NEW YORK STATE | Office of the Medicaid Inspector General

ERIN E. IVES
Acting Medicaid Inspector General

Audit of Claims for OPWDD Day Habilitation Services

Final Audit Report
Audit #: 19-1797

Anderson Center Services, Inc.

Provider ID #: 02707862

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

ERIN E. IVES
Acting Medicaid Inspector General

November 4, 2020

[redacted]
Anderson Center Services, Inc.
4885 Route 9
Staatsburg, New York 12580

Re: Final Audit Report
Audit #: 19-1797
Provider ID #: 02707862

Dear [redacted]

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Anderson Center Services, Inc. (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 OPWDD day habilitation claims paid to the Provider from January 1, 2015, through December 31, 2017. The audit universe consisted of 69,463 claims totaling $12,889,396.80. The audit consisted of a random sample of 100 claims with Medicaid payments totaling $18,430.61 (Attachment A).

The Provider's September 29, 2020 response to OMIG's August 26, 2020 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 $398,886. The adjusted lower confidence limit of the amount overpaid is $22,580. 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 $22,580.

If you have any questions or comments concerning this report, please contact [redacted] or through email at [redacted] Please refer to audit number 19-1797 in all correspondence.

[redacted]
Division of Medicaid Audit
Office of the Medicaid Inspector General

Attachments
Certified Mail Number: 7014 2120 0002 1928 5327
Return Receipt Requested
[redacted]

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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 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.

Outpatient services provided to persons with developmental disabilities are offered at programs licensed by the Office for People With Developmental Disabilities (OPWDD). The purpose of these programs is to offer a comprehensive system of services, which has as its primary purpose the promotion and attainment of independence, inclusion, and productivity for persons with mental retardation and developmental disabilities. These services are furnished at clinic and day treatment facilities and through a home and community based services (HCBS) Federal waiver program. The waiver program, established under the authority of section 1915 (c) of the Social Security Act, is intended for persons with mental retardation and developmental disabilities who would otherwise need the level of care provided in an intermediate care facility. The specific standards and criteria for OPWDD services are outlined in Title 14 NYCRR Parts 635, 671, 679, and 690.

Objective

The objective of this audit was to assess Anderson Center Services, Inc.'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 rate codes were billed for services rendered;
- recipient 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 OPWDD day habilitation claims paid to the Provider by Medicaid for payment dates included in the period beginning January 1, 2015, and ending December 31, 2017, was completed.

The audit universe consisted of 69,463 claims totaling $12,889,396.80. The audit sample consisted of 100 claims totaling $18,430.61 (Attachment A).

Regulations of General Application

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)*

Audit Findings

OMIG issued a Draft Audit Report to the Provider on August 26, 2020. The Provider's September 29, 2020 response (Attachment D) to the August 26, 2020 Draft Audit Report stated that the Provider is in agreement with the Draft Audit Report findings. As a result, the total sample overpayment of $2,795.52 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

Error Description	Number of Errors
Missing Required Elements in Day Habilitation Service Documentation (Group/Supplemental Group)	10
Failure to Forward Revised Habilitation Plan for Day Habilitation Within 30 Days to the Service Coordinator	3
Missing Day Habilitation Plan	2
Staff Member Delivering the Day Habilitation Service Absent on Date of Service	1
Missing Required Elements of the Day Habilitation Plan	1

Audit Findings Detail

OMIG's review of Medicaid claims paid to the Provider from January 1, 2015, through December 31, 2017, identified 15 claims with at least one error, for a total sample overpayment of $2,795.52 (Attachment C).

1. **Missing Required Elements in Day Habilitation Service Documentation (Group/Supplemental Group)**

"**Medicaid rules require that service documentation be contemporaneous with the service provision.** Required service documentation elements are:

1. **Consumer's name and Medicaid number (CIN).**
2. **Identification of category of waiver service provided.**
3. **A daily description of the required minimum number of face-to-face services provided by staff.**
4. **Documentation that the minimum service duration requirement was met.**
   - **For Group Day Habilitation,** ...indicating the service start time and service stop time. Alternatively, the provider may elect to document the program day duration with a daily affirmation, stating the minimum duration was met in either a narrative note or checklist format...
   - **For Supplemental Group Day Habilitation,** the provider must document the service start time and the service stop time.
5. **The consumer's response to the service.**
6. **The date the service was provided.**
7. **The primary service location.**
8. **Verification of service provision by the Group Day Habilitation staff person delivering the service.** Initials are permitted if a 'key' is provided, which identifies the title, signature and full name associated with the staff initials.
9. **The signature and title of the Group Day Habilitation staff person documenting the service.**
10. **The date the service was documented.**"

OPWDD Administrative Memorandum #2006-01, pp. 3-5

In 10 instances pertaining to 9 recipients, one or more required elements were missing in the day habilitation service note. This finding applies to Sample #s 2, 8, 20, 23, 28, 31, 35, 40, 72 and 88.

The breakdown is listed below:

In 9 instances, the date the service was documented was missing on the monthly summary note. This finding applied to Sample #s 2, 8, 20, 23, 28, 31, 35, 40 and 72.

