



**Office of the
Medicaid Inspector
General**

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

**REVIEW OF ADDICTIONS CARE CENTER OF ALBANY
CLAIMS FOR OASAS OUTPATIENT CHEMICAL DEPENDENCE SERVICES
PAID FROM
JULY 1, 2011 – JUNE 30, 2014**

**FINAL AUDIT REPORT
AUDIT #: 16-1012**

**Dennis Rosen
Medicaid Inspector General**

August 19, 2016



**Office of the
Medicaid Inspector
General**

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

August 19, 2016

[REDACTED]

Addictions Care Center of Albany
90 McCarty Avenue
Albany, New York 12202-1151

Re: Final Audit Report
Audit #: 16-1012
Provider ID #: [REDACTED]
NPI #: [REDACTED]

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Addictions Care Center of Albany" (Provider) paid claims for OASAS outpatient chemical dependence services covering the period July 1, 2011, through June 30, 2014.

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

The OMIG has attached the sample detail for the paid claims determined to be in error. The adjusted mean point estimate overpaid is \$250,459. The adjusted lower confidence limit of the amount overpaid is \$123,103. 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 \$123,103.

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED]. Please refer to report number 16-1012 in all correspondence.

[REDACTED]

Division of Medicaid Audit, Albany Office
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.

Outpatient chemical dependence services are provided in either hospital-based or free-standing settings. Regardless of the setting in which they are provided, these services must be furnished in one of two distinct programs: an outpatient chemical dependence clinic program or an outpatient chemical dependence rehabilitation program. The purpose of outpatient programs for individuals with a diagnosis of chemical dependence is to provide medical evaluation, clinical care management, clinical services, and rehabilitation services. The specific standards and criteria for chemical dependence clinics are outlined in Title 14 NYCRR Part 822 and Title 18 NYCRR Section 505.27. The MMIS Provider Manual for Clinics also provides program guidance for claiming Medicaid reimbursement for chemical dependence services.

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OASAS outpatient chemical dependence services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to OASAS outpatient chemical dependence, this audit covered services paid by Medicaid from July 1, 2011, through June 30, 2014.

SUMMARY OF FINDINGS

We inspected a random sample of 100 services with \$8,100.08 in Medicaid payments. Of the 100 services in our random sample, 18 services had at least one error and did not comply with state requirements. Of the 100 noncompliant services, some contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Missing Discharge Summary	4
Failure to Meet Group Counseling Requirements	3
Incorrect Healthcare Common Procedure Coding System (HCPCS) Code Billed	3
Failure to Meet Half-Day Outpatient Rehabilitation Requirements	2
Missing Discharge Plan	2
Missing Treatment Plan Review	1
Missing/Late Individual Treatment Plan	1

Failure to Meet Complex Medication Management Requirements	1
Missing Physician Signature on Treatment Plan	1
Missing Signature on Treatment Plan	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$1,221.57 in sample overpayments with an extrapolated adjusted point estimate of \$250,459. The adjusted lower confidence limit of the amount overpaid is \$123,103.

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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 OASAS outpatient chemical dependence 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 OASAS Outpatient Chemical Dependence Program

Outpatient chemical dependence services are provided in either hospital-based or free-standing settings. Regardless of the setting in which they are provided, these services must be furnished in one of two distinct programs: an outpatient chemical dependence clinic program or an outpatient chemical dependence rehabilitation program. The purpose of outpatient programs for individuals with a diagnosis of chemical dependence is to provide medical evaluation, clinical care management, clinical services, and rehabilitation services. The specific standards and criteria for chemical dependence clinics are outlined in Title 14 NYCRR Part 822 and Title 18 NYCRR Section 505.27. The MMIS Provider Manual for Clinics also provides program guidance for claiming Medicaid reimbursement for chemical dependence services.

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OASAS outpatient chemical dependence 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 OASAS outpatient chemical dependence services paid by Medicaid from July 1, 2011, through June 30, 2014. Our audit universe consisted of 33,856 claims totaling \$2,773,477.49.

