



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Acting Medicaid Inspector General

May 27, 2015

[REDACTED]
St. Joseph's Hospital Health Center
742 James Street
Syracuse, New York 13203

Re: Final Audit Report
Audit #: 14-2447
Provider ID #: [REDACTED]
FEIN: [REDACTED]
NPI #: [REDACTED]

Dear [REDACTED]:

Enclosed is the Office of the Medicaid Inspector General's (OMIG) final audit report entitled "Review of St. Joseph's Hospital Health Center" (Provider) paid claims for OMH rehabilitative 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 17, 2015. The mean point estimate overpaid is \$99,043. The lower confidence limit of the amount overpaid is \$33,903. 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 \$33,903.

Please note that OMH will determine if the Provider is due a refund for previously paid exempt income corresponding to the audit period January 1, 2009, through December 31, 2011. If a refund is due, it will be paid to the Provider prior to the collection of the overpayment identified in this audit.

[REDACTED]
Page 2
May 27, 2015

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 14-2447 in all correspondence.

[REDACTED]
Division of Medicaid Audit, Syracuse
Office of the Medicaid Inspector General

Enclosure

CERTIFIED MAIL #: [REDACTED]
RETURN RECEIPT REQUESTED

[REDACTED]



Office of the
Medicaid Inspector
General

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF ST. JOSEPH'S HOSPITAL HEALTH CENTER
CLAIMS FOR OMH REHABILITATIVE SERVICES
PAID FROM
JANUARY 1, 2009 – DECEMBER 31, 2011

FINAL AUDIT REPORT
AUDIT #: 14-2447

Dennis Rosen
Acting Medicaid Inspector General

May 27, 2015

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.

Reimbursement under the Medicaid Program is available for OMH rehabilitative services provided by residential programs that are licensed in accordance with the provisions of Article 31 of the Mental Hygiene Law. Residential programs primarily have a rehabilitative focus and provide an array of rehabilitative and supportive services to individuals diagnosed with severe and persistent mental illness. The purpose of these programs is to provide varied services which support and assist individuals with their goal of integration into the community.

OMH rehabilitative services provided by residential programs are based upon a comprehensive client assessment and must have the written authorization of a physician. Providers must implement an individualized written service plan for each resident identifying the specific services to be offered. These services are intended to focus on improving or maintaining resident skills that enable a resident to remain living in community housing. The specific standards and criteria for OMH Rehabilitative services within residential programs are outlined in Title 14 NYCRR Parts 593 and 595. The Provider Manual pertaining to OMH Certified Rehabilitation Services also provides program guidance in claiming Medicaid reimbursement for OMH Rehabilitative services.

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OMH rehabilitative services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to OMH rehabilitative 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 \$249,381.99 in Medicaid payments. Of the 100 services in our random sample, 6 services had at least one error and did not comply with state requirements. Of the 6 noncompliant services, one contained more than one deficiency. Specifics are as follows:

| <u>Error Description</u> | <u>Number of Errors</u> |
|---|-------------------------|
| Failure to Document Four Different Rehabilitative Services for a Full Month Claim | 3 |
| Missing Initial Physician Authorization | 2 |
| Missing Documentation of Rehabilitative Service | 1 |
| Recipient Not in Residence 21 Days in Month | 1 |

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$11,665.89 in sample overpayments with an extrapolated point estimate of \$99,043. The lower confidence limit of the amount overpaid is \$33,903.

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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 OMH rehabilitative 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 OMH Rehabilitative Services Program

Reimbursement under the Medicaid Program is available for OMH rehabilitative services provided by residential programs that are licensed in accordance with the provisions of Article 31 of the Mental Hygiene Law. Residential programs primarily have a rehabilitative focus and provide an array of rehabilitative and supportive services to individuals diagnosed with severe and persistent mental illness. The purpose of these programs is to provide varied services which support and assist individuals with their goal of integration into the community.

