NEW YORK STATE | Office of the Medicaid Inspector General

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

Audit of Encounter Data for OASAS Outpatient Chemical Dependence and Opioid Treatment Program Services Provided in Excess of APG Category Specific Medicaid Billing Parameters Reported by Medicaid Managed Care Organizations From January 1, 2017 to December 31, 2021

Final Audit Report
Audit #:22-7417

United Healthcare Community Plan of NY, Inc.
Provider ID #: 04054091

NEW YORK STATE | Office of the Medicaid Inspector General

KATHY HOCHUL
Governor

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

March 15, 2023

[redacted]
United Healthcare Community Plan of NY, Inc.
One Penn Plaza, 8th Floor
New York, New York 10119

RE: Final Audit Report
Audit #: 22-7417
Plan ID #: 04054091

Dear [redacted]

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for United Healthcare Community Plan of NY, Inc. (Plan).

In accordance with Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York (NYCRR) Section 517.5 and the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Contract (Contract), Sections 30, 31 and 32 of the New York State Public Health Law, OMIG identified instances in which OASAS outpatient chemical dependence and opioid treatment program services were provided in excess of APG category specific Medicaid billing parameters. The audit reviewed these OASAS services reported by Medicaid Managed Care Organizations with payment dates included in the period beginning January 1, 2017 and ending December 31, 2021. The attached Final Audit Report represents the final determination on the issues found during OMIG's audit.

The Plan's February 27, 2023 response to the Draft Audit Report dated December 22, 2022 stated that the Plan did not dispute the Draft Audit Report findings. As a result, the overpayments identified in this Final Audit Report remain unchanged from those cited in the Draft Audit Report. The total amount due is $64,219.48.

Exhibit A referenced in this Final Audit Report will be sent via the Health Commerce System (HCS). If contact information has changed, please provide an updated contact person with a dedicated HCS account to [redacted] through email at [redacted] to obtain the Exhibit A. If you have any questions or comments concerning this report, please contact [redacted] or through email at [redacted]. Please refer to audit number 22-7417 in all correspondence.

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

Exhibits
Certified Mail #: 7019-2280-0000-6788-2088
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 Office of Mental Hygiene (Title 14 of the New York Codes Rules and Regulations), the regulations of the Education Department (Title 8 of the New York Codes Rules and Regulations), DOH's Medicaid Provider Manuals and *Medicaid Update* publications.

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

"Opioid treatment program" (OTP) means one or more NYS Office of Addiction Services and Supports (OASAS) certified sites where methadone or other approved medications are administered to treat opioid dependency, following one or more medical treatment protocols as defined in 14 NYCRR Parts 822 and 841. This encompasses medical and support services including counseling, educational and vocational rehabilitation. OTP services are provided in either hospital-based or free-standing settings. The Medicaid Management information System's (MMIS) Provider Manual for Clinics also provides program guidance for claiming Medicaid reimbursement for OTP services.

In accordance with 18 NYCRR Parts 517 and 518 and pursuant to the Contract, specifically Section 19.6 (OMIG's Right to Audit and Recover Overpayments Caused by Contractor's Misstated Encounter Data), Section 19.7 (OMIG Audit Authority), and Section 21.19 (Behavioral Health Service Providers), OMIG can recover the Plan's payments to providers for OASAS outpatient chemical dependence and opioid treatment program services provided in excess of APG category specific Medicaid billing parameters.

Objective

The objective of this audit was to assess the Plan's adherence to the Contract and applicable laws, regulations, rules and policies governing the New York State Medicaid program, and to:

- recover portions of NYS Office of Addiction Services and Supports (OASAS) outpatient chemical dependence encounters in which the daily allowable procedure limit was exceeded.
- recover portions of OASAS OTP encounters in which the daily allowable procedure limit was exceeded.

Audit Scope

OASAS Outpatient Chemcial Dependence and OASAS OTP services reported by the Plan that were provided in excess of APG category specific Medicaid billing parameters for the review period beginning January 1, 2017 and ending December 31, 2021.

