



**Office of the
Medicaid Inspector
General**

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

**REVIEW OF EASTERN LONG ISLAND HOSPITAL ASSOCIATION, INC.
CLAIMS FOR OASAS INPATIENT CHEMICAL DEPENDENCE
REHABILITATION TREATMENT CLAIMS
PAID FROM
JANUARY 1, 2010 – DECEMBER 31, 2012**

**FINAL AUDIT REPORT
OMIG AUDIT #: 13-6888
CMS AUDIT #: 1-28307481**

**Dennis Rosen
Medicaid Inspector General**

October 30, 2015



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

October 30, 2015

[REDACTED]

Eastern Long Island Hospital Association, Inc.
201 Manor Place
Greenport, New York 11944-1222

Re: Final Audit Report
OMIG Audit #: 13-6888
CMS Audit #: 1-28307481
Provider ID #: [REDACTED]
NPI #: [REDACTED]

Dear [REDACTED]:

The IPRO Healthcare Integrity Group (IPRO) has been contracted by the Centers for Medicare & Medicaid Services (CMS) to audit providers participating in the New York Medicaid program. Under authority of the Medicaid Integrity Program, IPRO conducted an audit of OASAS inpatient chemical dependence rehabilitation treatment claims paid to Eastern Long Island Hospital Association, Inc. (Provider) between January 1, 2010, and December 31, 2012. IPRO issued a draft audit report to the Provider on May 20, 2015.

In accordance with the collaborative audit plan approved by the CMS and OMIG, OMIG is charged with reviewing IPRO's audit findings and issuing the enclosed final audit report.

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. The adjusted mean point estimate overpaid is \$1,034,808. The adjusted lower confidence limit of the amount overpaid is \$540,704. 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 adjusted lower confidence limit of \$540,704.

[REDACTED]

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If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED]. Please refer to report number 13-6888 in all correspondence.

Sincerely,

[REDACTED]

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

[REDACTED]

Enclosure

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

[REDACTED]

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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

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. 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 inpatient chemical dependency rehabilitation treatment 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 Office of Alcohol and Substance Abuse Services

Chemical dependence inpatient rehabilitation services are provided in either hospital-based or free-standing settings. The purpose of chemical dependence inpatient rehabilitation programs for individuals with a diagnosis of chemical dependence is to provide medical evaluation, clinical care management, clinical services, and rehabilitation services. The specific standards and criteria for chemical dependence inpatient rehabilitation programs are outlined in Title 14 NYCRR Part 818 and Title 18 NYCRR Section 505.27. The MMIS Provider Manual for Clinics also provides program guidance for claiming Medicaid reimbursement for chemical dependence inpatient rehabilitation services.

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for claims 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

The audit period covered payments to the Provider for OASAS inpatient chemical dependence rehabilitation treatment claims paid by Medicaid from January 1, 2010, through December 31, 2012. The audit universe consisted of 634 cases with a total Medicaid payment of \$8,445,796.34.

During this audit, IPRO did not review the overall internal control structure of the Provider. Rather, they limited the internal control review to the objective of the audit.

Auditors reviewed a random sample of 96 cases with \$1,083,473.82 in Medicaid payments. Of the 96 cases in the random sample, 66 cases had at least one error and did not comply with state requirements. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Missing Discharge Summary	59
Not Medically Necessary	9
Missing Discharge Plan	6
Missing Treatment Plan Review	5
Missing Comprehensive Individual Treatment Plan	2
Missing Comprehensive Evaluation	1
Missing Preliminary Individual Treatment Plan	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$200,843.31 in sample overpayments with an extrapolated adjusted point estimate of \$1,034,808. The adjusted lower confidence limit of the amount overpaid is \$540,704.

Methodology

To accomplish the objective, IPRO:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with the Provider's management personnel to gain an understanding of the Pharmacy program;
- ran computer programming application of claims in the Medicaid data warehouse that identified 634 cases for OASAS inpatient chemical dependence rehabilitation treatment, totaling \$8,445,796.34;
- selected a random sample of 96 cases from the population of 634 cases; and,
- estimated the overpayment paid in the population of 634 cases.

