Office of the
Medicaid Inspector
General

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF UNITED CEREBRAL PALSY ASSOCIATION OF PUTNAM & SOUTHERN DUTCHESS CLAIMS FOR OPWDD DAY HABILITATION SERVICES PAID FROM JANUARY 1, 2009 – DECEMBER 31, 2011

FINAL AUDIT REPORT
AUDIT #: 13-5288

Dennis Rosen
Medicaid Inspector General

July 2, 2015

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

July 2, 2015

[redacted]
United Cerebral Palsy Association of
Putnam & Southern Dutchess
40 Jon Barrett Road
Patterson, New York 12563-2164

Re: Final Audit Report
Audit #: 13-5288
Provider ID #: [redacted]
FEIN: [redacted]

Dear [redacted]:

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of United Cerebral Palsy Association of Putnam & Southern Dutchess" (Provider) paid claims for OPWDD day habilitation services covering the period January 1, 2009, through December 31, 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 March 3, 2015. The mean point estimate overpaid is $1,074,917. The lower confidence limit of the amount overpaid is $626,409. 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 $626,409.

If the Provider has any questions or comments concerning this final audit report, please contact at or through email at . Please refer to report number 13-5288 in all correspondence.

Sincerely

Division of Medicaid Audit, White Plains
Office of the Medicaid Inspector General

Enclosure

CERTIFIED MAIL #
RETURN RECEIPT REQUESTED

cc:

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.

People with developmental disabilities can enjoy meaningful relationships with family, friends and other people in their lives, experience personal health and growth, live in the home of their choice and fully participate in their communities. People with developmental disabilities may have difficulty learning as quickly as others, expressing themselves clearly, or taking care of their physical needs. But it is difficult to define the limits of people with developmental disabilities; what they need most, therefore, is not only encouragement and understanding – but an opportunity to become part of the community they live in. This is where the significance of the Home and Community Based Services (HCBS) waiver has its greatest impact. In providing residential habilitation services, the HCBS waiver helps people achieve a functional connection to supports and services in the person's residence.

Outpatient services provided to persons with developmental disabilities are offered at programs licensed by the Office for People With Developmental Disabilities (OPWDD). The purpose of these programs is to offer a comprehensive system of services, which has as its primary purpose the promotion and attainment of independence, inclusion, and productivity for persons with mental retardation and developmental disabilities. These services are furnished at clinic and day treatment facilities and through a home and community based Federal waiver program. The waiver program, established under the authority of section 1915 [c] of the Social Security Act, is intended for persons with mental retardation and developmental disabilities who would otherwise need the level of care provided in an intermediate care facility. The specific standards and criteria for OPWDD services are outlined in Title 14 NYCRR Parts 635, 671, 679, and 690.

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OPWDD day habilitation services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to OPWDD day habilitation services, this audit covered services paid by Medicaid from January 1, 2009, through December 31, 2011.

SUMMARY OF FINDINGS

We inspected a random sample of 100 services with $16,738.96 in Medicaid payments. Of the 100 services in our random sample, 14 services had at least one error and did not comply with state requirements. Of the 14 noncompliant services, some contained more than one deficiency. Specifics are as follows:

Error Description	Number of Errors
Missing Day Habilitation Monthly Summary Note	6
Staff Member Delivering the Day Habilitation Service Absent on Date of Service	6
Missing Day Habilitation Service Documentation (Group/Supplemental Group)	5
Missing Required Elements of the Day Habilitation Plan	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid $2,426.12 in sample overpayments with an extrapolated point estimate of $1,074,917. The lower confidence limit of the amount overpaid is $626,409.

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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 OPWDD day habilitation 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 OPWDD Day Habilitation Program

Outpatient services provided to persons with developmental disabilities are offered at programs licensed by the Office for People With Developmental Disabilities (OPWDD). The purpose of these programs is to offer a comprehensive system of services, which has as its primary purpose the promotion and attainment of independence, inclusion, and productivity for persons with mental retardation and developmental disabilities. These services are furnished at clinic and day treatment facilities and through a home and community based Federal waiver program. The waiver program, established under the authority of section 1915 [c] of the Social Security Act, is intended for persons with mental retardation and developmental disabilities who would otherwise need the level of care provided in an intermediate care facility. The specific standards and criteria for OPWDD services are outlined in Title 14 NYCRR Parts 635, 671, 679, and 690.

