



**Office of the  
Medicaid Inspector  
General**

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

**REVIEW OF PHOENIX MEDICAL CENTER, INC.  
CLAIMS FOR DIAGNOSTIC AND TREATMENT CENTER SERVICES  
PAID FROM  
JANUARY 1, 2004 – DECEMBER 31, 2006**

**FINAL AUDIT REPORT  
AUDIT #: 07-4581**

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**Dennis Rosen  
Medicaid Inspector General**

**March 15, 2016**



Office of the  
Medicaid Inspector  
General

ANDREW M. CUOMO  
Governor

DENNIS ROSEN  
Medicaid Inspector General

March 15, 2016

[REDACTED]  
Phoenix Medical Center, Inc.  
29 Steven Lane  
Great Neck, New York 11024

Re: Final Audit Report  
Audit #: 07-4581  
Provider ID #: [REDACTED]  
NPI #: [REDACTED]

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Phoenix Medical Center, Inc." (Provider) paid claims for Diagnostic and Treatment Center services covering the period January 1, 2004, through December 31, 2006.

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 revised draft audit report dated August 21, 2015. The mean point estimate overpaid is \$1,299,355. The lower confidence limit of the amount overpaid is \$899,041. 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 \$899,041.

[REDACTED]  
Page 2  
March 15, 2016

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED] at [REDACTED] or through email at [REDACTED]. Please refer to report number 07-4581 in all correspondence.

Sincerely,

[REDACTED]  
Division of Medicaid Audit, New York City  
Office of the Medicaid Inspector General

[REDACTED]  
Enclosure

CERTIFIED MAIL # [REDACTED]  
RETURN RECEIPT REQUESTED

cc: [REDACTED]

Ver-5.2

## **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.

A diagnostic and treatment center is a medical facility with one or more health services which is not part of an inpatient hospital facility or vocational rehabilitation center. It is primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician or dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition. A diagnostic and treatment center is certified in accordance with Article 28 of the NYS Public Health Law and/or Article 31 of the Mental Hygiene Law to provide such services on an outpatient basis. The specific standards and criteria for diagnostic and treatment center services are principally found in various parts of 10 NYCRR Chapter V and 18 NYCRR Chapter II, as well as the MMIS Provider Manual for Clinics.

### PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for Diagnostic and Treatment Center services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to Diagnostic and Treatment Center claims, this audit covered services paid by Medicaid from January 1, 2004, through December 31, 2006.

### SUMMARY OF FINDINGS

We inspected a random sample of 100 services each for the years 2004, 2005 and 2006 with \$40,473.71 in Medicaid payments. Of the 300 services in our random sample, 67 services had at least one error and did not comply with state requirements. Of the 67 noncompliant services, none contained more than one deficiency. Specifics are as follows:

<u>2004 Error Description</u>	<u>Number of Errors</u>
Threshold Visit Billed for Non-Reimbursable Service	19
Missing Documentation	3
Threshold Visit Billed for Follow-up Service	2

  

<u>2005 Error Description</u>	<u>Number of Errors</u>
Threshold Visit Billed for Non-Reimbursable Service	15
Threshold Visit Billed for Follow-up Service	3

<u>2006 Error Description</u>	<u>Number of Errors</u>
Threshold Visit Billed for Non-Reimbursable Service	21
Threshold Visit Billed for Follow-up Service	3
Missing Documentation	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$9,078.78 in sample overpayments with an extrapolated point estimate of \$1,299,355. The lower confidence limit of the amount overpaid is \$899,041.

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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 Diagnostic and Treatment Center 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 Diagnostic and Treatment Center Program

A diagnostic and treatment center is a medical facility with one or more health services which is not part of an inpatient hospital facility or vocational rehabilitation center. It is primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician or dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition. A diagnostic and treatment center is certified in accordance with Article 28 of the NYS Public Health Law and/or Article 31 of the Mental Hygiene Law to provide such services on an outpatient basis. The specific standards and criteria for diagnostic and treatment center services are principally found in various parts of 10 NYCRR Chapter V and 18 NYCRR Chapter II, as well as the MMIS Provider Manual for Clinics.

### PURPOSE, SCOPE, AND METHODOLOGY

#### Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for Diagnostic and Treatment Center 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 Diagnostic and Treatment Center services paid by Medicaid from January 1, 2004, through December 31, 2006. Our audit universe consisted of 42,783 claims totaling \$5,759,120.17. Universe and sample information is as follows:

<u>Audit Years</u>	<u>Sample</u>		<u>Universe</u>	
	<u>Services</u>	<u>Dollars Paid</u>	<u>Services</u>	<u>Dollars Paid</u>
1/1/2004 – 12/31/2004	100	\$13,413.71	17,550	\$2,345,112.63
1/1/2005 – 12/31/2005	100	\$13,527.00	13,289	\$1,798,812.58
1/1/2006 – 12/31/2006	<u>100</u>	<u>\$13,533.00</u>	<u>11,944</u>	<u>\$1,615,194.96</u>
Totals	300	\$40,473.71	42,783	\$5,759,120.17

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 Diagnostic and Treatment Center services program;
- ran computer programming application of claims in our data warehouse that identified paid Diagnostic and Treatment Center claims, as indicated above;
- selected a random sample of 100 services each year for the years 2004, 2005 and 2006 from the population of services as indicated above; and,
- estimated the overpayment paid for each year in the population of services, as indicated above.

