



**Office of the  
Medicaid Inspector  
General**

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

**REVIEW OF HUDSON MOHAWK RECOVERY CENTER  
CLAIMS FOR OASAS CHEMICAL DEPENDENCE OUTPATIENT SERVICES  
PAID FROM  
JULY 1, 2009 – JUNE 30, 2011**

**FINAL AUDIT REPORT  
AUDIT #: 15-2808**

**Dennis Rosen  
Medicaid Inspector General**

**December 14, 2015**



Office of the  
Medicaid Inspector  
General

**ANDREW M. CUOMO**  
Governor

**DENNIS ROSEN**  
Medicaid Inspector General

December 14, 2015

[REDACTED]

Hudson Mohawk Recovery Center, Inc.  
1724 Fifth Avenue  
Troy, New York 12180-3320

Re: Final Audit Report  
Audit #: 15-2808  
Provider ID #: [REDACTED]  
NPI #: [REDACTED]

Dear [REDACTED]:

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Hudson Mohawk Recovery Center, Inc.'s" (Provider) paid claims for OASAS chemical dependence outpatient services covering the period July 1, 2009, through June 30, 2011.

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 October 20, 2015. The adjusted mean point estimate overpaid is \$170,898. The adjusted lower confidence limit of the amount overpaid is \$87,207. 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 \$87,207.

[REDACTED]  
Page 2  
December 14, 2015

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED] Please refer to report number 15-2808 in all correspondence.

Sincerely,

[REDACTED]

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

[REDACTED]  
Enclosure

CERTIFIED MAIL # [REDACTED]  
RETURN RECEIPT REQUESTED

[REDACTED]

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

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

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

### **DIVISION OF MEDICAID AUDIT**

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

### **DIVISION OF MEDICAID INVESTIGATIONS**

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

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

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

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

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

## EXECUTIVE SUMMARY

### BACKGROUND

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

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 chemical dependence outpatient services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to OASAS chemical dependence outpatient service claims, this audit covered services paid by Medicaid from July 1, 2009, through June 30, 2011.

### SUMMARY OF FINDINGS

We inspected a random sample of 100 services with \$6,815.38 in Medicaid payments. Of the 100 services in our random sample, 33 services had at least one error and did not comply with state requirements. Of the 33 noncompliant services, some contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Missing Discharge Summary	14
Missing Discharge Plan	7
No Service Provided	6
Missing Services Schedule	3
Missing Level of Care Determination	3
Missing Comprehensive Evaluation	3
Improper Billing for Outpatient Rehabilitation Services	1

Incorrect Rate Code Billed	1
Group Counseling Patient Limit Exceeded	1
Excessive Preadmission Visits	1
Missing Physician Signature on Treatment Plan	1
Missing Treatment Plan Review	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$2,182.20 in sample overpayments with an extrapolated adjusted point estimate of \$170,898. The adjusted lower confidence limit of the amount overpaid is \$87,207.

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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 chemical dependence outpatient services 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 Chemical Dependence Outpatient 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 chemical dependence outpatient 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 chemical dependence outpatient services paid by Medicaid from July 1, 2009, through June 30, 2011. Our audit universe consisted of 24,203 claims totaling \$1,650,385.

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 chemical dependence outpatient program;
- ran computer programming application of claims in our data warehouse that identified 24,203 paid OASAS chemical dependence outpatient service claims, totaling \$1,650,385;
- selected a random sample of 100 services from the population of 24,203 services; and,
- estimated the overpayment paid in the population of 24,203 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 October 20, 2015. The attached Bridge Schedule (Attachment D) indicates any changes to the findings as a result of your response.

## AUDIT FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from July 1, 2009, through June 30, 2011 identified 33 claims with at least one error, for a total sample overpayment of \$2,182.20 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated October 20, 2015. Appropriate adjustments were made to the findings.

