



**Office of the
Medicaid Inspector
General**

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

Audit of Claims for Assisted Living Program (ALP) Services

**Final Audit Report
Audit #: 14-3476**

Boulevard ALP

Provider ID #: 02632451



**Office of the
Medicaid Inspector
General**

ANDREW M. CUOMO
Governor

FRANK T. WALSH, JR
Acting Medicaid Inspector General

July 1, 2021

[REDACTED]
Boulevard ALP
71-61 159th Street
Flushing, New York 11365

Re: Final Audit Report
County Demonstration Project
New York City
Audit #: 14-3476
Provider ID #: 02632451

Dear [REDACTED]

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Boulevard ALP (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 assisted living program services claims paid to the Provider by Medicaid for New York City recipients from January 1, 2009, through December 31, 2011. The audit universe consisted of 203,948 claims totaling \$15,952,772.44. The audit consisted of a random sample of 100 claims with Medicaid payments totaling \$8,019.64 (Attachment A).

OMIG has attached the sample detail for the paid claims determined to be in error. This Final Audit Report incorporates consideration of any additional documentation and information presented in the Provider's response to the Draft Audit Report dated October 8, 2020. The point estimate overpaid is \$7,160,268. The lower confidence limit of the amount overpaid is \$5,754,485. 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 lower confidence limit of \$5,754,485.

If you have any questions or comments concerning this report, please contact [REDACTED] at [REDACTED] or through email at [REDACTED]. Please refer to audit number 14-3476 in all correspondence.

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

Attachments

Certified Mail Number: 7021 0350 0000 6247 0364

Return Receipt Requested

[REDACTED]

Table of Contents

Background	1
Objective	1
Audit Scope	2
Regulations of General Application	3-4
Audit Findings	5-12
Repayment Options	13
Hearing Rights	14
Contact Information	15
Remittance Advice	
Attachments:	
A - Sample Design	
B - Sample Results and Estimates	
C - Detailed Audit Findings	
D - Bridge Schedule	

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.

An Assisted Living Program ("ALP") is an entity approved to operate, pursuant to 18 NYCRR Section 485.6(n), in adult homes and enriched housing programs. The ALP is established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible residents unrelated to the operator 18 NYCRR Section 494.2. For each Medicaid enrollee participating in the ALP, a daily rate is paid to the ALP for the provision of nine distinct home care services. No additional fee-for-service billing can be made for these home care services.

Services covered under the daily Medicaid rate and for which no additional separate billing may be made include:

- Title XIX Personal Care Services
- Home Health Aide Services
- Personal Emergency Response Services
- Nursing Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical supplies and equipment not requiring prior approval
- Adult Day Health Care

Objective

The objective of this audit was to assess Boulevard ALP'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;
- resident 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 assisted living program claims for New York City recipients paid to the Provider by Medicaid for the payment dates included in the period beginning January 1, 2009, and ending December 31, 2011, was completed.

The audit universe consisted of 203,948 claims totaling \$15,952,772.44. The audit sample consisted of 100 claims totaling \$8,019.64 (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 October 8, 2020. This Final Audit Report incorporates consideration of any additional documentation and information presented in the Provider's response to the Draft Audit Report. The attached Bridge Schedule (Attachment D) indicates any financial changes to the findings as a result of the Provider's response. 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 Plan of Care	27
Invalid Service Documentation	12
Missing Medical Reassessment	2
Missing Patient Review Instrument (PRI)	2
Missing/Invalid Signature on Medical Evaluation	1
Missing Service Documentation	1
Plan of Care Not Updated as Required	1
No Services Rendered	1
Missing Medical Evaluation	1

Audit Findings Detail

OMIG's review of Medicaid claims paid to the Provider from January 1, 2009, through December 31, 2011, identified 43 claims with at least one error, for a total sample overpayment of \$3,510.83 (Attachment C).

1. Missing Plan of Care

"Appropriate services shall be provided to an eligible person only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an assisted living program, either directly or through contract with a long term home health care program or certified home health agency. A reassessment shall be conducted as frequently as is required to respond to changes in the resident's condition and ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months. No person shall be admitted to or retained in an assisted living program unless the person can be safely and adequately cared for with the provision of services determined by such assessment or reassessment." *NYS Social Services Law 461-L(2)(d)(iii)*

"A plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, need for palliative care, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential." *10 NYCRR Section 766.3(b)*

"The plan of care is reviewed and revised as frequently as necessary to reflect the changing care needs of the patient, but no less frequently than every six months..." *10 NYCRR Section 766.3(d)*

"The agency shall maintain a confidential record for each patient admitted to care to include . . . (4) an individualized plan of care." *10 NYCRR 766.6(a)(4)*

In 27 instances pertaining to 26 residents, the record did not include a Plan of Care for the claim date of service. This finding applies to Sample #s 4, 5, 7, 17, 20, 32, 36, 40, 50, 51, 53, 54, 57, 58, 59, 67, 69, 79, 82, 85, 86, 89, 90, 92, 93, 98, and 100.

