



Office of the  
Medicaid Inspector  
General

DENNIS ROSEN  
Medicaid Inspector General

# **Audit of Claims for OASAS Outpatient Chemical Dependence Services**

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**Final Audit Report  
Audit #: 19-2529**

## **Finger Lakes Addictions Counseling and Referral Agency**

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**Provider ID #: 00590372**



**Office of the  
Medicaid Inspector  
General**

**ANDREW M. CUOMO**  
Governor

**DENNIS ROSEN**  
Medicaid Inspector General

January 8, 2020

[REDACTED]  
Finger Lakes Addictions Counseling and Referral Agency  
28 East Main Street  
Clifton Springs, New York 14432

Re: Final Audit Report  
Audit #: 19-2529  
Provider ID #: 00590372

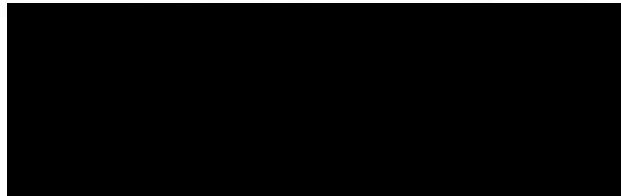
Dear [REDACTED]

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Finger Lakes Addictions Counseling and Referral Agency (Provider).

In accordance with Sections 30, 31 and 32 of 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 Office of Addiction Services and Supports (OASAS) claims paid to the Provider from January 1, 2014, through December 31, 2016. The audit universe consisted of 86,377 claims totaling \$6,740,679.26. The audit consisted of a random sample of 100 claims with Medicaid payments totaling \$7,545.95 (Attachment A).

The Provider's January 6, 2020 response to OMIG's December 2, 2019 Draft Audit Report stated that the Provider is in agreement with the Draft Audit Report findings. OMIG has attached the sample detail for the paid claims determined to be in error. The adjusted point estimate overpaid is \$235,217. The adjusted lower confidence limit of the amount overpaid is \$79,259. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the adjusted lower confidence limit of \$79,259.

If you have any questions or comments concerning this report, please contact [REDACTED]  
[REDACTED] or through email at [REDACTED] Please refer to audit number 19-  
2529 in all correspondence.



Division of Medicaid Audit  
Office of the Medicaid Inspector General

Attachments

Certified Mail Number: 7015-0640-0002-9036-2942

Return Receipt Requested

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## Background, Objective, and Audit Scope

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### 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 Office 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.

The purpose of outpatient chemical dependence programs is to provide individuals with a diagnosis of chemical dependence services that include medical evaluation, clinical care management, and clinical and rehabilitation services. Outpatient chemical dependence services are provided in either hospital-based or free-standing settings. Regardless of the setting in which they are provided, these services must be furnished in one of two distinct programs: an outpatient chemical dependence clinic program or an outpatient chemical dependence rehabilitation program. The specific standards and criteria for chemical dependence clinics are outlined in Title 14 NYCRR Part 822 and Title 18 NYCRR Section 505.27. the MMIS Provider Manual for Clinics also provides program guidance for claiming Medicaid reimbursement for chemical dependence services.

### Objective

The objective of this audit was to assess Finger Lakes Addictions Counseling and Referral Agency's (Provider) adherence to applicable 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 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 applicable rules and requirements.

### Audit Scope

A review of OASAS outpatient chemical dependence rehabilitation claims paid to the Provider by Medicaid for payment dates included in the period beginning January 1, 2014, and ending December 31, 2016, was completed.

The audit universe consisted of 86,377 claims totaling \$6,740,679.26. The audit sample consisted of 100 claims totaling \$7,545.95 (Attachment A).



## Regulations of General Application

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Each audit finding is supported by relevant regulations, policy statements and manuals. In addition, the audit findings in this audit are supported by regulations of general application to the Medicaid program. These regulations are provided below.

"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 under the medical assistance program. 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)*

"All bills for medical care, services and supplies shall contain: (1) patient name, case number and date of service; (2) itemization of the volume and specific types of care, services and supplies provided (including for a physician, his final diagnosis, and for drugs, the prescription filled); (3) the unit price and total cost of the care, services and supplies provided; . . . and (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are 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)*

**For Services Prior to 8/25/2015:**

"Programs must maintain an individual case record (either electronic or paper) for each patient who receives services. The case record must demonstrate a chronological pattern of delivered medical and treatment services consistent with the patient's treatment/recovery plan."

