NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

August 18, 2016

Dr. Gabriel L. Dassa
7 Carlton Drive
Mount Kisco, New York 10549

Re: Final Audit Report
Medicaid EHR Incentive Program
Audit # 16-1172
NPI # [redacted]
Provider ID # [redacted]

Dear Dr. Dassa:

This letter serves as the Office of the Medicaid Inspector General's (OMIG) Final Audit Report of payment made to you under the New York State Medicaid Electronic Health Record (EHR) Incentive Program for Meaningful Use during the calendar year ending December 31, 2012.

BACKGROUND, PURPOSE AND SCOPE

The New York State Department of Health (the Department) is responsible for the administration of the Medicaid program. As part of this responsibility, the Office of the Medicaid Inspector General (OMIG), an independent office within the Department, conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the 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)], the Medicaid Management Information System (MMIS) Provider Manuals and Department *Medicaid Updates*.

The OMIG recently completed a review of the information attested to in your attestation for the NYS Medicaid EHR Incentive Program. Medicaid EHR Incentive payments were authorized by the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implemented by Federal regulation principally at 42 CFR Part 495. This review examined the supporting documentation for your submitted attestation, signed November 14, 2013, for payment for Meaningful Use during the calendar year ending December 31, 2012. You were paid an EHR incentive payment of $8,500 for this submitted attestation. The purpose of the audit was to ensure your compliance with applicable Federal and State laws, regulations, rules, and policies governing the New York State Medicaid EHR Incentive Program, including verification of eligibility for the EHR Incentive Program and the Meaningful Use of a certified EHR system.

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, 42 CFR § 495-Standards for The Electronic Health Record Technology Incentive Program.

- 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)

DETERMINATION

After reviewing your response to the OMIG's May 5, 2016 Draft Audit Report, the overpayment in the Final Audit Report remains unchanged to the overpayment identified in the Draft Audit Report.

The OMIG's review of your payment for the Medicaid EHR Incentive Program identified at least one error, for a total overpayment of $8,500. The errors identified in the audit are described in the Detailed Findings section below.

DETAILED FINDINGS

1. Failure to Support Medicaid Patient Volume

Federal regulations state, "*Additional requirements for the Medicaid EP.* To qualify for an EHR incentive payment, a Medicaid EP must, for each year for which the EP seeks an EHR incentive payment, not be hospital-based as defined at §495.4 of this subpart, and meet one of the following criteria: (1) Have a minimum 30 percent patient volume attributable to individuals receiving Medicaid. (2) Have a minimum 20 percent patient volume attributable to individuals receiving Medicaid, and be a pediatrician." *42 CFR § 495.304(c)(1) and (2)*

Federal regulations state, "*Methodology, patient encounter* — (1) *EPs.* To calculate Medicaid patient volume, an EP must divide: (*i*) The total Medicaid patient encounters in any representative, continuous 90-day period in the preceding calendar year; by (*ii*) The total patient encounters in the same 90-day period." *42 CFR § 495.306(c)(1)*

Federal regulations state, "For purposes of this section, the following rules apply: (1) For purposes of calculating EP patient volume, a Medicaid encounter means services rendered to an individual on any one day where—(i) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service; or (ii) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, and cost-sharing." *42 CFR § 495.306(e)(1)*

Federal regulations state, "*Group practices.* Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations: (1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP. (2) There is an auditable data source to support the clinic's or group practice's patient volume determination. (3) All EPs in the group practice or clinic must use the same methodology for the payment year. (4) The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way. (5) If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters." *42 CFR § 495.306(h)*

2. <u>Failure to Support Meaningful Use Core Measures/Exclusions</u>

Federal regulations state: "Stage 1 criteria for EPs— (1) General rule regarding Stage 1 criteria for meaningful use for EPs. Except as specified in paragraphs (a)(2) and (a)(3) of this section, EPs must meet all objectives and associated measures of the Stage 1 criteria specified in paragraph (d) of this section ... to meet the definition of a meaningful EHR user."
42 CFR §495.6(a)

The following Stage 1 Core measures/exclusions were not supported:

