



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

September 17, 2015

[REDACTED]
[REDACTED]
Hampton Homecare, Inc.
50 Alexander Court, Suite 3
Ronkonkoma, New York 11968

Final Audit Report

Audit #09-4806

Provider ID # [REDACTED]

Dear [REDACTED]:

This letter will serve as our final audit report of the recently completed review of payments made to Hampton Homecare, Inc. (the Provider) under the New York State Medicaid Program

The New York State Department of Health (DOH) is responsible for the administration of the Medicaid program. As part of this responsibility, the Office of the Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assessing provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Department of Health [Titles 10 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 18 NYCRR)] and the Medicaid Management Information System (MMIS) Provider Manuals.

Department regulations define durable medical appliances, equipment and supplies (DME) as follows: durable medical equipment is devices and equipment, other than prosthetic and orthotic appliances, which have been ordered by a practitioner in the treatment of a specific medical condition. Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment or orthopedic footwear, which have been ordered by a practitioner in the treatment of a specific medical condition. Orthotic appliances and devices are those used to support a weak or deformed body member, or to restrict or eliminate motion in a diseased or injured part of the body. Prosthetic appliances and devices (excluding artificial eyes and dental prostheses) are those ordered by a qualified practitioner, which replace any missing part of the body. Orthopedic footwear is shoes, shoe modifications, or shoe additions used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased part of the ankle or foot, or to form an integral part of a brace. The specific standards and criteria pertaining to DME are outlined in Title 18 NYCRR Section 505.5 and the MMIS Provider Manual for Durable Medical Equipment et al.

A review of payments to the Provider for DME services paid by Medicaid September 1, 2004, through December 31, 2008, was recently completed. During the audit period, \$3,926,053.54 was paid for 45,069 claims for services rendered. This review consisted of a random sample of 100 claims with Medicaid payments of \$9,547.29. The purpose of this audit was to verify that: durable medical appliances; equipment and supplies (DME) were properly authorized by a licensed practitioner; Medicaid reimbursable equipment; supplies and services were rendered for the dates billed; appropriate procedure codes were billed for equipment; supplies and services rendered; vendor records contained the documentation required by the regulations; and claims for payment were submitted in accordance with Department regulations and the Provider Manuals for Durable Medical Equipment.

The Provider's failure to comply with Title(s) 10, or 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) and the MMIS Provider Manual for Durable Medical Equipment resulted in a total sample overpayment of \$3,778.67.

The statistical sampling methodology employed allows for extrapolation of the sample findings to the universe of services (18 NYCRR Section 519.18). The adjusted mean per unit point estimate of the amount overpaid is \$1,552,790. The adjusted lower confidence limit of the amount overpaid is \$1,107,075. We are 95% certain that the actual amount of the overpayment is greater than the adjusted lower confidence limit (Exhibit I). This audit may be settled through repayment of the adjusted lower confidence limit of \$1,107,075.

The following detailed findings reflect the results of our audit. This audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report dated July 22, 2014. The attached Bridge Schedule indicates any changes to the findings as a result of your response (Exhibit XIV).

DETAILED FINDINGS

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)

1. No Written Order

Regulations state, "All durable medical equipment, medical/surgical supplies, may be furnished only upon a written order of a practitioner."

18 NYCRR Section 505.5(b)(1)

Medicaid policy states, "All medical/surgical supplies, durable medical equipment . . . must be supported by the original, signed written order of a licensed physician, dentist, podiatrist, physician assistant or nurse practitioner."

*NYS Medicaid Program Durable Medical Equipment Manual
Policy Guidelines, Version 2004-1, Section III*

In 6 instances pertaining to 5 patients, the written order for the items provided was missing. This resulted in a sample overpayment of \$1,189.54 (Exhibit II).