Documentation Reviewed

Documentation and original paper and electronic medical records to support services reimbursed by New York State Department of Health were available for review following the entrance conference. A sample of original records was reviewed onsite by the audit team. All records and documentation were copied to discs, provided to the audit team and hand carried to IPRO's Albany office for further review. No original records were removed from the Provider's premises.

The documents collected were analyzed to identify any billing irregularities, or deviations from Medicaid laws, regulations and policies. These documents included patient medical records, accounting records, and billing information.

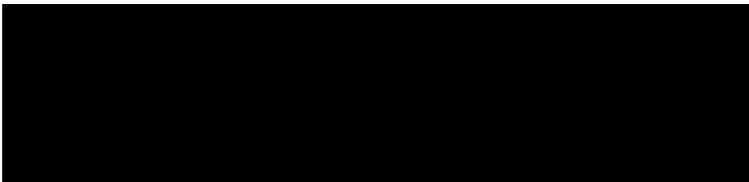
The claims universe was focused on identifying paid claims for OASASD inpatient chemical dependence rehabilitation treatments.

An exit conference was held with Eastern Long Island Hospital Association, Inc. and its representatives on September 17, 2014. The Provider's response to the exit conference, dated September 27, 2014, was considered in the preparation of the Draft Audit Report.

The Provider's response to the Draft Audit Report, dated June 23, 2015, was considered in the preparation of the Final Audit Report, and certain findings were reduced or eliminated as a result. The results of the review are contained in Section III of this report.

Audit Staff:

The following staff conducted this audit:



LAWS, REGULATIONS, RULES AND POLICIES

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

- Departments of Health, Mental Hygiene and Social Services [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, Title 18 NYCRR Section 540.6.
- 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

The following detailed findings reflect the results of the audit:

1. Missing Discharge Summary

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

14 NYCRR Section 818.4(s)

In 59 cases, the discharge summaries were prepared more than 20 days after discharge, ranging from 23 to 452 days after discharge.

Note: This finding will not result in the extrapolation of an associated sampled claim.

2. Not Medically Necessary

Regulations state: "Medical review errors include, but are not limited to the following: vii) Medically unnecessary services."

42 CFR Section 431.960(c)(3)(vii)

Regulations state: "By enrolling the provider agrees: 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."

18 NYCRR Section 504.3(e)

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 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)

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. In this respect, the department may recover the amount paid for such care, services or supplies from the person ordering or prescribing them even though payment was made to another person. 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)

Medical necessity is defined as: "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or health care provider."

American Medical Association Policy H-320.953(3)

Based on IPRO's review of the documentation furnished by the provider, IPRO's Medical Director determined that for 9 cases, the services rendered were not medically necessary either in part or in its entirety; in 4 of these cases the admissions were deemed not medically necessary and in the remaining 5 cases, the lengths of stay were deemed longer than medically necessary.

3. Missing Discharge Plan

Regulations state: "The discharge planning process shall begin as soon as the patient is admitted to the inpatient service and shall be considered a part of the treatment planning process. The discharge plan shall be developed in collaboration with the patient and any significant other(s) the patient chooses to involve."

14 NYCRR Section 818.4(p)

In 6 cases, discharge plans were missing.

4. Missing Treatment Plan Review

Regulations state: "The treatment plan, once established, shall be reviewed and revised at least every fourteen days thereafter by the responsible clinical staff member in consultation with the patient and multidisciplinary team."

14 NYCRR Section 818.4(l)

In 5 cases, the treatment plan review was missing.

5. Missing Comprehensive Individual Treatment Plan

Regulations state: "A comprehensive written individual treatment plan ("the treatment plan") shall be developed and implemented within seven days after admission...."

14 NYCRR Section 818.4(f)

In 2 cases, the comprehensive individual treatment plan was missing.

6. Missing Comprehensive Evaluation

Regulations state: "No later than three days after admission, staff shall complete the patient's comprehensive evaluation..."

14 NYCRR Section 818.4(a)(4)

In 1 case, the comprehensive evaluation was missing.

Note: This finding will not result in the extrapolation of an associated sampled claim.

