



NEW YORK STATE
DEPARTMENT OF HEALTH
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF PLANNED PARENTHOOD HUDSON – PECONIC, INC.
CLAIMS FOR HIV COUNSELING WITHOUT TESTING SERVICES
PAID FROM
JULY 1, 2004 - JUNE 30, 2007

FINAL AUDIT REPORT

James G. Sheehan
Medicaid Inspector General

April 15, 2011



STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, NY 12207

ANDREW M. CUOMO
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

April 15, 2011

Mr. Andrew J. Bracco
Senior Vice President of Finance and Information Technology
Planned Parenthood Hudson-Peconic, Inc.
4 Skyline Drive
Hawthorne, NY 10532

Re: Final Audit Report
Audit #: 09-2542

Dear Mr. Bracco:

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Planned Parenthood Hudson – Peconic, Inc." (Planned Parenthood Hudson – Peconic) paid claims for HIV Counseling Without Testing Services covering the period July 1, 2004, through June 30, 2007.

In the attached final audit report, the OMIG has detailed our objectives and scope, procedures, laws, regulations, rules and policies, sampling technique, findings, provider rights, and statistical analysis.

The 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 response to the draft audit report dated September 17, 2010. The mean point estimate overpaid is \$2,226,859. The lower confidence limit of the amount overpaid is \$2,059,003. 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 \$2,059,003.

Mr. Andrew J. Bracco

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April 15, 2011

If Planned Parenthood Hudson - Peconic has any questions or comments concerning this final audit report, please contact Mr. Ed Waaler at (518) 402-0066 or through email at Edgar.Waaler@omig.ny.gov. Please refer to report number 09-2542 in all correspondence.

Sincerely,



Bruce J. Gembala
Director of Provider Audit
Bureau of Fee for Service Audit
Office of the Medicaid Inspector General

cc: Ms. Reina Schiffrin, President and CEO
Ms. Leslie Pargament, Sr. Vice President, Compliance and HR
James W. Lytle, Esq., Manatt, Phelps & Phillips

Enclosure

CERTIFIED MAIL #7010-1870-0000-4853-0129

RETURN RECEIPT REQUESTED

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve 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.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to ensure compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to ensure the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

DIVISION OF MEDICAID INVESTIGATIONS

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and state governments jointly fund and administer the Medicaid program. In New York State, the Department of Health (DOH) administers the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the 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] and the Medicaid Provider Manuals.

A diagnostic and treatment center is a medical facility with one or more health services which is not part of an inpatient hospital facility or vocational rehabilitation center. It is primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician or dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition. A diagnostic and treatment center is certified in accordance with Article 28 of the NYS Public Health Law and/or Article 31 of the Mental Hygiene Law to provide such services on an outpatient basis. The specific standards and criteria for diagnostic and treatment center services are principally found in various parts of 10 NYCRR Chapter V and 18 NYCRR Chapter II, as well as the MMIS Provider Manual for Clinics.

OBJECTIVE AND SCOPE

The objective of our audit was to ensure Planned Parenthood Hudson – Peconic's compliance with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to HIV Counseling Without Testing Services, our audit covered services paid by Medicaid from July 1, 2004, through June 30, 2007.

SUMMARY OF FINDINGS

We inspected a random sample of 100 services with \$9,012.00 in Medicaid payments. Of the 100 services in our random sample, 83 services had at least one error and did not comply with state requirements. Of the 83 noncompliant services, a number contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
No Documentation of Patient Decision Declining Test	68
Claims Submitted Over 90 days from the Date of Service	8
No Documentation of HIV Pre-test Counseling	7
Duplicate Billing for HIV Pre-test Counseling	7
No Documentation of Patient Reason for Declining Test	4
No Documentation of HIV Testing Follow-up Plan	2
No Medical Record	2
No Documentation for Date of Service	1

Based on the procedures performed, the OMIG has determined that Planned Parenthood Hudson – Peconic was overpaid \$7,479.96 in sample overpayments with an extrapolated point estimate of \$2,226,859. The lower confidence limit of the amount overpaid is \$2,059,003.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including Diagnostic and Treatment Center claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the 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] and the Medicaid Provider Manuals.

