



Office of the
Medicaid Inspector
General

DENNIS ROSEN
Medicaid Inspector General

Audit of NYS Medicaid EHR Incentive Payment

**Final Audit Report
Audit #: 19-2019**

Dr. Christian Hietanen

**Provider ID #: 02746207
NPI #: 1558322958**



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

August 29, 2019

Dr. Christian Hietanen

1 Webster Avenue, Suite 302
Poughkeepsie, New York 12601

Re: Final Audit Report
Audit #: 19-2019
Provider #: 02746207
NPI #: 1558322958

Dear Dr. Hietanen:

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Dr. Hietanen (Provider).

In accordance with the New York State Public Health Law, and Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York (NYCRR) Parts 504 and 517, OMIG performed an audit of the Provider's submitted attestation, signed October 27, 2013, for the meaningful use (MU) of a certified EHR system during the calendar year ending December 31, 2013. The Provider was paid an EHR incentive payment of \$8,500 for the submitted attestation. The purpose of the audit is to ensure compliance with applicable Federal and State laws, regulations, rules, and policies governing the New York State Medicaid EHR Incentive Program, including verification of eligibility for the EHR Incentive Program and the meaningful use (MU) of a certified EHR system.

If you have any questions or comments concerning this Final Audit Report, please contact [REDACTED] at [REDACTED] or through email at [REDACTED]. Please refer to audit number 19-2019 in all correspondence.

[REDACTED]
Bureau of Managed Care Audit & Program Reviews
Division of Medicaid Audit
Office of the Medicaid Inspector General

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Background, Objective, and Audit Scope

Background

The New York State Department of Health (DOH) is the single state agency responsible for the administration of the Medicaid program. As part of its responsibility as an independent entity within DOH, 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 in New York Public Health Law, New York Social Services Law, the regulations of DOH (Titles 10 and 18 of the New York Codes Rules and Regulations), the regulations of the Department of Mental Hygiene (Title 14 of the New York Codes Rules and Regulations), the regulations of the Education Department (Title 8 of the New York Codes Rules and Regulations), DOH's Medicaid Provider Manuals and *Medicaid Update* publications.

Medicaid EHR Incentive payments were authorized by the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implemented by Federal regulation principally at 42 CFR Part 495. Through the NYS Medicaid EHR Incentive Program, eligible hospitals (EH) and eligible professionals (EP) in New York who adopt, implement, or upgrade certified EHR technology, and subsequently become meaningful users of the EHR technology, may qualify for financial incentives.

Objective

The objective of this audit was to assess the Provider's adherence to the applicable Federal and State laws, regulations, rules, and policies governing the New York State Medicaid EHR Incentive Program, including verification of eligibility for the EHR Incentive Program and the meaningful use (MU) of a certified EHR system.

Audit Scope

This audit examined the supporting documentation for the Provider's submitted attestation, signed October 27, 2013, regarding payment for the meaningful use (MU) of a certified EHR system during the calendar year ending December 31, 2013.

Regulations of General Application

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, 42 CFR § 495-Standards for The Electronic Health Record Technology Incentive Program.
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

"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

"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)

"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)

"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

"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)

"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)

"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)

"The inspector shall have the following functions, duties and responsibilities:...(9) to require and compel the production of such books, papers, records and documents as he or she may deem to be relevant or material to an investigation, examination or review undertaken pursuant to this section..."

Public Health Law §32(9)

During enrollment in the NYS EHR Incentive Program each provider attested to the following: "I hereby agree to keep such records as are necessary to demonstrate that I met all Medicaid EHR Incentive Program requirements...failure to furnish subsequently requested information or documents will result in the issuance of an overpayment demand letter followed by recoupment procedures."

NYS EHR Incentive Program Attestation

Audit Findings

Since you did not respond to our Draft Audit Report dated June 27, 2019, the findings in the Final Audit Report remain identical to the Draft Audit Report.

The OMIG's review of your payment for the Medicaid EHR Incentive Program identified at least one error, for a total overpayment of \$8,500. The errors identified in the audit are described in the Detailed Findings below.

