



**Office of the  
Medicaid Inspector  
General**

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

**REVIEW OF NEW YORK MEDICAL AND DIAGNOSTIC CENTER  
CLAIMS FOR DIAGNOSTIC AND TREATMENT CENTER SERVICES  
PAID FROM  
JANUARY 1, 2004 – DECEMBER 31, 2008**

**FINAL AUDIT REPORT  
AUDIT #: 09-4163**

**Dennis Rosen  
Medicaid Inspector General**

**May 13, 2016**



Office of the  
Medicaid Inspector  
General

ANDREW M. CUOMO  
Governor

DENNIS ROSEN  
Medicaid Inspector General

May 13, 2016

[REDACTED]

New York Medical and Diagnostic Center  
80-46 Kew Gardens Road  
Kew Gardens, New York 11415

Re: Final Audit Report  
Audit #: 09-4163  
Provider ID #: [REDACTED]  
NPI: [REDACTED]

Dear [REDACTED]:

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of New York Medical and Diagnostic Center" (Provider) paid claims for diagnostic and treatment center services covering the period January 1, 2004, through December 31, 2008.

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 November 16, 2015. The adjusted mean point estimate overpaid is \$572,991. The adjusted lower confidence limit of the amount overpaid is \$378,288. 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 \$378,288.

[REDACTED]

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May 13, 2016

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED] Please refer to report number 09-4163 in all correspondence.

Sincerely,

[REDACTED]

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

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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

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

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

### **DIVISION OF MEDICAID AUDIT**

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

### **DIVISION OF MEDICAID INVESTIGATIONS**

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

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

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

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

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

## EXECUTIVE SUMMARY

### BACKGROUND

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

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, 2008.

### SUMMARY OF FINDINGS

We inspected a random sample of 150 services with \$12,077.29 in Medicaid payments. Of the 150 services in our random sample, 107 services had at least one error and did not comply with state requirements. Of the 107 noncompliant services, some contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Incorrect Servicing Provider on Claim	95
Missing Documentation	12
No Written Order by Physician and /or Dentist for Rehabilitation Services	7
Missing Plan of Care for Rehabilitation Services	6
Medical Entry Not Signed	4
Billing for Services Unauthorized by the Operating Certificate	2

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$8,214.16 in sample overpayments with an extrapolated adjusted point estimate of \$572,991. The adjusted lower confidence limit of the amount overpaid is \$378,288.

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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, 2008. Our audit universe consisted of 43,517 claims totaling \$3,469,958.85.

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 43,517 paid diagnostic and treatment center services claims, totaling \$3,469,958.85;
- selected a random sample of 150 services from the population of 43,517 services; and,
- estimated the overpayment paid in the population of 43,517 services.

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

- Medicaid electronic claim information
- Patient record, including, but not limited to:
  - Patient Medical Records
  - Practitioner Medical Orders
  - Third Party Payor EOB's
  - Patient Account Ledgers
- 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 other applicable program regulations, for example, 14 NYCRR Part 822.
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."  
*18 NYCRR Section 504.3*

Regulations state: "Fee-for-service providers. (1) All providers . . . must prepare and maintain contemporaneous records demonstrating their right to receive payment . . . All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor . . . must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department . . . for audit and review."  
*18 NYCRR Section 517.3(b)*

Regulations require that bills for medical care, services and supplies contain patient name, case number and date of service; itemization of the volume and specific types of care, services and supplies provided; the unit price and total cost of the care, services and supplies provided; and a dated certification by the provider that the care, services and supplies itemized have been in fact furnished; that the amounts listed are in fact due and owing; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may

be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided.

*18 NYCRR Section 540.7(a) (1)-(3) and (8)*

Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake."

*18 NYCRR Section 518.1(c)*

Regulations state: "Vendor payments for medical care and other items of medical assistance shall not be made unless such care or other items of assistance have been furnished on the basis of the appropriate authorization prescribed by the rules of the board and regulations of the department."

*18 NYCRR Section 540.1*

Regulations state: "The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim."

