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 #: 19-5197

Dr. Salvador Onesimo Perez

Provider ID #: 02872273
NPI #: 1104024314

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

ERIN E. IVES
Acting Medicaid Inspector General

January 7, 2021

Dr. Salvador Onesimo Perez
10005 Roosevelt Avenue Suite 201
Corona, New York 11368

Re: Final Audit Report
Audit #: 19-5197
Provider #: 02872273
NPI #: 1104024314

Dear Dr. Perez:

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Dr. Perez (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 November 30, 2015, for the meaningful use (MU) of a certified EHR system during the calendar year ending December 31, 2015. 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] or through email at [redacted] Please refer to audit number 19-5197 in all correspondence.

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

Certified Mail Number: 7019-2280-0000-6785-5693
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 November 30, 2015, regarding payment for the meaningful use (MU) of a certified EHR system during the calendar year ending December 31, 2015.

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 December 19, 2019 Draft Audit Report, the overpayment in the Final Audit Report remains unchanged to the overpayment identified in 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 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 2015 payment year:

Patient Electronic Access to 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. (A) Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request. (B) Beginning 2014, 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. (ii) Measure. (A) 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. (B) Beginning 2014, subject to paragraph (c) of this section, more than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online 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. (A) Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period. (B) Beginning 2014, any EP who neither orders nor creates any of the information listed for inclusion as part of this measure. *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)*

2. **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 2015 payment year:

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 (10) of this section unless the EP has an exclusion from five or more objectives in this paragraph (e), in which case the EP must meet all remaining objectives and associated measures in paragraph (e) of this section. (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-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 (10) of this section unless the EP has an exclusion from five or more objectives in this paragraph (e), in which case the EP must meet all remaining objectives and associated measures in paragraph (e) of this section. (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, 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. Salvador Onesimo Perez
10005 Roosevelt Avenue Suite 201
Corona, New York 11368

Provider ID #: 02872273

Audit #: 19-5197

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 19-5197**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 #: 19-5197
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.