NEW YORK STATE | Office of the Medicaid Inspector General

ERIN E. IVES
Acting Medicaid Inspector General

Audit of NYS Medicaid EHR Incentive Payment

Final Audit Report
Audit #: 19-6971

Dr. Tanzila Chaudhry

Provider ID #: 04233749
NPI #: 1831582931

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

ERIN E. IVES
Acting Medicaid Inspector General

January 7, 2021

Dr. Tanzila Chaudhry
70 Jordan Avenue Apartment 1
Jersey City, New Jersey 07306

Re: Final Audit Report
Audit #: 19-6971
Provider #: 04233749
NPI #: 1831582931

Dear Dr. Chaudhry:

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Dr. Chaudhry (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 April 16, 2018, for the meaningful use (MU) of a certified EHR system during the calendar year ending December 31, 2016. The Provider was paid an EHR incentive payment of $21,250 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] or through email at [redacted] Please refer to audit number 19-6971 in all correspondence.

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

Certified Mail Number: 7019-2280-0000-6785-5709
Return Receipt Requested

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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 April 16, 2018, regarding payment for the meaningful use (MU) of a certified EHR system during the calendar year ending December 31, 2016.

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

After reviewing your response to the OMIG's October 1, 2020 Draft Audit Report, the overpayment in the Final Audit Report remains unchanged to the overpayment identified in the Draft Audit Report.

OMIG's review of the Provider's 2016 Medicaid EHR incentive payment identified at least one error, resulting in an overpayment for that year of $21,250 (see finding #s 1-4 below). The recovery of the identified overpayment for 2016 also results in an additional overpayment of $8,500 for payment year 2017 (see finding #5, below).

As a result, the total overpayment for audit # 19-6971 is $29,750

Payment Year	Overpayment Amount	Audit Findings Reference #
2016	$21,250	1-4
2017	$8,500	5
Total:	**$29,750**	

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)*

For the 2016 payment year, the Provider failed to produce documentation upon audit demonstrating that the Provider met the minimum Medicaid patient volume threshold during a continuous 90-day period in the calendar year preceding the payment year, or in the 12 months before the Provider's 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 and to furnish such records and information, upon request...(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 § 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, including any prescription or fiscal order for the service or supply, must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department..." *18 NYCRR § 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." *NY Medicaid 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 2016 payment year.

4. **Failure to Support Meaningful Use Objective(s)/Measure(s)**

"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)*

"Criteria for EPs for 2015 through 2017—(1) General rule regarding criteria for meaningful use for 2015 through 2017 for EPs. Except as specified in paragraph (b)(2) of this section, EPs must meet all objectives and associated measures of the meaningful use criteria specified under paragraph (e) of this section to meet the definition of a meaningful EHR user." *42 CFR § 495.22(b)*

The Provider failed to produce documentation upon audit to support that the following Modified Stage 2 objectives/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 2016 payment year:

Protect Electronic Health Information

"Meaningful use objectives and measures for 2015 through 2017...(1)(i) Objective. Protect electronic protected health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities. (ii) Measures—(A) EP measure. Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process." *42 CFR § 495.22(e)(1)*

Clinical Decision Support

"Meaningful use objectives and measures for 2015 through 2017...(2)(i) Objective. Use clinical decision support to improve performance on high-priority health conditions. (ii) EP measures—(A) Measure. In order for EPs to meet the objective they must satisfy both of the following measures: (1) Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. (2) Enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. (B) Exclusion in accordance with paragraph (b)(2) of this section. An EP who writes fewer than 100 medication orders during the EHR reporting period may be excluded from the measure under paragraph (e)(2)(i)(A)(2) of this section." *42 CFR § 495.22(e)(2)*

Computerized Provider Order Entry

"Meaningful use objectives and measures for 2015 through 2017...(3)(i) Objective. Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines. (ii) EP measures—(A) Measures. An EP must meet the following 3 measures, subject to paragraph (d) of this section: (1) More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. (2) More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. (3) More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. (B) Exclusion in accordance with paragraph (b)(2) of this section. (1) For the measure specified in paragraph (e)(3)(ii)(A)(1) of this section, any EP who writes fewer than 100 medication orders during the EHR reporting period. (2) For the measure specified in paragraph (e)(3)(ii)(A)(2) of this section, any EP who writes fewer than 100 laboratory orders during the EHR reporting period. (3) For the measure specified in paragraph (e)(3)(ii)(A)(3) of this section, any EP who writes fewer than 100 radiology orders during the EHR reporting period. (C) Alternate exclusions and specifications....An EP previously scheduled to be in Stage 1 in 2016 may exclude the measures outlined under paragraphs (e)(3)(ii)(A)(2) and (3) of this section for an EHR reporting period in 2016....Alternate exclusions in 2016. An EP scheduled to be in Stage 1 in 2016 may exclude the measure specified in paragraphs (e)(3)(ii)(A)(2) and (e)(3)(ii)(A)(3) of this section in 2016."