2. Invalid Service Documentation

"By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years . . . all records necessary to disclose the nature and extent of services furnished" *18 NYCRR Section 504.3(a)*

"By enrolling the provider agrees: (e) to submit claims for payment only for services actually furnished . . . ; (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(e), (h), and (i)*

"Resident services: (a) The operator is responsible for providing or arranging for resident services which must include, at minimum: room, board, housekeeping, supervision, personal care, case management activities and home health services (b) Services included in the medical

assistance capitated rate are: (1) personal care services which are reimbursable under title XIX of the Federal Social Security Act; (2) home health aide services; (3) personal emergency response services; (4) nursing services; (5) physical therapy; (6) occupational therapy; (7) speech therapy; (8) medical supplies and equipment not requiring prior authorization; and (9) adult day health care in a program approved by the Commissioner of Health."

18 NYCRR Section 494.5

"Appropriate services must be provided to or arranged for an eligible individual only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conduct by an assisted living program, or if the assisted living program itself is not an approved long-term home health care program or certified home health agency, by an assisted living program and a long-term home health care program or certified home health agency."

18 NYCRR Section 494.4(b)

"Federal Law and State Regulations require providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to Medicaid recipients. Providers must furnish information regarding any payment claimed to authorized officials upon request of the State Medicaid Program or the local department of social services. For medical facilities subject to inspection and licensing requirements provided in Article 28 of the Public Health Law, the State Hospital Code contains specific details concerning content and maintenance of medical records. Practitioners providing diagnostic and treatment services must keep medical records on each recipient. Records include: . . . Nature and extent of services provided; . . . The dates of service provided. . ."

Provider Manual Policy Guidelines, Version 2006-1 Section II

"At a minimum the operator shall maintain: (vii) staff records, including personnel procedures, job descriptions, staffing schedules and payment records."

18 NYCRR Section 487.10(d)(5)(vii)

"At a minimum, the operator must maintain: (vii) staff records, including personnel procedures, job descriptions, staffing schedules and payment records; . . ."

18 NYCRR Section 488.10(d)(4)(vii)

"The agency shall ensure for all personnel: (i) that time and payment records are maintained for all personnel; . . ."

10 NYCRR Section 763.13(i)

In 12 instances pertaining to 12 residents, the record contained invalid service documentation. This finding applies to Sample #s 1, 8, 11, 12, 16, 30, 33, 34, 63, 78, 84, and 94.

- In 10 instances pertaining to 10 residents, the name/initials of the aide worker performing the service was missing from the service documentation. This finding applies to Sample #s 1, 8, 11, 12, 16, 30, 33, 34, 63, and 94.
- In 2 instances pertaining to 2 residents, the date on the service documentation was changed to reflect the sample date of service. This finding applies to Sample #s 78 and 84.

3. Missing Medical Reassessment

"Appropriate services shall be provided to an eligible person only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an assisted living program, either directly or through contract with a long term home health care program or certified home health agency. A reassessment shall be conducted as frequently as is required to respond to changes in the resident's condition and ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months. No person shall be admitted to or retained in an assisted living program unless the person can be safely and adequately cared for with the provision of services determined by such assessment or reassessment." *NYS Social Services Law 461-L(2)(d)(iii)*

"The agency shall maintain a confidential record for each patient admitted to care to include: . . . (2) medical orders, if applicable; . . ." *10 NYCRR Section 766.6(a)(2)*

In 2 instances pertaining to 2 residents, the record did not include a medical reassessment for the date of service. This finding applies to Sample #s 20 and 64.