7. Missing Preliminary Individual Treatment Plan

Regulations state: "A preliminary written individual treatment plan addressing the patient's immediate needs shall be developed and implemented within three days after admission."

14 NYCRR Section 818.4(f)

In 1 case, the preliminary individual treatment plan was missing.

OVERPAYMENTS

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2010, through December 31, 2012, identified 66 cases with at least one error, for a total sample overpayment of \$200,843.31 (Appendix A). The extrapolated adjusted point estimate overpayment is \$1,034,808 and the lower confidence limit overpayment of \$540,704. The Provider's response to the Draft Audit Report, dated June 23, 2015, was considered in the preparation of the Final Audit Report. The results of the review are contained in the Audit Findings section of this report.

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 \$540,704, 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:


New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #14-1956
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


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 \$1,034,808. 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]
Eastern Long Island Hospital
Association, Inc.
201 Manor Place
Greenport, New York 11944-1222

AMOUNT DUE: \$540,704

PROVIDER ID # [REDACTED]

AUDIT #13-6888

	<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 #13-6888
Albany, New York 12237

Thank you for your cooperation.

Appendix A
 Findings for Each Sample Item

Sample #	Date(s) of Service		Rate Code	Date of Payment	Amount Paid	Corrected Amount	Recoupment Amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	Error Codes						
	From:	To:									1. Missing Discharge Summary * @	2. Not Medically Necessary	3. Missing Discharge Plan	4. Missing Treatment Plan Review	5. Missing Comprehensive Individual Treatment Plan	6. Missing Comprehensive Evaluation @	7. Missing Preliminary Individual Treatment Plan
1	01/18/10	03/03/10	2957	03/15/10	\$ 28,096.64	\$ -	\$ 28,096.64	2010	61.59%	\$ 17,304.72	X	X					
2	08/31/09	10/01/09	2957	08/02/10	\$ 27,565.82	\$ 2,667.66	\$ 24,898.16	2010	61.59%	\$ 15,334.78			X				X
4	09/09/09	10/07/09	2957	05/17/10	\$ 24,898.16	\$ 24,008.94	\$ 889.22	2010	61.59%	\$ 547.67	X						
5	07/02/09	07/30/09	2957	06/14/10	\$ 24,898.16	\$ 24,008.94	\$ 889.22	2010	61.59%	\$ 547.67	X						
8	02/02/11	03/07/11	2957	03/21/11	\$ 21,521.61	\$ 4,565.19	\$ 16,956.42	2011	58.77%	\$ 9,965.29	X	X					