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 OASAS outpatient chemical dependence program;
- ran computer programming application of claims in our data warehouse that identified 33,856 paid OASAS outpatient chemical dependence claims, totaling \$2,773,477.49;
- selected a random sample of 100 services from the population of 33,856 services; and,
- estimated the overpayment paid in the population of 33,856 services.

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

- Medicaid electronic claim information
- Patient record, including, but not limited to:
 - Comprehensive Evaluations
 - Level of Care Determinations
 - Treatment Plans and Treatment Plan Reviews
 - Progress Notes
 - Group Sign-Ins
 - Discharge Plans and Summaries
- 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, Mental Hygiene and Social Services [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, and 14 NYCRR Part 822.
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

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

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

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

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

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

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

18 NYCRR Section 518.1(c)

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

18 NYCRR Section 540.1

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

18 NYCRR Section 518.3(a)

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

18 NYCRR Section 518.3(b)

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

18 NYCRR Section 518.3(b)

AUDIT FINDINGS

This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated June 27, 2016. The information provided resulted in no change to any of the disallowances. The findings in the Final Audit Report are identical to those in the Draft Audit Report.

AUDIT FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from July 1, 2011, through June 30, 2014, identified 18 claims with at least one error, for a total sample overpayment of \$1,221.57 (Attachment C).

1. Missing Discharge Summary

Regulations state, "Within 45 days of discharge, a discharge summary must be prepared and included in each patient's record." *14 NYCRR Section 822-4.6(e)*

In 4 instances pertaining to 3 patients, a summary was not completed. This finding applies to Sample #'s 54, 64, 73, and 87.

2. Failure to Meet Group Counseling Requirements

Regulations state, "No more than one group counseling service may be billed for any patient per day. The program must document at least 60 minutes of face-to-face contact with the patient." *14 NYCRR 822-3.1(h)(6)*

Regulations also state, "Group counseling progress notes must document the attendance and individual participation of each patient..." *14 NYCRR Section 822-2.5(b)(6)(ii)*

In 3 instances pertaining to 3 patients, the requirements for group counseling were not met. This finding applies to Sample #'s 5, 11, and 93.

3. Incorrect Healthcare Common Procedure Coding System (HCPCS) Code Billed

Regulations state, "Payment for chemical dependence services shall be at fees established by the Department of Health and approved by the Director of the Division of the Budget as contained in the fee schedule for chemical dependence outpatient services." *18 NYCRR Section 505.27(d)(1)*

In 3 instances pertaining to 3 patients, the incorrect HCPCS code was billed which resulted in higher reimbursement than indicated in the fee schedule for the proper HCPCS code. This finding applies to Sample #'s 22, 42, and 64.

4. Failure to Meet Half-Day Outpatient Rehabilitation Requirements

Regulations state, "No more than one outpatient rehabilitation service may be billed for any patient per day. Programs that provide outpatient rehabilitation services may also bill for medication administration and observation, medication management, complex care coordination, peer support services and collateral visits consistent with the standards set forth in this subdivision. Programs may not bill for any other service categories while a patient is admitted to the outpatient rehabilitation service." *14 NYCRR 822-3.1(h)(11)*

Regulations also state, "2-4 hour duration - The program must document at least 2 hours of services but less than 4 hours of services." *14 NYCRR 822-3.1(h)(11)(i)*

Regulations further state, "Outpatient rehabilitation services documentation must include a daily attendance note." *14 NYCRR Section 822-2.5(b)(11)(i)*

In 2 instances pertaining to 2 patients, the requirements for half-day rehabilitation were not met. This finding applies to Sample #'s 14 and 89.

5. Missing Discharge Plan

Regulations state, "The discharge planning process must begin upon admission, be closely coordinated with the treatment/recovery plan, be based on the patient's self-reported confidence in maintaining abstinence and be included in the patient record. A discharge plan must be developed in collaboration with the patient and any collateral person(s) the patient chooses to involve." *14 NYCRR Section 822-4.6(b)*

In 2 instances pertaining to 2 patients, a discharge plan was not completed. This finding applies to Sample #'s 48 and 79.