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

- Medicaid electronic claim information
- Patient record, including, but not limited to:
  - Progress Notes
  - Orders for Rehabilitative Services
  - Labs and X-ray reports
- 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.
- 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 Revised Draft Audit Report dated August 21, 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, 2004, through December 31, 2004, identified 24 claims with at least one error, for a total sample overpayment of \$3,251.16 (Attachment C-2004). The OMIG's review of Medicaid claims paid to the Provider from January 1, 2005, through December 31, 2005, identified 18 claims with at least one error, for a total sample overpayment of \$2,433.12 (Attachment C-2005). The OMIG's review of Medicaid claims paid to the Provider from January 1, 2006, through December 31, 2006, identified 25 claims with at least one error, for a total sample overpayment of \$3,394.50 (Attachment C-2006). This audit report incorporates consideration of any additional documentation and information presented in response to the Revised Draft Audit Report dated August 21, 2015. Appropriate adjustments were made to the findings.

#### 1. Threshold Visit Billed for Non-Reimbursable Service

Regulations state:

“(c) The following shall not constitute threshold visits within the meaning of subdivisions (a) and (b) of this section:

- (1) visits solely for the purpose of receiving ordered ambulatory services;
- (2) visits solely for the purpose of receiving pharmacy services;
- (3) visits solely for the purpose of receiving nutrition services;
- (4) visits solely for the purpose of receiving respiratory therapy;
- (5) visits solely for the purpose of receiving recreation therapy;
- (6) visits solely for the purpose of receiving medical social services, except for clinical social worker psychotherapy services as defined in subdivision (g) of this section;
- (7) visits solely for the purpose of receiving group services, except for clinical group psychotherapy services in accordance with the provisions of subdivision (h) of this section;
- (8) offsite services, defined as medical services provided by a facility's clinic staff at locations other than those operated by and under the licensure of the facility, or visits related to the provision of such offsite services, except in accordance with the provisions of subdivision (i) of this section.”

*10 NYCRR Section 86-4.9(c)*

For audit year 2004, in 19 instances pertaining to 18 patients, a threshold visit was incorrectly billed. For 17 of these instances pertaining to 16 patients, a threshold visit was incorrectly billed for pharmacy services. This finding applies to Sample #'s 7, 14, 18, 19, 22, 23, 35, 41, 50, 58, 75, 76, 78, 81, 87, 89 and 97. For 2 of these instances pertaining to 2 patients, a threshold visit was incorrectly billed for medical social services. This finding applies to Sample #'s 39 and 65.

For audit year 2005, in 15 instances pertaining to 15 patients, a threshold visit was incorrectly billed. For 12 of these instances pertaining to 12 patients, a threshold visit was incorrectly billed for pharmacy services. This finding applies to Sample #'s 6, 9, 12, 27, 30, 36, 41, 51, 53, 70, 78 and 91. For 3 of these instances pertaining to 3 patients, a threshold visit was incorrectly billed for medical social services. This finding applies to Sample #'s 8, 32 and 54.

For audit year 2006, in 21 instances pertaining to 21 patients, a threshold visit was incorrectly billed. For 19 of these instances pertaining to 19 patients, a threshold visit was incorrectly billed to pharmacy services. This finding applies to Sample #'s 2, 5, 11, 16, 17, 21, 24, 33, 36, 39, 46, 56, 66, 67, 69, 76, 98, 99, and 100. For 2 of these instances pertaining to 2 patients, a threshold visit was incorrectly billed to medical social services. This finding applies to Sample #'s 42 and 53.

## **2. Threshold Visit Billed for Follow-up Service**

Medicaid policy states: "When a Medicaid-eligible patient receives treatment during a threshold clinic visit which cannot be completed due to administrative or scheduling problems, the Article 28 facility may not bill additional clinic visits for completion of the service. For example, the completion of clinical laboratory tests or x-rays, the results of which are interpreted on a day subsequent to the patient's initial threshold visit, do not qualify for reimbursement unless the patient is seen for purposes of discussing the finding and for definitive treatment planning."

*MMIS Policy Guidelines Manual for Article 28  
Certified Clinics, Version 2007-2, Section I;  
Version 2007-1, Section I*

For audit year 2004, in 2 instances pertaining to 2 patients, a threshold visit was billed for a visit that was completing the services initiated at an earlier visit. This finding applies to Sample #'s 62 and 95.

For audit year 2005, in 3 instances pertaining to 3 patients, a threshold visit was billed for a visit that was completing the services initiated at an earlier visit. This finding applies to Sample #'s 22, 23 and 80.

For audit year 2006, in 3 instances pertaining to 3 patients, a threshold visit was billed for a visit that was completing the services initiated at an earlier visit. This finding applies to Sample #'s 47, 57 and 74.

## **3. Missing Documentation**

Regulations require that the Medicaid provider agrees, "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years . . . all records necessary to disclose the nature and extent of services furnished. . ."