*14 NYCRR Section 822-2.2(a)*

**For Services 8/25/2015 and After:**

"All programs must maintain an individual case record (either electronic or paper) for each patient who receives services. The case record must demonstrate a chronological pattern of delivered medical and treatment services consistent with the patient's prior treatment history, if any, and the patient's evolving treatment/recovery plan."

*14 NYCRR Section 822.10(a)*

"This Section shall govern Medicaid rates of payments for OASAS certified or co-certified ambulatory care services provided in the following categories of facilities: (1) chemical dependence outpatient clinics certified or co-certified pursuant to Part 822 of this Title; . . . (3) chemical dependence outpatient rehabilitation programs certified or co-certified pursuant to Part 822 of this Title."

*14 NYCRR Section 841.14(a)(1) and (3)*

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**Audit Findings**

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OMIG issued a Draft Audit Report to the Provider on December 2, 2019. The Provider's January 6, 2020 response to the Draft Audit Report stated that the Provider is in agreement with the Draft Audit Report findings. As a result, the total sample overpayment of \$414.14 remains unchanged from the sample overpayment cited in the Draft Audit Report. A description of each finding, regulations, and the list of samples supporting each finding, appear below. Each sample may contain more than one error, and may be listed in more than one category of finding. A sample may only be disallowed once in an audit, however, each sample is subject to disallowance based on a single error.

**Summary of Audit Findings**

<u>Error Description</u>	<u>Number of Errors</u>
Missing Discharge Summary	4
Missing Comprehensive Evaluation Update	2
Missing Discharge Plan	2
Missing/Late Individual Treatment/Recovery Plan Review	1
No Documentation of Service Provided	1



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**Audit Findings Detail**

OMIG's review of Medicaid claims paid to the Provider from January 1, 2014, through December 31, 2016, identified 9 claims with at least one error, for a total sample overpayment of \$414.14 (Attachment C).

**1. Missing Discharge Summary****For Services Prior to 8/25/2015:**

"In addition to those requirements set forth in section 822-2.2(b) of this Subpart the individual case record for every patient admitted to an outpatient program must also include: ... (4) discharge plan and summary, including the circumstances of the discharge; ..."

*14 NYCRR Section 822-2.3(a)(4)*

"Within 45 days of discharge, a discharge summary must be prepared and included in each patient's record ..."

*14 NYCRR Section 822-4.6(e)*

**For Services 8/25/2015 and After:**

"Within 45 days of discharge, a discharge summary must be prepared and included in each patient's record ..."

*14 NYCRR Section 822.12(d)*

In 4 instances pertaining to 4 patients, a discharge summary was either missing or late. This finding applies to Sample #s 1, 26, 57, and 98.

**2. Missing Comprehensive Evaluation Update**

"In addition to those requirements set forth in section 822-2.2(b) of this Subpart the individual case record for every patient admitted to an outpatient program must also include: ... (2) documentation of the comprehensive evaluation; ..."

*14 NYCRR Section 822-2.3(a)(2)*

"... The comprehensive evaluation must be updated annually as part of treatment/recovery plan review."

*14 NYCRR Section 822-4.5(g)*

In 2 instances pertaining to 2 patients, the updated comprehensive evaluation was missing. This finding applies to Sample #s 52 and 72.

**3. Missing Discharge Plan**

"In addition to those requirements set forth in section 822-2.2(b) of this Subpart the individual case record for every patient admitted to an outpatient program must also include: ... (4) discharge plan and summary, including the circumstances of the discharge; ..."

*14 NYCRR Section 822-2.3(a)(4)*

"The discharge planning process must begin upon admission, be closely coordinated with the treatment/recovery plan, be based on the patient's self-reported confidence in maintaining abstinence and be included in the patient record. A discharge plan must be developed in collaboration with the patient and any collateral person(s) the patient chooses to involve...."

