



**Office of the
Medicaid Inspector
General**

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

**REVIEW OF BELLEVUE HOSPITAL CENTER
CLAIMS FOR OMH COMPREHENSIVE PSYCHIATRIC
EMERGENCY PROGRAM (CPEP) SERVICES
PAID FROM
JANUARY 1, 2010 – DECEMBER 31, 2012**

**FINAL AUDIT REPORT
AUDIT #: 15-1013**

**Dennis Rosen
Medicaid Inspector General**

September 8, 2015



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

September 8, 2015

[REDACTED]
Bellevue Hospital Center
462 1st Avenue
New York, New York 10016

Re: Final Audit Report
Audit #: 15-1013
Provider ID #: [REDACTED]
FEIN: [REDACTED]
NPI #: [REDACTED]

Dear [REDACTED]:

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Bellevue Hospital Center" (Provider) paid claims for Office of Mental Health (OMH) Comprehensive Psychiatric Emergency Programs (CPEP) services covering the period January 1, 2010, through December 31, 2012. Since you did not respond to our draft audit report dated July 10, 2015, the findings in the final audit report are identical to those in the draft 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. The adjusted mean point estimate overpaid is \$241,455. The adjusted lower confidence limit of the amount overpaid is \$127,301. We are 95% certain that the actual amount of the overpayment is greater than the adjusted lower confidence limit. This audit may be settled through repayment of the adjusted lower confidence limit of \$127,301.

[REDACTED]

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September 8, 2015

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED]. Please refer to report number 15-1013 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]

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 purpose of comprehensive psychiatric emergency programs is to provide emergency observation, evaluation, care, and treatment in a safe and comfortable environment. The program is intended to establish a primary entry point into the mental health system for the catchment area it serves. Comprehensive psychiatric emergency program services will include crisis intervention services within an emergency room setting, mobile crisis outreach services, crisis residential services, beds for extended observation of patients, and triage and referral services. The standards for a comprehensive psychiatric emergency program which provides a full range of psychiatric emergency services within a defined geographic area are established in Title 14 NYCRR Parts 590 and 591.

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OMH CPEP services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to OMH CPEP services, this audit covered services paid by Medicaid from January 1, 2010, through December 31, 2012.

SUMMARY OF FINDINGS

We inspected a random sample of 100 services with \$42,907.49 in Medicaid payments. Of the 100 services in our random sample, 15 services had at least one error and did not comply with state requirements. Of the 15 noncompliant services, one contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Interim Crisis Service Provided in Excess of Five Days from Discharge	8
Physician Examination Not Initiated Within Six Hours	2
Brief Emergency Visit Billed as a Full Emergency Visit	2
Incomplete Brief Emergency Visit	1
No Documentation of Service	1
Incomplete Full Emergency Visit	1
Incomplete Case Record	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$7,976.13 in sample overpayments with an extrapolated adjusted point estimate of \$241,455. The adjusted lower confidence limit of the amount overpaid is \$127,301.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including OMH CPEP services claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

New York State's OMH Comprehensive Psychiatric Emergency Programs (CPEP)

The purpose of comprehensive psychiatric emergency programs is to provide emergency observation, evaluation, care, and treatment in a safe and comfortable environment. The program is intended to establish a primary entry point into the mental health system for the catchment area it serves. Comprehensive psychiatric emergency program services will include crisis intervention services within an emergency room setting, mobile crisis outreach services, crisis residential services, beds for extended observation of patients, and triage and referral services. The standards for a comprehensive psychiatric emergency program which provides a full range of psychiatric emergency services within a defined geographic area are established in Title 14 NYCRR Parts 590 and 591.

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OMH CPEP services complied with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,

- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

Scope

Our audit period covered payments to the Provider for OMH CPEP services paid by Medicaid from January 1, 2010, through December 31, 2012. Our audit universe consisted of 3,444 claims totaling \$1,580,686.97.