4. Missing Patient Review Instrument (PRI)

"The agency shall maintain a confidential record for each patient admitted to care to include . . . (3) nursing assessments conducted to provide services." *10 NYCRR Section 766.6(a)(3)*

"The operator of a residential health care facility shall ensure: (1) that the patient review form (PRI) is completed for all patients of the facility pursuant to subdivision (a) of this section; (2) that the patient review form (PRI) is completed by a registered professional nurse who is qualified by experience and demonstrated competency in long-term care and who has successfully completed a training program in patient case mix assessment approved by the department to train individuals in the completion of the patient review form (PRI) for the purposes of establishing a facility's case mix financial reimbursement; and (3) that the patient review form (PRI) is certified by the operator and the nurse assessor responsible for completion of the patient review form (PRI). (The form of the certification required shall be as prescribed in the report form provided by the department.)." *10 NYCRR Section 86-2.30(c)*

"By enrolling the provider agrees: (i) to comply with the rules, regulations, and official directives of the department." *18 NYCRR Section 504.3(i)*

"A true and accurate representation of the resident must be reflected on the PRI and substantiated in the medical record to support the Medicaid payment. Fiscal penalties will be assessed to providers for the inappropriate practice of claiming services not provided to or needed by ALP residents (18 NYCRR 515.2). Providers are reminded that they are responsible for ensuring that assessments are completed accurately and reflect the needs of the resident being evaluated for admission to or for continued stay in the ALP. Lack of appropriate documentation to support the assigned RUG grouping and subsequent payment may result in fiscal penalties being assessed."

NYS DOH DAL HCBS 08-02: Completion of the PRI for Individuals Participating in the ALP

In 2 instances pertaining to 2 residents, the record did not include a PRI for the date of service. This finding applies to Sample #s 73 and 90.

5. Missing/Invalid Signature on Medical Evaluation

"An operator must not admit nor retain an individual without a determination being made that the enriched housing program can support the physical and social needs of the resident. Such determination must be based upon: (1) a medical evaluation (DSS-3122 or an approved substitute) written and signed by a physician . . ."

18 NYCRR Section 488.4(d)(1)

In 1 instance, the patient medical record did not contain a valid signature on the Medical Evaluation. This finding applies to Sample # 40.

6. Missing Service Documentation

"Appropriate services must be provided to or arranged for an eligible individual only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conduct by an assisted living program, or if the assisted living program itself is not an approved long-term home health care program or certified home health agency, by an assisted living program and a long-term home health care program or certified home health agency."

18 NYCRR Section 494.4(b)

"...to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years . . . all records necessary to disclose the nature and extent of services furnished . . ."

18 NYCRR Section 504.3(a)

"Payment for assisted living program services (1) The MA program will pay an assisted living program for services provided to eligible MA recipients who are assisted living program residents at a capitated rate of payment established in accordance with the regulations of the Department of Health, based upon assessments of the recipients conducted pursuant to section 494.4 of this Title. Such capitated rate of payment is payment in full for the following MA services provided to MA recipients: (i) adult day health care provided in a program approved by the Department of Health; (ii) home health aide services; (iii) medical supplies and equipment not requiring prior approval pursuant to this Title; (iv) nursing services; (v) personal care services; (vi) personal emergency response services; and (vii) physical therapy, speech therapy, and occupational therapy."

18 NYCRR Section 505.35(h)(1)

"All providers, who are not paid at rates or fees approved by the State Director or the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, 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."

18 NYCRR Section 517.3(b)(1)

In 1 instance, the record did not include documentation for services claimed on the date of service. This finding applies to Sample # 42.

7. Plan of Care not Updated as Required

"The plan of care is reviewed and revised as frequently as necessary to reflect the changing care needs of the patient, but no less frequently than every six months; (1) each review shall be documented in the patient's clinical record; and (2) agency professional personnel shall promptly alert the patient's authorized practitioner and other affected care providers to any significant changes in the patient's condition that indicate a need to alter the plan of care."

10 NYCRR Section 766.3(d)

"...the agency shall maintain a confidential record for each patient admitted to care to include . . . (4) an individualized plan of care."

10 NYCRR 766.6(a)(4)

"Appropriate services must be provided to or arranged for an eligible individual only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conduct by an assisted living program, or if the assisted living program itself is not an approved long-term home health care program or certified home health agency, by an assisted living program and a long-term home health care program or certified home health agency."

18 NYCRR Section 494.4(b)

In 1 instance, the record did not include a plan of care that was updated and reviewed at least every 6 months. This finding applies to Sample # 72.

8. No Services Rendered

"Appropriate services must be provided to or arranged for an eligible individual only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conduct by an assisted living program, or if the assisted living program itself is not an approved long-term home health care program or certified home health agency, by an assisted living program and a long-term home health care program or certified home health agency."