New York State's HIV Primary Care Medicaid Program

A diagnostic and treatment center enrolled in the HIV Primary Care Medicaid Program, and choosing to be a provider of the HIV Test Counseling Only service package, may be reimbursed for HIV counseling without testing (Rate Code 3109, also called HIV pre-test counseling) provided to any Medicaid recipient whose serostatus is unknown or in question. Providers may be reimbursed for a pre-test counseling visit when the patient declines testing after the provider has complied with the intent of Article 27-F of the Public Health Law and DOH regulations implementing that law (10 NYCRR Part 63). The specific standards and criteria for a HIV pre-test counseling visit are primarily outlined therein, and in DOH memoranda and agreements for participants in the HIV Primary Care Medicaid Program (DOHM 93-26 and DOHM AI 06-01).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to ensure Planned Parenthood Hudson – Peconic's compliance with applicable Federal and State 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 or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,

- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

Scope

Our audit period covered payments to Planned Parenthood Hudson – Peconic for HIV Counseling Without Testing services paid by Medicaid from July 1, 2004, through June 30, 2007. Our audit universe consisted of 29,771 claims totaling \$2,682,737.52.

During our audit, we did not review the overall internal control structure of Planned Parenthood Hudson - Peconic. Rather, we limited our internal control review to the objective of our audit.

Methodology

To accomplish our objective, we:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with Planned Parenthood Hudson – Peconic management personnel to gain an understanding of the HIV Counseling Without Testing services program;
- ran computer programming application of claims in our data warehouse that identified 29,771 paid HIV Counseling Without Testing services claims, totaling \$2,682,737.52;
- selected a random sample of 100 services from the population of 29,771 services; and,
- estimated the overpayment paid in the population of 29,771 services.

For each sample selection we inspected, as available, the following:

- Medicaid electronic claim information
- Patient record, including, but not limited to:
 - Registration/admission forms;
 - Medical chart for date of service;
 - Provider's patient account for date of service, and
- Any additional documentation deemed by Planned Parenthood Hudson - Peconic necessary to substantiate the Medicaid paid claim

LAWS, REGULATIONS, RULES AND POLICIES

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, DOH memoranda and agreements for participants in the HIV Primary Care Medicaid Program (DOHM 93-26 and DOHM AI 06-01).
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "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

Regulations state: "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 . . . ; 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)

Regulations state: "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)

Furthermore, according to regulations, all providers must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. In addition, the provider must keep, for a period of six years, all records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply. This information is subject to audit for a period of six years and must be furnished, upon request.

18 NYCRR Section 517.3(b)

DETAILED FINDINGS

The OMIG's review of Medicaid claims paid to Planned Parenthood Hudson – Peconic from July 1, 2004, through June 30, 2007 identified 83 claims with at least one error, for a total sample overpayment of \$7,479.96 (Attachment C).

Sample Selection

1. No Documentation of Patient Decision Declining Test

For Services Prior to November 1, 2006:

DOH Memorandum 93-26 requires that "The Provider agrees to provide or arrange primary care for persons with HIV infection; this includes pre- and post-test counseling, testing and follow-up care according to the clinic services descriptions in Attachment I". . . Attachment I states "Medical record documentation standards. . . are as follows: An entry documenting that HIV pre-test counseling has been provided; An entry as to the patient's decision, including the reason he/she declined to be tested, if applicable, or the signed informed consent to HIV testing. . . ."

For Services November 1, 2006 and After:

DOH Memorandum AI 06-01 requires that "Providers enrolled in the HIV Primary Care Medicaid Program must meet all medical record documentation requirements set forth in Sections 405.10 (for hospitals) and 751.7 (for diagnostic and treatment centers) of Title 10 NYCRR. Additional HIV-specific medical record documentation standards are included in Chart 2." Chart 2 states that for "HIV Pre-test Counseling Without Testing" that "Medical Record Documentation Requirements" are "A notation that counseling was provided, The reason the patient declined testing, Follow-up plan, including indications for further counseling and testing."

*NYS Department of Health Memorandum 93-26
HIV Primary Care Provider Agreement - Attachment
I and*

*NYS Department of Health Memorandum AI 06-01
HIV Primary Care Provider Agreement – Section 3
Billing Instructions*

2, 6, 7, 8, 12, 13, 14, 16, 17, 21, 22,
23, 26, 28, 29, 30, 33, 34, 35, 36,
37, 38, 39, 40, 41, 42, 45, 49, 50,
51, 52, 53, 55, 56, 57, 59, 60, 61,
62, 63, 65, 66, 67, 70, 72, 74, 75,
76, 77, 78, 79, 80, 82, 83, 84, 85,
86, 88, 90, 92, 93, 94, 95, 96, 97,
98, 99, 100

In 68 instances pertaining to 67 patients, the HIV Pre-test Counseling records did not document the patient's decision to decline the HIV test and did not document the reason the patient declined testing.

