



**Office of the
Medicaid Inspector
General**

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

**REVIEW OF SIBLEY NURSING PERSONNEL SERVICES INC. TBI
CLAIMS FOR TRAUMATIC BRAIN INJURY SERVICES
PAID FROM
JANUARY 1, 2007 – DECEMBER 31, 2010**

**FINAL AUDIT REPORT
AUDIT #: 11-5735**

**Dennis Rosen
Medicaid Inspector General**

September 15, 2015



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

September 15, 2015

[REDACTED]

Lifetime Care – owner of Sibley Nursing Personnel Services Inc.
3111 South Winton Road
Rochester, New York 14623

Re: Final Audit Report
Audit #: 11-5735
Provider ID #: [REDACTED]

Dear [REDACTED]:

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Sibley Nursing Personnel Services Inc. TBI" (Provider) paid claims for Traumatic Brain Injury services covering the period January 1, 2007, through December 31, 2010.

In the attached final audit report, the OMIG has detailed our scope, procedures, laws, regulations, rules and policies, sampling technique, findings, provider rights, and statistical analysis.

The OMIG has attached the sample detail for the paid claims determined to be in error. This final audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report dated July 31, 2015. The mean point estimate overpaid is \$736,372. The lower confidence limit of the amount overpaid is \$309,472. 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 \$309,472.

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED]. Please refer to report number 11-5735 in all correspondence.

Sincerely,

[REDACTED]

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

[REDACTED]

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

Cc: [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]

[REDACTED]

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

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

DIVISION OF MEDICAID AUDIT

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

DIVISION OF MEDICAID INVESTIGATIONS

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

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

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

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

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

EXECUTIVE SUMMARY

BACKGROUND

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

The Home and Community Based Services Waiver for Traumatic Brain Injury (HCBS/TBI) is a federally approved New York State Department of Health (Department) program to make thirteen different services, not included in the State's Medicaid Plan, available to persons with traumatic brain injury who meet certain eligibility criteria. The services focus on the community repatriation of New York State TBI individuals who reside in high cost institutionalized settings, and the avoidance of institutional placement for those who are at significant risk. The waiver is funded under the Medicaid Program and the costs are shared by the Federal, State and local governments.

HCBS/TBI services may be provided by not-for-profit or proprietary health and human service agencies. Providers of services must be approved by the Department for participation in the waiver, sign a contract agreement with the Department, and meet the standards established for each waiver service. Services provided by a HCBS/TBI provider are based on a written service plan for each participant that is developed with the waiver participant (or designated advocate) and a service coordinator selected by the participant. All plans are approved by the Department.

A HCBS/TBI Waiver provider is generally subject to Title XIX of the Federal Social Security Act and Article 27-CC of the New York State Public Health Law. The specific standards and criteria for HCBS/TBI waiver services are outlined in the Department HCBS/TBI Provider Manual, the related MMIS Manual, various administrative directives issued by the Department, and the contractual agreement with the Department for the HCBS/TBI Waiver

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for Traumatic Brain Injury services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to Traumatic Brain Injury claims, this audit covered services paid by Medicaid from January 1, 2007, through December 31, 2010.

SUMMARY OF FINDINGS

We inspected a random sample of 100 claims with \$16,203.20 in Medicaid payments. Of the 100 claims in our random sample, 17 claims had at least one error and did not comply with state requirements. Of the 17 noncompliant claims, none contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Partial Service Hours Were Billed Incorrectly	12
TBI Training Not Completed – Home and Community Support Services (HCSS)	2
Missing Documentation of Service	1
Incorrect Rate Code Billed	1
Services Performed by Unqualified Home and Community Support Services (HCSS) Staff	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$1,061.56 in sample overpayments with an extrapolated point estimate of \$736,372. The lower confidence limit of the amount overpaid is \$309,472.

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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 Traumatic Brain Injury 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 Traumatic Brain Injury Program

The Home and Community Based Services Waiver for Traumatic Brain Injury (HCBS/TBI) is a federally approved New York State Department of Health (Department) program to make thirteen different services, not included in the State's Medicaid Plan, available to persons with traumatic brain injury who meet certain eligibility criteria. The services focus on the community repatriation of New York State TBI individuals who reside in high cost institutionalized settings, and the avoidance of institutional placement for those who are at significant risk. The waiver is funded under the Medicaid Program and the costs are shared by the Federal, State and local governments.