18 NYCRR Section 494.4(b)

"Resident services: (a) The operator is responsible for providing or arranging for resident services which must include, at minimum: room, board, housekeeping, supervision, personal care, case management activities and home health services (b) Services included in the medical assistance capitated rate are: (1) personal care services which are reimbursable under title XIX of the Federal Social Security Act; (2) home health aide services; (3) personal emergency response services; (4) nursing services; (5) physical therapy; (6) occupational therapy; (7) speech therapy; (8) medical supplies and equipment not requiring prior authorization; and (9) adult day health care in a program approved by the Commissioner of Health."

18 NYCRR Section 494.5

"Payment for assisted living program services: (1) The MA program will pay an assisted living program for services provided to eligible MA recipients who are assisted living program residents at a capitated rate of payment established in accordance with the regulations of the Department of Health, based upon assessments of the recipients conducted pursuant to section 494.4 of this Title. Such capitated rate of payment is payment in full for the following MA services provided to MA recipients: (i) adult day health care provided in a program approved by the Department of Health; (ii) home health aide services; (iii) medical supplies and equipment not requiring prior approval pursuant to this Title; (iv) nursing services; (v) personal care services; (vi) personal

emergency response services; and (vii) physical therapy, speech therapy, and occupational therapy" *18 NYCRR Section 505.35(h)(1)*

"All bills for medical care, services and supplies shall contain . . . (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 and that, except as noted, no part thereof has been paid; that payment of fees and rates made in accordance with established schedules is accepted as payment in full for the care, services and supplies provided . . ."

18 NYCRR Section 540.7(a)(8)

"All providers, who are not paid at rates or fees approved by the State Director or the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, 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."

18 NYCRR Section 517.3(b)(1)

In 1 instance, the record did not include documentation of any required services for the claim. This finding applies to Sample # 72.

9. Missing Medical Evaluation

"An operator shall not admit an individual before a determination has been made that the facility program can support the physical, psychological and social needs of the resident."

18 NYCRR Section 487.4(d)

"Such a determination shall be based upon: (1) receipt and consideration of a medical evaluation."

18 NYCRR Section 487.4(e)(1)

"The agency shall maintain a confidential record for each patient admitted to care to include: . . . (2) medical orders, if applicable; . . ."

10 NYCRR Section 766.6(a)(2)

"An operator must not admit nor retain an individual without a determination being made that the enriched housing program can support the physical and social needs of the resident. Such determination must be based upon: (1) a medical evaluation (DSS-3122 or an approved substitute) written and signed by a physician . . ."

18 NYCRR Section 488.4(d)(1)

"Each medical evaluation (DSS-3122 or an approved substitute) shall be a written, and signed report from a physician which includes: (1) the date of examination, significant medical history and current conditions, known allergies, the prescribed medication regimen, including information on the applicant's ability to self-administer medications, recommendations for diet, exercise, recreation, frequency of medical examinations and assistance needed in the activities of daily living; (2) a statement that the resident is not medically or mentally unsuited for care in the facility; (3) a statement that the resident does not require placement in a hospital or residential health care facility; and (4) a statement that the physician has physically examined

the resident within 30 days prior to the date of admission or, for required annual evaluations, within 30 days prior to the date of the report.” *18 NYCRR Section 487.4(f)*

In 1 instance, the record did not contain a medical evaluation for the date of service. This finding applies to Sample # 73.

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]
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.

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 lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where OMIG would seek and defend the point estimate of \$7,160,268. 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

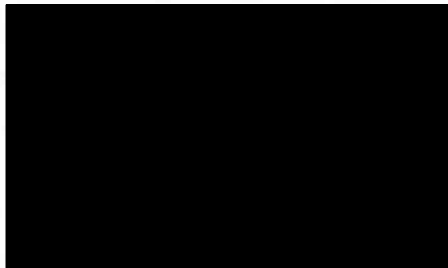
Questions regarding the request for a hearing should be directed to Office of Counsel, at [REDACTED]

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
800 North Pearl Street
Albany, New York 12204

Mission

The mission of the Office of the Medicaid Inspector General is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care.

Vision

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



Office of the
Medicaid Inspector
General

REMITTANCE ADVICE

[REDACTED]
Boulevard ALP
71-61 159th Street
Flushing, New York 11365

Provider ID #: 02632451

Audit #: 14-3476

Amount Due: \$5,754,485

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.