



STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, New York 12204

DAVID A. PATERSON
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

December 20, 2010

Middletown Community Health Center
Administrator
PO Box 987
Middletown, NY 10940-0987

FINAL AUDIT REPORT
Audit #2009Z33-132W
Provider [REDACTED]

Dear Administrator:

The New York State Office of the Medicaid Inspector General (the "OMIG") completed an audit of Medicaid claims paid for Prenatal Care Assistance Program (PCAP) services provided to Medicaid recipients. In accordance with Section 517.5 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18 NYCRR), this report represents the final determination on issues found during the OMIG's review.

After reviewing your response to the OMIG's August 26, 2009 Draft Audit Report, the OMIG reduced the Draft Audit Report disallowances of \$141,243.75 to \$127,499.05 in the Final Report. A detailed explanation of the revision is included in the Final Report.

Based on this determination, restitution of the overpayments as defined in 18 NYCRR 518.1 is required in the amount of \$127,499.05. Since you voided claims totaling \$225.00, an outstanding balance of \$127,274.05 remains.

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 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 enclosed Remittance Advice form, signed and dated, to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 1237
Albany, New York 12237

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. 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:

Collections Management Group
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Do not submit claim voids or adjustments in response to this Final Audit Report.

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 secure payment and liquidate the overpayment 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.

The Facility has the right to challenge this action and determination by requesting an administrative hearing within sixty (60) days of the date of this notice. In accordance with 18 NYCRR Section 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If you wish to request a hearing, the request must be submitted in writing to:

General Counsel
Division of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

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.

Questions concerning this audit may be directed to [REDACTED] at [REDACTED]

Sincerely,

[REDACTED]

Bureau of Business Intelligence
Office of the Medicaid Inspector General

Enclosure

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

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

NAME AND ADDRESS OF AUDITEE

Middletown Community Health Ctr
PO Box 987
Middletown, NY 10940-0987

Provider [REDACTED]

AUDIT #2009Z33-132W

AMOUNT DUE: \$127,274.05

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:

[REDACTED]
Medicaid Financial Management
New York State Department of Health
GNARESP Corning Tower, Room 1237
File #2009Z33-132W
Albany, New York 12237

5. If the provider number shown above is incorrect, please enter the correct number below.

CORRECT PROVIDER NUMBER

NEW YORK STATE OFFICE OF THE MEDICAID INSPECTOR GENERAL

DAVID A. PATERSON
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

FINAL REPORT

MIDDLETOWN COMMUNITY HEALTH CENTER
PO BOX 987
MIDDLETOWN, NY 10940-0987

PRENATAL CARE ASSISTANCE PROGRAM
#2009Z33-132W



ISSUED DECEMBER 20, 2010

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BACKGROUND, PURPOSE AND SCOPE

The New York State Department of Health (DOH) is responsible for the administration of the Medicaid program. As an independent office within DOH, the OMIG conducts audits and reviews of 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 in NY Public Health Law, NY Social Services Law, regulations of the Departments of Health, [Titles 10 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

The Prenatal Care Assistance Program (PCAP) is a comprehensive prenatal care program that offers complete pregnancy care and other services to women. Facilities enter into a contract with DOH to become a PCAP provider and in doing so, agree to provide comprehensive prenatal services to pregnant women who are eligible for Medicaid.

Such services may be provided directly or through qualified medical professionals and/or professional agents (such as a laboratory, university, etc.) with whom the PCAP provider contracts or subcontracts. The PCAP provider is reimbursed by Medicaid for all PCAP services through the all-inclusive, enhanced PCAP clinic rates established by DOH. Each PCAP provider agrees to establish procedures whereby it is ensured that ancillary services such as lab and ultrasound procedures related to prenatal care are not billed directly to Medicaid.

The PCAP provider is responsible for compensating any outside vendors for services they provide. When ordering diagnostic services such as lab or ultrasounds, the PCAP provider must utilize a referral form that does not contain any information that would allow billing to Medicaid and clearly identifies the PCAP provider as the party responsible for making payment.

The OMIG reviewed billings for PCAP patients to ensure that:

- Clinic services were billed appropriately and in accordance with DOH rules and regulations, and provider billing guidelines;
- Other Medicaid enrolled providers who performed PCAP covered services did not bill Medicaid.

To accomplish this, claims submitted with payment dates from January 1, 2006 through December 31, 2008 were reviewed.