*18 NYCRR Section 518.3(a)*

Regulations state: "The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished...."

*18 NYCRR Section 518.3(b)*

Regulations state: "Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record."

*18 NYCRR Section 518.3(b)*

## AUDIT FINDINGS

This audit report incorporates consideration of any additional documentation and information presented in response to the Revised Draft Audit Report dated November 16, 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, 2008, identified 107 claims with at least one error, for a total sample overpayment of \$8,214.16 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Revised Draft Audit Report dated November 16, 2015. Appropriate adjustments were made to the findings.

#### 1. Incorrect Servicing Provider on Claim

Regulations state, "By enrolling the provider agrees ... that the information provided in relation to any claim for payment shall be true, accurate and complete; and to comply with the rules, regulations and official directives of the department."

*18 NYCRR Section 504.3(h) & (i)*

Medicaid policy states that the Office of the Medicaid Management activated a series of edits that require the identification of servicing and referring practitioners. These edits verify that the practitioner's license or MMIS provider ID numbers reported on clinic claims are accurate and legitimate.

*Medicaid Update, June 2002, Volume 17, Number 6*

In 95 instances pertaining to 83 patients, the servicing practitioner was not accurately identified. The servicing practitioner's name on the 95 claims did not match the name of the practitioner who signed the medical entry. The breakdown of the errors is listed below:

In 45 instances pertaining to 43 patients, the servicing practitioner was listed as "New York Med & Diagnostic Center". This finding applies to Sample #'s 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140 and 141.

In 18 instances pertaining to 18 patients, the servicing practitioner was listed as "Rabinovich Faye MD". This finding applies to Sample #'s 8, 19, 20, 22, 37, 38, 40, 44, 46, 49, 50, 52, 59, 66, 67, 82, 84 and 94.

In 16 instances pertaining to 15 patients, the servicing practitioner was listed as 'Shekin Kambiz MD'. This finding applies to Sample #'s 1, 2, 3, 5, 10, 11, 12, 14, 17, 21, 28, 31, 145, 147, 149 and 150.

In 11 instances pertaining to 11 patients, the servicing practitioner was blank. This finding applies to Sample #'s 4, 13, 24, 45, 51, 53, 54, 63, 64, 72 and 88.

In 2 instances pertaining to 2 patients, the servicing practitioner was listed as "Samuel Boulous". This finding applies to Sample #'s 61 and 73.

In 2 instances pertaining to 1 patient, the servicing practitioner was listed as "Tabari Isaac". This finding applies to Sample #'s 39 and 43.

In 1 instance the servicing practitioner was listed as "David Mariañ MD". This finding applies to Sample # 25.

## 2. 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*

Regulations also state, "Only covered services which are actually delivered to eligible recipients shall be reimbursed."  
*18 NYCRR Section 505.25(f)(1)*

In addition, "All reimbursable billings shall only be for a documented, definable medical service of face-to-face professional exchange between provider and client or collateral, in accordance with goals stated in the treatment plan."

*18 NYCRR Section 505.25(e)(5)*

In 12 instances pertaining to 12 patients, the services were not documented. This finding applies to Sample #'s 7, 13, 16, 24, 25, 34, 64, 75, 81, 85, 92 and 126.

**3. No Written Order by Physician and /or Dentist for Rehabilitation Services**

Regulations require that for each professional service provided, the D&T operator shall ensure that "treatment is given upon the written order or referral of a physician or dentist for physical therapy and speech-language pathology services and upon written order or a referral of a physician for occupational therapy services."

*10 NYCRR Section 752-1.1(d)*

In 7 instances pertaining to 7 patients, there was no written order by a physician or dentist for the physical therapy and/or speech therapy services billed, or there was no written order by a physician for occupational therapy services billed. This finding applies to Sample #'s 22, 33, 49, 61, 94, 131 and 140.