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 Plan on December 22, 2022 that identified $64,219.48 in Medicaid overpayments. The Plan's February 27, 2023 response (Exhibit B) to the Draft Audit Report dated December 22, 2022 stated that the Plan did not dispute the Draft Audit Report findings. As a result, the total overpayment of $64,219.48 remains unchanged from the overpayment cited in the Draft Audit Report.

OMIG identified the following finding:

OASAS Outpatient Chemical Dependence and Opioid Treatment Program Services Billed in Excess of APG Category Specific Medicaid Billing Parameters Paid by the Plan to Providers

For Medicaid reimbursement, the Ambulatory Patient Group (APG) reimbursement methodology has replaced the threshold visit reimbursement system for OASAS certified clinic and rehabilitation programs, opiate treatment, and outpatient chemical dependency for youth programs. The APG payment methodology pays differential amounts for ambulatory care services based on the resources required for each service provided during a patient visit. In addition, APGs support discrete Medicaid reimbursement for some chemical dependence services that were not previously billable, and allow for some services that are integral to the treatment of patients in chemical dependency treatment such as mental and physical health services.

Providers must use certain APG specific CPT and HCPCS codes to bill Medicaid, and providers may, for the same patient on the same date, be able to bill Medicaid for multiple services. While a provider can provide multiple services for the same patient on the same day, there are APG category specific Medicaid billing parameters that providers must understand. These parameters set a limit of one service per patient per day for certain types of APG service categories. The types of services that fall under the one-per-day limitation include the following: Group Counseling, Individual Counseling, Admission Assessments, Outpatient Rehabilitation Services, Brief Treatments, Brief Interventions, Medication Administration and Observations, Medication Managements, and Screenings. In addition to these limits, Medicaid rules also state that a provider cannot bill an Intensive Outpatient Service or Outpatient Rehabilitation Service in conjunction with any other services.

Admission assessment services. Admission assessment services consist of three levels of billable services: brief assessment, normative assessment and extended assessment. No more than one admission assessment visit may be billed for any patient per day.

14 NYCRR 841.14(i)(1)

Brief intervention. No more than one brief intervention may be billed for any patient per day.

14 NYCRR 841.14(i)(2)

Brief treatment. No more than one brief treatment may be billed for any patient per day.

14 NYCRR 841.14(i)(3)

Group counseling. No more than one group counseling service may be billed for any patient per day.

14 NYCRR 841.14(i)(6)

Individual counseling. No more than one individual counseling service may be billed for any patient per day.

14 NYCRR 841.14(i)(7)

Medication administration and observation. No more than one medication administration and observation service may be billed for any patient per day.

14 NYCRR 841.14(i)(9)

Medication management....No more than one medication management service may be billed for any patient per day.

14 NYCRR 841.14(i)(10)

Outpatient rehabilitation services. No more than one outpatient rehabilitation service may be billed for any patient per day. Programs that provide outpatient rehabilitation services may also bill for medication administration and observation, medication management, complex care coordination, peer support services and collateral visits consistent with the standards set forth in this subdivision. Programs may not bill for any other service categories while a patient is admitted to the outpatient rehabilitation service.

14 NYCRR 841.14(i)(11)

Screening. No more than one screening may be billed for any patient within an episode of care.

14 NYCRR 841.14(i)(13)

The Office of the Medicaid Inspector General (OMIG) can perform audits of the Contractor's submitted encounter data after DOH has reviewed and accepted the Contractor's encounter data submission. If the audit determines the Contractor's encounter data was incorrectly submitted and the Contractor received additional or higher Medicaid managed care capitation rate payments and/or Supplemental Newborn Capitation Payments and/or Supplemental Maternity Capitation Payments, and/or other reimbursement due to the incorrect encounter data, OMIG can recover from the Contractor the additional Medicaid funds that the Contractor received because of the encounter data misstatement....Nothing in this section shall limit SDOH, OMIG or any other auditing entity from the development of alternative audit and/or recovery rights for time periods prior to the contract period, during the contract period, or subsequent to the contract period or limit other remedies or rights available to SDOH, OMIG or any other auditing entity relating to the timeliness, completeness and/or accuracy of the Contractor's reporting submission. *Contract, Section 19.6*