<u>Drug Interaction Checks Measure</u>

Federal regulations state: "Stage 1 Core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (2)(i) Objective. Implement drug-drug and drug-allergy interaction checks. (ii) Measure. The EP has enabled this functionality for the entire EHR reporting period."
42 CFR § 495.6(d)(2)

<u>Clinical Decision Support Rule Measure</u>

Federal regulations state: "Stage 1 Core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (11)(i) Objective. Implement one clinical decision support rules relevant to specialty or high clinical priority along with the ability to track compliance with that rule. (ii) Measure. Implement one clinical decision support rule." *42 CFR § 495.6(d)(11)*

Electronic Exchange of Clinical Information Measure

Federal regulations state: "Stage 1 Core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (14)(i) Objective. Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically. (ii) Measure. (A) Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information." *42 CFR § 495.6(d)(14)*

Security Risk Analysis to Protect Electronic Health Information Measure

Federal regulations state: "Stage 1 Core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (15)(i) Objective. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. (ii) Measure. Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process." *42 CFR § 495.6(d)(15)*

3. Failure to Support Meaningful Use Menu Measures/Exclusions

Federal regulations state: "Stage 1 criteria for EPs— (1) General rule regarding Stage 1 criteria for meaningful use for EPs. Except as specified in paragraphs (a)(2) and (a)(3) of this section, EPs must meet ... five objectives of the EP's choice from paragraph (e) of this section to meet the definition of a meaningful EHR user." *42 CFR §495.6(a)*

The following Stage 1 menu measures/exclusions were not supported:

Drug Formulary Checks Measure/Exclusion

Federal regulations state: "*Stage 1 menu set criteria for EPs.* An EP must meet five of the following objectives and associated measures, one of which must be either paragraph (e)(9) or (e)(10) of this section, except that the required number of objectives and associated measures is reduced by an EP's paragraph (a)(2) of this section exclusions specified in this paragraph: (1)(i) Objective. Implement drug-formulary checks. (ii) Measure. The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period. (iii) Exclusion in accordance with paragraph (a)(2) of this section. Any EP who writes fewer than 100 prescriptions during the EHR reporting period." *42 CFR § 495.6(e)(1)*

Patient Lists Generated By Conditions Measure

Federal regulations state: "*Stage 1 menu set criteria for EPs.* An EP must meet five of the following objectives and associated measures, one of which must be either paragraph (e)(9) or (e)(10) of this section, except that the required number of objectives and associated measures is reduced by an EP's paragraph (a)(2) of this section exclusions specified in this paragraph: (3)(i) Objective. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach. (ii) Measure. Subject to paragraph (c) of this section, generate at least one report listing patients of the EP with a specific condition."

42 CFR § 495.6(e)(3)

Immunization Registries Data Submission Measure/Exclusion

Federal regulations state: "*Stage 1 menu set criteria for EPs.* An EP must meet five of the following objectives and associated measures, one of which must be either paragraph (e)(9) or (e)(10) of this section, except that the required number of objectives and associated measures is reduced by an EP's paragraph (a)(2) of this section exclusions specified in this paragraph: (9)(i) Objective. Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice. (ii) Measure. Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically). (iii) Exclusion in accordance with paragraph (a)(2) of this section. An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically."

42 CFR § 495.6(e)(9)

PROVIDER RIGHTS

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

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

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

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the Final Audit Report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

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

You have the right to challenge these findings by requesting an administrative hearing. Issues you may raise shall be limited to those issues relating to determinations contained in the Final Audit Report. You may only request a hearing to challenge specific audit adjustments which you challenged in a response to the Draft Audit Report. Your hearing request may not address issues regarding the methodology used to determine any rate of payment or fee.

At the hearing you have the right to:

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

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, New York 12204

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

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

If you have any questions regarding the above, please contact [redacted] Thank you for your cooperation.

[redacted]

Division of Medicaid Audit
Office of the Medicaid Inspector General

[redacted]

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE
Dr. Gabriel L. Dassa
7 Carlton Drive
Mount Kisco, New York 10549

PROVIDER ID # [redacted]

AUDIT # 16-1172

AUDIT TYPE
[ ] PROVIDER
[ ] RATE
[ ] PART B
[X] OTHER

AMOUNT DUE: $8,500

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 Audit #** 16-1172HIT
4. **Mail check to:**

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

Thank you for your cooperation.