**4. Missing Plan Of Care for Rehabilitation Services**

Regulations require that for each professional service provided, the D&T operator shall ensure that "treatment is given upon the written order or referral of a physician or dentist for physical therapy and speech-language pathology services and upon written order or a referral of a physician for occupational therapy services; and a written plan of care and results of treatment is reviewed every 30 days by the physician and appropriate professional staff except when an order or referral specifies treatment of a longer duration, in which case the plan of care is reviewed by the physician and appropriate professional staff at least every 90 days."

*10 NYCRR Section 752-1.1(d)(1)*

In 6 instances pertaining to 6 patients, the required Plan Of Care review was missing. This finding applies to Sample #'s 1, 73, 94, 117, 140 and 144.

**5. Medical Entry Not Signed**

Regulations state, "The operator shall . . . ensure that entries in the medical record are current, legible, signed and dated by the person making the entry."

*10 NYCRR Section 751.7(f)*

In 4 instances pertaining to 4 patients, the practitioner did not sign the entry in the medical record. This finding applies to Sample #'s 77, 80, 86 and 99.

**6. Billing for Services Unauthorized by the Operating Certificate**

Regulations state, "No operator shall change or modify a facility, or the services originally approved and stipulated by the operating certificate, without the prior written approval of the department."

*18 NYCRR Section 485.5(f)*

Regulations also state, "If a license, registration or certification is required to render the medical care, services or supplies to be furnished, an applicant must hold a proper and currently valid license, registration and/or certification to be eligible to furnish the care, services or supplies under the medical assistance program."

*18 NYCRR Section 504.1(c)*

Medicaid policy states, "Hospital outpatient departments and diagnostic and treatment centers may provide those necessary medical, surgical, and rehabilitative services and items authorized by their operating certificates."

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

In 2 instances pertaining to 2 patients, services were billed that were not authorized by the operating certificate. This finding applies to Sample #'s 37 and 128.

## PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the adjusted lower confidence limit amount of \$378,288, 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 #09-4163  
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 adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the adjusted point estimate of \$572,991. 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]

New York Medical and Diagnostic  
Center  
80-46 Kew Gardens Road  
Kew Gardens, New York 11415

**PROVIDER ID #** [REDACTED]

**AUDIT #09-4163**

**AMOUNT DUE: \$378,288**

	<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 #09-4163  
Albany, New York 12237

*Thank you for your cooperation.*

## **SAMPLE DESIGN**

The sample design used for Audit #09-4163 was as follows:

- Universe - Medicaid claims for diagnostic and treatment center services paid during the period January 1, 2004, through December 31, 2008.
- 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, 2008.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2004, through December 31, 2008.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 150 services.

### SAMPLE RESULTS AND ESTIMATES

Universe Size	43,517
Sample Size	150
Sample Value	\$ 12,077.29
Sample Overpayments	\$ 8,214.16
Confidence Level	90%

#### Extrapolation of Sample Findings

Sample Overpayments	\$ 8,214.16
<b>Less Overpayments Not Extrapolated*</b>	<u>(6,260.68)</u>
Sample Overpayments for Extrapolation Purposes	\$ 1,953.48
Sample Size	150
Mean Dollars in Error for Extrapolation Purposes	\$ 13.0232
Universe Size	43,517
Point Estimate of Total Dollars	\$ 566,730
<b>Add Overpayments Not Extrapolated*</b>	<u>6,261</u>
Adjusted Point Estimate of Totals Dollars	<u>\$ 572,991</u>
Lower Confidence Limit	\$ 372,027
<b>Add Overpayments Not Extrapolated*</b>	<u>6,261</u>
Adjusted Lower Confidence Limit	<u>\$ 378,288</u>

\* The actual dollar disallowance for the following finding was subtracted from the sample overpayment and added to the Point Estimate and Lower Confidence Limit:

- **Finding #1 – Incorrect Servicing Provider on Claim**

The dollar disallowance associated with this finding was not used in the extrapolation. However, this does not apply if an extrapolated finding was also identified for a sampled claim.