2. **Missing Documentation Confirming Receipt/Delivery of Item**

Regulations state, "Written orders for durable medical equipment, medical/surgical supplies, prosthetic or orthotic devices, or orthopedic footwear must be maintained by the provider submitting the claim for audit by the department or other authorized agency for six years from the date of payment." *18 NYCRR Section 505.5(c)(2)*

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) and Section 517.3

Medicaid policy states, "For audit purposes, . . . written orders, in addition to other supporting documentation such as invoices and delivery receipts, must be kept on file for six years from the date the service was furnished or billed, whichever is later."

*NYS Medicaid Program Durable Medical Equipment Manual
Policy Guidelines, Version 2004-1, Section I*

In 5 instances pertaining to 5 patients, documentation confirming receipt/delivery of item was missing. This resulted in a sample overpayment of \$617.42 (Exhibit III).

3. **Item Billed in Excess of Quantity Ordered**

Regulations state, "When used in the context of an order for a prescription item, the order must also meet the requirements for a prescription under section 6810 of the Education Law. When used in the context of a nonprescription item, the order must also contain the following information: name of the item, quantity ordered. . . ." *18 NYCRR Section 505.5(b)(3)*

In 21 instances pertaining to 21 patients, the item was billed in excess of the quantity prescribed by the orderer. This resulted in a sample overpayment of \$615.11 (Exhibit IV).

4. **Order Refilled More Than 180 Days After It Has Been Initiated by the Prescriber**

Regulations state, "No order can be refilled more than 180 days from the original date ordered." *18 NYCRR Section 505.5(b)(4)(iii)*

In 4 instances pertaining to 4 patients, the order was refilled more than 180 days after the date initiated by the prescriber. This resulted in a sample overpayment of \$359.40 (Exhibit V).

5. Ordering Prescriber Conflicts with Claim Prescriber

Medicaid policy states that the billing provider is to enter the New York State Medicaid ID number of the ordering prescriber on the claim. If the ordering prescriber is not enrolled in Medicaid, enter his/her license number.

When a prescription or order originates from a hospital or clinic, and is written by an intern or resident, the supervising physician's Medicaid ID number should be entered. If the supervising physician is not enrolled in the Medicaid program, his or her state license number may be used instead. When the order is originated in an Article 28 facility and these numbers are unavailable, it is permissible to use the facility's New York State Medicaid ID number.

*NYS Medicaid Program Durable Medical Equipment Manual
Billing Guidelines, Version 2004-1, Section II*

Regulations state: "The identity of the practitioner who ordered the ...medical/surgical supply, must be recorded by the provider on the claim for payment by entering in the license or MMIS provider identification number of the practitioner where indicated."

18 NYCRR Section 505.5(c)(1)

In 4 instances pertaining to 4 patients, the ordering prescriber on the claim conflicts with the ordering prescriber denoted on the fiscal order. This resulted in a sample overpayment of \$334.05 (Exhibit VI). For this category of findings, OMIG will disallow only the actual amount of the sample overpayment and will not extrapolate the sample findings to the universe of services.

6. Item Billed Does Not Match Ordered Item

Regulations state, "When used in the context of an order for a prescription item, the order must also meet the requirements for a prescription under section 6810 of the Education Law. When used in the context of a nonprescription item, the order must also contain the following information: name of the item. . . ."

18 NYCRR Section 505.5(b)(3)

In 2 instances pertaining to 2 patients, the item billed does not match the ordered item. This resulted in a sample overpayment of \$209.40 (Exhibit VII).

7. Other Insurance Payments Not Applied

Regulations state, "MA program as payment source of last resort. Where a third party, such as health insurer or responsible person, has a legal liability to pay for MA-covered services on behalf of a recipient, the department or social services will pay only the amount by which the MA reimbursement rate for the services exceeds the amount of the third party liability."

18 NYCRR Section 360-7.2

Regulations state, "Any insurance payments including Medicare must be applied against the total purchase price of the item."

18 NYCRR Section 505.5(d)(1)(v)

In 2 instances pertaining to 2 patients, a third party insurance payment was not applied against the total purchase price of the item. This resulted in a sample overpayment of \$181.92 (Exhibit VIII).