### 1. Missing Discharge Summary

Regulations state, "A summary which includes the course and results of care and treatment, must be prepared and included in each patient's record within 45 days of discharge."

*14 NYCRR Section 822.4(y)*

In 14 instances pertaining to 14 recipients, a summary was not completed. This finding applies to Sample #'s 1, 16, 21, 33, 35, 36, 46, 47, 57, 63, 66, 67, 90, and 93.

### 2. Missing Discharge Plan

Regulations state, "The discharge planning process shall begin upon admission, be closely coordinated with the treatment plan, and be included in the patient record."

*14 NYCRR Section 822.4(u)*

Regulations also state, "A discharge plan shall be developed in collaboration with the patient and any significant other(s) the patient chooses to involve."

*14 NYCRR Section 822.4(v)*

In 7 instances pertaining to 6 recipients, a discharge plan was not completed. This finding applies to Sample #'s 2, 4, 17, 28, 72, 77, and 87.

### 3. No Service Provided

Regulations state, "All occasions of service provided during a visit must be documented in the patient's treatment record."

*18 NYCRR Section 505.27(b)(5)*

Furthermore, "The content and/or outcome of all visits must be fully documented in the individual patient or significant other's treatment record."

*14 NYCRR Section 822.11(f)*

In 6 instances pertaining to 5 recipients, the patient record did not document that a service was provided. This finding applies to Sample #'s 23, 38, 54, 57, 81, and 97.

### 4. Missing Services Schedule

Regulations state, "The treatment plan shall: (6) include schedules for the provision of all services prescribed to the patient and their significant others as appropriate;"

*14 NYCRR Section 822.4(l)(6)*

In 3 instances pertaining to 2 patients, the individual treatment plans did not contain the required schedule for the provision of services prescribed to the patient. This finding applies to Sample #'s 23, 38, and 55.

**5. Missing Level of Care Determination**

Regulations state, "If an individual is determined to be appropriate for chemical dependence services, a level of care determination shall be made ... . The level of care determination shall be signed and dated by the clinical staff member [and] shall be made promptly and in no event not later than after two visits to the service, or after two weeks for minors."  
*14 NYCRR Section 822.3(c)*

Regulations also state, "The level of care determination process must ... incorporate the use of an Office approved protocol."  
*14 NYCRR Section 822.3(d)*

In 3 instances pertaining to 2 patients, the medical record did not contain a level of care determination signed and dated within two visits to the service, or two weeks for minors. This finding applies to Sample #'s 23, 38, and 47.

**6. Missing Comprehensive Evaluation**

Regulations state, "Within two weeks of admission, staff shall complete the patient's comprehensive evaluation ...."  
*14 NYCRR Section 822.4(a)(4)*

In 3 instances pertaining to 2 patients, a comprehensive evaluation for the patient was not found. This finding applies to Sample #'s 23, 38, and 47.

**7. Improper Billing for Outpatient Rehabilitation Services**

Regulations state, "A patient receiving outpatient rehabilitation services shall typically be scheduled for services three to five days per week for at least four hours per day."  
*14 NYCRR Section 822.2(g)*

In 1 instance, outpatient rehabilitation services lasting less than 2 hours were billed. In 1 instance, a half day billing was disallowed where services were less than 2 hours. This finding applies to Sample # 2.

**8. Incorrect Rate 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 1 instance, the incorrect rate code was billed which resulted in higher reimbursement than indicated in the fee schedule for the proper rate code. This finding applies to Sample # 10.

**9. Group Counseling Patient Limit Exceeded**

Regulations state, "Each outpatient service must directly provide the following: group counseling (containing no more than 15 persons.)"

*14 NYCRR Section 822.2(c)(2)*

In 1 instance, the maximum number of patients allowed for group counseling services was exceeded. This finding applies to Sample # 18.

**10. Excessive Preadmission Visits**

Regulations state, "There shall be no more than two visits per patient and/or significant other prior to admission to an outpatient service."