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 NEW YORK MEDICAL AND DIAGNOSTIC CENTER  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 09-4163  
 REVIEW PERIOD: 1/1/2004 - 12/31/2008

Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS							
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. Incorrect Servicing Provider on Claim	2. Missing Documentation	3. No Written Order by Physician and/or Dentist for Rehabilitation Services	4. Missing Plan of Care for Rehabilitation	5. Medical Entry Not Signed	6. Billing for Services Unauthorized by the Operating Certificate		
1	04/06/05	1610		\$ 98.89	\$ -	\$ 98.89	\$ -		X						
2	04/18/05	1610		98.89	-	-	98.89	X							
3	04/29/05	1610		98.89	-	-	98.89	X							
4	05/04/05	1610		98.89	-	-	98.89	X							
5	05/03/05	1610		98.89	-	-	98.89	X							
6	01/06/05	1610	1610	101.89	101.89	-	-								
7	05/10/05	1610		98.89	-	98.89	-			X					
8	02/02/04	1610		101.89	-	-	101.89	X							
9	06/21/05	1610	1610	98.89	98.89	-	-								
10	02/17/05	1610		98.89	-	-	98.89	X							
11	07/14/05	1610		98.89	-	-	98.89	X							
12	07/18/05	1610		101.89	-	-	101.89	X							
13	04/27/05	1610		98.89	-	98.89	-	X	X						
14	08/08/05	1610		98.89	-	-	98.89	X							
15	07/19/05	1610	1610	19.06	19.06	-	-								
16	06/27/05	1610		2.31	-	2.31	-			X					
17	05/26/05	1610		13.64	-	-	13.64	X							
18	09/09/05	1610	1610	101.89	101.89	-	-								
19	10/06/05	1610		98.89	-	-	98.89	X							
20	11/17/05	1610		98.89	-	-	98.89	X							
21	11/25/05	1610		98.89	-	-	98.89	X							
22	12/02/05	1610		101.89	-	101.89	-	X			X				
23	12/13/05	1610	1610	101.89	101.89	-	-								
24	12/14/05	1610		98.89	-	98.89	-	X	X						
25	12/19/05	1610		98.89	-	98.89	-	X	X						

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 NEW YORK MEDICAL AND DIAGNOSTIC CENTER  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 09-4163  
 REVIEW PERIOD: 1/1/2004 - 12/31/2008

Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS						
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. Incorrect Servicing Provider on Claim	2. Missing Documentation	3. No Written Order by Physician and/or Dentist for Rehabilitation Services	4. Missing Plan of Care for Rehabilitation Services	5. Medical Entry Not Signed	6. Billing for Services Unauthorized by the Operating Certificate	
26	12/23/05	1610	1610	\$ 101.89	\$ 101.89	\$ -	\$ -							
27	01/10/06	1610	1610	98.89	98.89	-	-							
28	01/02/06	1610		98.89	-	-	98.89	X						
29	02/02/06	1610	1610	98.89	98.89	-	-							
30	03/09/06	1610	1610	98.89	98.89	-	-							
31	02/17/06	1610		101.89	-	-	101.89	X						
32	02/15/06	1610	1610	98.89	98.89	-	-							
33	03/06/06	1610		101.89	-	101.89	-			X				
34	03/21/06	1610		101.89	-	101.89	-			X				
35	04/27/06	1610	1610	98.89	98.89	-	-							
36	06/06/06	1610	1610	98.89	98.89	-	-							
37	06/15/06	1610		98.89	-	98.89	-	X						X
38	05/20/06	1610		98.89	-	-	98.89	X						
39	06/27/06	1610		98.89	-	-	98.89	X						
40	06/05/06	1610		98.89	-	-	98.89	X						
41	07/18/06	1610	1610	98.89	98.89	-	-							
42	07/19/06	1610	1610	98.89	98.89	-	-							
43	07/25/06	1610		98.89	-	-	98.89	X						
44	08/16/06	1610		98.89	-	-	98.89	X						
45	08/24/06	1610		98.89	-	-	98.89	X						
46	09/02/06	1610		101.89	-	-	101.89	X						
47	09/13/06	1610	1610	98.89	98.89	-	-							
48	09/19/06	1610	1610	98.89	98.89	-	-							
49	09/20/06	1610		98.89	-	98.89	-	X		X				
50	09/15/06	1610		98.89	-	-	98.89	X						