Please note that due to the implementation of the National Provider Identifier (NPI) on September 1, 2008, there may be multiple Provider Identification Numbers associated with the Primary Provider Identification Number. The NPI is linked to the Primary Provider Identification Number. The Primary Provider Identification Number is used for correspondence and recoupment.

DETAILED FINDINGS

The exhibits are detailed in six categories. All or a combination of the following six exhibits are included in this Final Audit Report.

1. Multiple Initial Prenatal Care Visits

Regulations state: "By enrolling the provider agrees ... that the information provided in relation to any claim for payment shall be true, accurate, and complete;"

18 NYCRR 504.3(h)

Regulations state: "By enrolling, the provider agrees... to comply with the rules, regulations and official directives of the department."

18 NYCRR 504.3(i)

PCAP Billing Guidelines state: "Only one initial prenatal visit may be billed per pregnancy regardless of the number of visits it takes to complete all the components."

PCAP Billing Guidelines Booklet, May 2005

Initial visits receive the highest PCAP clinic reimbursement and only one initial visit is allowed to be billed by a PCAP provider during each pregnancy. Exhibit I lists PCAP recipients for whom more than one initial visit was billed. This resulted in an overpayment of \$0.

2. Initial, Follow-up and Postpartum Services Billed Incorrectly After Delivery

Regulations state: "By enrolling the provider agrees ... that the information provided in relation to any claim for payment shall be true, accurate, and complete;"

18 NYCRR 504.3(h)

Regulations state: "By enrolling, the provider agrees... to comply with the rules, regulations and official directives of the department."

18 NYCRR 504.3(i)

PCAP Billing Guidelines state: "Only one postpartum visit can be billed."

PCAP Billing Guidelines Booklet, May 2005

PCAP Billing Guidelines also state: "Following delivery, if additional visits are necessary due to medical complications, claims should be submitted with the clinic's general medicine rate codes."

PCAP Billing Guidelines Booklet, May 2005

The postpartum visit is for the purpose of providing postpartum care for a period of up to 60 days following delivery. A postpartum visit should be billed using the appropriate postpartum rate code. Only one postpartum visit can be billed. Initial visit and follow-up visit rate codes should not be used when billing for a postpartum visit. Following delivery, if additional visits are necessary due to medical complications, claims should be submitted with the clinic's general medicine rate codes. PCAP initial and follow-up visits billed after delivery were

reduced to the lower postpartum visit rate or, in some cases with multiple postpartum visits, reduced to the general medicine clinic rate.

Exhibit II is a list of postpartum visit claims that were billed incorrectly. This resulted in an overpayment of \$137.54.

3. Laboratory Services Billed Fee for Service That Are Included in the PCAP Rate

Regulations state: "Prenatal diagnostic and treatment services provided shall include but not be limited to the following: ...standard laboratory tests and procedures; (iii) needed special laboratory tests as indicated..."

10 NYCRR 85.40(i)(1)(ii)(iii)

The Medicaid Physician Manual states: "The PCAP providers are reimbursed for all prenatal and postpartum visits, laboratory and ultrasound (sonogram) procedures".

*Medicaid Provider Manual for Physicians, Policy Guidelines
Section II, Physician Services*

PCAP Billing Guidelines state that the: "...Initial Visit shall include Laboratory Screening".

PCAP Billing Guidelines Booklet, May 2005

Regulations state: "The Department may require overpayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted..."

*18 NYCRR 518.3(a)
(emphasis added)*

Laboratory services necessary to monitor the health of the patient during pregnancy are included in the PCAP clinic reimbursement, whether the service is performed at the PCAP clinic's own laboratory or at an outside laboratory. The PCAP provider is responsible for reimbursing the laboratory service provider for these procedures. When laboratory services ordered during the PCAP visit are billed in addition to a PCAP clinic rate, a duplicate payment occurs.

Exhibit III is a list of laboratory procedures that were billed incorrectly. This resulted in an overpayment of \$15,415.29.

4. Ultrasound Services and Diagnostic Procedure Services Billed Fee for Services That Are Included In the PCAP Rate – Facility Billed

The PCAP Billing Guidelines Manual states: "What is included in the PCAP subsequent visit? ...Recommended Laboratory Tests and Other Procedures: Obstetrical ultrasound, as clinically indicated..."