1. Failure to Support Medicaid Patient Volume

"Additional requirements for the Medicaid EP. To qualify for an EHR incentive payment, a Medicaid EP must, for each year for which the EP seeks an EHR incentive payment, ... meet one of the following criteria: (1) Have a minimum 30 percent patient volume attributable to individuals enrolled in a Medicaid program. (2) Have a minimum 20 percent patient volume attributable to individuals enrolled in a Medicaid program, and be a pediatrician."

42 CFR § 495.304(c)(1) and (2)

"Methodology, patient encounter — (1) EPs. To calculate Medicaid patient volume, an EP must divide: (i) The total Medicaid patient encounters in any representative, continuous 90-day period in the calendar year preceding the EP's payment year, or in the 12 months before the EP's attestation; by (ii) The total patient encounters in the same 90-day period."

42 CFR § 495.306(c)(1)

"For purposes of this section, the following rules apply: (1) A Medicaid encounter means services rendered to an individual on any one day where: (i) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service. (ii) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, and cost-sharing. (iii) The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided."

42 CFR § 495.306(e)(1)

"Group practices. Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations: (1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP. (2) There is an auditable data source to support the clinic's or group practice's patient volume determination. (3) All EPs in the group practice or clinic must use the same methodology for the payment year. (4) The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way. (5) If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters."

42 CFR § 495.306(h)

"Rules for Medicaid EPs. The Medicaid EP's incentive payments are subject to all of the following limitations: (4) *Limitation.* For a Medicaid EP who is a pediatrician described in paragraph (b) of this section payment is limited as follows: (i) The maximum payment in the first payment year is further reduced by two-thirds, which equals \$14,167. (ii) The maximum payment

in subsequent payment years is further reduced by two-thirds, which equals \$5,667."

42 CFR § 495.310(a)(4)(i) and (ii)

"Optional exception for pediatricians. A pediatrician described in this paragraph is a Medicaid EP who does not meet the 30 percent patient volume requirements described in §495.304 and §495.306, but who meets the 20 percent patient volume requirements described in such sections."

42 CFR § 495.310(b)

For the 2013 payment year, the Provider failed to produce documentation upon audit demonstrating that he/she met the minimum Medicaid patient volume threshold during a continuous 90-day period in the preceding calendar year, or preceding 12-month period from the date of the attestation as required by federal regulations and, therefore, was not eligible to receive an incentive payment for that year.

2. Failure to Submit Documentation to Support Eligibility

"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

Furthermore, according to regulations, all providers must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. In addition, the provider must keep, for a period of six years, 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. This information is subject to audit for a period of six years and must be furnished, upon request.

18 NYCRR Section 517.3(b)

"The inspector shall have the following functions, duties and responsibilities:...(9) to require and compel the production of such books, papers, records and documents as he or she may deem to be relevant or material to an investigation, examination or review undertaken pursuant to this section..."

Public Health Law §32(9)

During enrollment in the NYS EHR Incentive Program each provider attested to the following: "I hereby agree to keep such records as are necessary to demonstrate that I met all Medicaid EHR Incentive Program requirements...failure to furnish subsequently requested information or documents will result in the issuance of an overpayment demand letter followed by recoupment procedures."

NYS EHR Incentive Program Attestation

3. Failure to be a Meaningful User

"To be considered a meaningful EHR user, at least 50 percent of an EP's patient encounters during an EHR reporting period for a payment year ... must occur at a practice/location or practices/locations equipped with certified EHR technology." 42 CFR § 495.4

"Subsequent payment years. (1) In the second, third, fourth, fifth, and sixth payment years, to receive an incentive payment, the Medicaid EP or eligible hospital must demonstrate that during the EHR reporting period for the applicable payment year, it is a meaningful EHR user, as defined in § 495.4." 42 CFR § 495.314(b)

The Provider failed to produce documentation upon audit to demonstrate that at least 50 percent of his/her patient encounters during the EHR reporting period occurred at a practice/location or practices/locations equipped with certified EHR technology as required by federal regulations and, therefore, was not eligible to receive an incentive payment for the 2013 payment year.