OMH rehabilitative services provided by residential programs are based upon a comprehensive client assessment and must have the written authorization of a physician. Providers must implement an individualized written service plan for each resident identifying the specific services to be offered. These services are intended to focus on improving or maintaining resident skills that enable a resident to remain living in community housing. The specific standards and criteria for OMH Rehabilitative services within residential programs are outlined in Title 14 NYCRR Parts 593 and 595. The Provider Manual pertaining to OMH Certified Rehabilitation Services also provides program guidance in claiming Medicaid reimbursement for OMH Rehabilitative services.

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OMH rehabilitative 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 OMH rehabilitative services paid by Medicaid from January 1, 2009, through December 31, 2011. Our audit universe consisted of 849 claims totaling \$2,145,040.82.

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 OMH rehabilitative services program;
- ran computer programming application of claims in our data warehouse that identified 849 paid OMH rehabilitative services claims, totaling \$2,145,040.82;
- selected a random sample of 100 services from the population of 849 services; and,
- estimated the overpayment paid in the population of 849 services.

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

- Medicaid electronic claim information
- Patient record, including, but not limited to:
 - Service Plan and Service Plan Reviews
 - Rehabilitative Service Documentation
 - Authorization and Reauthorizations
 - Personnel Records for staff who made entries in the record
- 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 14 NYCRR Parts 593 and 595.
- 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 17, 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 6 claims with at least one error, for a total sample overpayment of \$11,665.89 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated March 17, 2015. Appropriate adjustments were made to the findings.

1. Failure to Document Four Different Rehabilitative Services For a Full Month Claim

Regulations state: "Service definitions for programs serving adults.

- (1) Assertiveness/self advocacy training...
- (2) Community integration...
- (3) Daily living skills training...
- (4) Health services ...
- (5) Medication management and training ...
- (6) Parenting training...
- (7) Rehabilitation counseling...
- (8) Skill development services...
- (9) Socialization...
- (10) Substance abuse services...
- (11) Symptom management..."

14 NYCRR Section 593.4(b)

Regulations require that, "At least four different community rehabilitative services must have been provided" in order to be reimbursed for a full monthly rate.

14 NYCRR Section 593.7(b)(1)

Medicaid policy states, "Full month billing requires as a minimum: ...Four different rehabilitation services."

*Office of Mental Health Rehabilitation In Community Residences,
Policy Guidelines, Version 2006-1, Section III*

In 3 instances pertaining to 3 residents, the record did not document four different community rehabilitative services provided in the month claimed. The claims were reduced from full-month to half-month. This finding applies to Sample #'s 4, 44, and 74.

2. Missing Initial Physician Authorization

Regulations state, "In order to receive reimbursement for the provision of community rehabilitation services to an individual, the provider of service must ensure that the individual has been authorized in writing by a physician, prior to or upon admission, to receive services as provided by the program. The written authorization must be retained as a part of the individual's case record. The physician's authorization must:

- (1) be based upon appropriate clinical information and assessment of the individual. The initial authorization must include a face-to-face assessment;
- (2) delineate the maximum duration of the authorization to receive such services; and
- (3) specify that the individual is in need of community rehabilitation services as defined in section 593.4(b) of this Part."

14 NYCRR Section 593.6(a)

Medicaid policy states, "Each client prior to or upon admission into a Licensed Residential/Housing Program (which includes CR, FBT and TFH) must be seen by a licensed physician who makes a determination that services are appropriate and signs a written authorization which is kept on file by the provider."

*Office of Mental Health Rehabilitation In Community Residences,
Policy Guidelines, Version 2006-1, Section I*

In 2 instances pertaining to 2 residents, the record did not contain the required initial authorization signed by a physician at the time rehabilitative services were delivered. In both instances, the initial authorization was signed by a Nurse Practitioner only. Initial authorizations must be signed by a physician. This finding applies to Sample #'s 8 and 10.

3. Missing Documentation of Rehabilitative Service

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 state, "There shall be a complete case record maintained for each resident. Such case record shall be maintained in accordance with recognized and acceptable principles of recordkeeping...."