9	12/22/10	01/24/11	2957	02/07/11	\$ 21,385.51	\$ 20,737.46	\$ 648.05	2011	58.77%	\$ 380.86	X						
14	02/05/10	03/05/10	2957	05/24/10	\$ 17,879.68	\$ 8,939.84	\$ 8,939.84	2010	61.59%	\$ 5,506.05	X			X			
15	10/13/12	11/12/12	2957	12/03/12	\$ 19,299.00	\$ 18,655.70	\$ 643.30	2013	50.00%	\$ 321.65	X						
16	10/18/12	11/15/12	2957	12/03/12	\$ 18,012.40	\$ 17,369.10	\$ 643.30	2013	50.00%	\$ 321.65	X						
17	07/20/12	08/17/12	2957	09/03/12	\$ 18,012.40	\$ 17,369.10	\$ 643.30	2012	50.00%	\$ 321.65	X						
19	07/01/10	07/29/10	2957	08/16/10	\$ 17,854.68	\$ 17,217.01	\$ 637.67	2010	61.59%	\$ 392.74	X						
21	03/08/10	04/05/10	2957	04/19/10	\$ 17,879.68	\$ 8,939.84	\$ 8,939.84	2010	61.59%	\$ 5,506.05				X			
24	03/11/10	04/08/10	2957	04/26/10	\$ 17,879.68	\$ 8,939.84	\$ 8,939.84	2010	61.59%	\$ 5,506.05				X			
26	09/26/11	10/24/11	2957	12/26/11	\$ 18,067.20	\$ 9,033.60	\$ 9,033.60	2012	50.00%	\$ 4,516.80				X			
29	02/02/12	02/28/12	2957	05/14/12	\$ 16,700.80	\$ 7,065.72	\$ 9,635.08	2012	50.00%	\$ 4,817.54		X					
30	07/25/10	08/22/10	2957	09/06/10	\$ 17,879.68	\$ 17,241.12	\$ 638.56	2010	61.59%	\$ 393.29	X						
32	03/11/11	04/08/11	2957	05/16/11	\$ 18,218.62	\$ 17,567.96	\$ 650.67	2011	56.88%	\$ 370.10	X						
34	09/17/10	10/11/10	2957	10/25/10	\$ 15,325.44	\$ 14,686.88	\$ 638.56	2011	61.59%	\$ 393.29	X						
35	01/07/10	01/18/10	2957	02/01/10	\$ 7,024.16	\$ 6,385.60	\$ 638.56	2010	61.59%	\$ 393.29	X						
36	01/06/12	01/21/12	2957	02/06/12	\$ 9,649.50	\$ 3,859.80	\$ 5,789.70	2012	50.00%	\$ 2,894.85		X					
37	01/23/12	02/03/12	2957	04/23/12	\$ 7,076.30	\$ -	\$ 7,076.30	2012	50.00%	\$ 3,538.15	X	X					
39	07/02/11	07/18/11	2957	08/01/11	\$ 10,338.40	\$ 3,876.90	\$ 6,461.50	2011	50.00%	\$ 3,230.75	X	X					
40	09/23/10	10/11/10	2957	10/25/10	\$ 11,494.08	\$ 10,855.52	\$ 638.56	2011	61.59%	\$ 393.29	X						
42	02/23/10	03/05/10	2957	03/15/10	\$ 6,385.60	\$ 5,747.04	\$ 638.56	2010	61.59%	\$ 393.29	X						
44	08/30/11	09/09/11	2957	12/26/11	\$ 6,461.50	\$ 5,815.35	\$ 646.15	2012	50.00%	\$ 323.08	X						
45	02/24/10	03/07/10	2957	03/22/10	\$ 7,024.16	\$ 6,385.60	\$ 638.56	2010	61.59%	\$ 393.29	X		X				
46	01/25/10	02/03/10	2957	02/22/10	\$ 5,747.04	\$ -	\$ 5,747.04	2010	61.59%	\$ 3,539.60	X	X					
47	07/12/10	07/21/10	2957	08/02/10	\$ 5,747.04	\$ 5,108.48	\$ 638.56	2010	61.59%	\$ 393.29			X				
49	01/19/11	02/04/11	2957	02/14/11	\$ 10,434.72	\$ 9,782.55	\$ 652.17	2011	58.77%	\$ 383.28	X						