During our audit, we did not review the overall internal control structure of the Provider. Rather, we limited our internal control review to the objective of our audit.

Methodology

To accomplish our objective, we:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with the Provider's management personnel to gain an understanding of the OMH CPEP program;
- ran computer programming application of claims in our data warehouse that identified 3,444 paid OMH CPEP claims, totaling \$1,580,686.97;
- selected a random sample of 100 services from the population of 3,444 services; and,
- estimated the overpayment paid in the population of 3,444 services.

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

- Medicaid electronic claim information
- Patient record, including, but not limited to:
 - Mental Health Diagnostic Examination
 - Psychosocial Assessment
 - Medical Examination
 - Assessment of Treatment Needs
 - Progress Notes
 - Discharge Summary
- 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, 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, and 14 NYCRR Parts 590 and 591.
- 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 10, 2015.

Since you did not respond to the Draft Audit Report, the findings remain the same.

AUDIT FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2010, through December 31, 2012, identified 15 claims with at least one error, for a total sample overpayment of \$7,976.13 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to Draft Audit Report dated July 10, 2015.

1. Interim Crisis Service Provided in Excess of Five Days from Discharge

Regulations state, "A patient may receive interim crisis services for a period not to exceed five days after release from the emergency room of the comprehensive psychiatric emergency program." *14 NYCRR Section 591.4(f)*

In 8 instances pertaining to 8 patients, the patient received an interim crisis service in excess of five days after release from the emergency room of the comprehensive psychiatric emergency program. This finding applies to Sample #'s 9, 14, 35, 42, 46, 57, 58 and 96.

2. Physician Examination Not Initiated Within Six Hours

Regulations state, "Any person admitted into the emergency room of the comprehensive psychiatric emergency program must be examined by a staff physician as soon as practicable and in any event within six hours after being received into the emergency room." *14 NYCRR Section 590.8(b)*

Regulations state, "The staff and services must conform with the requirements of Part 590 of this Title." *14 NYCRR Section 591.4(b)*

In 2 instances pertaining to 2 patients, the patient was examined by the physician more than six hours after being received into the emergency room. This finding applies to Sample #'s 27 and 89.

3. Brief Emergency Visit Billed as a Full Emergency Visit

Regulations state, "Brief emergency visit means a face-to-face interaction between a patient and a staff physician, preferably a psychiatrist, to determine the scope of emergency service required....For those persons who are discharged from the comprehensive psychiatric emergency program and who require additional mental health services, the brief emergency visit must include a discharge plan." *14 NYCRR Section 591.3(a)*

Regulations also state, "Full emergency visit means a face-to-face interaction between a patient and a psychiatrist....It must include a psychiatric or mental health diagnostic examination; psychosocial assessment; and medical examination; which results in a comprehensive psychiatric emergency treatment plan and a discharge plan when comprehensive psychiatric emergency program or services are completed." *14 NYCRR Section 591.3(d)*

In 2 instances pertaining to 2 patients, a full emergency visit rate was billed when a brief emergency visit was documented. The full emergency visit rate was reduced to a brief emergency visit rate. This finding applies to Sample #'s 59 and 64.

4. Incomplete Brief Emergency Visit

Regulations state, "Brief emergency visit means a face-to-face interaction between a patient and a staff physician, preferably a psychiatrist, to determine the scope of emergency service required....For those persons who are discharged from the comprehensive psychiatric emergency program and who require additional mental health services, the brief emergency visit must include a discharge plan."

14 NYCRR Section 591.3(a)

In 1 instance, a face-to-face interaction between the patient and a staff physician was not documented. This finding applies to Sample # 11.

5. No Documentation of Service

Regulations require that the Medicaid provider agrees, "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years . . . all records necessary to disclose the nature and extent of services furnished. . . ."