*18 NYCRR Section 504.3(a)*

Regulations also require that bills for medical care, services and supplies contain a certification that such records as are necessary to disclose fully the services provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years. These records must be furnished to the Department upon request.

*18 NYCRR Section 540.7(a)(8)*

Regulations further state: "All records necessary to disclose the nature and extent of services furnished and the medical necessity therefore . . . 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."

*18 NYCRR Section 517.3(b)(1)*

Regulations also state;

"The operator shall:

- (a) maintain a medical record system;
- (b) designate a staff member who has overall supervisory responsibility for the medical record system;
- (c) ensure that the medical record supervisor receives consultation from a qualified medical record practitioner when such supervisor is not a qualified medical record practitioner;
- (d) ensure that the medical record for each patient contains and centralizes all pertinent information which identifies the patient, justifies the treatment and documents the results of such treatment;
- (e) ensure that the following are included in the patient's record as appropriate:
  - (1) patient identification information;
  - (2) consent forms;
  - (3) medical history;
  - (4) immunization and drug history with special notation of allergic or adverse reactions to medications;
  - (5) physical examination reports;
  - (6) diagnostic procedures/tests reports;
  - (7) consultative findings;
  - (8) diagnosis or medical impression;
  - (9) medical orders;
  - (10) psychosocial assessment;

- (11) documentation of the services provided and referrals made;
- (12) anesthesia record;
- (13) progress note(s);
- (14) follow-up plans; and
- (15) discharge summaries, when applicable;

f) ensure that entries in the medical record are current, legible, signed and dated by the person making the entry;

(g) ensure that medical, social, personal and financial information relating to each patient is kept confidential and made available only to authorized persons;

(h) ensure that when a patient is treated by an outside health-care provider, and that treatment is relevant to the patient's care, a clinical summary or other pertinent documents are obtained to promote continuity of care. If documents cannot be obtained, the reason is noted in the medical record;

(i) maintain medical records at the center in a safe and secure place which can be locked and which is readily accessible to staff; and

(j) retain medical records for at least six years after the last date of service rendered to a patient or, in the case of a minor, for at least six years after the last date of service or three years after he/she reaches majority whichever time period is longer.

*10 NYCRR Section 751.7*

For audit year 2004, in 3 instances pertaining to 3 patients, the services were not documented. For 2 of these instances, no medical record was presented for review. This finding applies to Sample #'s 13 and 37. For the other 1 instance, the medical record did not contain the requested date of service. This finding applies to Sample # 17.

For audit year 2006, in 1 instance, the medical record did not contain the requested date of service. 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 lower confidence limit amount of \$899,041, 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 # 07-4581  
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 \$1,299,355. 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**

██████████  
Phoenix Medical Center, Inc.  
29 Steven Lane  
Great Neck, New York 11024

**PROVIDER ID #** ██████████

**AUDIT #07-4581**

**AMOUNT DUE: \$899,041**

<b>AUDIT</b>	<input checked="" type="checkbox"/> <b>PROVIDER</b>
	<input type="checkbox"/> <b>RATE</b>
<b>TYPE</b>	<input type="checkbox"/> <b>PART B</b>
	<input type="checkbox"/> <b>OTHER:</b>

**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  
File # 07-4581  
Albany, New York 12237

*Thank you for your cooperation.*

## **SAMPLE DESIGN**

The sample design used for Audit # 07-4581 was as follows:

- Universe - Medicaid claims for Diagnostic and Treatment Center services paid during the period January 1, 2004, through December 31, 2006.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for Diagnostic and Treatment Center services paid during the period January 1, 2004, through December 31, 2006.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2004, through December 31, 2006.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 services each for the years 2004, 2005 and 2006.

**SAMPLE RESULTS AND ESTIMATES**

	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>Total</u>
Universe Size	17,550	13,289	11,944	42,783
Sample Size	100	100	100	300
Sample Value	\$ 13,413.71	\$ 13,527.00	\$ 13,533.00	\$ 40,473.71
Sample Overpayments	\$ 3,251.16	\$ 2,433.12	\$ 3,394.50	\$ 9,078.78
Confidence Level	90%	90%	90%	90%

**Extrapolation of Sample Findings**

Sample Overpayments	\$ 3,251.16	\$ 2,433.12	\$ 3,394.50	\$ 9,078.78
Sample Size	100	100	100	300
Mean Dollars in Error for Extrapolation Purposes	\$ 32.5116	\$ 24.3312	\$ 33.9450	
Universe Size	17,550	13,289	11,944	42,783
Point Estimate of Total Dollars	\$ 570,579	\$ 323,337	\$ 405,439	\$ 1,299,355
Lower Confidence Limit	\$ 401,652	\$ 208,627	\$ 288,762	\$ 899,041

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 PHOENIX MEDICAL CENTER, INC.  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 07-4581  
 REVIEW PERIOD: 1/1/2004 - 12/31/2004