14 NYCRR Section 595.14(a)

Regulations state: "The case record shall ... include the following information...

(8) documentation of the type of service provided, the date it was provided, its duration and the name of the person rendering the service;"

14 NYCRR Section 595.14(b)(8)

Medicaid policy states, "All services and contacts must be recorded for audit purposes."

*Office of Mental Health Rehabilitation In Community Residences,
Policy Guidelines, Version 2006-1, Section III*

In 1 instance, the record did not document that any rehabilitative services were provided during our review month. In this instance, the resident's date of admission was late in the month, yet a full-month billing was submitted the next month. OMH rehabilitative services cannot be billed until the month after service was provided, so there was no documentation to support this billing. This finding applies to Sample # 47.

4. Recipient Not in Residence 21 Days in Month

Regulations state, "A full monthly rate will be paid for services provided to an eligible resident in residence for at least 21 days in a calendar month...."

14 NYCRR Section 593.7(b)(1)

Medicaid policy states, "Full month billing requires as a minimum: ...21 days in residence (excluding discharge day, days in a hospital or in any other Medicaid reimbursable facility)."

*Office of Mental Health Rehabilitation In Community Residences,
Policy Guidelines, Version 2006-1, Section III*

In 1 instance, a full monthly rate was paid for services provided to a client in residence less than 21 days. This finding applies to Sample # 8.

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 \$33,903, 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 #: 14-2447
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 \$99,043. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

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

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

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

St. Joseph's Hospital Health Center
742 James Street
Syracuse, New York 13203

AMOUNT DUE: \$33,903

PROVIDER ID #: [REDACTED]

AUDIT #: 14-2447

| | | |
|-------|-------------------------------------|----------|
| | <input checked="" type="checkbox"/> | PROVIDER |
| AUDIT | <input type="checkbox"/> | RATE |
| | <input type="checkbox"/> | PART B |
| TYPE | <input type="checkbox"/> | 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 #: 14-2447
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN

The sample design used for Audit #: 14-2447 was as follows:

- Universe - Medicaid claims for OMH rehabilitative 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 OMH rehabilitative 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.

SAMPLE RESULTS AND ESTIMATES

| | |
|--------------------------|---------------|
| Universe Size | 849 |
| Sample Size | 100 |
| Sample Value | \$ 249,381.99 |
| Sample Overpayments | \$ 11,665.89 |
| Net Financial Error Rate | 4.7% |
| Confidence Level | 90% |

Extrapolation of Sample Findings

| | |
|--|--------------|
| Sample Overpayments for Extrapolation Purposes | \$ 11,665.89 |
| Sample Size | 100 |
| Mean Dollars in Error for Extrapolation Purposes | \$ 116.6589 |
| Universe Size | 849 |
| Point Estimate of Total Dollars | \$ 99,043 |
| Lower Confidence Limit | \$ 33,903 |

OFFICE OF THE MEDICAID INSPECTOR GENERAL
ST. JOSEPHS HOSPITAL HEALTH CENTER
REVIEW OF OMH REHABILITATIVE SERVICES
PROJECT NUMBER: 14-2447
REVIEW PERIOD: 01/01/2009 - 12/31/2011

| Sample Number | Date of Service | Rate Code | | Amount | | Overpayment Extrapolated | DETAILED AUDIT FINDINGS | | | |
|---------------|-----------------|-----------|---------|-------------|-------------|--------------------------|--|---|--|--|
| | | Billed | Derived | Paid | Derived | | 1. Failure to Document Four Different Rehabilitative Services for a Full Month Claim | 2. Missing Initial Physician Authorization for a Full Month | 3. Missing Documentation of Rehabilitative Service | 4. Recipient Not in Residence 21 Days in Month |
| 1 | 01/01/11 | 4369 | 4369 | \$ 2,656.26 | \$ 2,656.26 | \$ - | | | | |
| 2 | 05/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 3 | 07/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 4 | 04/01/09 | 4369 | 4369 | 2,575.73 | 1,287.87 | 1,287.86 | X | | | |
| 5 | 09/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 6 | 12/01/08 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 7 | 08/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 8 | 05/01/11 | 4369 | - | 2,623.45 | - | 2,623.45 | | X | | X |
| 9 | 10/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 10 | 01/01/09 | 4369 | - | 2,575.73 | - | 2,575.73 | | X | | |
| 11 | 09/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 12 | 07/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 13 | 02/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 14 | 07/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 15 | 06/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 16 | 04/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 17 | 03/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 18 | 03/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 19 | 06/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 20 | 12/01/08 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 21 | 01/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 22 | 06/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 23 | 08/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 24 | 07/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 25 | 08/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |