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
NEW YORK MEDICAL AND DIAGNOSTIC CENTER  
REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
PROJECT NUMBER: 09-4163  
REVIEW PERIOD: 1/1/2004 - 12/31/2008

Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS						
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. Incorrect Servicing Provider on Claim	2. Missing Documentation	3. No Written Order by Physician and/or Dentist for Rehabilitation Services	4. Missing Plan of Care for Rehabilitation	5. Medical Entry Not Signed	6. Billing for Services Unauthorized by the Operating Certificate	
51	09/27/06	1610		\$ 98.89	\$ -	\$ -	\$ 98.89	X						
52	07/22/06	1610		98.89	-	-	98.89	X						
53	11/22/06	1610		98.89	-	-	98.89	X						
54	10/27/06	1610		101.89	-	-	101.89	X						
55	01/11/07	1610	1610	98.89	98.89	-	-							
56	03/12/07	1610	1610	98.89	98.89	-	-							
57	03/13/07	1610	1610	98.89	98.89	-	-							
58	03/21/07	1610	1610	98.89	98.89	-	-							
59	04/21/07	1610		98.89	-	-	98.89	X						
60	04/06/07	1610	1610	98.89	98.89	-	-							
61	05/09/07	1610		98.89	-	98.89	-	X		X				
62	05/10/07	1610	1610	98.89	98.89	-	-							
63	06/06/07	1610		98.89	-	-	98.89	X						
64	06/13/07	1610		98.89	-	98.89	-	X	X					
65	07/17/07	1610	1610	98.89	98.89	-	-							
66	08/15/07	1610		98.89	-	-	98.89	X						
67	08/29/07	1610		98.89	-	-	98.89	X						
68	06/19/07	1610	1610	98.89	98.89	-	-							
69	07/24/07	1610	1610	98.89	98.89	-	-							
70	11/16/07	1610	1610	98.89	98.89	-	-							
71	11/29/07	1610	1610	98.89	98.89	-	-							
72	12/04/07	1610		98.89	-	-	98.89	X						
73	01/21/08	1610		101.89	-	101.89	-	X			X			
74	02/06/08	1610	1610	98.89	98.89	-	-							
75	04/21/08	1610		98.89	-	98.89	-		X					

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 NEW YORK MEDICAL AND DIAGNOSTIC CENTER  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 09-4163  
 REVIEW PERIOD: 1/1/2004 - 12/31/2008

Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS						
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. Incorrect Servicing Provider on Claim	2. Missing Documentation	3. No Written Order by Physician and/or Dentist for Rehabilitation Services	4. Missing Plan of Care for Rehabilitation	5. Medical Entry Not Signed	6. Billing for Services Unauthorized by the Operating Certificate	
76	05/08/08	1610	1610	\$ 98.89	\$ 98.89	\$ -	\$ -							
77	11/08/06	1610		9.05	-	9.05	-						X	
78	12/01/06	1610	1610	14.90	14.90	-	-							
79	12/04/06	1610	1610	14.90	14.90	-	-							
80	05/31/08	1610		98.89	-	98.89	-						X	
81	07/26/07	1610		9.19	-	9.19	-		X					
82	09/24/07	1610		9.19	-	-	9.19	X						
83	06/20/08	1610	1610	98.89	98.89	-	-							
84	01/11/07	1610		4.92	-	-	4.92	X						
85	10/20/06	1610		3.47	-	3.47	-			X				
86	07/12/07	1610		9.19	-	9.19	-						X	
87	12/07/06	1610	1610	25.53	25.53	-	-							
88	08/29/08	1610		98.89	-	-	98.89	X						
89	10/15/08	1610	1610	98.89	98.89	-	-							
90	01/22/08	1610	1610	15.92	15.92	-	-							
91	10/23/08	1610	1610	98.89	98.89	-	-							
92	08/19/08	1610		3.38	-	3.38	-			X				
93	12/01/08	1610	1610	98.89	98.89	-	-							
94	07/22/08	1610		5.81	-	5.81	-	X			X	X		
95	12/04/08	1610	1610	98.89	98.89	-	-							
96	12/10/08	1610	1610	98.89	98.89	-	-							
97	12/24/03	1610		101.89	-	-	101.89	X						
98	12/29/03	1610		98.89	-	-	98.89	X						
99	01/02/04	1610		98.89	-	98.89	-	X					X	
100	01/05/04	1610		98.89	-	-	98.89	X						