8. **Billing of Item Prior to Delivery**

Medicaid policy states, "No item/service (including refills) may be billed prior to being furnished."
*NYS Medicaid Program Durable Medical Equipment Manual
 Policy Guidelines, Version 2004-1, Section III*

In 2 instances pertaining to 2 patients, the item was billed prior to being delivered. This resulted in a sample overpayment of \$95.44 (Exhibit IX).

9. **No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items**

Medicaid policy requires that, for items provided to Medicaid recipients who are also Medicare beneficiaries, "All charges must first be billed to Medicare. Only after an Explanation of Medical Benefits (EOB) is received from the Medicare intermediary and payment made, where appropriate, may a claim be submitted for Medicaid reimbursement. The provider must maintain the EOB on file for six years following the date of payment for audit purposes."

*NYS Medicaid Program Durable Medical Equipment Manual
 Policy Guidelines, Version 2004-1, Section III*

Medicaid policy states: Medicaid law and regulations require that, when a recipient is eligible for both Medicare and Medicaid or has other insurance benefits: The provider must bill Medicare or the other insurance first for **covered** services **prior** to submitting a claim to Medicaid.

- If the service is covered, or the provider does not know if the service is covered by Medicare and/or other available insurance, the provider must first submit a claim to Medicare and/or other insurance.
- **Only when you are certain that Medicare or another insurer does not cover the service, can you bill Medicaid solely, and not bill other insurer first.**

DOH Medicaid Update December 2005 Vol. 20, No. 13, Office of Medicaid Management

In 2 instances pertaining to 2 patients, no EOB was found for a Medicare eligible patient who received an item covered by Medicare. This resulted in a sample overpayment of \$81.34 (Exhibit X).

10. **No Documentation of Service**

Regulations state, "Written orders for durable medical equipment, medical/surgical supplies, prosthetic or orthotic devices, or orthopedic footwear must be maintained by the provider submitting the claim for audit by the department or other authorized agency for six years from the date of payment."
18 NYCRR Section 505.5(c)(2)

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 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 517.3

Medicaid policy states, "Federal Law and State Regulations require providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to Medicaid enrollees."

NYS Medicaid Program Provider Manual Information for all Providers, Version 2004-1, Section II

In 1 instance, the service billed was not documented. This resulted in a sample overpayment of \$75.00 (Exhibit XI).

11. Improper Medicaid Billings for Medicare Crossover Patients

Regulations state, "MA program as payment source of last resort. Where a third party, such as health insurer or responsible person, has a legal liability to pay for MA-covered services on behalf of a recipient, the department or social services will pay only the amount by which the MA reimbursement rate for the services exceeds the amount of the third party liability."

18 NYCRR Section 360-7.2

Regulations state, "The MA program will pay on behalf of qualified Medicare beneficiaries...the full amount of any deductible and coinsurance costs incurred under Part A or B of Title XVIII of the Social Security Act (Medicare)."

18 NYCRR Section 360-7.7(a)

Medicaid policy requires that, for items provided to Medicaid recipients who are also Medicare beneficiaries, "All charges must first be billed to Medicare. Only after an Explanation of Medical Benefits (EOB) is received from the Medicare intermediary and payment made, where appropriate, may a claim be submitted for Medicaid reimbursement. The provider must maintain the EOB on file for six years following the date of payment for audit purposes."

NYS Medicaid Program Durable Medical Equipment Manual Policy Guidelines, Version 2004-1, Section III

Medicaid policy also states that, "Medicaid is required to pay the Medicare co-insurance and deductible for Medicare covered supplies, equipment and appliances provided to Medicaid recipients who are also Medicare beneficiaries. Medicaid will pay the difference between the Medicare approved amount and the Medicare paid amount."

NYS Medicaid Program Durable Medical Equipment Manual Policy Guidelines, Version 2004-1, Section III

In 1 instance, an incorrect Medicaid co-payment was billed for services also paid by Medicare. This resulted in a sample overpayment of \$20.05 (Exhibit XII).