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OPWDD day habilitation 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 OPWDD day habilitation services paid by Medicaid from January 1, 2009, through December 31, 2011. Our audit universe consisted of 44,306 claims totaling $7,510,900.67.

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 OPWDD day habilitation service program;
- ran computer programming application of claims in our data warehouse that identified 44,306 paid OPWDD day habilitation service claims, totaling $7,510,900.67;
- selected a random sample of 100 services from the population of 44,306 services; and,
- estimated the overpayment paid in the population of 44,306 services.

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

- Medicaid electronic claim information

- Patient record, including, but not limited to:
  - Level of Care/Diagnosis,
  - Individualized Service Plans
  - Day Habilitation Plans/Reviews,
  - Daily and Monthly Summary Notes
  - Bus Logs for Date of Service
  - Staff Time Sheets/Payroll for the Dates of Service

- Any additional documentation deemed by the Provider necessary to substantiate the Medicaid paid claim

LAWS, REGULATIONS, RULES AND POLICIES

The following are applicable Laws, Regulations, Rules and Policies of the Medicaid program referenced when conducting this audit:

- Departments of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].

- Medicaid Management Information System and eMedNY Provider Manual.

- Specifically, Title 18 NYCRR Section 540.6 and OPWDD Administrative memorandum #2003-03 and #2006-01.

- 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 March 3, 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 January 1, 2009, through December 31, 2011, identified 14 claims with at least one error, for a total sample overpayment of $2,426.12 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated March 3, 2015. Appropriate adjustments were made to the findings.

1. Missing Day Habilitation Monthly Summary Note

OPWDD Administrative Memorandum #2003-03 states, ". . . at least monthly, . . . a narrative note is written that: a) summarizes the implementation of person's Habilitation Plan, b) addresses the person's response to the services provided, ...".

OPWDD Administrative Memorandum #2003-03, p. 4

OPWDD Administrative Memorandum #2006-01 and #2006-02 both state that if a checklist or chart format is used "....a monthly summary note is also required." If a [daily service] narrative note format is used and the daily note does not include the consumer's response to the service, a monthly summary note is required.

OPWDD Administrative Memorandum #2006-01, p. 5
OPWDD Administrative Memorandum #2006-02, p. 6

In 6 instances pertaining to 4 recipients, the required monthly summary note was not available for review. This finding applies to Sample #'s 17, 23, 29, 37, 89 and 97.

2. Staff Member Delivering the Day Habilitation Service Absent on Date of Service

OPWDD Administrative Memorandum #2006-01 states, "Group Day Habilitation and Supplemental Group Day Habilitation services are billed as either a Full Unit or a Half Unit. A Full Unit may be billed when staff deliver and document at least two individualized face-to-face Group Day Habilitation services to a consumer during the program day, and the program day duration is four to six hours in duration. A Half Unit of Group Day Habilitation or Supplemental Group Day Habilitation may be billed when staff deliver and document at least one individualized face-to-face Group Day Habilitation service to a consumer during the program day, and the program day duration is at least two hours."

OPWDD Administrative Memorandum #2006-01, p. 3

In 6 instances pertaining to 6 recipients, the agency's time and attendance records indicated that the staff member delivering the day habilitation service was absent for the date of service. This finding applies to Sample #'s 6, 19, 64, 76, 77 and 87.

3. Missing Day Habilitation Service Documentation (Group/Supplemental Group)

Regulations state, "Unit of service for reimbursement of group day habilitation and supplemental group day habilitation...(a) The agency may bill a full unit of service when the agency delivers and documents at least two face-to-face services delivered in accordance with the individual's day habilitation plan and provides a program day duration of four to six hours ...(b) The agency may bill a half unit of service when the agency delivers and documents at least one face-to-face service delivered in

accordance with the individual's day habilitation plan and provides a program day duration of at least two hours."