Sample Number	Date of Service	Rate Code		Amount		Overpayment	DETAILED AUDIT FINDINGS		
		Billed	Derived	Paid	Derived		1. Threshold Visit Billed for Non-Reimbursable Services	2. Threshold Visit Billed for Follow-up Service	3. Missing Documentation
1	06/15/04	1610	1610	\$ 137.34	\$ 137.34	\$ -			
2	03/09/04	1610	1610	134.34	134.34	-			
3	12/23/03	1610	1610	134.34	134.34	-			
4	11/26/03	1610	1610	134.34	134.34	-			
5	03/04/04	1610	1610	137.34	137.34	-			
6	11/20/03	1610	1610	137.34	137.34	-			
7	12/01/03	1610		134.34	-	134.34	X		
8	05/01/04	1610	1610	134.34	134.34	-			
9	09/21/04	1610	1610	134.34	134.34	-			
10	07/07/04	1610	1610	134.34	134.34	-			
11	02/23/04	1610	1610	134.34	134.34	-			
12	02/14/04	1610	1610	134.34	134.34	-			
13	06/29/04	1610		134.34	-	134.34			X
14	07/08/04	1610		134.34	-	134.34	X		
15	11/19/04	1610	1610	134.34	134.34	-			
16	04/24/04	1610	1610	134.34	134.34	-			
17	03/23/04	1610		137.34	-	137.34			X
18	02/20/04	1610		137.34	-	137.34	X		
19	11/25/03	1610		134.34	-	134.34	X		
20	06/05/04	1610	1610	137.34	137.34	-			
21	05/20/04	1610	1610	134.34	134.34	-			
22	08/31/04	1610		137.34	-	137.34	X		
23	10/15/04	1610		134.34	-	134.34	X		
24	06/25/04	1610	1610	137.34	137.34	-			
25	05/06/04	1610	1610	134.34	134.34	-			

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 PHOENIX MEDICAL CENTER, INC.  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 07-4581  
 REVIEW PERIOD: 1/1/2004 - 12/31/2004

Sample Number	Date of Service	Rate Code		Amount		Overpayment	DETAILED AUDIT FINDINGS		
		Billed	Derived	Paid	Derived		1. Threshold Visit Billed for Non-Reimbursable Services	2. Threshold Visit Billed for Follow-up Service	3. Missing Documentation
26	10/01/04	1610	1610	\$ 137.34	\$ 137.34	\$ -			
27	07/28/04	1610	1610	134.34	134.34	-			
28	04/17/04	1610	1610	134.34	134.34	-			
29	06/24/04	1610	1610	134.34	134.34	-			
30	06/11/04	1610	1610	134.34	134.34	-			
31	05/12/04	1610	1610	134.34	134.34	-			
32	07/22/04	1610	1610	134.34	134.34	-			
33	06/08/04	1610	1610	134.34	134.34	-			
34	01/17/04	1610	1610	134.34	134.34	-			
35	08/16/04	1610		134.34	-	134.34	X		
36	03/20/04	1610	1610	134.34	134.34	-			
37	08/04/04	1610		134.34	-	134.34			X
38	09/09/04	1610	1610	134.34	134.34	-			
39	09/14/04	1610		134.34	-	134.34	X		
40	10/18/04	1610	1610	134.34	134.34	-			
41	11/07/03	1610		134.34	-	134.34	X		
42	02/03/04	1610	1610	134.34	134.34	-			
43	10/30/04	1610	1610	137.34	137.34	-			
44	12/11/04	1610	1610	134.34	134.34	-			
45	04/10/04	1610	1610	134.34	134.34	-			
46	10/09/04	1610	1610	134.34	134.34	-			
47	01/05/04	1610	1610	134.34	134.34	-			
48	02/02/04	1610	1610	134.34	134.34	-			
49	03/29/04	1610	1610	137.34	137.34	-			
50	03/03/04	1610		137.34	-	137.34	X		

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 PHOENIX MEDICAL CENTER, INC.  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 07-4581  
 REVIEW PERIOD: 1/1/2004 - 12/31/2004

Sample Number	Date of Service	Rate Code		Amount		Overpayment	DETAILED AUDIT FINDINGS		
		Billed	Derived	Paid	Derived		1. Threshold Visit Billed for Non-Reimbursable Services	2. Threshold Visit Billed for Follow-up Service	3. Missing Documentation
51	02/23/04	1610	1610	\$ 137.34	\$ 137.34	\$ -			
52	07/15/04	1610	1610	137.34	137.34	-			
53	09/07/04	1610	1610	134.34	134.34	-			
54	11/05/04	1610	1610	137.34	137.34	-			
55	07/17/04	1610	1610	134.34	134.34	-			
56	01/05/04	1610	1610	137.34	137.34	-			
57	03/11/04	1610	1610	137.34	137.34	-			
58	08/14/04	1610		137.34	-	137.34	X		
59	04/19/04	1610	1610	134.34	134.34	-			
60	09/22/04	1610	1610	137.34	137.34	-			
61	08/27/04	1610	1610	134.34	134.34	-			
62	08/28/04	1610		134.34	-	134.34		X	
63	10/06/04	1610	1610	137.34	137.34	-			
64	02/11/04	1610	1610	134.34	134.34	-			
65	05/21/04	1610		134.34	-	134.34	X		
66	02/14/04	1610	1610	134.34	134.34	-			
67	12/31/03	1610	1610	134.34	134.34	-			
68	10/22/04	1610	1610	137.34	137.34	-			
69	10/25/04	1610	1610	137.34	137.34	-			
70	09/07/04	1610	1610	134.34	134.34	-			
71	12/27/03	1610	1610	134.34	134.34	-			
72	06/07/04	1610	1610	134.34	134.34	-			
73	11/24/04	1610	1610	137.34	137.34	-			
74	12/29/03	1610	1610	134.34	134.34	-			
75	08/10/04	1610		134.34	-	134.34	X		