42 CFR § 495.22(e)(3)

Electronic Prescribing (eRx)

"Meaningful use objectives and measures for 2015 through 2017...(4)(i) Objective. For EPs, generate and transmit permissible prescriptions electronically (eRx)....(ii) EP measure—(A) Measure. Subject to paragraph (d) of this section, more than 50 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT. (B) Exclusion in accordance with paragraph (b)(2) of this section. Any EP who—(1) Writes fewer than 100 permissible prescriptions during the EHR reporting period; or (2) Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period." *42 CFR § 495.22(e)(4)*

Health Information Exchange

"Meaningful use objectives and measures for 2015 through 2017...(5)(i) Objective. The EP...who transitions a patient to another setting of care or provider of care or refers a patient to another provider of care provides a summary care record for each transition of care or referral. (ii) EP measure. (A) Measure. Subject to paragraph (d) of this section, the EP who transitions or refers his or her patient to another setting of care or provider of care must do the following: (1) Use CEHRT to create a summary of care record. (2) Electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals. (B) Exclusion in accordance with paragraph (b)(2) of this section. Any EP who transfers a patient to another

setting or refers a patient to another provider less than 100 times during the EHR reporting period." *42 CFR § 495.22(e)(5)*

Patient-Specific Education Resources

"Meaningful use objectives and measures for 2015 through 2017...(6)(i) Objective. Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient. (ii) EP measure—(A) Measure. Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period. (B) Exclusion in accordance with paragraph (b)(2) of this section. Any EP who has no office visits during the EHR reporting period." *42 CFR § 495.22(e)(6)*

Medication Reconciliation

"Meaningful use objectives and measures for 2015 through 2017...(7)(i) Objective. The EP...that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation. (ii) EP measure—(A) Measure. Subject to paragraph (d) of this section, the EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP. (B) Exclusion in accordance with paragraph (b)(2) of this section. Any EP who was not the recipient of any transitions of care during the EHR reporting period." *42 CFR § 495.22(e)(7)*

Patient Electronic Access

"Meaningful use objectives and measures for 2015 through 2017...(8)(i) EP objective. Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP. (A) EP measures. An EP must meet the following 2 measures: (1) Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download and transmit to a third party their health information subject to the EP's discretion to withhold certain information. (2) Measure 2: For an EHR reporting period—(i) in 2015 and 2016, at least 1 patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period. (B) Exclusion in accordance with paragraph (b)(2) of this section—(1) Any EP who neither orders nor creates any of the information listed for inclusion as part of the measure in paragraph (e)(8)(ii)(A)(1) or (2) of this section, except for "Patient name" and "Provider's name and office contact information," is excluded from paragraphs (e)(8)(ii)(A)(1) and (2) of this section. (2) Any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission on the first day of the EHR reporting period is excluded from paragraph (e)(8)(ii)(A)(2) of this section." *42 CFR § 495.22(e)(8)*

Secure Electronic Messaging

"Meaningful use objectives and measures for 2015 through 2017...(9)(i) EP objective. Use secure electronic messaging to communicate with patients on relevant health information. (ii)

EP measure—(A) Measure. For an EHR reporting period...(2) In 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period....(B) Exclusion in accordance with paragraph (b)(2) of this section. An EP may exclude from the measure if he or she—(1) Has no office visits during the EHR reporting period; or (2) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission on the first day of the EP's EHR reporting period."

42 CFR § 495.22(e)(9)

Public Health Reporting

"Meaningful use objectives and measures for 2015 through 2017...(10)(i) EP Public Health Reporting—(A) Objective. The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT, except where prohibited, and in accordance with applicable law and practice. (B) Measures. In order to meet the objective under paragraph (e)(10)(i)(A) of this section, an EP must choose from measures 1 through 3 (as specified in paragraphs (e)(10)(i)(B)(1) through (3) of this section) and must successfully attest to any combination of two measures. The EP may attest to measure 3 (as specified in paragraph (e)(10)(i)(B)(3) of this section more than one time. These measures may be met by any combination in accordance with applicable law and practice. (1) Immunization registry reporting. The EP is in active engagement with a public health agency to submit immunization data. (2) Syndromic surveillance reporting. The EP is in active engagement with a public health agency to submit syndromic surveillance data. (3) Specialized registry reporting. The EP is in active engagement to submit data to specialized registry. (C) Exclusions in accordance with paragraph (b)(2) of this section. (1) Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure in paragraph (e)(10)(i)(B)(1) of this section if the EP: (i) Does not administer any immunizations to any of the populations for which data is collected by his or her jurisdiction's immunization registry or immunization information system during the EHR reporting period. (ii) Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of his or her EHR reporting period. (iii) Operates in a jurisdiction in which no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period. (2) Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure described in paragraph (e)(10)(i)(B)(2) of the section if the EP: (i) Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system; (ii) Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period. (iii) Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period. (3) Any EP who meets one or more of the following criteria may be excluded from the specialized registry reporting measure described in paragraph (e)(10)(i)(B)(3) of this section if the EP: (i) Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period;

(ii) Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (iii) Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period." *42 CFR § 495.22(e)(10)*

5. **No Valid Participation Year Prior to 2017**

"An EP may not begin receiving payments any later than CY 2016."

42 CFR § 495.310(a)(iii)

"A provider's first participation year may be any year between 2011 through 2016. The last year a Medicaid EP or EH may begin receiving payments under the Medicaid EHR Incentive Program is 2016. Therefore, if 2016 was the providers' first year of participation in the Medicaid EHR Incentive Program and they fail a post payment audit of the 2016 attestation, the provider would lose eligibility to attest for 2017 and any subsequent years. If the provider already attested and received payment for any program year after 2016, all future payments should be recouped."

Centers for Medicare and Medicaid Services (CMS) FAQ #10755
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/FAQs.pdf

With the recovery of the Provider's 2016 incentive payment, the Provider will not have met the federal requirement to begin participation in the Medicaid EHR Incentive Program between payment years 2011 through 2016. This results in the Provider's loss of eligibility for all payment years subsequent to payment year 2016. Since the Provider was already paid for payment year 2017, that year must also be recouped.

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
  [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

You have 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 you wish 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]

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.

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.

NEW YORK STATE | Office of the Medicaid Inspector General

REMITTANCE ADVICE

Dr. Tanzila Chaudhry **1995 3rd Avenue** **New York, New York 10029**	**Provider ID #: 04233749** **Audit #: 19-6971**
Amount Due: $29,750	**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 19-6971**HIT** 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
Audit #: 19-6971
Albany, New York 12204
[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.