2. Claims Submitted Over 90 days From the Date of Service 11, 15, 17, 32, 50, 59, 64, 90

Regulations state: "Claims for payment for medical care, services or supplies furnished by any provider under the medical assistance program must be initially submitted within 90 days of the date the medical care, services or supplies were furnished to an eligible person to be valid and enforceable against the department or a social services district unless the provider's submission of the claims is delayed beyond 90 days due to circumstances beyond the control of the provider. Such circumstances include but are not limited to attempts to recover from a third-party insurer, legal proceedings against a responsible third-party or the recipient of the medical care, services or supplies or delays in the determination of client eligibility by the social services district. All claims submitted after 90 days must be accompanied by a statement of the reason for such delay and must be submitted within thirty days from the time submission came within the control of the provider, subject to the limitations of paragraph (3) of this submission."

The MMIS Provider Manual states: "Medicaid regulations require that claims for payment of medical care, services, or supplies to eligible enrollees be initially submitted within 90 days of the date of service to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider."

18 NYCRR Section 540.6(a)(1) and

*MMIS Provider Manual Information For All Providers
General Billing, page 6*

In 8 instances pertaining to 8 patients, the claims were submitted more than 180 days after the date of service without the valid use of an exception code as the reason for late submission of claims. Regulations require a claim to be submitted within 90 days of the date of service; however, the OMIG

disallowed claims submitted more than 180 days after the date of service without supporting documentation. This is in keeping with general industry standards.

3. No Documentation of HIV Pre-test Counseling

28, 53, 59, 65, 72, 84, 95

For Services Prior to November 1, 2006:

DOH Memorandum 93-26 requires that "The Provider agrees to provide or arrange primary care for persons with HIV infection; this includes pre- and post-test counseling, testing and follow-up care according to the clinic services descriptions in Attachment I". . . Attachment I states "Medical record documentation standards. . . are as follows: An entry documenting that HIV pre-test counseling has been provided; An entry as to the patient's decision, including the reason he/she declined to be tested, if applicable, or the signed informed consent to HIV testing. . . ."

For Services November 1, 2006 and After:

DOH Memorandum AI 06-01 requires that "Providers enrolled in the HIV Primary Care Medicaid Program must meet all medical record documentation requirements set forth in Sections 405.10 (for hospitals) and 751.7 (for diagnostic and treatment centers) of Title 10 NYCRR. Additional HIV-specific medical record documentation standards are included in Chart 2." Chart 2 states that for "HIV Pre-test Counseling Without Testing" that "Medical Record Documentation Requirements" are "A notation that counseling was provided, The reason the patient declined testing, Follow-up plan, including indications for further counseling and testing."

*NYS Department of Health Memorandum 93-26
HIV Primary Care Provider Agreement - Attachment
I and*

*NYS Department of Health Memorandum AI 06-01
HIV Primary Care Provider Agreement – Section 3
Billing Instructions*

In 7 instances pertaining to 7 patients, the HIV Pre-test Counseling records did not document the provision of counseling.

4. Duplicate Billing for HIV Pre-test Counseling 18, 25, 32, 44, 71, 73, 89

The MMIS Manual states, "claims for medical care, services or supplies for which payments should not have been made, the Department may require repayment of the amount overpaid. 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."

MMIS Provider Manual for Clinics, Section 2.1.14

In 7 instances pertaining to 7 patients, when the patient was counseled and then consented to testing, the provider submitted and was paid both for HIV Pre-test Counseling Without Testing and the separate rate for HIV Pre-test Counseling With Testing.

5. No Documentation of Patient Reason for Declining Testing 19, 54, 64, 91

For Services Prior to November 1, 2006:
DOH Memorandum 93-26 requires that "The Provider agrees to provide or arrange primary care for persons with HIV infection; this includes pre- and post-test counseling, testing and follow-up care according to the clinic services descriptions in Attachment I". . . Attachment I states "Medical record documentation standards. . . are as follows: An entry documenting that HIV pre-test counseling has been provided; An entry as to the patient's decision, including the reason he/she declined to be tested, if applicable, or the signed informed consent to HIV testing. . . ."

