



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

REVIEW OF SEGUNDO RUIZ BELVIS DIAGNOSTIC AND  
TREATMENT CENTER  
CLAIMS FOR DIAGNOSTIC AND TREATMENT CENTER SERVICES  
PAID FROM  
JANUARY 1, 2007 – DECEMBER 31, 2008

FINAL AUDIT REPORT

James G. Sheehan  
Medicaid Inspector General

April 13, 2011



STATE OF NEW YORK  
OFFICE OF THE MEDICAID INSPECTOR GENERAL  
445 Hamilton Avenue, Suite 506  
White Plains, NY 10601

ANDREW M. CUOMO  
GOVERNOR

JAMES G. SHEEHAN  
MEDICAID INSPECTOR GENERAL

April 13, 2011

Ms. Elizabeth Rodriguez  
Senior Associate Director  
Segundo Ruiz Belvis Diagnostic & Treatment Center  
545 East 142<sup>nd</sup> Street  
Bronx, New York, 10454

Re: Final Audit Report  
Audit #: 10-1023

Dear Ms. Rodriguez:

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Segundo Ruiz Belvis Diagnostic & Treatment Center" (Belvis) paid claims for Diagnostic & Treatment Center services covering the period January 1, 2007, through December 31, 2008.

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 audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report dated November 10, 2010. The mean point estimate overpaid is \$153,817. The lower confidence limit of the amount overpaid is \$61,472. 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 \$61,472.

Ms. Elizabeth Rodriguez  
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April 13, 2011

If Belvis has any questions or comments concerning this report, please contact Tony Wu at (914) 397-1766 or through email at [Tung.Wu@omig.ny.gov](mailto:Tung.Wu@omig.ny.gov). Please refer to report number 10-1023 in all correspondence.

Sincerely,



George D. Vislocky, Acting Director  
Division of Medicaid Audit, White Plains  
Office of the Medicaid Inspector General

GDV:vb  
Enclosure

CERTIFIED MAIL #7005-0390-0004-2390-3937  
RETURN RECEIPT REQUESTED

## **OFFICE OF THE MEDICAID INSPECTOR GENERAL**

[www.omig.ny.gov](http://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 Belvis' compliance with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to Diagnostic and Treatment Center services, our audit covered services paid by Medicaid from January 1, 2007, through December 31, 2008.

### SUMMARY OF FINDINGS

We inspected a random sample of 100 services with \$13,115.78 in Medicaid payments. Of the 100 services in our random sample, 11 services had one error and did not comply with state requirements. Of the 11 noncompliant services, one contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Claims Submitted Over 90 Days From the Date of Service	4
Missing Documentation	3
Threshold Visit Incorrectly Billed for Completion of Service	3
Incorrect Servicing Provider on Claim	2

Based on the procedures performed, the OMIG has determined, on a preliminary basis that Belvis was overpaid \$1,053.19 in sample overpayments with an extrapolated point estimate of \$153,817. The lower confidence limit of the amount overpaid is \$61,472.

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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 Diagnostic and Treatment Center Program

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, SCOPE, AND METHODOLOGY

#### Objective

The objective of our audit was to ensure Belvis' 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 Belvis for diagnostic and treatment center services paid by Medicaid from January 1, 2007, through December 31, 2008. Our audit universe consisted of 16,115 claims totaling \$2,167,634.65.

During our audit, we did not review the overall internal control structure of Belvis. 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 Belvis' management personnel to gain an understanding of the diagnostic and treatment center program;
- ran computer programming application of claims in our data warehouse that identified 16,115 paid diagnostic and treatment center claims, totaling \$2,167,634.65;
- selected a random sample of 100 services from the population of 16,115 services; and,
- estimated the overpayment paid in the population of 16,115 services.

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

- Medicaid electronic claim information
- Patient record, including, but not limited to:
  - Practitioner's medical orders
  - Third party payor EOBs
- Any additional documentation deemed by Belvis 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, Public Health Law Article 28, Title 10 NYCRR Parts 86-4, 751, 752, Title 18 NYCRR Part 505, the MMIS Provider Manual for Clinics and Medicaid Update June 2002.
- 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 Segundo Ruiz Belvis from January 1, 2007, through December 31, 2008 identified 11 claims with at least one error, for a total sample overpayment of \$1,053.19 (Attachment C).

### Sample Selection

1. **Claims Submitted Over 90 Days From the Date of Service** 18, 27, 28, 44

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 outside of 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 days must be accompanied by a statement of the reason for such delay and must be submitted within 30 days from the time submission came within the control of the provider, subject to the limitations of paragraph (3) of this subdivision."

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 4 instances pertaining to 4 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. The claim was not substantiated.

**2. Missing Documentation**

1, 13, 38

Regulations require that the Medicaid provider agrees, "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. . . ."

Regulations also require that bills for medical care, services and supplies contain a certification that such records as are necessary to disclose fully the services provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years. These records must be furnished to the Department upon request.

*18 NYCRR Section 504.3(a)*  
*18 NYCRR Section 540.7(a)(8) and*  
*18 NYCRR Section 517.3(b)(1)*

In 3 instances pertaining to 3 patients, the services were not documented.

**3. Threshold Visit Incorrectly Billed for Completion of Service**

23, 38, 60

The MMIS Manual states: "When a Medicaid patient receives treatment during a threshold clinic visit which cannot be completed due to administrative or scheduling problems, the Article 28 facility may not bill additional clinic visits for completion of the service. For example, the completion of clinical laboratory tests or x-rays, the results of which are interpreted on a day subsequent to the patient's initial threshold visit, do not qualify for reimbursement unless the patient is seen for purposes of discussing the findings and for definitive treatment planning...."

*MMIS Provider Manual for Clinics, Section 2.2.1 (G)*

In 3 instances pertaining to 3 patients, a threshold visit was billed for a visit that was completing the services initiated at an earlier visit.

**4. Incorrect Servicing Provider on the Claim**

34, 95

Regulations state, "By enrolling the provider agrees...that the information provided in relation to any claim for payment shall be true, accurate and complete; and comply with the rules, regulations and official directives of the department...."

The June, 2002 Medicaid Update that the Office of Medicaid Management activated a series of edit that require the identification of servicing and referring practitioners. These edits verify the practitioner's license or MMIS provider ID numbers reported on clinic claims are accurate and legitimate.

*18 NYCRR Section 504.3(h)(i) and*  
Medicaid Update, June 2002, Volume 17, Number 6, Page 3.

In 2 instances pertaining to 2 patients, the servicing practitioner was not accurately identified. The servicing practitioner's name on the 2 claims did not match the name of the practitioner who signed medical entry.

## 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 \$61,472, 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 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 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 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 \$153,817. 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**

NAME AND ADDRESS OF AUDITEE  
Ms. Elizabeth Rodriguez  
Senior Associate Director  
Segundo Ruiz Belvis Diagnostic &  
Treatment Center  
545 East 142<sup>nd</sup> Street  
Bronx, New York 10454

PROVIDER ID # [REDACTED]

AUDIT #10-1023

AMOUNT DUE: \$61,472

AUDIT

TYPE

PROVIDER  
 RATE  
 PART B  
 OTHER:

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 #10-1023  
Albany, New York 12237-0048

*Thank you for your cooperation.*