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 PHOENIX MEDICAL CENTER, INC.  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 07-4581  
 REVIEW PERIOD: 1/1/2004 - 12/31/2004

Sample Number	Date of Service	Rate Code		Amount		Overpayment	DETAILED AUDIT FINDINGS		
		Billed	Derived	Paid	Derived		1. Threshold Visit Billed for Non-Reimbursable Services	2. Threshold Visit Billed for Follow-up Service	3. Missing Documentation
76	03/02/04	1610		\$ 137.34	\$ -	\$ 137.34	X		
77	09/01/04	1610	1610	134.34	134.34	-			
78	05/27/04	1610		134.34	-	134.34	X		
79	04/03/03	1610	1610	9.05	9.05	-			
80	04/28/04	1610	1610	134.34	134.34	-			
81	09/10/04	1610		137.34	-	137.34	X		
82	02/02/04	1610	1610	137.34	137.34	-			
83	05/14/04	1610	1610	134.34	134.34	-			
84	10/22/04	1610	1610	137.34	137.34	-			
85	07/03/04	1610	1610	137.34	137.34	-			
86	04/08/04	1610	1610	134.34	134.34	-			
87	09/09/04	1610		137.34	-	137.34	X		
88	03/18/04	1610	1610	134.34	134.34	-			
89	04/10/04	1610		134.34	-	134.34	X		
90	12/23/03	1610	1610	137.34	137.34	-			
91	01/00/00	1610	1610	137.34	137.34	-			
92	04/30/04	1610	1610	134.34	134.34	-			
93	08/07/04	1610	1610	134.34	134.34	-			
94	01/02/04	1610	1610	137.34	137.34	-			
95	10/25/04	1610		137.34	-	137.34		X	
96	10/18/04	1610	1610	134.34	134.34	-			
97	12/29/03	1610		134.34	-	134.34	X		
98	10/15/04	1610	1610	137.34	137.34	-			
99	09/24/04	1610	1610	134.34	134.34	-			
100	04/17/04	1610	1610	137.34	137.34	-			
<b>Totals</b>				<b>\$ 13,413.71</b>	<b>\$ 10,162.55</b>	<b>\$ 3,251.16</b>	<b>19</b>	<b>2</b>	<b>3</b>

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 PHOENIX MEDICAL CENTER, INC.  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 07-4581  
 REVIEW PERIOD: 1/1/2005 - 12/31/2005

Sample Number	Date of Service	Rate Code		Amount		Overpayment	DETAILED AUDIT FINDINGS	
		Billed	Derived	Paid	Derived			
1	05/26/05	1610	1610	\$ 134.34	\$ 134.34	\$ -		
2	12/15/04	1610	1610	134.34	134.34	-		
3	05/05/05	1610	1610	134.34	134.34	-		
4	08/09/05	1610	1610	137.34	137.34	-		
5	09/20/05	1610	1610	134.34	134.34	-		
6	08/11/05	1610		134.34	-	134.34	X	
7	12/05/05	1610	1610	134.34	134.34	-		
8	09/22/05	1610		134.34	-	134.34	X	
9	08/17/05	1610		134.34	-	134.34	X	
10	12/24/04	1610	1610	134.34	134.34	-		
11	06/22/05	1610	1610	134.34	134.34	-		
12	05/11/05	1610		134.34	-	134.34	X	
13	11/12/05	1610	1610	137.34	137.34	-		
14	07/30/05	1610	1610	134.34	134.34	-		
15	03/26/05	1610	1610	137.34	137.34	-		
16	08/29/05	1610	1610	137.34	137.34	-		
17	07/14/05	1610	1610	134.34	134.34	-		
18	01/14/05	1610	1610	134.34	134.34	-		
19	04/21/05	1610	1610	134.34	134.34	-		
20	02/01/05	1610	1610	137.34	137.34	-		
21	05/24/05	1610	1610	134.34	134.34	-		
22	08/11/05	1610		134.34	-	134.34		X
23	12/15/04	1610		134.34	-	134.34		X
24	10/28/05	1610	1610	137.34	137.34	-		
25	04/02/05	1610	1610	134.34	134.34	-		

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 PHOENIX MEDICAL CENTER, INC.  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 07-4581  
 REVIEW PERIOD: 1/1/2005 - 12/31/2005