In 1 instance, the signature of the Group Day Habilitation staff person documenting the service was missing on the daily note. This finding applies to Sample # 88.

2. **Failure to Forward Revised Habilitation Plan for Day Habilitation Within 30 Days to the Service Coordinator**

"...If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services), the relevant habilitation plan(s)

must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider...." *14 NYCRR Section 635-99.1(bk)*

"Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan." *OPWDD Administrative Memorandum #2012-01, pp. 3-4*

In 3 instances pertaining to 3 recipients, the revised day habilitation services plan was not forwarded within 30 days to the service coordinator. This finding applies to Sample #s 11, 74 and 77.

3. Missing Day Habilitation Plan

"...If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, prevocational services), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider...." *14 NYCRR Section 635-99.1(bk)*

"In addition to the service note(s) supporting . . . Day Habilitation billing claims, your agency must maintain the following documentation: . . .

- The **Group Day Habilitation Plan** developed by your agency that conforms to the Habilitation Plan requirements found in ADM 2003-03. . . . The Group Day Habilitation Plan must 'cover' the time period of the Group Day Habilitation service claim."
OPWDD Administrative Memorandum #2006-01, p. 6

"In addition to the service note(s) supporting the Individual Day Habilitation billing claim, your agency must maintain the following documentation: . . .

- The **Individual Day Habilitation Plan** developed by your agency that conforms to the Habilitation Plan requirements found in ADM 2003-03. . . . The Individual Day Habilitation Plan must 'cover' the time period of the Individual Day Habilitation service claim."
OPWDD Administrative Memorandum #2006-02, pp.6- 7

"The ... Habilitation Plan must be written by the Habilitation Service Provider and should be developed in collaboration with the person, their advocate and service coordinator ... and is forwarded to the Service Coordinator... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator... after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan." *OPWDD Administrative Memorandum #2012-01, pp. 2-3*

In 2 instances pertaining to 1 recipient, the day habilitation plan valid for the service date was not available. This finding applies to Sample #s 8 and 28.

4. Staff Member Delivering the Day Habilitation Service Absent on Date of Service

"Group Day Habilitation and Supplemental Group Day Habilitation services are billed as either a Full Unit or a Half Unit. A Full Unit may be billed when staff deliver and document at least two individualized face-to-face Group Day Habilitation services to a consumer during the program

day, and the program day duration is four to six hours in duration. A Half Unit of Group Day Habilitation or Supplemental Group Day Habilitation may be billed when staff deliver and document at least one individualized face-to-face Group Day Habilitation service to a consumer during the program day, and the program day duration is at least two hours."

OPWDD Administrative Memorandum #2006-01, p. 3

In 1 instance, the agency's time and attendance records indicated that the staff member delivering the day habilitation service was absent for the date of service. This finding applies to Sample # 16.

5. Missing Required Elements of the Day Habilitation Plan

"...If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, prevocational services), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider...." *14 NYCRR Section 635-99.1(bk)*

"Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually." *OPWDD Administrative Memorandum #2012-01, p. 3*

"For every habilitation service, an individual must have a Habilitation Plan that contains the following elements:

1. The individual's name.
2. The individual's Medicaid Identification Number (CIN), if the person is a Medicaid enrollee.
3. The habilitation service provider's agency name.
4. Identification of the habilitation service(s) provided.
5. The date on which the Habilitation Plan was reviewed.
6. Identification of at least one valued outcome that is derived from the individual's ISP.
7. Description of the services and supports the habilitation staff will provide to the person.
8. The safeguards (health and welfare) that will be provided by the habilitation service provider.
9. The printed name, signature and title of the staff who wrote the Habilitation Plan.
10. The date that staff signed the Habilitation Plan."

OPWDD Administrative Memorandum #2012-01, p. 7

In 1 instance, the safeguards (health and welfare) that will be provided by the habilitation service provider were missing. This finding applies to Sample # 52.

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, money order, or OMIG's Online Payment Portal 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, should include the audit number on the memo line, and be mailed with the attached remittance advice to:

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]

- If you elect to pay electronically through OMIG's Online Payment Portal, please visit [redacted] or contact OMIG's Bureau of Collections Management by telephone or email, at the above number or address.

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's acceptance of a 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, by telephone or email, as provided above.

Should you fail to select a payment option above within 20 days of the date of this Report, OMIG will initiate recoupment by withholding all or a part of your payments otherwise payable, in accordance with 18 NYCRR 518.6. Additionally, OMIG reserves the right to 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.

Hearing Rights

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 $398,886. 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.

Contact Information

Office Address:

New York State
Office of the Medicaid Inspector General
Division of Medicaid Audit
445 Hamilton Avenue, Suite 506
White Plains, New York 10601

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.

NEW YORK STATE | Office of the Medicaid Inspector General

REMITTANCE ADVICE

[redacted]
Anderson Center Services, Inc.
4885 Route 9
Staatsburg, New York 12580

Provider ID #: 02707862

Audit #: 19-1797

Amount Due: $22,580

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

If you elect to pay electronically through OMIG's Online Payment Portal, please visit [redacted] or contact OMIG's Bureau of Collections Management by telephone or email, at the above number or address.