*The recoupment amount is a one day disallowance for missing discharge summary unless there are other errors for this claim.

@ This finding will not result in the extrapolation of an associated sampled claim.

Appendix A
 Findings for Each Sample Item

Sample #	Date(s) of Service		Rate Code	Date of Payment	Amount Paid	Corrected Amount	Recoupment Amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	Error Codes						
	From:	To:									1. Missing Discharge Summary * @	2. Not Medically Necessary	3. Missing Discharge Plan	4. Missing Treatment Plan Review	5. Missing Comprehensive Individual Treatment Plan	6. Missing Comprehensive Evaluation @	7. Missing Preliminary Individual Treatment Plan
50	12/17/10	12/29/10	2957	02/14/11	\$ 7,662.72	\$ 1,915.68	\$ 5,747.04	2011	58.77%	\$ 3,377.54	X						X
51	12/29/10	01/07/11	2957	02/28/11	\$ 5,828.70	\$ 5,181.07	\$ 647.63	2011	58.77%	\$ 380.61	X						
52	06/12/10	06/23/10	2957	07/19/10	\$ 7,024.16	\$ 6,385.60	\$ 638.56	2010	61.59%	\$ 393.29	X						
53	05/09/11	05/23/11	2957	06/06/11	\$ 9,021.10	\$ -	\$ 9,021.10	2011	56.88%	\$ 5,131.20	X	X					
55	03/12/10	03/31/10	2957	04/12/10	\$ 12,132.64	\$ 11,494.08	\$ 638.56	2010	61.59%	\$ 393.29	X						
56	01/10/12	01/21/12	2957	02/06/12	\$ 7,076.30	\$ 2,573.20	\$ 4,503.10	2012	50.00%	\$ 2,251.55	X			X			
57	09/06/11	09/16/11	2957	10/17/11	\$ 6,461.50	\$ 3,230.75	\$ 3,230.75	2012	50.00%	\$ 1,615.38	X	X					
58	10/25/11	11/04/11	2957	04/09/12	\$ 6,461.50	\$ 5,815.35	\$ 646.15	2012	50.00%	\$ 323.08	X						
59	11/20/12	12/08/12	2957	12/24/12	\$ 11,579.40	\$ 10,936.10	\$ 643.30	2013	50.00%	\$ 321.65	X						
60	04/26/11	05/10/11	2957	05/23/11	\$ 9,021.10	\$ 8,376.74	\$ 644.36	2011	56.88%	\$ 366.51	X						
61	06/03/10	06/13/10	2957	06/28/10	\$ 6,385.60	\$ 5,747.04	\$ 638.56	2010	61.59%	\$ 393.29	X						
62	09/12/12	10/02/12	2957	10/22/12	\$ 12,866.00	\$ 12,222.70	\$ 643.30	2013	50.00%	\$ 321.65	X						
63	08/29/10	09/17/10	2957	10/04/10	\$ 12,132.64	\$ 11,494.08	\$ 638.56	2011	61.59%	\$ 393.29	X						
64	02/17/11	02/26/11	2957	03/14/11	\$ 5,844.53	\$ 5,195.14	\$ 649.39	2011	58.77%	\$ 381.65	X						
67	08/28/12	09/10/12	2957	09/24/12	\$ 8,362.90	\$ 7,719.60	\$ 643.30	2012	50.00%	\$ 321.65	X						
68	05/18/12	06/01/12	2957	06/18/12	\$ 9,006.20	\$ 8,362.90	\$ 643.30	2012	50.00%	\$ 321.65	X						
69	09/29/11	10/16/11	2957	12/26/11	\$ 10,959.55	\$ 4,512.76	\$ 6,446.79	2012	50.00%	\$ 3,223.40	X		X	X			
70	03/31/10	04/19/10	2957	05/03/10	\$ 12,132.64	\$ 11,494.08	\$ 638.56	2010	61.59%	\$ 393.29	X						
73	12/12/10	12/30/10	2957	02/21/11	\$ 11,469.08	\$ 10,831.91	\$ 637.17	2011	58.77%	\$ 374.47	X						
74	01/24/11	02/06/11	2957	02/21/11	\$ 8,453.21	\$ 7,802.96	\$ 650.25	2011	58.77%	\$ 382.15	X						
75	03/17/12	03/22/12	2957	05/21/12	\$ 3,216.50	\$ 2,573.20	\$ 643.30	2012	50.00%	\$ 321.65	X						
76	08/09/10	08/15/10	2957	08/30/10	\$ 3,806.36	\$ 3,171.97	\$ 634.39	2010	61.59%	\$ 390.72	X						
77	03/20/12	03/22/12	2957	04/02/12	\$ 1,261.60	\$ 630.80	\$ 630.80	2012	50.00%	\$ 315.40	X						
78	11/04/10	11/08/10	2957	11/22/10	\$ 2,554.24	\$ 1,915.68	\$ 638.56	2011	61.59%	\$ 393.29	X	X					
79	11/23/11	11/23/11	2957	12/26/11	\$ 621.15	\$ -	\$ 621.15	2012	50.00%	\$ 310.58	X						
82	04/27/12	05/04/12	2957	05/21/12	\$ 4,503.10	\$ 3,859.80	\$ 643.30	2012	50.00%	\$ 321.65	X						
83	04/09/10	04/11/10	2957	04/26/10	\$ 1,252.12	\$ 626.06	\$ 626.06	2010	61.59%	\$ 385.59	X						
84	03/09/12	03/16/12	2957	04/02/12	\$ 4,503.10	\$ 3,859.80	\$ 643.30	2012	50.00%	\$ 321.65	X	X					
85	06/27/11	07/01/11	2957	07/18/11	\$ 2,584.60	\$ 1,938.45	\$ 646.15	2011	50.00%	\$ 323.08	X						

*The recoupment amount is a one day disallowance for missing discharge summary unless there are other errors for this claim.