Sample Number	Date of Service	Rate Code		Amount			Overpayment	DETAILED AUDIT FINDINGS	
		Billed	Derived	Paid	Derived				
26	05/03/05	1610	1610	\$ 137.34	\$ 137.34	\$ -			
27	05/17/05	1610		134.34	-	134.34		X	
28	11/10/05	1610	1610	137.34	137.34	-			
29	03/05/05	1610	1610	137.34	137.34	-			
30	05/23/05	1610		137.34	-	137.34		X	
31	02/15/05	1610	1610	137.34	137.34	-			
32	05/09/05	1610		137.34	-	137.34		X	
33	04/14/05	1610	1610	134.34	134.34	-			
34	10/17/05	1610	1610	134.34	134.34	-			
35	05/13/00	1610	1610	134.34	134.34	-			
36	02/24/05	1610		137.34	-	137.34		X	
37	04/02/05	1610	1610	134.34	134.34	-			
38	04/18/05	1610	1610	134.34	134.34	-			
39	10/11/05	1610	1610	134.34	134.34	-			
40	06/29/05	1610	1610	134.34	134.34	-			
41	08/10/05	1610		134.34	-	134.34		X	
42	09/20/05	1610	1610	134.34	134.34	-			
43	07/13/05	1610	1610	134.34	134.34	-			
44	07/30/05	1610	1610	134.34	134.34	-			
45	10/12/05	1610	1610	134.34	134.34	-			
46	09/21/05	1610	1610	134.34	134.34	-			
47	03/05/05	1610	1610	137.34	137.34	-			
48	04/13/05	1610	1610	134.34	134.34	-			
49	02/08/05	1610	1610	134.34	134.34	-			
50	04/06/05	1610	1610	134.34	134.34	-			

DETAILED AUDIT FINDINGS

1. Threshold Visit Billed for Non-Reimbursable Service

2. Threshold Visit Billed for Follow-up Service

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 PHOENIX MEDICAL CENTER, INC.  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 07-4581  
 REVIEW PERIOD: 1/1/2005 - 12/31/2005

Sample Number	Date of Service	Rate Code		Amount		Overpayment	DETAILED AUDIT FINDINGS	
		Billed	Derived	Paid	Derived			
51	09/27/05	1610		\$ 134.34	\$ -	\$ 134.34	X	
52	06/15/05	1610	1610	134.34	134.34	-		
53	08/10/05	1610		134.34	-	134.34	X	
54	04/12/05	1610		134.34	-	134.34	X	
55	01/19/05	1610	1610	134.34	134.34	-		
56	09/07/05	1610	1610	134.34	134.34	-		
57	10/26/05	1610	1610	137.34	137.34	-		
58	05/12/05	1610	1610	134.34	134.34	-		
59	01/12/05	1610	1610	137.34	137.34	-		
60	11/25/05	1610	1610	137.34	137.34	-		
61	04/19/05	1610	1610	134.34	134.34	-		
62	03/30/05	1610	1610	137.34	137.34	-		
63	02/16/05	1610	1610	134.34	134.34	-		
64	06/22/05	1610	1610	134.34	134.34	-		
65	11/26/05	1610	1610	137.34	137.34	-		
66	12/12/05	1610	1610	137.34	137.34	-		
67	11/11/05	1610	1610	134.34	134.34	-		
68	07/07/05	1610	1610	134.34	134.34	-		
69	11/26/05	1610	1610	134.34	134.34	-		
70	01/17/05	1610		137.34	-	137.34	X	
71	02/07/05	1610	1610	134.34	134.34	-		
72	03/29/05	1610	1610	137.34	137.34	-		
73	11/07/05	1610	1610	137.34	137.34	-		
74	11/17/05	1610	1610	134.34	134.34	-		
75	05/20/05	1610	1610	137.34	137.34	-		

DETAILED AUDIT FINDINGS

1. Threshold Visit Billed for Non-Reimbursable Service

2. Threshold Visit Billed for Follow-up Service

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 PHOENIX MEDICAL CENTER, INC.  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 07-4581  
 REVIEW PERIOD: 1/1/2005 - 12/31/2005

Sample Number	Date of Service	Rate Code		Amount		Overpayment	DETAILED AUDIT FINDINGS 1. Threshold Visit Billed for Non-Reimbursable Service 2. Threshold Visit Billed for Follow-up Service	
		Billed	Derived	Paid	Derived			
76	11/01/05	1610	1610	\$ 137.34	\$ 137.34	\$ -		
77	12/13/05	1610	1610	134.34	134.34	-		
78	01/19/05	1610		137.34	-	137.34	X	
79	09/09/05	1610	1610	134.34	134.34	-		
80	09/21/05	1610		134.34	-	134.34		X
81	01/31/05	1610	1610	137.34	137.34	-		
82	12/01/04	1610	1610	137.34	137.34	-		
83	08/26/05	1610	1610	134.34	134.34	-		
84	09/13/05	1610	1610	134.34	134.34	-		
85	05/17/05	1610	1610	134.34	134.34	-		
86	11/01/05	1610	1610	134.34	134.34	-		
87	06/02/05	1610	1610	134.34	134.34	-		
88	09/14/05	1610	1610	134.34	134.34	-		
89	07/14/05	1610	1610	134.34	134.34	-		
90	08/27/05	1610	1610	134.34	134.34	-		
91	04/25/05	1610		134.34	-	134.34	X	
92	12/29/04	1610	1610	134.34	134.34	-		
93	01/22/05	1610	1610	137.34	137.34	-		
94	10/15/05	1610	1610	134.34	134.34	-		
95	07/25/05	1610	1610	137.34	137.34	-		
96	12/11/04	1610	1610	134.34	134.34	-		
97	06/27/05	1610	1610	134.34	134.34	-		
98	12/01/05	1610	1610	134.34	134.34	-		
99	06/29/05	1610	1610	134.34	134.34	-		
100	02/25/05	1610	1610	137.34	137.34	-		
<b>Totals</b>				<b>\$ 13,527.00</b>	<b>\$ 11,093.88</b>	<b>\$ 2,433.12</b>	<b>15</b>	<b>3</b>