In accordance with New York State Public Health Law Sections 30 – 36, and as authorized by federal or state laws and regulations, the Office of the Medicaid Inspector General (OMIG) may review, audit, and investigate contracts, encounter data, cost reports, plan benefit design or any other information used, directly or indirectly, to determine expenditures, claims, bills and all other expenditures of medical assistance program funds to determine compliance with federal and state laws and regulations and take such corrective actions as are authorized by federal or state laws and regulations.

Contract, Section 19.7

Pursuant to Chapter 111 of the Laws of 2010, Chapter 57 of the Laws of 2017, 14 NYCRR 841 and 14 NYCRR Part 599, the Contractor must reimburse hospital-based and free-standing clinics dually licensed and/or certified under Article 28 of the Public Health Law, and Article 31 or Article 32 of the Mental Hygiene Law, or mental health clinics and chemical dependence clinics (including outpatient and opioid treatment clinics) licensed or certified pursuant to either Article 31 or Article 32 of the Mental

Hygiene Law for outpatient mental health services or outpatient Substance Use Disorder or opioid treatment services at an amount equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by SDOH, the Office of Alcoholism and Substance Abuse Services or by the Office of Mental Health for rate-setting purposes, including any such modifier codes as may affect the calculated reimbursement.

Contract, Section 21.19(f)

"ii) The parties acknowledge that the New York State Office of the Attorney General, SDOH, the Office of the Medicaid Inspector General (OMIG) and the Office of the State Comptroller (OSC) have the right to recover overpayments, penalties, and other damages from Participating Providers, Non-Participating Providers, Contractors, subcontractors, and third parties in the Contractor's network as a result of any investigation, audit or action commenced by the New York State Office of the Attorney General, SDOH, OMIG, and OSC, including, but not limited to any litigation brought pursuant to State Finance Law § 187 et seq. or 31 U.S.C. § 3729 et seq. by, or on behalf of the New York State Office of the Attorney General. The Contractor shall not have a right to recover from the State any recovery obtained by the State pursuant to 31 U.S.C. § 3729 et seq., State Finance Law § 187 et seq., 18 NYCRR Parts 515, 516, 517, or 518, or other New York or Federal statutes, regulations or rules."

Contract, Section 22.7(a)(ii)

"d) Nothing in this Agreement shall be construed to limit the authority of the New York State Office of the Attorney General, OMIG, OSC or SDOH to investigate, audit or otherwise obtain recoveries from any Participating Provider, Non-Participating Provider, Contractor, subcontractor, or third party."

Contract, Section 22.7(d)

Exhibit A is a list of claims that were improperly billed to Medicaid, because services were provided in excess of APG category specific Medicaid billing parameters. These resulted in overpayments in the amount of $64,219.48. Based on this determination, the total amount due to DOH, as defined in 18 NYCRR Section 518.1, is $64,219.48 (Exhibit A).

Do not submit claim voids in response to this Final Audit Report. Repayment instructions are outlined on the next page.

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

The Plan has the right to challenge this action and determination by requesting an administrative hearing within sixty (60) days of the date of this notice.

If the Plan wishes to request a hearing, the request must be submitted in writing within sixty (60) days of the date of this notice to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 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, the Plan may have a person represent it or the Plan may represent itself. If the Plan chooses to be represented by someone other than an attorney, the Plan must supply along with its hearing request a signed authorization permitting that person to represent the Plan at the hearing; the Plan may call witnesses and present documentary evidence on its 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
259 Monroe Avenue, Suite 312
Rochester, New York 14607

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.

[redacted]

[redacted]

[redacted]

United Healthcare Community Plan of NY, Inc.
One Penn Plaza, 8th Floor
New York, New York 10119

Plan ID #: 04054091

Audit #: 22-7417

Amount Due: $64,219.48

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

[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.