@ This finding will not result in the extrapolation of an associated sampled claim.

**Appendix A
 Findings for Each Sample Item**

Sample #	Date(s) of Service		Rate Code	Date of Payment	Amount Paid	Corrected Amount	Recoupment Amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	Error Codes						
	From:	To:									1. Missing Discharge Summary * @	2. Not Medically Necessary	3. Missing Discharge Plan	4. Missing Treatment Plan Review	5. Missing Comprehensive Individual Treatment Plan	6. Missing Comprehensive Evaluation @	7. Missing Preliminary Individual Treatment Plan
86	04/18/11	04/22/11	2957	05/02/11	\$ 2,584.60	\$ 1,938.45	\$ 646.15	2011	56.88%	\$ 367.53	X						
87	07/07/10	07/11/10	2957	07/26/10	\$ 2,554.24	\$ 1,915.68	\$ 638.56	2010	61.59%	\$ 393.29	X						
88	10/27/12	10/29/12	2957	11/12/12	\$ 1,261.60	\$ 630.80	\$ 630.80	2013	50.00%	\$ 315.40	X						
89	08/18/09	08/28/09	2957	01/10/11	\$ 1,068.00	\$ 961.20	\$ 106.80	2011	58.77%	\$ 62.77	X						
91	04/19/12	04/25/12	2957	05/14/12	\$ 3,859.80	\$ 3,216.50	\$ 643.30	2012	50.00%	\$ 321.65	X						
92	01/19/12	01/27/12	2957	02/13/12	\$ 5,146.40	\$ 4,503.10	\$ 643.30	2012	50.00%	\$ 321.65	X	X					
93	06/01/10	06/02/10	2957	06/21/10	\$ 638.56	\$ -	\$ 638.56	2010	61.59%	\$ 393.29	X						
96	03/30/11	04/01/11	2957	04/18/11	\$ 1,304.34	\$ 652.17	\$ 652.17	2011	56.88%	\$ 370.95	X						
					\$ 671,359.44	\$ 470,516.13	\$ 200,843.31			\$115,014.74	59	9	6	5	2	1	1

Federal Share Summary**	
Federal FY	Federal Share Amount
2010	\$ 59,287.83
2011	\$ 27,421.90
2012	\$ 26,703.01
2013	\$ 1,602.00
Total	\$ 115,014.74

**The Extrapolated Federal Share is \$303,186.28

*The recoupment amount is a one day disallowance for missing discharge summary unless there are other errors for this claim.

@ This finding will not result in the extrapolation of an associated sampled claim.

Appendix B Sample Design

The sample design used for Audit #13-6888 was as follows:

- Universe - Medicaid claims for OASAS inpatient chemical dependence rehabilitation treatment paid during the period January 1, 2010, through December 31, 2012.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for OASAS inpatient chemical dependence rehabilitation treatment paid during the period January 1, 2010, through December 31, 2012.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2010, through December 31, 2012.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 96 cases.

Appendix C
Extrapolation of Sample Findings

Total Sample Recoupment	\$ 200,843.31
Less Recoupments Not Projected*	<u>(28,178.29)</u>
Sample Recoupment for Extrapolation Purposes	\$ 172,665.02
Cases in Sample	96
Overpayments Per Sample Case	\$ 1,798.59
Cases in Universe	634
Mean Point Estimate	\$ 1,006,630
Add Overpayments Not Projected*	<u>28,178</u>
Adjusted Mean Point Estimate	<u>\$ 1,034,808</u>
Lower Confidence Limit	\$ 512,526
Add Overpayments Not Projected*	<u>28,178</u>
Adjusted Lower Confidence Limit	<u>\$ 540,704</u>

* The actual dollar disallowance for the "**Missing Discharge Summary**" finding was subtracted from the total sample overpayment and added to the Meanpoint Estimate and the Lower Confidence Limit. The dollars associated with this finding were not used in the extrapolation.