or DSS 3139) is a tool used to determine whether the individual's total health and social care needs can be met in the home environment. The Summary of Service Requirements and Plan of Care are developed from the abstract. In items 12 and 13 of the HAA, a registered nurse (RN) from the provider agency records all clinical information regarding the individual's health status. The RN is responsible for assessing the home with regard to safety and ease of activities of daily living and records that information Item 12. The nurse must assess the recovery potential anticipated for the individual, and records the result in Item 13. The RN must also assess individual abilities in the activities of daily living (such as bathing, dressing and grooming) and records the results in Item 14. The RN must ensure that the reassessment is done within 120 days and is responsible for revising the nursing goals and updating the Plan of Care.

*Long Term Home Health Care Program Reference Manual, June 2006
Chapter 2*

"In addition, at least once every 180 days, a reassessment of the participant must be conducted by the LTHHCP agency RN and the LDSS staff to verify the participant's eligibility for the LTHHCP waiver program and determine whether the participant's POC needs to be modified based upon the results of the reassessment of the participant's condition."

*Long Term Home Health Care Program Medical Waiver Program Manual, May 2012
Section II*

The waiver renewal implements legislation enacted in June 2010 to extend the reassessment time frame from every 120 days to every 180 days, or more frequently when a participant's service needs change. LDSS staff were instructed to phase-in the new policy effective September 1, 2010, as participants' existing 120 day authorizations expired and subsequent reassessments could then be authorized for 180 days.

11 OLTC/ ADM-1

In 20 instances pertaining to 19 patients, the Home Assessment Abstract was not completed within the regulatory time frame. This finding applies to Sample #'s 8, 10, 11, 13, 19, 33, 40, 45, 47, 50, 53, 54, 57, 60, 67, 69, 85, 90, 97 and 98.

3. Billed for Services in Excess of Ordered Hours/Visits

Regulations state: "It is the policy of the department to pay for home health services under the medical assistance program only when the services are medically necessary."

18 NYCRR Section 505.23(a)(1)(i)&(ii)

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)

For Services Prior to 11/17/2010

Regulations state: "Home health services mean the following services when prescribed by a physician and provided to an MA recipient in his or her home . . . (i) nursing services . . . (ii) physical therapy, occupational therapy, or speech pathology and audiology services; and (iii) home health aide services. . . ."

18 NYCRR Section 505.23(a)(3)(i)-(iii)

For Services 11/17/2010 and After

Regulations state: "Home health services mean the following services when prescribed by a physician and provided to an MA recipient in his or her home . . . (i) nursing services . . . (ii) physical therapy, occupational therapy, or speech pathology and audiology services; and (iii) home health aide services. . . ."

18 NYCRR Section 505.23(a)(2)(i)-(iii)

Regulations state: "Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency and duration of such services. . . ."

10 NYCRR Section 763.6(d)

The Home Health Manual states: "Any such service provided [by a certified home health agency] to a Recipient must be ordered by his/her physician as part of a written plan of care..."

MMIS Provider Manual for Home Health Services, Revised February 1992, Section 2

NYS Medicaid Program Provider Manual for Home Health, Policy Guidelines,

Version 2007-1, Section III

Version 2008-1, Section III

The Department of Social Services administrative directive dated December 30, 1983 states, "In addition to the actual provision of services, LTHHCP providers have management responsibilities. These responsibilities include . . . Obtaining necessary physician orders . . . Notifying the local social services districts the first working day following the noting of a change in the patient's condition and concerning any changes in the authorized summary of services. Seeking prior authorization for any service change which exceeds by 10% or more the 75% cap for the patient. . . ."

Department of Social Services 83 ADM-74, December 30, 1983

Section I, paragraph K. 2 and 7

"The client's physician must indicate that care in the home setting is appropriate for the client and must provide orders for treatment, medication and services."

Medicaid Management Information System Provider Manual

Long Term Home Health Care Program Services, February 1992

In 5 instances pertaining to 5 patients, billed home care services exceeded the maximum frequency of visits or number of hours or services specified on the authorized practitioner's order. The portion of the sampled claim exceeding the order will be disallowed. This finding applies to Sample #'s 7, 13, 55, 75 and 80.

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 #15-6671
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 adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where OMIG would seek and defend the adjusted point estimate of \$176,082. 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]
Hudson Valley LTHHC Program
260 Vineyard Avenue
Highland, New York 12528-2343

PROVIDER ID # [REDACTED]

AUDIT #15-6671

AMOUNT DUE: \$2,841

AUDIT

PROVIDER

RATE

PART B

TYPE

OTHER:

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, B.A.M.
GNARESP Corning Tower, Room 2739
Audit #15-6671
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN

The sample design used for Audit #15-6671 was as follows:

- **Universe** - Medicaid claims for long term home health care agency services paid during the period April 1, 2010, through December 31, 2012.
- **Sampling Frame** - The sampling frame for this objective is the Medicaid electronic database of Provider claims for long term home health care agency services paid during the period April 1, 2010, through December 31, 2012.
- **Sample Unit** - The sample unit is a Medicaid claim paid during the period April 1, 2010, through December 31, 2012.
- **Sample Design** – Simple sampling was used for sample selection.
- **Sample Size** – The sample size is 100 claims.