For Services November 1, 2006 and After:
DOH Memorandum AI 06-01 requires that "Providers enrolled in the HIV Primary Care Medicaid Program must meet all medical record documentation requirements set forth in Sections 405.10 (for hospitals) and 751.7 (for diagnostic and treatment centers) of Title 10 NYCRR. Additional HIV-specific medical record documentation standards are included in Chart 2." Chart 2 states that for "HIV Pre-test Counseling Without Testing" that "Medical Record Documentation Requirements" are "A notation that counseling was provided, The reason the patient declined testing,

Follow-up plan, including indications for further counseling and testing.”

*NYS Department of Health Memorandum 93-26
HIV Primary Care Provider Agreement - Attachment
I and*

*NYS Department of Health Memorandum AI 06-01
HIV Primary Care Provider Agreement – Section 3
Billing Instructions*

In 4 instances pertaining to 4 patients, the HIV Pre-test Counseling records did not document the patient reason for declining testing.

6. No Documentation of HIV Testing Follow-up Plan 29, 67

For Services November 1, 2006 and After:
DOH Memorandum AI 06-01 requires that “Providers enrolled in the HIV Primary Care Medicaid Program must meet all medical record documentation requirements set forth in Sections 405.10 (for hospitals) and 751.7 (for diagnostic and treatment centers) of Title 10 NYCRR. Additional HIV-specific medical record documentation standards are included in Chart 2.” Chart 2 states that for “HIV Pre-test Counseling Without Testing” that “Medical Record Documentation Requirements” are “A notation that counseling was provided, The reason the patient declined testing, Follow-up plan, including indications for further counseling and testing.”

*NYS Department of Health Memorandum AI 06-01
HIV Primary Care Provider Agreement – Section 3
Billing Instructions*

In 2 instances pertaining to 2 patients, the HIV Pre-test Counseling records did not document a follow-up plan, including indications for further counseling and testing.

7. No Medical Record 15, 58

MMIS Provider Manual states: “The maintenance and furnishing of information relative to care included on a Medicaid claim is a basic condition

for participation in the Program. For auditing purposes, records on enrollees must be maintained and be available to authorized Medicaid officials for six years following the date of payment. Failure to conform to these requirements may affect payment and may jeopardize a provider's eligibility to continue as a Medicaid participant.

NYS Medicaid Provider Manuals, General Policy, Section 2 ("Record Keeping Requirements")

In 2 instances pertaining to 2 patients, the patient medical record was not available for review.

8. No Documentation for Date of Service

68

MMIS Provider Manual states: "The maintenance and furnishing of information relative to care included on a Medicaid claim is a basic condition for *participation in the Program. For auditing purposes, records on enrollees must be maintained and be available to authorized Medicaid officials for six years following the date of payment. Failure to conform to these requirements may affect payment and may jeopardize a provider's eligibility to continue as a Medicaid participant.

NYS Medicaid Provider Manuals, General Policy, Section 2 ("Record Keeping Requirements")

In 1 instance, the patient medical record had no documentation for the claimed date of service.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the lower confidence limit amount of \$2,059,003, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order 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 and be sent with the attached Remittance Advice to:

Mr. Donald Collins
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 1237
Albany, New York 12237-0048

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. 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%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 15% withhold after 20 days until the agreement is established.

Furthermore, the OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. The OMIG will notify you no later than 5 days after initiating such action. If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
Phone #: (518) 474-5878
Fax#: (518) 408-0593

If within 20 days, you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to recover payment and liquidate the lower confidence limit amount, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of \$2,226,859. 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, New York 12204

Questions regarding the request for a hearing should be directed to Charlene D. Fleszar, Esq., Office of Counsel, at (518) 408-5811.

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing you have the right to:

- a) be represented by an attorney or other representative, or to represent yourself;
- b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
- c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

PLANNED PARENTHOOD HUDSON-
PECONIC, INC.
4 SKYLINE DRIVE
HAWTHORNE, NY 10532

PROVIDER ID # [REDACTED]

AUDIT #09-2542

DIAGNOSTIC AND
TREATMENT CENTER
SERVICES AUDIT

PROVIDER
 RATE
 PART B
 OTHER:

AMOUNT DUE: \$2,059,003

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 check to:

Mr. Donald Collins
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 1237
File #09-2542
Albany, New York 12237-0048

Thank you for your cooperation.