4. Failure to Support Meaningful Use Core Measures/Exclusions

"Subsequent payment years (1) In the second, third, fourth, fifth, and sixth payment years, to receive an incentive payment, the Medicaid EP or eligible hospital must demonstrate that during the EHR reporting period for the applicable payment year, it is a meaningful EHR user, as defined in § 495.4." 42 CFR § 495.314(b)

"Stage 1 criteria for EPs— (1) General rule regarding Stage 1 criteria for meaningful use for EPs. Except as specified in paragraphs (a)(2) and (a)(3) of this section, EPs must meet all objectives and associated measures of the Stage 1 criteria specified in paragraph (d) of this section ... to meet the definition of a meaningful EHR user." 42 CFR § 495.6(a)

The Provider failed to produce documentation upon audit to support that the following Stage 1 core measures/exclusions were met during the EHR reporting period as required by federal regulations and, therefore, the Provider was not eligible to receive an incentive payment for the 2013 payment year:

Computerized Provider Order Entry (CPOE) Measure/Exclusion

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (1)(i) Objective. Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines. (ii) Measure. (A) Subject to paragraph (c) of this section, more than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE. (B) Subject to paragraph (c) of this section, more than 30 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry, or the measure specified in paragraph (d)(1)(ii)(A) of this section. (iii) Exclusion in accordance with paragraph (a)(2) of this section Any EP who writes fewer than 100 prescriptions during the EHR reporting period." 42 CFR § 495.6(d)(1)

Drug Interaction Checks Measure

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (2)(i) Objective. Implement drug-drug and drug-allergy interaction checks. (ii) Measure. The EP has enabled this functionality for the entire EHR reporting period." 42 CFR § 495.6(d)(2)

Maintain Problem List Measure

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (3)(i) Objective. Maintain an up-to-date problem list of current and active diagnoses. (ii) Measure. More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data." 42 CFR § 495.6(d)(3)

e- Prescribing (eRx) Measure/Exclusion

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (4)(i) Objective. Generate and transmit permissible prescriptions electronically (eRx). (ii) Measure. Subject to paragraph (c) of this section, more than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. (iii) Exclusion in accordance with paragraph (a)(2) of this section (A) Any EP who writes fewer than 100 prescriptions during the EHR reporting period. (B) Beginning 2013, any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period, or the exclusion specified in (d)(4)(iii)(A) of this section." 42 CFR § 495.6(d)(4)

Active Medication List Measure

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (5)(i) Objective. Maintain active medication list. (ii) Measure. More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data." 42 CFR § 495.6(d)(5)

Medication Allergy List Measure

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (6)(i) Objective. Maintain active medication allergy list. (ii) Measure. More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data." 42 CFR § 495.6(d)(6)

Record Demographics Measure

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (7)(i) Objective. Record all of the following demographics: (A) Preferred language. (B) Gender. (C) Race. (D) Ethnicity. (E) Date of birth. (ii) Measure. More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data." 42 CFR § 495.6(d)(7)

Record Vital Signs Measure/Exclusion

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (8)(i) Objective. Record and chart changes in the following vital signs: (A) Height. (B) Weight. (C) Blood pressure. (D) Calculate and display body mass index (BMI). (E)(1) Plot and display growth charts for children 2-20 years, including BMI. (2) For 2013, plot and display growth charts for patients 0-20 years, including body mass index, or paragraph (d)(8)(i)(E)(1) of this section. (3) (ii) Measure. (A) Subject to paragraph (c) of this section, more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data. (B) For 2013—(1) Subject to paragraph (c) of this section, more than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data; or (2) The measure specified in paragraph (d)(8)(ii)(A) of this section. (iii) Exclusion in accordance with paragraph (a)(2) of this section. (A) Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice. (B) For 2013, either of the following: (1) The exclusion specified in paragraph (d)(8)(iii)(A) of this section. (2) The exclusion for an EP who— (i) Sees no patients 3 years or older is excluded from recording blood pressure; (ii) Believes that all three vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; (iii) Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or (iv) Believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight." 42 CFR § 495.6(d)(8)

Record Smoking Status Measure/Exclusion

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (9)(i) Objective. Record smoking status for patients 13 years old or older. (ii) Measure. Subject to paragraph (c) of this section, more than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data (iii) Exclusion in accordance with paragraph (a)(2) of this section. Any EP who sees no patients 13 years or older."