Additional reasons for disallowance exist regarding certain findings. These findings are identified in Exhibit XIII.

Total sample overpayments for this audit amounted to \$3,778.67.

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 \$1,107,075, 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, B.A.M.
 GNARESP Corning Tower, Room 2739
 File #09-4806
 Albany, New York 12237-0048

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
 [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 meanpoint estimate of \$1,552,790. 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.

Should you have any questions, please contact [REDACTED]

Thank you for the cooperation and courtesy extended to our staff during this audit.

Sincerely,

[REDACTED]

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

[REDACTED]

Enc. Exhibits I-XIV

[REDACTED]

[REDACTED]

cc: [REDACTED]

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

██████████
Hampton Homecare, Inc.
50 Alexander Court, Suite 3
Ronkonkoma, New York, 11968

PROVIDER ID # ██████████

AUDIT # 09-4806

AMOUNT DUE: \$1,107,075

AUDIT	<input checked="" type="checkbox"/> PROVIDER
	<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:

██████████
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File #09-4806
Albany, New York 12237-0048

Thank you for your cooperation.

EXHIBIT I

HAMPTON HOMECARE, INC.
 DURABLE MEDICAL EQUIPMENT AUDIT
 AUDIT # 09-4806
 AUDIT PERIOD: 09/01/04 – 12/31/08

EXTRAPOLATION OF SAMPLE FINDINGS

Total Sample Overpayments	\$	3,778.67
Less Overpayments Not Projected*		<u>(334.05)</u>
Sample Overpayments for Extrapolation Purposes	\$	3,444.62
Services in Sample		100
Overpayments Per Sampled Service	\$	34.4462
Services in Universe		45,069
Meanpoint Estimate	\$	1,552,456
Add Overpayments Not Projected*		<u>334</u>
Adjusted Meanpoint Estimate	\$	<u>1,552,790</u>
Lower Confidence Limit	\$	1,106,741
Add Overpayments Not Projected*		<u>334</u>
Adjusted Lower Confidence Limit	\$	<u>1,107,075</u>

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

- **Finding #5 – Ordering Prescriber Conflicts with Claim Prescriber**

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.

HAMPTON HOMECARE, INC.

Provider Number: [REDACTED]

Audit Number: 09-4806

No Written Order

Sample #	Date of Service	Procedure Code	Amount Disallowed
2	04/11/06	B4035	\$249.60
56	10/22/07	B4150	\$154.35
85	07/07/08	T4524	\$179.00
87	12/13/05	T4521	\$90.24
97	10/12/07	B4154	\$266.75
98	08/16/06	B4035	<u>\$249.60</u>
Total Services:		<u>6</u>	<u>\$1,189.54</u>

HAMPTON HOMECARE, INC.

Provider Number: [REDACTED]

Audit Number: 09-4806

Missing Documentation Confirming Receipt/Delivery of Item

Sample #	Date of Service	Procedure Code	Amount Disallowed
10	09/11/06	T4522	\$76.50
36	05/11/06	A4554	\$84.00
46	07/11/06	T4523	\$170.00
62	10/26/07	B4160	\$189.00
81	12/04/06	T4522	\$97.92
Total Services: <u>5</u>			<u>\$617.42</u>

HAMPTON HOMECARE, INC.

Provider Number: [REDACTED]

Audit Number: 09-4806

Item Billed in Excess of Quantity Ordered

Sample #	Date of Service	Procedure Code	Amount Disallowed
8	06/12/07	B4150	\$13.23
11	06/27/08	B4160	\$52.02
13	09/24/07	B4154	\$12.75
17	03/29/07	B4160	\$9.36
19	09/07/07	B4150	\$13.23
20	02/18/08	B4150	\$48.51
26	10/17/07	B4150	\$48.51
28	09/26/08	B4160	\$24.42
35	07/25/08	B4160	\$61.02
45	03/30/07	B4150	\$55.86
58	10/29/08	B4150	\$14.21
59	03/13/08	B4150	\$48.51
63	07/02/08	B4150	\$44.10
68	04/02/08	B4150	\$13.23
77	07/31/08	B4150	\$41.16
80	04/07/08	B4150	\$44.10
88	02/21/07	B4150	\$20.58
89	05/08/07	B4150	\$13.23
90	03/02/07	B4160	\$9.36
96	09/27/07	B4160	\$9.36
100	10/15/07	B4160	\$18.36
Total Services:			<u>21</u>
			<u>\$615.11</u>

HAMPTON HOMECARE, INC.