14 NYCRR Section 635-10.5 (c)(6)(i)(a) and (b)

OPWDD Administrative Memorandum #2006-01 states, "...services are billed as either a Full Unit or a Half Unit. A Full Unit may be billed when staff deliver and document at least two individualized face-to-face Group Day Habilitation services to a consumer during the program day, and the program day duration is four to six hours in duration. A Half Unit of Group Day Habilitation or Supplemental Group Day Habilitation may be billed when staff deliver and document at least one individualized face-to-face Group Day Habilitation service to a consumer during the program day, and the program day duration is at least two hours."

OPWDD Administrative Memorandum #2006-01, p. 3

In 5 instances pertaining to 4 recipients, a group or supplemental group day habilitation service was not documented. This finding applies to Sample #'s 23, 29, 37, 96 and 98.

4. **Missing Required Elements of the Day Habilitation Plan**

Regulations state: "If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation *[5/26/10 and after]*, supported employment, pre-vocational services), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider. The service coordinator shall attach the relevant habilitation plan(s) to the ISP."

For services prior to 8/01/07, 14 NYCRR Section 635-99.1(bf)
For services 8/1/07 to 12/31/07, 14 NYCRR Section 635-99.1(bi)
For services 1/1/08 to 1/31/09, 14 NYCRR Section 635-99.1(bg)
For services 2/01/09 to 5/31/10, 14 NYCRR Section 635-99.1(bi)
For services 6/01/10 to 1/24/12, 14 NYCRR Section 635-99.1(bj)
For services 1/25/12 and after, 14 NYCRR Section 635-99.1(bk)

OPWDD Administrative Memorandum #2003-03 states, "**The Habilitation Plan Must Contain the Following Seven Elements:**

1. The person's **(a) name and (b) Medicaid Identification Number (CIN),** if the person is a Medicaid enrollee.
2. The **Habilitation Service Provider agency name and type of Habilitation Service provided . . .**
3. The **date on which the Habilitation Plan was last reviewed. . . .**
4. The person's **valued outcome(s)** that will be addressed through the Habilitation Service. . . .
5. A description of the **services and supports** the Habilitation Service Provider staff will provide to the person. . . .
6. The **safeguards** (health and welfare) that will be provided by the Habilitation Service Provider. . . .
   a. Safeguards for persons receiving IRA Residential Habilitation are addressed in the individual's Plan of Protective Oversight in accord with 14 NYCRR Section 686.16. The individual's Plan of Protective Oversight is *attached* to the IRA Residential Habilitation Plan.
   b. For all other Habilitation Services . . .
   c. As required in 14 NYCRR Part 633, the medication records stand-alone from the Habilitation Plan.

d. Providers of residential habilitation . . . must have written procedures for providing back-up supports to consumers when the absence of the provider's regularly scheduled staff would pose a serious threat to the person's health or safety.

7. The **printed name, signature and title** of the person who wrote the Habilitation Plan and the **date** it was written or revised."

OPWDD Administrative Memorandum #2003-03, pp. 2-4

In 1 instance, one or more required elements were missing in the day habilitation plan. The printed name, signature or title of the person who wrote the day habilitation plan was missing. This finding applies to Sample # 76.

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 lower confidence limit amount of $626,409, 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 #13-5288
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
Phone #: [redacted]
Fax#: [redacted]

If you choose not to settle this audit through repayment of the lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of $1,074,917. 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]

United Cerebral Palsy Assocation
of Putnam & Southern Dutchess
40 Jon Barrett Road
Patterson, New York 12563-2164

AMOUNT DUE: $626,409

PROVIDER ID # [redacted]

AUDIT #13-5288

AUDIT TYPE	[X] 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:**

[redacted]

New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #13-5288
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN

The sample design used for Audit #13-5288 was as follows:

- Universe - Medicaid claims for OPWDD day habilitation services paid during the period January 1, 2009, through December 31, 2011.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for OPWDD day habilitation services paid during the period January 1, 2009, through December 31, 2011.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2009, through December 31, 2011.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 services.

Attachment B

SAMPLE RESULTS AND ESTIMATES

Universe Size	44,306
Sample Size	100
Sample Value	$ 16,738.96
Sample Overpayments	$ 2,426.12
Net Financial Error Rate	14.5%
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	$ 2,426.12
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	$ 24.2612
Universe Size	44,306
Point Estimate of Total Dollars	$ 1,074,917
Lower Confidence Limit	$ 626,409