42 CFR § 495.6(d)(9)

Clinical Decision Support Rule Measure

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (11)(i) Objective. Implement one clinical decision support rules relevant to specialty or high clinical priority along with the ability to track compliance with that rule. (ii) Measure. Implement one clinical decision support rule." 42 CFR § 495.6(d)(11)

Electronic Copy of Health Information Measure/Exclusion

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (12)(i) Objective. Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request. (ii) Measure. Subject to paragraph (c) of this section, more than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days. (iii) Exclusion in accordance with paragraph (a)(2) of this section. Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period." 42 CFR § 495.6(d)(12)

Clinical Summaries Measure/Exclusion

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (13)(i) Objective. Provide clinical summaries for patients for each office visit. (ii) Measure. Subject to paragraph (c) of this section, clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days. (iii) Exclusion in accordance with paragraph (a)(2) of this section. Any EP who has no office visits during the EHR reporting period." 42 CFR § 495.6(d)(13)

Security Risk Analysis to Protect Electronic Health Information Measure

"Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph: (15)(i) Objective. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. (ii) Measure. Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process." 42 CFR § 495.6(d)(15)

5. Failure to Support Meaningful Use Menu Measures/Exclusions

"Subsequent payment years (1) In the second, third, fourth, fifth, and sixth payment years, to receive an incentive payment, the Medicaid EP or eligible hospital must demonstrate that during

the EHR reporting period for the applicable payment year, it is a meaningful EHR user, as defined in § 495.4." 42 CFR § 495.314(b)

"Stage 1 criteria for EPs— (1) General rule regarding Stage 1 criteria for meaningful use for EPs. Except as specified in paragraphs (a)(2) and (a)(3) of this section, EPs must meet ... five objectives of the EP's choice from paragraph (e) of this section to meet the definition of a meaningful EHR user." 42 CFR §495.6(a)

The Provider failed to produce documentation upon audit to support that the following Stage 1 menu measures/exclusions were met during the EHR reporting period as required by federal regulations and, therefore, the Provider was not eligible to receive an incentive payment for the 2013 payment year:

Clinical Lab Testing Measure/Exclusion

"Stage 1 menu set criteria for EPs. An EP must meet five of the following objectives and associated measures, one of which must be either paragraph (e)(9) or (e)(10) of this section, except that the required number of objectives and associated measures is reduced by an EP's paragraph (a)(2) of this section exclusions specified in this paragraph: (2)(i) *Objective*. Incorporate clinical lab-test results into EHR as structured data. (ii) *Measure*. Subject to paragraph (c) of this section, more than 40 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/ negative or numerical format are incorporated in certified EHR technology as structured data. (iii) *Exclusion in accordance with paragraph (a)(2) of this section*. An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period."

42 CFR § 495.6(e)(2)

Patient Lists Generated By Conditions Measure

"Stage 1 menu set criteria for EPs. An EP must meet five of the following objectives and associated measures, one of which must be either paragraph (e)(9) or (e)(10) of this section, except that the required number of objectives and associated measures is reduced by an EP's paragraph (a)(2) of this section exclusions specified in this paragraph: (3)(i) *Objective*. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach. (ii) *Measure*. Subject to paragraph (c) of this section, generate at least one report listing patients of the EP with a specific condition."