Attachment B

SAMPLE RESULTS AND ESTIMATES**Audit Statistics**

Universe Size	53,752
Sample Size	100
Sample Value	\$ 11,567.53
Sample Overpayments	\$ 2,373.28
Net Financial Error Rate	20.52%
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	\$ 2,373.28
Less Overpayments Not Extrapolated	\$ (2,049.51)
Sample Overpayments for Extrapolation Purposes	\$ 323.77
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	\$ 3.2377
Universe Size	53,752
Point Estimate of Total Dollars	\$ 174,032
Add Overpayments Not Extrapolated	\$ 2,050
Adjusted Point Estimate of Total Dollars	\$ <u>176,082</u>
Lower Confidence Limit	\$ 791
Add Overpayments Not Extrapolated	\$ 2,050
Adjusted Lower Confidence Limit	\$ <u>2,841</u>

* The actual dollar disallowance for the following findings was subtracted from the total sample overpayment and added to the Point Estimate and Lower Confidence Limit:

- **Finding #1 – DMS-1 Not Documented/Late/Incomplete**
- **Finding #2 – Home Assessment Abstract Not Documented/Late/Incomplete**

The dollar disallowance associated with these findings was not used in the extrapolation. However, this does not apply if an extrapolated finding was also identified for a sampled claim

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Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS		
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. DMS-1 Not Documented/Late/Incomplete	2. Home Assessment Documented/Late/Incomplete	3. Billed for Services In Excess of Ordered Hourly/Visits
1	02/27/11	3851	3851	\$ 148.55	\$ 148.55	\$ -	\$ -			
2	07/18/12	3857	3857	49.38	49.38	-	-			
3	05/30/11	3857	3857	45.26	45.26	-	-			
4	06/23/11	3857	3857	181.04	181.04	-	-			
5	04/21/11	3857	3857	181.04	181.04	-	-			
6	06/30/10	3857	3857	93.60	93.60	-	-			
7	01/31/12	3857	3857	98.76	74.07	24.69	-			X
8	12/29/10	3857		140.40	-	-	140.40	X	X	
9	06/10/10	3857		163.80	-	-	163.80	X		
10	05/03/12	3852		95.69	-	-	95.69	X	X	
11	11/17/11	3857		45.26	-	-	45.26	X	X	
12	04/09/12	3857	3857	49.38	49.38	-	-			
13	02/02/12	3857	3857	123.45	74.07	49.38	-	X	X	X
14	05/25/11	3857	3857	90.52	90.52	-	-			
15	03/24/10	3851	3851	128.68	128.68	-	-			
16	09/13/12	3851	3851	139.89	139.89	-	-			
17	10/07/10	3857	3857	70.20	70.20	-	-			
18	04/05/11	3857	3857	113.15	113.15	-	-			
19	04/03/10	3857		70.20	-	-	70.20	X	X	
20	02/17/10	3852	3852	99.12	99.12	-	-			
21	06/17/10	3857	3857	93.60	93.60	-	-			
22	09/13/12	3851	3851	139.89	139.89	-	-			
23	03/04/10	3851	3851	128.68	128.68	-	-			
24	05/04/12	3851	3851	139.89	139.89	-	-			
25	04/25/11	3857	3857	90.52	90.52	-	-			

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Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS 1. DMS-1 Not Documented/Late/Incomplete 2. Home Assessment Abstract Not Documented/Late/Incomplete 3. Billed for Services in Excess of Ordered Hours/Visits		
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated			
26	04/04/11	3857	3857	\$ 90.52	\$ 90.52	\$ -	\$ -			
27	03/16/12	3857	3857	148.14	148.14	-	-			
28	08/27/12	3857	3857	148.14	148.14	-	-			
29	09/10/10	3857	3857	93.60	93.60	-	-			
30	01/29/12	3857	3857	74.07	74.07	-	-			
31	11/10/10	3851	3851	128.68	128.68	-	-			
32	11/17/10	3853	3853	93.16	93.16	-	-			
33	10/16/09	3853		90.63	-	-	90.63	X	X	
34	09/01/11	3852	3852	0.70	0.70	-	-			
35	12/14/10	3857	3857	93.60	93.60	-	-			
36	10/03/11	3857	3857	37.35	37.35	-	-			
37	10/29/10	3857	3857	70.20	70.20	-	-			
38	01/26/11	3857	3857	137.22	137.22	-	-			
39	01/09/12	3857	3857	74.07	74.07	-	-			
40	07/19/10	3857		93.60	-	-	93.60	X	X	
41	09/09/10	3853	3853	93.16	93.16	-	-			
42	06/22/11	3852	3852	97.01	97.01	-	-			
43	10/26/11	3857	3857	158.41	158.41	-	-			
44	10/13/10	3857	3857	93.60	93.60	-	-			
45	02/25/12	3857		98.76	-	-	98.76	X	X	
46	09/16/11	3852	3852	97.01	97.01	-	-			
47	03/18/10	3857		70.20	-	-	70.20	X	X	
48	07/04/12	3857	3857	148.14	148.14	-	-			
49	10/04/12	3857	3857	74.07	74.07	-	-			
50	05/21/10	3857		70.20	-	-	70.20	X	X	