OFFICE OF THE MEDICAID INSPECTOR GENERAL
ST. JOSEPHS HOSPITAL HEALTH CENTER
REVIEW OF OMH REHABILITATIVE SERVICES
PROJECT NUMBER: 14-2447
REVIEW PERIOD: 01/01/2009 - 12/31/2011

| Sample Number | Date of Service | Rate Code | | Amount | | Overpayment Extrapolated | DETAILED AUDIT FINDINGS 1. Failure to Document Four Different Rehabilitative Services for a Full Month 2. Missing Initial Physician Authorization 3. Missing Documentation of Rehabilitative Service 4. Recipient Not in Residence 21 Days in Month | | | |
|---------------|-----------------|-----------|---------|----------|-------------|--------------------------|---|---|--|--|
| | | Billed | Derived | Paid | Derived | | | | | |
| 26 | 03/01/09 | 4369 | 4369 | 2,575.73 | \$ 2,575.73 | \$ - | | | | |
| 27 | 04/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 28 | 10/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 29 | 01/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 30 | 04/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 31 | 01/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 32 | 11/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 33 | 09/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 34 | 08/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 35 | 07/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 36 | 05/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 37 | 02/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 38 | 05/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 39 | 10/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 40 | 06/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 41 | 08/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 42 | 08/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 43 | 06/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 44 | 03/01/10 | 4369 | 4369 | 2,535.07 | 1,267.54 | 1,267.53 | X | | | |
| 45 | 04/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 46 | 06/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 47 | 05/01/11 | 4369 | - | 2,623.45 | - | 2,623.45 | | X | | |
| 48 | 02/01/11 | 4369 | 4369 | 2,656.26 | 2,656.26 | - | | | | |
| 49 | 07/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 50 | 02/01/11 | 4369 | 4369 | 2,656.26 | 2,656.26 | - | | | | |

OFFICE OF THE MEDICAID INSPECTOR GENERAL
ST. JOSEPHS HOSPITAL HEALTH CENTER
REVIEW OF OMH REHABILITATIVE SERVICES
PROJECT NUMBER: 14-2447
REVIEW PERIOD: 01/01/2009 - 12/31/2011

| Sample Number | Date of Service | Rate Code | | Amount | | Overpayment Extrapolated | DETAILED AUDIT FINDINGS | | | |
|---------------|-----------------|-----------|---------|----------|-------------|--------------------------|--|--|--|--|
| | | Billed | Derived | Paid | Derived | | 1. Failure to Document Four Different Rehabilitative Services for a Full Month Claim | 2. Missing Initial Physician Authorization | 3. Missing Documentation of Rehabilitative Service | 4. Recipient Not in Residence 21 Days in Month |
| 51 | 05/01/09 | 4369 | 4369 | 2,575.73 | \$ 2,575.73 | \$ - | | | | |
| 52 | 02/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 53 | 07/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 54 | 05/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 55 | 09/01/09 | 4370 | 4370 | 1,287.86 | 1,287.86 | - | | | | |
| 56 | 05/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 57 | 01/01/11 | 4369 | 4369 | 2,656.26 | 2,656.26 | - | | | | |
| 58 | 02/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 59 | 11/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 60 | 12/01/09 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 61 | 09/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 62 | 09/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 63 | 02/01/11 | 4369 | 4369 | 2,656.26 | 2,656.26 | - | | | | |
| 64 | 06/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 65 | 05/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 66 | 04/02/09 | 4371 | 4371 | 1,287.86 | 1,287.86 | - | | | | |
| 67 | 06/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 68 | 12/01/08 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 69 | 04/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 70 | 08/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 71 | 10/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 72 | 07/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 73 | 04/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 74 | 02/01/09 | 4369 | 4369 | 2,575.73 | 1,287.86 | 1,287.87 | X | | | |
| 75 | 11/01/10 | 4370 | 4370 | 1,267.54 | 1,267.54 | - | | | | |