6. Missing Treatment Plan Review

Regulations state, "The entire treatment plan, once established, shall be thoroughly reviewed and revised at least every ninety calendar days thereafter for the first year and at least every 180 calendar days thereafter." *14 NYCRR Section 822-4.5(g)*

In 1 instance, the required treatment plan review was not completed. This finding applies to Sample # 12.

7. Missing Late Individual Treatment Plan

Regulations state, "Within 45 days of admission to an outpatient program, a written comprehensive individualized patient-centered treatment/recovery plan for each patient must be developed by the responsible clinical staff member and reviewed and approved by the multidisciplinary team." *14 NYCRR Section 822.4-5(a)*

In 1 instance, the required individual treatment plan was not completed. This finding applies to Sample # 33.

8. Failure to Meet Complex Medication Management Requirements

Regulations state, "No more than one medication management service may be billed for any patient per day." *14 NYCRR 822-3.1(h)(10)*

Regulations also state, "Complex medication management - The program must document at least 15 minutes of services including face-to-face contact with the patient and patient observation." *14 NYCRR 822-3.1(h)(10)(ii)*

In 1 instance, the requirements for complex medication management were not met. This finding applies to Sample # 38.

9. Missing Physician Signature on Treatment Plan

Regulations state, "The treatment plan shall be signed by the responsible clinical staff member and be reviewed, approved, signed and dated by the medical director or other physician employed by the outpatient program within ten days after review."

14 NYCRR Section 822-4.5(c)(11)

In 1 instance, the treatment plan lacked the required physician signature. This finding applies to Sample # 68.

10. Missing Signature on Treatment Plan

Regulations state, "The treatment plan shall be signed by the responsible clinical staff member"

14 NYCRR Section 822-4.5(c)(11)

Regulations state, "The treatment plan shall be approved, signed, and dated by all members of the multidisciplinary team at or sometime following the case conference but in no event more than 45 days after admission."

14 NYCRR Section 822-4.5(c)(10)

In 1 instance, the treatment plan lacked the required approval as denoted by signature of the multidisciplinary team, or was signed more than 45 days after admission. This finding applies to Sample # 71.

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 #16-1012
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 \$250,459. 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

████████████████████
Addictions Care Center of Albany
90 McCarty Avenue
Albany, New York 12202-1151

PROVIDER ID # ██████████

AUDIT #16-1012

AMOUNT DUE: \$123,103

AUDIT

TYPE

PROVIDER

RATE

PART B

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:

████████████████████
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
Audit #16-1012
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN

The sample design used for Audit #16-1012 was as follows:

- **Universe** - Medicaid claims for OASAS outpatient chemical dependence services paid during the period July 1, 2011, through June 30, 2014.
- **Sampling Frame** - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for OASAS outpatient chemical dependence services paid during the period July 1, 2011 through June 30, 2014.
- **Sample Unit** - The sample unit is a Medicaid claim paid during the period July 1, 2011, through June 30, 2014.
- **Sample Design** – Simple sampling was used for sample selection.
- **Sample Size** – The sample size is 100 services.

SAMPLE RESULTS AND ESTIMATES

Universe Size	33,856
Sample Size	100
Sample Value	\$ 8,100.08
Sample Overpayments	\$ 1,221.57
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	\$ 1,221.57
Less Overpayments Not Extrapolated*	<u>(483.22)</u>
Sample Overpayments for Extrapolation Purposes	\$ 738.35
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	\$ 7.3835
Universe Size	33,856
Point Estimate of Total Dollars	\$ 249,975
Add Overpayments Not Extrapolated*	<u>483</u>
Adjusted Point Estimate of Totals Dollars	<u>\$ 250,459</u>
Lower Confidence Limit	\$ 122,620
Add Overpayments Not Extrapolated*	<u>483</u>
Adjusted Lower Confidence Limit	<u>\$ 123,103</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 – Missing Discharge Summary**
- **Finding #5 – Missing Discharge Plan**

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