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Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS		
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. DMS-1 Not Documented/Late/Incomplete	2. Home Assessment Documented/Late/Incomplete	3. Billed for Services In Excess of Ordered Hours/Visits
51	02/04/12	3857	3857	\$ 74.07	\$ 74.07	\$ -	\$ -			
52	03/04/11	3857	3857	182.96	182.96	-	-			
53	02/03/12	3857		74.07	-	-	74.07	X	X	
54	02/11/12	3851		139.89	-	-	139.89	X	X	
55	01/02/10	3857	3857	210.60	187.20	23.40	-			X
56	05/04/10	3853	3853	93.16	93.16	-	-			
57	02/10/12	3857		74.07	-	-	74.07	X	X	
58	01/13/12	3853	3853	91.58	91.58	-	-			
59	09/24/10	3853	3853	93.16	93.16	-	-			
60	03/01/10	3857		163.80	-	-	163.80	X	X	
61	10/30/10	3857	3857	163.80	163.80	-	-			
62	08/24/10	3857	3857	234.00	234.00	-	-			
63	03/26/11	3853	3853	94.85	94.85	-	-			
64	12/06/10	3857	3857	163.80	163.80	-	-			
65	12/03/10	3857	3857	187.20	187.20	-	-			
66	07/06/12	3857	3857	148.14	148.14	-	-			
67	11/22/11	3853		93.91	-	-	93.91	X	X	
68	06/08/12	3853	3853	91.58	91.58	-	-			
69	03/15/12	3857		74.07	-	-	74.07	X	X	
70	06/15/12	3857	3857	49.38	49.38	-	-			
71	10/11/12	3857	3857	49.38	49.38	-	-			
72	05/28/12	3857	3857	49.38	49.38	-	-			
73	11/21/10	3857	3857	257.40	257.40	-	-			
74	04/30/11	3852	3852	97.01	97.01	-	-			
75	12/09/11	3857	3857	135.78	90.52	45.26	-			X

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Sample Number	Date of Service	Rate Code		Amount		Overpayment		1. DMS-1 Not Documented/Late/Incomplete	2. Home Assessment Documented/Late/Incomplete	3. Billed for Services in Excess of Ordered Hours/Visits
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated			
76	05/28/11	3857	3857	\$ 67.89	\$ 67.89	\$ -	\$ -			
77	11/03/11	3851	3851	85.71	85.71	-	-			
78	02/14/11	3857	3857	160.09	160.09	-	-			
79	10/25/11	3857	3857	90.52	90.52	-	-			
80	07/12/11	3857	3857	497.86	316.82	181.04	-			X
81	11/21/12	3853	3853	91.58	91.58	-	-			
82	10/30/12	3852	3852	95.69	95.69	-	-			
83	07/28/10	3852	3852	99.12	99.12	-	-			
84	04/23/11	3857	3857	67.89	67.89	-	-			
85	05/10/10	3857		93.60	-	-	93.60	X	X	
86	10/05/10	3853	3853	93.16	93.16	-	-			
87	10/14/11	3851	3851	147.09	147.09	-	-			
88	02/07/11	3851	3851	148.55	148.55	-	-			
89	10/01/10	3851	3851	128.68	128.68	-	-			
90	08/28/10	3853		93.16	-	-	93.16	X	X	
91	07/02/11	3857	3857	181.04	181.04	-	-			
92	03/10/12	3857	3857	222.21	222.21	-	-			
93	12/08/11	3857	3857	135.78	135.78	-	-			
94	04/12/12	3851	3851	139.89	139.89	-	-			
95	03/09/11	3857	3857	91.48	91.48	-	-			
96	06/30/12	3852	3852	95.69	95.69	-	-			
97	06/30/10	3857		210.60	-	-	210.60	X	X	
98	03/26/10	3857		93.60	-	-	93.60	X	X	
99	07/20/11	3852	3852	97.01	97.01	-	-			
100	06/07/11	3857	3857	158.41	158.41	-	-			
Totals				\$ 11,567.53	\$ 9,194.25	\$ 323.77	\$ 2,049.51	21	20	5