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 NEW YORK MEDICAL AND DIAGNOSTIC CENTER  
 REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
 PROJECT NUMBER: 09-4163  
 REVIEW PERIOD: 1/1/2004 - 12/31/2008

Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS						
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. Incorrect Servicing Provider on Claim	2. Missing Documentation	3. No Written Order by Physician and/or Dentist for Rehabilitation Services	4. Missing Plan of Care for Rehabilitation Services	5. Medical Entry Not Signed	6. Billing for Services Unauthorized by the Operating Certificate	
101	01/12/04	1610		\$ 98.89	\$ -	\$ -	\$ 98.89	X						
102	07/29/03	1610		14.61	-	-	14.61	X						
103	01/13/04	1610		98.89	-	-	98.89	X						
104	01/14/04	1610		98.89	-	-	98.89	X						
105	11/14/03	1610		8.82	-	-	8.82	X						
106	01/27/04	1610		101.89	-	-	101.89	X						
107	02/05/04	1610		98.89	-	-	98.89	X						
108	02/03/04	1610		98.89	-	-	98.89	X						
109	12/30/03	1610		6.05	-	-	6.05	X						
110	02/13/04	1610		98.89	-	-	98.89	X						
111	02/20/04	1610		101.89	-	-	101.89	X						
112	02/26/04	1610		101.89	-	-	101.89	X						
113	02/23/04	1610		5.86	-	-	5.86	X						
114	04/01/04	1610		98.89	-	-	98.89	X						
115	03/17/04	1610		11.91	-	-	11.91	X						
116	03/09/04	1610		15.99	-	-	15.99	X						
117	04/19/04	1610		98.89	-	98.89	-	X			X			
118	04/21/04	1610		98.89	-	-	98.89	X						
119	05/12/04	1610		98.89	-	-	98.89	X						
120	06/05/04	1610		98.89	-	-	98.89	X						
121	06/10/04	1610		101.89	-	-	101.89	X						
122	11/01/03	1610		98.89	-	-	98.89	X						
123	05/18/04	1610		5.88	-	-	5.88	X						
124	05/25/04	1610		12.84	-	-	12.84	X						
125	07/29/04	1610		101.89	-	-	101.89	X						

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
NEW YORK MEDICAL AND DIAGNOSTIC CENTER  
REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES  
PROJECT NUMBER: 09-4163  
REVIEW PERIOD: 1/1/2004 - 12/31/2008

Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS					
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. Incorrect Servicing Provider on Claim	2. Missing Documentation	3. No Written Order by Physician and/or Dentist for Rehabilitation Services	4. Missing Plan of Care for Rehabilitation	5. Medical Entry Not Signed	6. Billing for Services Unauthorized by the Operating Certificate
126	06/22/04	1610		\$ 1.18	\$ -	\$ 1.18	\$ -	X	X				
127	10/25/04	1610		98.89	-	-	98.89	X					
128	10/09/04	1610		101.89	-	101.89	-	X					X
129	08/10/04	1610		98.89	-	-	98.89	X					
130	08/19/04	1610		98.89	-	-	98.89	X					
131	05/07/04	1610		2.37	-	2.37	-	X		X			
132	09/04/04	1610		98.89	-	-	98.89	X					
133	09/07/04	1610		98.89	-	-	98.89	X					
134	09/14/04	1610		98.89	-	-	98.89	X					
135	04/21/04	1610		19.33	-	-	19.33	X					
136	07/26/04	1610		15.92	-	-	15.92	X					
137	09/02/04	1610		8.67	-	-	8.67	X					
138	08/23/04	1610		12.19	-	-	12.19	X					
139	10/11/04	1610		98.89	-	-	98.89	X					
140	10/20/04	1610		13.62	-	13.62	-	X		X	X		
141	10/11/04	1610		14.71	-	-	14.71	X					
142	12/07/04	1610	1610	98.89	98.89	-	-						
143	12/16/04	1610	1610	98.89	98.89	-	-						
144	12/27/04	1610		98.89	-	98.89	-				X		
145	11/15/04	1610		8.86	-	-	8.86	X					
146	10/23/03	1610	1610	98.89	98.89	-	-						
147	02/11/05	1610		101.89	-	-	101.89	X					
148	02/16/05	1610	1610	101.89	101.89	-	-						
149	12/28/04	1610		98.89	-	-	98.89	X					
150	03/16/05	1610		101.89	-	-	101.89	X					
<b>Totals</b>				<b>\$ 12,077.29</b>	<b>\$ 3,863.13</b>	<b>\$ 1,953.48</b>	<b>\$ 6,260.68</b>	<b>95</b>	<b>12</b>	<b>7</b>	<b>6</b>	<b>4</b>	<b>2</b>