18 NYCRR Section 504.3(a)

Regulations 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

Regulations state, "The written records of the reimbursed unit of service, including presentation log, case records and discharge plans and summaries, as appropriate, must conform with the requirements of Part 590 of this Title."

14 NYCRR Section 591.4(c)

In 1 instance, patient records did not document a service. This finding applies to Sample # 34.

6. Incomplete Full Emergency Visit

Regulations state, "Full emergency visit means a face-to-face interaction between a patient and a psychiatrist....It must include a psychiatric or mental health diagnostic examination; psychosocial assessment; and medical examination; which results in a comprehensive psychiatric emergency treatment plan and a discharge plan when comprehensive psychiatric emergency program or services are completed."

14 NYCRR Section 591.3(d)

In 1 instance, a face-to-face interaction between a patient and a psychiatrist was not documented. This finding applies to Sample # 53.

7. Incomplete Case Record

Regulations state, "(c) All individuals admitted by the comprehensive psychiatric emergency program must have a case record which, at a minimum, includes a presentation note which indicates: (1) a brief description of the presenting problem, critical needs and overall conditions; and (2) a brief description of the care and treatment required to safely and effectively address the individual's needs during the initial period after admission. (d) ... each case record for individuals who receive a full emergency visit, or are admitted to an extended observation bed or receive crisis outreach services or receive interim crisis services or receive crisis residential services shall include: (1) patient identifying information and available psychiatric medical and relevant social history, including the person's residential situation and the details of the circumstances leading to the individual's presentation at the comprehensive psychiatric emergency program, and the name of the person or persons who have brought the individual to the comprehensive psychiatric emergency program, if any. In the case of individuals brought to the comprehensive psychiatric emergency program by law enforcement officers, the officers should be interviewed and identified in the case record; (2) diagnosis; (3) assessment of the patient's treatment needs based upon psychiatric, physical, social and functional evaluations; (4) reports of all mental and physical diagnostic exams, assessments, tests, and consultations; (5) progress notes which relate to goals and objectives of treatment; (6) notes which relate to special circumstances and untoward incidents; (7) dated and signed orders for all medications; and (8) discharge summary, including referrals to other programs and services, which must be completed within five days of discharge. (e) A description of services provided in the emergency room, extended observation beds and crisis residential services, and by the crisis outreach teams shall become part of the complete case record."

14 NYCRR Section 590.12(c),(d),and (e)

Regulations state, "The written records of the reimbursed unit of service, including presentation log, case records and discharge plans and summaries, as appropriate, must conform with the requirements of Part 590 of this Title."

14 NYCRR Section 591.4(c)

In 1 instance, an assessment of the patient's treatment needs and the diagnosis was missing from the case record. This finding applies to Sample # 53.

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 \$127,301, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order within 20 days of the date of the final audit report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #15-1013
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
[REDACTED]

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the adjusted point estimate of \$241,455. 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]
Bellevue Hospital Center
462 1st Avenue
New York, New York 10016

PROVIDER ID # [REDACTED]

AUDIT #15-1013

AMOUNT DUE: \$127,301

**AUDIT
TYPE**

PROVIDER
 RATE
 PART B
 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 #15-1013
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN

The sample design used for Audit #15-1013 was as follows:

- **Universe** - Medicaid claims for OMH CPEP services 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 OMH CPEP services 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 100 services.

SAMPLE RESULTS AND ESTIMATES

Universe Size	3,444
Sample Size	100
Sample Value	\$ 42,907.49
Sample Overpayments	\$ 7,976.13
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	\$ 7,976.13
Less Overpayments Not Extrapolated*	<u>(994.12)</u>
Sample Overpayments for Extrapolation Purposes	\$ 6,982.01
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	\$ 69.8201
Universe Size	3,444
Point Estimate of Total Dollars	\$ 240,460
Add Overpayments Not Extrapolated*	<u>994</u>
Adjusted Point Estimate of Totals Dollars	<u>\$ 241,455</u>
Lower Confidence Limit	\$ 126,307
Add Overpayments Not Extrapolated*	<u>994</u>
Adjusted Lower Confidence Limit	<u>\$ 127,301</u>