HCBS/TBI services may be provided by not-for-profit or proprietary health and human service agencies. Providers of services must be approved by the Department for participation in the waiver, sign a contract agreement with the Department, and meet the standards established for each waiver service. Services provided by a HCBS/TBI provider are based on a written service plan for each participant that is developed with the waiver participant (or designated advocate) and a service coordinator selected by the participant. All plans are approved by the Department.

A HCBS/TBI Waiver provider is generally subject to Title XIX of the Federal Social Security Act and Article 27-CC of the New York State Public Health Law. The specific standards and criteria for HCBS/TBI waiver services are outlined in the Department HCBS/TBI Provider Manual, the related MMIS Manual, various administrative directives issued by the Department, and the contractual agreement with the Department for the HCBS/TBI Waiver.

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for Traumatic Brain Injury 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 Traumatic Brain Injury services paid by Medicaid from January 1, 2007, through December 31, 2010. Our audit universe consisted of 69,367 claims totaling \$11,785,238.77.

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 Traumatic Brain Injury program;
- ran computer programming application of claims in our data warehouse that identified 69,367 paid Traumatic Brain Injury claims, totaling \$11,785,238.77
- selected a random sample of 100 claims from the population of 69,367 claims; and,
- estimated the overpayment paid in the population of 69,367 claims.

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

- Medicaid electronic claim information
- Patient record, including, but not limited to:
 - Notice of Decision/Notice of Ongoing Authorization
 - Initial and/or Revised Service Plan
 - Plan for Protective Oversight

- Service Documentation, e.g.; Service Coordination Notes, ILST Notes and HCSS Activity Sheets
- Any additional documentation deemed by the Provider necessary to substantiate the Medicaid paid claim

LAWS, REGULATIONS, RULES AND POLICIES

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

- Departments of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, Title 18 NYCRR Section 540.6.
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

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

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

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

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

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

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

18 NYCRR Section 518.1(c)

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

18 NYCRR Section 540.1

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

18 NYCRR Section 518.3(a)

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

18 NYCRR Section 518.3(b)

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

18 NYCRR Section 518.3(b)

AUDIT FINDINGS

This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated July 31, 2015. The information provided resulted in no change to any of the disallowances. The findings in the Final Audit Report are identical to those in the Draft Audit Report.

AUDIT FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2007, through December 31, 2010, identified 17 claims with at least one error, for a total sample overpayment of \$1,061.56 (Attachment C).

1. Partial Service Hours Were Billed Incorrectly

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 from the date of 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 and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health..." and "to comply with the rules, regulations and official directives of the Department."
18 NYCRR Section 504.3(a) and (i)

The HCBS/TBI Waiver Provider Manual states: "All HCBS/TBI Waiver Services must be documented in the Service Plan, and provided by individuals or agencies approved as a provider of this waiver service by the State Department of Social Services. The services will be reimbursed on an hourly basis".

HCBS/TBI Waiver Provider Manual, Section V

The HCBS/TBI Waiver Provider Manual states that, "Independent Living Skills Training and Development are services individually designed to improve the ability of the waiver participant to live as independently as possible in the community. . . . This service will be reimbursed on an hourly basis."

HCBS/TBI Waiver Provider Manual, Section V

The HCBS/TBI Waiver Provider Manual states that, "Home and Community Support Services are individually designed support services essential for the waiver participant's health and welfare. . . . This service will be reimbursed on an hourly basis".

HCBS/TBI Waiver Provider Manual, Section V

The January 2005 Medicaid Update states that, ". . .service of less than one hour should be carried forward to the next service date and combined to accumulate billable time in whole hours. This practice should be fully documented.

DOH Medicaid Update January 2005, Volume 20, No. 1

The Traumatic Brain Injury Program Manual states: "Due to cognitive, physical or behavioral limitations related to a traumatic brain injury (e.g. short term memory, low frustration level, etc.), a participant may benefit from services in shorter intervals than the billable unit of service. In these situations, units of service may be accumulated in 15-minute intervals and billed when a full billable unit has been provided. The provider is responsible for maintaining sufficient documentation to verify the dates and times for services provided."

*Traumatic Brain Injury Program Manual,
June 2006, Section VI*

The Traumatic Brain Injury Program Manual also states: "Due to cognitive, physical or behavioral limitations related to a traumatic brain injury (e.g. short term memory, low frustration level, etc.), a participant may benefit from services in shorter intervals than the billable unit of service. In these situations, units of service may be accumulated in 15-minute intervals and billed when a full billable unit has been provided. The provider is responsible for maintaining sufficient documentation to verify the dates and times for services provided."