PCAP Billing Guidelines Manual, May 2005

The PCAP Medicaid Policy Guidelines Manual states: "Clinic visit rates established for PCAP are considered reimbursement in full for the following: ...diagnostic testing..."

PCAP Medicaid Policy Guidelines Manual, January 2007

The Medicaid Update states: "When ordering diagnostic services such as labs or ultrasounds, the PCAP provider must utilize a referral form that states that the provider should not bill Medicaid.

An ultrasound, non-stress test and/or biophysical profile performed during a prenatal follow-up visit, is part of the follow-up visit and may not be billed separately.

If a client has been referred to a non-PCAP provider for an ultrasound, non-stress test or biophysical profile, the PCAP provider is responsible for reimbursing the medical provider who performs these services."

*DOH Medicaid Update
September 2008, Vol. 24, No. 10*

Regulations state: "The Department may require overpayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted..."

*18 NYCRR 518.3(a)
(emphasis added)*

Ultrasounds and other diagnostic procedures related to monitoring the patient's pregnancy are included in the PCAP reimbursement, whether the service is performed at the PCAP facility or outside the PCAP facility. These procedures should not be billed fee for service. When a facility bills these services in addition to the PCAP clinic rate, a duplicate payment occurs. The PCAP provider is responsible for reimbursing the service provider for these services. We identified obstetrical ultrasounds and diagnostic procedures performed within 30 days of a PCAP visit, excluding any procedures associated with visits to other facilities or non-obstetrical providers.

Exhibit IV is a list of ultrasounds and other diagnostic procedures that were billed incorrectly. This resulted in an overpayment of \$32,522.80. The exhibit reflects credit for voids totalling \$225.00, resulting in a remaining balance of \$32,297.80.

5. Ultrasound Services and Diagnostic Procedure Services Billed Fee for Services That Are Included in the PCAP Rate – Physician Billed

The Medicaid Update states: "When ordering diagnostic services such as labs or ultrasounds, the PCAP provider must utilize a referral form that states that the provider should not bill Medicaid.

An ultrasound, non-stress test and/or biophysical profile performed during a prenatal follow-up visit, is part of the follow-up visit and may not be billed separately.

If a client has been referred to a non-PCAP provider for an ultrasound, non-stress test or biophysical profile, the PCAP provider is responsible for reimbursing the medical provider who performs these services."

*DOH Medicaid Update
September 2008, Vol. 24, No. 10*

Regulations state: "The Department may require overpayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted..."

18 NYCRR 518.3(a)
(emphasis added)

Ultrasounds and other diagnostic procedures related to monitoring the patient's pregnancy are included in the PCAP reimbursement, whether the service is performed at the PCAP facility or outside the PCAP facility. These procedures should not be billed fee for service. When a physician bills these services in addition to the PCAP clinic rate, a duplicate payment occurs. The PCAP provider is responsible for reimbursing the physician for these services. We identified obstetrical ultrasounds and diagnostic procedures performed within 30 days of a PCAP visit, excluding any procedures associated with visits to other facilities or non-obstetrical providers.

Exhibit V is a list of ultrasounds and other diagnostic procedures that were billed in addition to the PCAP clinic rate. This resulted in an overpayment of \$48,300.60.

6. Vitamin and Iron Supplement Services Billed Fee for Service That Are Included In the PCAP Rate

The PCAP Services Description states: "Prices established for the three clinic services provide full reimbursement for the following: ... prenatal vitamins and iron supplements."

*New York State Department of Health
PCAP Services Description, March 2003*

Regulations state: "The Department may require overpayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted..."

18 NYCRR 518.3(a)
(emphasis added)

Vitamin and iron supplements as defined by drug therapeutic codes are included in the PCAP reimbursement and should not be billed fee for service. The PCAP provider is responsible for providing these services.

Exhibit VI is a list of vitamin and iron supplement claims that were paid in addition to the PCAP clinic rate. This resulted in an overpayment of \$17,857.12.

DETERMINATION

In accordance with 18 NYCRR 518.4, interest may be collected on any overpayments identified in this audit and will accrue at the current rate from the preliminary determination of the overpayment. For the overpayments identified in this audit, the OMIG has determined that accrued interest totals \$13,265.70.

Based on this determination, the total amount of overpayment, as defined in 18 NYCRR 518.1(c) is \$127,274.05, inclusive of interest. Restitution of \$127,274.05 is due the New York State Department of Health.