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

- **Finding #2 - Physician Examination Not Initiated Within Six Hours**
- **Finding #7 - Incomplete Case Record**

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

OFFICE OF THE MEDICAID INSPECTOR GENERAL
BELLEVUE HOSPITAL CENTER
REVIEW OF OMH-CPEP SERVICES
PROJECT NUMBER: 15-1013
REVIEW PERIOD: 1/1/2010 - 12/31/2012

Sample Number	Date of Service	Rate Code		Amount		Overpayment		1. Interim Crisis Service Provided in Excess of Five Days from Discharge	2. Physician Examination Not Initiated Within Six Hours	3. Brief Emergency Visit Not Initiated	4. Incomplete Brief Emergency Visit	5. No Documentation of Emergency Visit	6. Incomplete Full Emergency Visit	7. Incomplete Case Record
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated							
1	07/26/10	4008	4008	\$ 497.06	\$ 497.06	\$ -	\$ -							
2	01/24/12	4009	4009	491.59	491.59	-	-							
3	02/11/10	4010	4010	497.06	497.06	-	-							
4	09/20/11	4008	4008	491.59	491.59	-	-							
5	03/09/10	4009	4009	26.81	26.81	-	-							
6	07/15/10	4009	4009	497.06	497.06	-	-							
7	01/05/11	4009	4009	497.06	497.06	-	-							
8	02/17/11	4009	4009	497.06	497.06	-	-							
9	03/01/11	4009	-	497.06	-	497.06	-	X						
10	02/05/12	4009	4009	491.59	491.59	-	-							
11	12/24/09	4007	-	81.64	-	81.64	-				X			
12	04/06/10	4008	4008	497.06	497.06	-	-							
13	01/12/12	4008	4008	491.59	491.59	-	-							
14	08/26/10	4009	-	497.06	-	497.06	-	X						
15	12/16/09	4008	4008	497.06	497.06	-	-							
16	09/26/11	4009	4009	491.59	491.59	-	-							
17	08/25/11	4008	4008	491.59	491.59	-	-							
18	04/30/10	4008	4008	497.06	497.06	-	-							
19	05/01/10	4008	4008	41.10	41.10	-	-							
20	10/01/11	4008	4008	491.59	491.59	-	-							
21	03/26/12	4007	4007	83.71	83.71	-	-							
22	01/20/11	4009	4009	497.06	497.06	-	-							
23	01/02/12	4008	4008	491.59	491.59	-	-							
24	11/19/10	4007	4007	84.64	84.64	-	-							
25	02/12/12	4008	4008	491.59	491.59	-	-							

OFFICE OF THE MEDICAID INSPECTOR GENERAL
BELLEVUE HOSPITAL CENTER
REVIEW OF OMH-CPEP SERVICES
PROJECT NUMBER: 15-1013
REVIEW PERIOD: 1/1/2010 - 12/31/2012