*Traumatic Brain Injury Program Manual,
April 2009, Section VI*

In 12 instances pertaining to 12 participants, partial service hours of the waiver services were rounded up to the next whole hour, rather than carried forward to the next service date. This finding applies to Sample #'s 10, 14, 16, 17, 19, 31, 48, 49, 65, 75, 79, and 85.

2. TBI Training Not Completed – Home and Community Support Services (HCSS)

The HCBS/TBI Waiver Provider Manual states that the individual who provides these services must complete training concerning traumatic brain injury. This training will be provided by the agency employing this individual, and will be completed prior to the provision of the service.

HCBS/TBI Waiver Provider Manual, Section V

The Traumatic Brain Injury Program Manual states that there are three components of required training for Waiver Service providers: (1) Basic Orientation Training, (2) Service Specific Training, and (3) Annual Training. An approved provider agency is responsible for: developing a written training curriculum to meet the requirements identified in this section, ensuring that individuals providing the training meet the qualifications specified in this section; providing Basic Orientation Training and the appropriate Service Specific Training to all waiver providers prior to any unsupervised contact with a waiver participant; providing required annual training to all service providers; and documenting all training in the employee file, including all related TBI training, seminars and conferences attended, whether offered by the provider or other entities.

*Traumatic Brain Injury Program Manual,
June 2006, Section VIII*

In 2 instances pertaining to 2 participants, the services were performed by staff that did not complete the required training. This finding applies to Sample #'s 61 and 67.

3. Missing Documentation of Service

The Social Security Act states that:

(a) A State plan for medical assistance must—

27. provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the state agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request.

Social Security Act Section 1902(a)(27) of the Act, 42 U.S.C. 1396(a)(27)

The CMS State Medicaid Manual states:

Statement of Policy – Federal financial participation (FFP) is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.

CMS State Medicaid Manual Section 2497.1

Medicaid policy states that providers are reminded that all Medicaid claims for reimbursement must be supported with a record of the services provided. At a minimum, this should include:

- the participant's name;
- the date of service;
- the start and end time of each session;
- a description of the activities performed during the session; and
- the participant's service plan goals that are being worked on and the participant's progress toward attaining those goals

DOH Medicaid Update January 2005, Volume 20, No. 1

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 from the date of 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 and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health” and “to comply with the rules, regulations and official directives of the Department.”

18 NYCRR Section 504.3(a) and (i)

The HCBS Provider Agreement states: Keep any records necessary to disclose the type and extent of services furnished to recipients and on request, furnish to DOH, its designees, the Secretary of the U.S. Department of Health and Human Services or the State Medicaid Fraud Control Unit, information regarding these services and payments claimed under Title XIX.

*NYS Department of Health-HCBS Provider Agreement,
June 2008, Section I*

The HCBS/TBI Waiver Provider Manual states: Providers of HCBS/TBI waiver services, other than Service Coordinators, shall maintain adequate records which include: a detailed plan describing for each HCBS/TBI waiver service the expected outcomes, method or type of intervention planned and frequency and intensity of the provision of service, billing records, any contacts with the Service Coordinator, and any contacts with the waiver providers.

HCBS/TBI Waiver Provider Manual, Section VI

The Traumatic Brain Injury Program Manual states: “Record keeping to document Medicaid billing is required of all Medicaid providers. The need to maintain the necessary records is discussed in the Provider Agreement, the eMedNY Provider Manual and in this Program Manual. It is the responsibility of the provider to have clear and accurate documentation to support all Medicaid claims.”

*Traumatic Brain Injury Program Manual,
June 2006, Section VII*

The Traumatic Brain Injury Program Manual states: "The provider must document each encounter with the participant as required by Medicaid for reimbursement. Documentation must include the date, location, time and a description of the activities, which are related to the goals established in the Detailed Plan. This information must be recorded as soon as possible after each contact and reviewed for completeness each month. All records must be maintained for seven years following termination of services to a participant."

*Traumatic Brain Injury Program Manual,
June 2006, Section VII*

The Traumatic Brain Injury Program Manual states: "Record keeping documenting Medicaid billing is required of all Medicaid providers. The need to maintain the necessary records is discussed in the Provider Agreement, the eMedNY Provider Manual and this program Manual. It is the responsibility of the provider to have clear and accurate documentation to support all Medicaid claims."