*14 NYCRR Section 822.11(i)*

In 1 instance, more than two preadmission visits were billed. This finding applies to Sample # 30.

**11. Missing Physician Signature on Treatment Plan**

Regulations state, "The treatment plan shall ... be reviewed, approved, signed and dated by the medical director or other physician employed by the service within seven days of review and approval by the multidisciplinary team."

*14 NYCRR Section 822.4(l)(10)*

In 1 instance, the treatment plan lacked the required physician signature. This finding applies to Sample # 32.

**12. 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 ..."

*14 NYCRR Section 822.4(n)*

In 1 instance, the required treatment plan review was not completed. This finding applies to Sample # 43.

## PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the adjusted lower confidence limit amount of \$87,207, one of the following repayment options must be selected within 20 days from the date of this letter:

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

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
File #15-2808  
Albany, New York 12237

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

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

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 the OMIG would seek and defend the adjusted point estimate of \$170,898. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

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

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

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

At the hearing you have the right to:

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

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

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

**NAME AND ADDRESS OF AUDITEE**

[REDACTED]  
Hudson Mohawk Recovery Center, Inc.  
1724 Fifth Avenue  
Troy, New York 12180-3320

**PROVIDER ID #** [REDACTED]

**AUDIT #15-2808**

**AMOUNT DUE: \$87,207**

**AUDIT**

**PROVIDER**  
 **RATE**

**TYPE**

**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:

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
File #15-2808  
Albany, New York 12237

*Thank you for your cooperation.*

## **SAMPLE DESIGN**

The sample design used for Audit #15-2808 was as follows:

- Universe - Medicaid claims for OASAS chemical dependence outpatient services paid during the period July 1, 2009, through June 30, 2011.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for OASAS chemical dependence outpatient services paid during the period July 1, 2009, through June 30, 2011.
- Sample Unit - The sample unit is a Medicaid claim paid during the period July 1, 2009 through June, 30 2011.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 services.

### SAMPLE RESULTS AND ESTIMATES

Universe Size	24,203
Sample Size	100
Sample Value	\$ 6,815.38
Sample Overpayments	\$ 2,182.20
Confidence Level	90%

#### Extrapolation of Sample Findings

Sample Overpayments	\$ 2,182.20
<b>Less Overpayments Not Extrapolated*</b>	<u>(1,482.22)</u>
Sample Overpayments for Extrapolation Purposes	\$ 699.98
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	\$ 6.9998
Universe Size	24,203
Point Estimate of Total Dollars	\$ 169,416
<b>Add Overpayments Not Extrapolated*</b>	<u>1,482</u>
Adjusted Point Estimate of Totals Dollars	<u>\$ 170,898</u>
Lower Confidence Limit	\$ 85,725
<b>Add Overpayments Not Extrapolated*</b>	<u>1,482</u>
Adjusted Lower Confidence Limit	<u>\$ 87,207</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 #2 – Missing Discharge Plan**
- **Finding #4 – Missing Services Schedule**
- **Finding #5 – Missing Level of Care Determination**
- **Finding #6 – Missing Comprehensive Evaluation**
- **Finding #10 – Excessive Preadmission Visits**

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









ATTACHMENT D

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

HUDSON MOHAWK RECOVERY CENTER  
 OASAS CHEMICAL DEPENDENCE OUTPATIENT SERVICES AUDIT  
 AUDIT #15-2808  
 AUDIT PERIOD: 7/1/2009 - 6/30/2011

BRIDGE SCHEDULE

SAMPLE #	FINDING	DRAFT REPORT AMOUNT DISALLOWED	FINAL REPORT AMOUNT DISALLOWED	CHANGE
10	Improper Billing for Outpatient Rehabilitation Services	\$73.67	\$9.18	(\$64.49)
TOTALS		<u>\$73.67</u>	<u>\$9.18</u>	<u>(\$64.49)</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.