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 PHOENIX MEDICAL CENTER, INC.  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 07-4581  
 REVIEW PERIOD: 1/1/2006 - 12/31/2006

Sample Number	Date of Service	Rate Code		Amount		Overpayment	DETAILED AUDIT FINDINGS 1. Threshold Visit Billed for Non-Reimbursable Service 2. Threshold Visit Billed for Follow-up Service 3. Missing Documentation		
		Billed	Derived	Paid	Derived				
1	01/21/06	1610	1610	\$ 137.34	\$ 137.34	\$ -			
2	06/20/06	1610		134.34	-	134.34	X		
3	12/30/05	1610	1610	134.34	134.34	-			
4	03/11/06	1610	1610	137.34	137.34	-			
5	05/22/06	1610		134.34	-	134.34	X		
6	05/04/06	1610	1610	134.34	134.34	-			
7	04/04/06	1610	1610	137.34	137.34	-			
8	12/08/06	1610	1610	134.34	134.34	-			
9	07/08/06	1610	1610	134.34	134.34	-			
10	06/05/06	1610	1610	137.34	137.34	-			
11	07/08/06	1610		137.34	-	137.34	X		
12	03/21/06	1610	1610	137.34	137.34	-			
13	09/11/06	1610	1610	134.34	134.34	-			
14	07/22/06	1610	1610	137.34	137.34	-			
15	04/25/06	1610	1610	134.34	134.34	-			
16	02/03/06	1610		134.34	-	134.34	X		
17	04/10/06	1610		137.34	-	137.34	X		
18	03/06/06	1610	1610	134.34	134.34	-			
19	06/24/06	1610	1610	134.34	134.34	-			
20	04/25/06	1610	1610	134.34	134.34	-			
21	11/03/06	1610		134.34	-	134.34	X		
22	03/16/06	1610	1610	137.34	137.34	-			
23	12/06/06	1610	1610	134.34	134.34	-			
24	10/17/06	1610		134.34	-	134.34	X		
25	09/20/06	1610	1610	137.34	137.34	-			

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 PHOENIX MEDICAL CENTER, INC.  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 07-4581  
 REVIEW PERIOD: 1/1/2006 - 12/31/2006

Sample Number	Date of Service	Rate Code		Amount		Overpayment	DETAILED AUDIT FINDINGS 1. Threshold Visit Billed for Non-Reimbursable Service 2. Threshold Visit Billed for Follow-up Service 3. Missing Documentation		
		Billed	Derived	Paid	Derived				
26	09/13/06	1610	1610	\$ 134.34	\$ 134.34	\$ -			
27	08/15/06	1610	1610	134.34	134.34	-			
28	08/03/06	1610	1610	134.34	134.34	-			
29	02/10/06	1610	1610	137.34	137.34	-			
30	02/06/06	1610	1610	134.34	134.34	-			
31	07/26/06	1610	1610	134.34	134.34	-			
32	04/12/06	1610	1610	134.34	134.34	-			
33	01/20/06	1610		137.34	-	137.34	X		
34	11/08/06	1610	1610	134.34	134.34	-			
35	08/21/06	1610	1610	134.34	134.34	-			
36	04/17/06	1610		134.34	-	134.34	X		
37	02/02/06	1610	1610	134.34	134.34	-			
38	04/12/06	1610	1610	134.34	134.34	-			
39	11/06/06	1610		137.34	-	137.34	X		
40	01/04/06	1610	1610	134.34	134.34	-			
41	12/19/05	1610	1610	134.34	134.34	-			
42	02/21/06	1610		137.34	-	137.34	X		
43	04/13/06	1610		137.34	-	137.34			X
44	02/14/06	1610	1610	134.34	134.34	-			
45	06/12/06	1610	1610	137.34	137.34	-			
46	09/13/06	1610		137.34	-	137.34	X		
47	10/30/06	1610		137.34	-	137.34		X	
48	01/06/06	1610	1610	134.34	134.34	-			
49	09/26/06	1610	1610	134.34	134.34	-			
50	06/13/06	1610	1610	134.34	134.34	-			

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 PHOENIX MEDICAL CENTER, INC.  
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 PROJECT NUMBER: 07-4581  
 REVIEW PERIOD: 1/1/2006 - 12/31/2006