Provider Number: [REDACTED]

Audit Number: 09-4806

Order Refilled More Than 180 Days After It Has Been Initiated by the Prescriber

Sample #	Date of Service	Procedure Code	Amount Disallowed
7	06/29/06	A4554	\$84.00
23	10/18/06	A4927	\$4.55
61	08/08/06	T4521	\$117.50
70	07/31/07	B4150	<u>\$153.35</u>
Total Services:		<u>4</u>	<u>\$359.40</u>

HAMPTON HOMECARE, INC.

Provider Number: [REDACTED]

Audit Number: 09-4806

Ordering Prescriber Conflicts with Claim Prescriber

Sample #	Date of Service	Procedure Code	Amount Disallowed
1	04/14/08	B4150	\$147.00
67	10/02/06	T4522	\$127.50
91	01/15/07	T4535	\$55.00
93	04/05/07	A4927	<u>\$4.55</u>
Total Services: 4			<u>\$334.05</u>

HAMPTON HOMECARE, INC.

Provider Number: [REDACTED]

Audit Number: 09-4806

Item Billed Does Not Match Ordered Item

Sample #	Date of Service	Procedure Code	Amount Disallowed
49	02/02/07	B4152	\$125.40
82	01/23/07	A4554	<u>\$84.00</u>
Total Services:		<u>2</u>	<u>\$209.40</u>

HAMPTON HOMECARE, INC.

Provider Number: [REDACTED]

Audit Number: 09-4806

Other Insurance Payments Not Applied

Sample #	Date of Service	Procedure Code	Amount Disallowed
38	03/14/08	T4522	\$97.92
39	12/26/06	A4554	<u>\$84.00</u>
Total Services:		<u>2</u>	<u>\$181.92</u>

HAMPTON HOMECARE, INC.

Provider Number: [REDACTED]

Audit Number: 09-4806

Billing of Item Prior to Delivery

Sample #	Date of Service	Procedure Code	Amount Disallowed
37	04/30/08	T4535	\$70.00
48	02/13/08	B4100	<u>\$25.44</u>
Total Services:		<u>2</u>	<u>\$95.44</u>

HAMPTON HOMECARE, INC.

Provider Number: [REDACTED]

Audit Number: 09-4806

No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items

Sample #	Date of Service	Procedure Code	Amount Disallowed
34	01/08/07	E0470	\$53.89
65	01/08/07	A6234	<u>\$25.45</u>
Total Services:		<u>2</u>	<u>\$81.34</u>

HAMPTON HOMECARE, INC.

Provider Number: [REDACTED]

Audit Number: 09-4806

No Documentation of Service

Sample #	Date of Service	Procedure Code	Amount Disallowed
40	11/21/03	L1810	<u>\$75.00</u>
Total Services:		<u>1</u>	<u>\$75.00</u>

HAMPTON HOMECARE, INC.