42 CFR § 495.6(e)(3)

Patient Electronic Access Measure/ Exclusion

"Stage 1 menu set criteria for EPs. An EP must meet five of the following objectives and associated measures, one of which must be either paragraph (e)(9) or (e)(10) of this section, except that the required number of objectives and associated measures is reduced by an EP's paragraph (a)(2) of this section exclusions specified in this paragraph: (5)(i) *Objective*. (A) Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP. (ii) *Measure*. (A) At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's

discretion to withhold certain information. (iii) Exclusion in accordance with paragraph (a)(2) of this section. Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) during the EHR reporting period." 42 CFR § 495.6(e)(5)

Patient-Specific Education Resources Measure

"Stage 1 menu set criteria for EPs. An EP must meet five of the following objectives and associated measures, one of which must be either paragraph (e)(9) or (e)(10) of this section, except that the required number of objectives and associated measures is reduced by an EP's paragraph (a)(2) of this section exclusions specified in this paragraph: (6)(i) Objective. Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate. (ii) Measure. More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources." 42 CFR § 495.6(e)(6)

Immunization Registries Data Submission Measure/Exclusion

"Stage 1 menu set criteria for EPs. An EP must meet five of the following objectives and associated measures, one of which must be either paragraph (e)(9) or (e)(10) of this section, except that the required number of objectives and associated measures is reduced by an EP's paragraph (a)(2) of this section exclusions specified in this paragraph: (9)(i) Objective. (A) Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice. (B) Beginning 2013, capability to submit electronic data to immunization registries or immunization information systems and actual submission except where prohibited and according to applicable law and practice. (ii) Measure. Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically). (iii) Exclusion in accordance with paragraph (a)(2) of this section. An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically." 42 CFR § 495.6(e)(9)

Repayment Options

In accordance with 18 NYCRR Part 518, which regulates the collection of overpayments, your repayment options are described below.

Option #1: Make a full payment by check or money order within 20 days of the date of this Final Audit Report. The check should be made payable to the **New York State Department of Health** with the audit number included, and be sent with the attached remittance advice to:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
Phone #: [REDACTED]
Fax#: [REDACTED]

Option #2: Enter into a repayment agreement with OMIG. If your repayment terms exceed 90 days from the date of this Final Audit Report, recoveries of amounts due are subject to interest charges at the Prime Rate plus two percent (2%). OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. 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 New York State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
Phone #: [REDACTED]
Fax#: [REDACTED]

Hearing Rights

The Provider has the right to challenge this action and determination by requesting an administrative hearing within sixty (60) days of the date of this notice. In accordance with 18 NYCRR Section 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If the Provider wishes to request a hearing, the request must be submitted in writing within sixty (60) days of the date of this notice to:

General Counsel
New York State
Office of the Medicaid Inspector General
Office of Counsel
800 North Pearl Street
Albany, New York 12204

Questions regarding the request for a hearing should be directed to Office of Counsel, at [REDACTED]
[REDACTED]

If a hearing is held, the Provider may have a person represent them or the Provider may represent themselves. If the Provider chooses to be represented by someone other than an attorney, the Provider must supply along with their hearing request a signed authorization permitting that person to represent the Provider at the hearing; the Provider may call witnesses and present documentary evidence on their behalf.

For a full listing of hearing rights please see 18 NYCRR Part 519.

Contact Information



Office Address:

New York State
Office of the Medicaid Inspector General
Division of Medicaid Audit
800 North Pearl Street
Albany, New York 12204

Mission

The mission of the Office of the Medicaid Inspector General is to enhance 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 while promoting high quality patient care.

Vision

To be the national leader in promoting and protecting the integrity of the Medicaid program.



Office of the
Medicaid Inspector
General

REMITTANCE ADVICE

Dr. Christian Hietanen

1 Webster Avenue, Suite 302
Poughkeepsie, New York 12601

Provider ID #: 02746207

Audit #: 19-2019

Amount Due: \$8,500

**Audit
Type**

- ☐ Managed Care
☐ Fee-for-Service
☒ Medicaid EHR

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 **19-2019HIT** on your check.
4. Mail the check to:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Audit #: 19-2019
Albany, New York 12204
Phone #: [REDACTED]
Fax#: [REDACTED]