Sample Number	Date of Service	Rate Code		Amount		Overpayment	DETAILED AUDIT FINDINGS 1. Threshold Visit Billed for Non-Reimbursable Service 2. Threshold Visit Billed for Follow-up Service 3. Missing Documentation		
		Billed	Derived	Paid	Derived				
51	04/12/06	1610	1610	\$ 134.34	\$ 134.34	\$ -			
52	05/08/06	1610	1610	137.34	137.34	-			
53	02/17/06	1610		137.34	-	137.34	X		
54	04/11/06	1610	1610	134.34	134.34	-			
55	11/04/06	1610	1610	134.34	134.34	-			
56	10/19/06	1610		137.34	-	137.34	X		
57	04/13/06	1610		134.34	-	134.34		X	
58	06/19/06	1610	1610	134.34	134.34	-			
59	09/14/06	1610	1610	134.34	134.34	-			
60	01/12/06	1610	1610	134.34	134.34	-			
61	10/03/06	1610	1610	137.34	137.34	-			
62	03/28/06	1610	1610	134.34	134.34	-			
63	03/01/06	1610	1610	134.34	134.34	-			
64	01/10/06	1610	1610	134.34	134.34	-			
65	08/16/06	1610	1610	134.34	134.34	-			
66	09/01/06	1610		134.34	-	134.34	X		
67	09/18/06	1610		137.34	-	137.34	X		
68	05/30/06	1610	1610	137.34	137.34	-			
69	09/07/06	1610		134.34	-	134.34	X		
70	12/01/06	1610	1610	134.34	134.34	-			
71	05/02/06	1610	1610	134.34	134.34	-			
72	03/25/06	1610	1610	137.34	137.34	-			
73	12/04/06	1610	1610	137.34	137.34	-			
74	04/26/06	1610	1610	137.34	-	137.34		X	
75	09/01/06	1610	1610	134.34	134.34	-			

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 PHOENIX MEDICAL CENTER, INC.  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 07-4581  
 REVIEW PERIOD: 1/1/2006 - 12/31/2006

Sample Number	Date of Service	Rate Code		Amount		Overpayment	DETAILED AUDIT FINDINGS 1. Threshold Visit Billed for Non-Reimbursable Service 2. Threshold Visit Billed for Follow-up Service 3. Missing Documentation		
		Billed	Derived	Paid	Derived				
76	03/31/06	1610		\$ 134.34	\$ -	\$ 134.34	X		
77	01/09/06	1610	1610	134.34	134.34	-			
78	11/29/06	1610	1610	134.34	134.34	-			
79	09/07/06	1610	1610	134.34	134.34	-			
80	05/18/06	1610	1610	134.34	134.34	-			
81	03/04/06	1610	1610	134.34	134.34	-			
82	10/11/06	1610	1610	134.34	134.34	-			
83	09/20/06	1610	1610	137.34	137.34	-			
84	06/26/06	1610	1610	134.34	134.34	-			
85	02/24/06	1610	1610	134.34	134.34	-			
86	01/23/06	1610	1610	137.34	137.34	-			
87	05/02/06	1610	1610	134.34	134.34	-			
88	01/23/06	1610	1610	137.34	137.34	-			
89	12/15/05	1610	1610	134.34	134.34	-			
90	06/14/06	1610	1610	134.34	134.34	-			
91	01/31/06	1610	1610	137.34	137.34	-			
92	08/28/06	1610	1610	137.34	137.34	-			
93	04/24/06	1610	1610	134.34	134.34	-			
94	08/30/06	1610	1610	134.34	134.34	-			
95	04/13/06	1610	1610	134.34	134.34	-			
96	05/02/06	1610	1610	134.34	134.34	-			
97	12/31/05	1610	1610	137.34	137.34	-			
98	05/10/06	1610		134.34	-	134.34	X		
99	11/20/06	1610		134.34	-	134.34	X		
100	03/11/06	1610		134.34	-	134.34	X		
<b>Totals</b>				<b>\$ 13,533.00</b>	<b>\$ 10,138.50</b>	<b>\$ 3,394.50</b>	<b>21</b>	<b>3</b>	<b>1</b>

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

PHOENIX MEDICAL CENTER, INC.  
 DIAGNOSTIC & TREATMENT CENTER SERVICES AUDIT  
 AUDIT # 07-4581  
 AUDIT PERIOD: 1/1/2004 - 12/31/2006

## BRIDGE SCHEDULE

SAMPLE #	FINDING	REVISED DRAFT REPORT AMOUNT DISALLOWED	FINAL REPORT AMOUNT DISALLOWED	CHANGE
4*	Threshold Visit Billed for Non-Reimbursable Service	\$137.34	\$0.00	(\$137.34)
25*	Threshold Visit Billed for Non-Reimbursable Service	\$134.34	\$0.00	(\$134.34)
47*	Threshold Visit Billed for Non-Reimbursable Service	\$137.34	\$0.00	(\$137.34)
79*	Threshold Visit Billed for Non-Reimbursable Service	\$134.34	\$0.00	(\$134.34)
65**	Threshold Visit Billed for Non-Reimbursable Service	\$134.34	\$0.00	(\$134.34)
<b>TOTALS</b>		<u>\$677.70</u>	<u>\$0.00</u>	<u>(\$677.70)</u>

\* Denotes samples for the year 2005

\*\* Denotes samples for the year 2006

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 Revised Draft Audit Report.