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

NEW YORK MEDICAL AND DIAGNOSTIC CENTER  
 DIAGNOSTIC AND TREATMENT CENTER SERVICES AUDIT  
 AUDIT #09-4163  
 AUDIT PERIOD: 01/01/2004 - 12/31/2008

BRIDGE SCHEDULE

SAMPLE #	FINDING	REVISED DRAFT REPORT AMOUNT DISALLOWED	FINAL REPORT AMOUNT DISALLOWED	CHANGE
2	Missing Plan of Care for Rehabilitation Services	\$98.89	\$0.00	(\$98.89)
*2	Incorrect Servicing Provider on Claim	\$0.00	\$98.89	\$98.89
8	Billing for Services Unauthorized by the Operating Certificate	\$101.89	\$0.00	(\$101.89)
*8	Incorrect Servicing Provider on Claim	\$0.00	\$101.89	\$101.89
14	Billing for Services Unauthorized by the Operating Certificate	\$98.89	\$0.00	(\$98.89)
*14	Incorrect Servicing Provider on Claim	\$0.00	\$98.89	\$98.89
20	Missing Plan of Care for Rehabilitation Services	\$98.89	\$0.00	(\$98.89)
*20	Incorrect Servicing Provider on Claim	\$0.00	\$98.89	\$98.89
22	Missing Plan of Care for Rehabilitation Services	\$101.89	\$0.00	(\$101.89)
*22	No Written Order by Physician and/or Dentist for Rehabilitation Services	\$0.00	\$101.89	\$101.89
*22	Incorrect Servicing Provider on Claim	\$0.00	\$0.00	\$0.00
31	Missing Plan of Care for Rehabilitation Services	\$101.89	\$0.00	(\$101.89)
*31	Incorrect Servicing Provider on Claim	\$0.00	\$101.89	\$101.89

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

NEW YORK MEDICAL AND DIAGNOSTIC CENTER  
 DIAGNOSTIC AND TREATMENT CENTER SERVICES AUDIT  
 AUDIT #09-4163  
 AUDIT PERIOD: 01/01/2004 - 12/31/2008

BRIDGE SCHEDULE

SAMPLE #	FINDING	REVISED DRAFT REPORT AMOUNT DISALLOWED	FINAL REPORT AMOUNT DISALLOWED	CHANGE
62	No Written Order by Physician and/or Dentist for Rehabilitation Services	\$98.89	\$0.00	(\$98.89)
74	Missing Plan of Care for Rehabilitation Services	\$98.89	\$0.00	(\$98.89)
115	Billing for Services Unauthorized by the Operating Certificate	\$11.91	\$0.00	(\$11.91)
*115	Incorrect Servicing Provider on Claim	\$0.00	\$11.91	\$11.91
<b>TOTALS</b>		<b>\$812.03</b>	<b>\$614.25</b>	<b>(\$197.78)</b>

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.

\* Additional Finding Remains