*14 NYCRR Section 822-4.6(b)*

In 2 instances pertaining to 2 patients, a discharge plan was missing. This finding applies to Sample #s 57 and 96.

**4. Missing/Late Individual Treatment/Recovery Plan Review**

"Continuing review of treatment/recovery plans. The treatment/recovery plan must be reviewed, and revised if necessary, at least once within every 90 calendar days from the date of admission for the first year and at least once within every 180 calendar day window period thereafter. Reviews should occur more frequently when a patient is not responding to treatment as planned or if a significant incident occurs. Reviews of the treatment plan shall be signed (physical or electronic signature) by either a physician, physician's assistant, licensed psychologist, nurse practitioner, or licensed clinical social worker." *14 NYCRR Section 822.9(c)*

"The case record must include, at a minimum, the following: . . . (4) the individual treatment/recovery plan and all reviews and updates thereto; . . ." *14 NYCRR Section 822.10(b)(4)*

In 1 instance, the required individual treatment/recovery plan review was missing. For Sample # 29, the individual treatment/recovery plan review was missing.

**5. No Documentation of Service Provided**

"All occasions of service provided during a visit must be documented in the patient's treatment record." *18 NYCRR Section 505.27(b)(5)*

"The case record must include, at a minimum, the following: . . . (9) documentation of service in accordance with section 822-2.5 . . . ." *14 NYCRR Section 822-2.2(b)(9)*

". . . all services delivered to or on behalf of a patient must be documented by a program as follows: (1) be written and signed by the staff member providing the service; (2) indicate the date the service was delivered; (3) record the results of the service, including any recommendations or determinations for initial, continued or revised treatment for the patient; (4) indicate the duration of the service provided; and (5) be included in a patient's case record." *14 NYCRR Section 822-2.5(a)*

In 1 instance, the patient record did not document that a service was provided. This finding applies to Sample # 68.

## Repayment Options

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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 the 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:

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
File # 19-2529  
Albany, New York 12237

**Option #2:** Enter into a repayment agreement with OMIG. 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%. 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. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

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

Should you fail to select a payment option above, OMIG, in its discretion, may use any remedy allowed by law to collect the amount due. Pursuant to the State Finance Law Section 18(5), a collection fee equal to twenty two percent (22%) of the amount due, including interest, may be added to the amount owed. OMIG's remedies may include, without limitation, filing this Final Audit Report as the final administrative determination for purposes of obtaining a judgment lien pursuant to Section 145-a of the New York State Social Services Law; withholding Medicaid payments otherwise payable to the provider or its affiliates pursuant to 18 NYCRR Section 518.6; and imposing a sanction, pursuant to 18 NYCRR Section 515.2, against a provider who fails to reimburse the department for overpayments discovered by this audit.

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## Hearing Rights

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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 OMIG would seek and defend the adjusted point estimate of \$235,217. 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]

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."

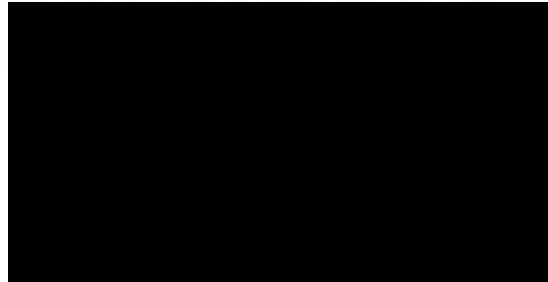
If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply along with your hearing request a signed authorization permitting that person to represent you at the hearing; you may call witnesses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

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

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## Contact Information

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Office Address:

New York State  
Office of the Medicaid Inspector General  
Division of Medicaid Audit  
259 Monroe Ave, Suite 312  
Rochester, New York 14607

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## 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

Ms. Jennifer Carlson, CEO  
Finger Lakes Addictions Counseling and  
Referral Agency  
28 East Main Street  
Clifton Springs, New York 14432

Provider ID #: 00590372

Audit #: 19-2529

Amount Due: \$79,259

Audit  
Type

- ☐ Managed Care  
☒ Fee-for-Service  
☐ Rate

### 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 the check to:

  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
File #19-2529  
Albany, New York 12237