Sample Number	Date of Service	Rate Code		Amount		Overpayment		1. Interim Crisis Service Provided in Excess of Five Days from Discharge	2. Physician Examination Not Initiated Within Six Hours	3. Brief Emergency Visit Not Initiated	4. Incomplete Brief Emergency Visit	5. No Documentation of Service	6. Incomplete Full Emergency Visit	7. Incomplete Case Record
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated							
26	01/04/12	4008	4008	\$ 84.96	\$ 84.96	\$ -	\$ -							
27	10/22/09	4008	-	497.06	-	-	497.06		X					
28	11/04/10	4008	4008	497.06	497.06	-	-							
29	07/09/10	4009	4009	497.06	497.06	-	-							
30	02/11/12	4008	4008	491.59	491.59	-	-							
31	07/22/10	4008	4008	497.06	497.06	-	-							
32	01/12/12	4008	4008	491.59	491.59	-	-							
33	07/19/11	4009	4009	491.59	491.59	-	-							
34	07/10/12	4009	-	1,060.00	-	1,060.00	-					X		
35	06/05/12	4009	-	491.59	-	491.59	-	X						
36	11/29/10	4007	4007	84.64	84.64	-	-							
37	09/18/12	4009	4009	1,060.00	1,060.00	-	-							
38	09/06/11	4009	4009	491.59	491.59	-	-							
39	10/27/10	4009	4009	497.06	497.06	-	-							
40	04/23/11	4009	4009	491.59	491.59	-	-							
41	11/28/10	4009	4009	497.06	497.06	-	-							
42	05/04/12	4009	-	491.59	-	491.59	-	X						
43	06/08/11	4009	4009	491.59	491.59	-	-							
44	10/24/11	4009	4009	491.59	491.59	-	-							
45	06/14/11	4009	4009	491.59	491.59	-	-							
46	10/10/12	4009	-	1,060.00	-	1,060.00	-	X						
47	08/27/11	4007	4007	83.71	83.71	-	-							
48	11/27/11	4009	4009	491.59	491.59	-	-							
49	05/30/10	4008	4008	497.06	497.06	-	-							
50	06/13/11	4008	4008	491.59	491.59	-	-							

OFFICE OF THE MEDICAID INSPECTOR GENERAL
BELLEVUE HOSPITAL CENTER
REVIEW OF OMH-CPEP SERVICES
PROJECT NUMBER: 15-1013
REVIEW PERIOD: 1/1/2010 - 12/31/2012

Sample Number	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS							
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. Interim Crisis Service Provided in Excess of Five Days from Discharge	2. Physician Examination Provided in Within Six Hours	3. Brief Emergency Visit Not Initiated	4. Incomplete Brief Emergency Visit	5. No Documentation of Service	6. Incomplete Full Emergency Visit	7. Incomplete Case Record	
76	04/26/10	4007	4007	\$ 84.64	\$ 84.64	\$ -	\$ -								
77	09/02/11	4009	4009	491.59	491.59	-	-								
78	09/21/10	4008	4008	497.06	497.06	-	-								
79	05/19/11	4008	4008	491.59	491.59	-	-								
80	11/07/11	4008	4008	491.59	491.59	-	-								
81	02/19/12	4007	4007	83.71	83.71	-	-								
82	07/12/10	4008	4008	497.06	497.06	-	-								
83	04/12/11	4008	4008	491.59	491.59	-	-								
84	12/21/11	4009	4009	491.59	491.59	-	-								
85	10/01/10	4009	4009	497.06	497.06	-	-								
86	07/10/12	4007	4007	181.00	181.00	-	-								
87	03/19/12	4008	4008	491.59	491.59	-	-								
88	05/08/12	4008	4008	491.59	491.59	-	-								
89	05/12/10	4008	-	497.06	-	-	497.06		X						
90	12/27/11	4008	4008	491.59	491.59	-	-								
91	06/15/12	4008	4008	491.59	491.59	-	-								
92	05/26/11	4009	4009	40.76	40.76	-	-								
93	12/27/09	4008	4008	497.06	497.06	-	-								
94	03/07/12	4009	4009	491.59	491.59	-	-								
95	02/06/11	4007	4007	84.64	84.64	-	-								
96	05/21/10	4010	-	497.06	-	497.06	-	X							
97	08/22/11	4007	4007	83.71	83.71	-	-								
98	07/20/11	4009	4009	491.59	491.59	-	-								
99	12/29/11	4009	4009	57.56	57.56	-	-								
100	06/25/12	4007	4007	83.71	83.71	-	-								
Totals				\$ 42,907.49	\$ 34,931.36	\$ 6,982.01	\$ 994.12	8	2	2	1	1	1	1	