*Traumatic Brain Injury Program Manual,
April 2009, Section VII*

The Traumatic Brain Injury Program Manual states: "The provider must document each encounter with the participant as required by Medicaid for reimbursement. Documentation must include the date, location, time and a description of the activities, which are related to the goals established in the Detailed Plan. This information must be recorded as soon as possible after each contact and reviewed for completeness each month. All records must be maintained for seven years following termination of services to a participant."

*Traumatic Brain Injury Program Manual,
April 2009, Section VII*

In 1 instance, services were not documented in the participant's record. This finding applies to Sample # 35.

4. Incorrect Rate Code Billed

The Social Security Act states that:

(a) A State plan for medical assistance must—

27. provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the state agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request.

Social Security Act Section 1902(a)(27) of the Act, 42 U.S.C. 1396(a)(27)

Statement of Policy – Federal financial participation (FFP) is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.

CMS State Medicaid Manual Section 2497.1

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 from the date of 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 and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health and to comply with the rules, regulations and official directives of the Department.

18 NYCRR Section 504.3(a) and (i)

Regulations state: b) Fee-for-service providers. (1) All providers, who are not paid at rates or fees approved by the State Director of the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply, 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, the Secretary of the United States Department of Health and Human Services, the Medicaid Fraud Control Unit or the New York State Department of Health for audit and review. This limitation does not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs an audit.

18 NYCRR Section 517.3(b)(1) and (2)

Regulations require a “. . . dated certification by the provider that the care, services and supplies itemized have in fact been furnished. . .”

18 NYCRR Section 540.7(a)(8)

The HCBS Provider Agreement states: Keep any records necessary to disclose the type and extent of services furnished to recipients and on request, furnish to DOH, its designees, the Secretary of the U.S. Department of Health and Human Services or the State Medicaid Fraud Control Unit, information regarding these services and payments claimed under Title XIX;

*NYS Department of Health-HCBS Provider Agreement,
June 2008, Section I*

In 1 instance, an incorrect rate code was billed which resulted in higher reimbursement than indicated for the proper code. The difference between the correct and incorrect rate codes was disallowed. This finding applies to Sample # 100.

5. Services Performed by Unqualified Home and Community Support Services (HCSS) Staff

The HCBS/TBI Waiver Provider Manual states: The individual who provides these services must complete training concerning traumatic brain injury. This training will be provided by the agency employing this individual, and will be completed prior to the provision of the service.

HCBS/TBI Waiver Provider Manual, Section V

The Traumatic Brain Injury Program Manual states: The HCSS must be at least 18 years old; be able to follow written and verbal instructions; and have the ability and skills necessary to meet the participant's needs that will be addressed through the service.

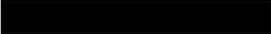
*Traumatic Brain Injury Program Manual,
June 2006, Section VI*

In 1 instance, the services were performed by staff that did not complete the professional qualifications and/or experience for Home and Community Support Services Staff. This finding applies to Sample # 55.

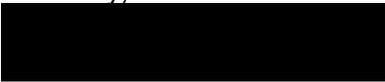
PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the lower confidence limit amount of \$309,472, 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 #11-5735
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 lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of \$736,372. 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**

████████████████████
████████████████████
Lifetime Care – owner of Sibley Nursing
Personnel Services Inc.
3111 South Winton Road
Rochester, New York 14623

PROVIDER ID # ██████████

AUDIT #11-5735

AMOUNT DUE: \$309,472

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
GNARESP Corning Tower, Room 2739
File #11-5735
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN

The sample design used for Audit #11-5735 was as follows:

- Universe - Medicaid claims for Traumatic Brain Injury services paid during the period January 1, 2007, through December 31, 2010.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for Traumatic Brain Injury services paid during the period January 1, 2007, through December 31, 2010.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2007, through December 31, 2010.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 claims.

SAMPLE RESULTS AND ESTIMATES

Universe Size	69,367
Sample Size	100
Sample Value	\$ 16,203.20
Sample Overpayments	\$ 1,061.56
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	\$ 1,061.56
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	\$ 10.6156
Universe Size	69,367
Point Estimate of Total Dollars	\$ 736,372
Lower Confidence Limit	\$ 309,472