OFFICE OF THE MEDICAID INSPECTOR GENERAL
ST. JOSEPHS HOSPITAL HEALTH CENTER
REVIEW OF OMH REHABILITATIVE SERVICES
PROJECT NUMBER: 14-2447
REVIEW PERIOD: 01/01/2009 - 12/31/2011

| Sample Number | Date of Service | Rate Code | | Amount | | Overpayment Extrapolated | DETAILED AUDIT FINDINGS | | | |
|---------------|-----------------|-----------|---------|----------------------|----------------------|--------------------------|--|--|--|--|
| | | Billed | Derived | Paid | Derived | | 1. Failure to Document Four Different Rehabilitative Services for a Full Month Claim | 2. Missing Initial Physician Authorization | 3. Missing Documentation of Rehabilitative Service | 4. Recipient Not in Residence 21 Days in Month |
| 76 | 07/01/11 | 4369 | 4369 | 2,623.45 | \$ 2,623.45 | \$ - | | | | |
| 77 | 02/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 78 | 02/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 79 | 05/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 80 | 04/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 81 | 04/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 82 | 12/01/08 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 83 | 04/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 84 | 07/01/11 | 4370 | 4370 | 1,311.72 | 1,311.72 | - | | | | |
| 85 | 05/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 86 | 08/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 87 | 03/01/08 | 4369 | 4369 | 2,154.97 | 2,154.97 | - | | | | |
| 88 | 06/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 89 | 03/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 90 | 03/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 91 | 10/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 92 | 11/01/09 | 4370 | 4370 | 1,287.86 | 1,287.86 | - | | | | |
| 93 | 10/01/09 | 4370 | 4370 | 1,287.86 | 1,287.86 | - | | | | |
| 94 | 09/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 95 | 01/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 96 | 01/01/09 | 4369 | 4369 | 2,575.73 | 2,575.73 | - | | | | |
| 97 | 06/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 98 | 09/01/11 | 4369 | 4369 | 2,623.45 | 2,623.45 | - | | | | |
| 99 | 03/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| 100 | 08/01/10 | 4369 | 4369 | 2,535.07 | 2,535.07 | - | | | | |
| Totals | | | | \$ 249,381.99 | \$ 237,716.10 | \$ 11,665.89 | 3 | 2 | 1 | 1 |

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

ST. JOSEPH'S HOSPITAL HEALTH CENTER
OMH REHABILITATIVE SERVICES AUDIT

AUDIT #: 14-2447

AUDIT PERIOD: 01/01/09 - 12/31/11

BRIDGE SCHEDULE

| SAMPLE # | FINDING | DRAFT REPORT | FINAL REPORT | CHANGE |
|---------------|---|----------------------|----------------------|---------------------|
| | | AMOUNT DISALLOWED | AMOUNT DISALLOWED | |
| 6 | Missing Documentation of Rehabilitative Service | \$2,575.73 | \$0.00 | (\$2,575.73) |
| 20 | Missing Documentation of Rehabilitative Service | \$2,575.73 | \$0.00 | (\$2,575.73) |
| 78 | Missing Documentation of Rehabilitative Service | \$2,575.73 | \$0.00 | (\$2,575.73) |
| 87 | Missing Documentation of Rehabilitative Service | \$2,154.97 | \$0.00 | (\$2,154.97) |
| TOTALS | | <u>\$9,882.16</u> | <u>\$0.00</u> | <u>(\$9,882.16)</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.