Provider Number: [REDACTED]

Audit Number: 09-4806

Improper Medicaid Billings for Medicare Crossover Patients

<u>Sample #</u>	<u>Date of Service</u>	<u>Procedure Code</u>	<u>Amount Disallowed</u>
21	11/19/05	K0003	<u>\$20.05</u>
Total Services:		1	<u>\$20.05</u>

HAMPTON HOMECARE, INC.
Provider Number: [REDACTED]
Audit Number: 09-4806

Additional Findings Pertaining to Sampled Items

Sample #	Date of Service	Primary Finding	Other Findings Pertaining to Sampled Item
7	06/29/2006	Order Refilled More Than 180 Days After It Has Been Initiated by the Prescriber	Telephone or Fax Order Lacks Signed** Follow Up Order Missing Documentation Confirming Receipt/Delivery of Item
10	09/11/2006	Missing Documentation Confirming Receipt/Delivery of Item	Ordering Prescriber Conflicts with Claim Prescriber
23	10/18/2006	Order Refilled More Than 180 Days After It Has Been Initiated by the Prescriber	Telephone or Fax Order Lacks Signed** Follow Up Order
36	05/11/2006	Missing Documentation Confirming Receipt/Delivery of Item	Ordering Prescriber Conflicts with Claim Prescriber
37	04/30/2008	Billing of Item Prior to Delivery	Other Insurance Payments Not Applied
49	02/02/2007	Item Billed Does Not Match Ordered Item	Item Billed in Excess of Quantity Ordered
61	08/08/2006	Order Refilled More Than 180 Days After It Has Been Initiated by the Prescriber	Telephone or Fax Order Lacks Signed** Follow Up Order Ordering Provider Conflicts with Claim Provider
65	01/08/2007	No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items	Missing Documentation Confirming Receipt/Delivery of Item Ordering Prescriber Conflicts with Claim Prescriber
87	12/13/2005	No Written Order	Missing Documentation Confirming Receipt/Delivery of Item

HAMPTON HOMECARE, INC.
Provider Number: [REDACTED]
Audit Number: 09-4806

Additional Findings Pertaining to Sampled Items

**** Telephone or Fax Order Lacks Signed Follow Up Order**

Medicaid policy states, "In the event an order for durable medical equipment, medical-surgical supplies, or orthotic or prosthetic appliances has been telephoned or faxed to the provider, it is the provider's responsibility to obtain the signed fiscal order from the ordering practitioner within 30 calendar days."

*NYS Medicaid Program Durable Medical Equipment Manual
Policy Guidelines, Version 2004-1, Section I*

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

HAMPTON HOMECARE, INC.
 DURABLE MEDICAL EQUIPMENT SERVICES AUDIT
 AUDIT #09-4806
 AUDIT PERIOD: 09/01/04 - 12/31/08

BRIDGE SCHEDULE

SAMPLE #	FINDING	DRAFT REPORT AMOUNT DISALLOWED	FINAL REPORT AMOUNT DISALLOWED	CHANGE
15	Missing Documentation Confirming Receipt/Delivery of Item	\$22.34	\$0.00	(22.34)
32	Missing Documentation Confirming Receipt/Delivery of Item	\$4.55	\$0.00	(4.55)
34	Missing Documentation Confirming Receipt/Delivery of Item	\$53.89	\$0.00	(53.89)
34	No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items	\$0.00	\$53.89	53.89
55	No Written Order	\$97.92	\$0.00	(97.92)
60	No Written Order	\$42.20	\$0.00	(42.20)
63	Missing Documentation Confirming Receipt/Delivery of Item	\$153.35	\$0.00	(153.35)
63	Item Billed In Excess of Quantity Ordered	\$0.00	\$44.10	44.10
69	Missing Documentation Confirming Receipt/Delivery of Item	\$2.68	\$0.00	(2.68)
72	Missing Documentation Confirming Receipt/Delivery of Item	\$97.50	\$0.00	(97.50)
75	No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items	\$97.63	\$0.00	(97.63)
79	Missing Documentation Confirming Receipt/Delivery of Item	\$146.88	\$0.00	(146.88)
80	Missing Documentation Confirming Receipt/Delivery of Item	\$153.35	\$0.00	(153.35)
80	Item Billed In Excess of Quantity Ordered	\$0.00	\$44.10	44.10
86	Missing Documentation Confirming Receipt/Delivery of Item	\$70.00	\$0.00	(70.00)
TOTALS		\$942.29	\$142.09	(800.20)

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.