



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

REVIEW OF NEW YORK SCHOOL FOR THE DEAF  
CLAIMS FOR SCHOOL SUPPORTIVE HEALTH SERVICES  
PROGRAM SERVICES  
PAID FROM  
JANUARY 1, 2009 – DECEMBER 31, 2009

FINAL AUDIT REPORT  
AUDIT #10-3736

James C. Cox  
Medicaid Inspector General

December 4, 2013



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

ANDREW M. CUOMO  
GOVERNOR

JAMES C. COX  
MEDICAID INSPECTOR GENERAL

December 4, 2013

[REDACTED]  
New York School for the Deaf  
555 Knollwood Road  
White Plains, New York 10603

Re: Final Audit Report  
Audit #: 10-3736

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of of New York School for the Deaf" (Provider) paid claims for School Supportive Health Services Program services covering the period January 1, 2009, through December 31, 2009.

In the attached final audit report, the OMIG has detailed our purpose 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 October 3, 2013. The mean point estimate overpaid is \$66,883. The lower confidence limit of the amount overpaid is \$59,164. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit will be settled at the lower confidence limit of \$59,164. The settlement for the audit will be made from the escrow account where New York State placed the Medicaid funds that the claims generated.

The New York School for the Deaf is a State-Supported Institution for the instruction of the deaf, blind, physically, or multiply disabled under §4201 of the New York State Education Law. During the OMIG's audit period the school was funded by New York State Education Department. The New York School for the Deaf is also an enrolled Medicaid provider of School Supportive Health Services to its Medicaid students. In 2009, the New York School for the Deaf filed Medicaid claims in the amount of \$114,337.00. These claims were processed by the New York State Department of Health and their contractor, Computer Science Corporation. New York State Education Department took the Medicaid funds that the New York School for the Deaf generated and placed them into an escrow account. The OMIG will apply funds from the escrow account to settle the audit disallowance. The OMIG will not pursue recovery of any part of the projected claim disallowance from the New York School for the Deaf.

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED] or through email at [REDACTED]. Please refer to report number 10-3736 in all correspondence.

Sincerely,

[REDACTED]

Division of Medicaid Audit, Albany Office  
Office of the Medicaid Inspector General

Ver-4.0

[REDACTED]  
cc: [REDACTED]

Enclosure

CERTIFIED MAIL [REDACTED]  
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 assess compliance with 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 assess the required involvement of professionals in planning care to program beneficiaries; to 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 and penalties, and also 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 conducted to determine if the provider complied 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.

Reimbursement under the Medicaid program is available under the School Supportive Health Services Program and Preschool Supportive Health Services Program (SSHSP and PSHSP) for certain diagnostic and health support services provided to students with, or suspected of having disabilities. SSHSP applies to the 5-21 year old population and PSHSP applies to the 3-4 year old population pursuant to §4410 of the Education Law. In 1988, Section 1903 of subdivision (c), of the Social Security Act (SSA) was added by §411(k)(13)(A) of the Medicare Catastrophic Act of 1988 (PL 100-360), to clarify Congressional intent by stating that nothing in Title XIX of the SSA shall preclude Medicaid coverage of services included in a disabled student's Individualized Education Program (IEP). New York State implemented the Federal law in 1989 by amending Section 368 (d) and (e) of Chapter 558 of the Social Services Laws to authorize payment of medical assistance funds for PSHSP and SSHSP services.

### PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for School Supportive Health Services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to School Supportive Health Services, this audit covered services paid by Medicaid from January 1, 2009, through December 31, 2009.

### SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM COMPLIANCE AGREEMENT

In July 2009, the United States Department of Justice, on behalf of the Office of Inspector General (OIG) of the Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS) entered into a Settlement Agreement (Settlement Agreement) with the State of New York, the City of New York, and the Board of Education of the City School District of the City of New York to end litigation related to the New York State School Health Services Program (Program). In addition to the Settlement Agreement, CMS entered into Program Compliance Agreement (Compliance Agreement) with New York State Department of Health (DOH), New York State Department of Education and the New York State Office of the Medicaid Inspector General (OMIG) with respect to the Program's compliance with all rules and regulations applicable to this program. Under the terms of the Program Compliance Agreement, the OMIG must conduct payment audits of the Program's compliance with all applicable federal laws and regulations regarding claims for federal Medicaid participation. The payment audits will focus on program physical therapy, occupational therapy, speech therapy, audiological evaluations, evaluations for all available services, nursing services, psychological services, transportation, medical evaluations, targeted case management services, initial individual education plan (IEP), triennial IEP, annual IEP, requested or amended IEP and ongoing service coordination.

The OMIG is required to perform separate payment Program claim audits for the New York City School District and for school districts and Counties in the rest of the State. The results of these audits must be provided to CMS.

## SUMMARY OF FINDINGS

We inspected a random sample of 100 claims with \$42,021.00 in Medicaid payments. Of the 100 claims in our random sample, 84 claims had at least one error and did not comply with state requirements. Of the 84 noncompliant claims, some contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
No Recommendation or Written Order	47
No Provider Agreement/Statement of Reassignment	31
No Documentation of Supervision and Direction by Meeting with Child Prior to Services and Periodically	23
No Referral for a Formal Evaluation	5
No Signed Service Report	4
No Child/Therapist Attendance Records	4
No Signed Progress Note for Date of Service	2
No Supervision/Direction by Availability for Consultation	2
No Supervision/Direction by Meeting with Therapist	2
No Individualized Education Program	2
No Documentation of Two Services During Month of Service	1
No Signed, Dated Evaluation Report	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$24,410.00 in sample overpayments with an extrapolated point estimate of \$66,883. The lower confidence limit of the amount overpaid is \$59,164.

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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 SSHSP and PSHSP 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 conducted to determine if the provider complied 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 School Supportive Health Services Program and Preschool Supportive Health Services Program**

Reimbursement under the Medicaid program is available under the School Supportive Health Services Program and Preschool Supportive Health Services Program (SSHSP and PSHSP) for certain diagnostic and health support services provided by a school or county to students with, or suspected of having disabilities. Services (physical therapy, occupational therapy, speech pathology/therapy, psychological counseling, skilled nursing services), evaluations (basic and comprehensive psychological evaluations, medical evaluations, medical specialist evaluations, audiological evaluations) and special transportation must be provided by qualified professionals either under contract with, or employed by, school districts/§4201 schools/county agencies. In addition, school districts are able to claim Medicaid reimbursement for five additional services identified as Targeted Case Management (TCM). Furthermore, the school districts/§4201 schools/counties must be enrolled as Medicaid providers in order to bill Medicaid.

The specific standards and criteria for SSHSP and PSHSP services are primarily outlined in the provider manual "Medicaid Claiming/Billing Handbook – (UPDATE #6)" as updated by the New York State Department of Health with the New York State Education Department, Part 200 of the Regulations of the Commissioner of the New York State Education Department, and the Questions and Answers posted on the New York State Education Department website, under NYS Medicaid in Education.

## **School Supportive Health Services Program Compliance Agreement**

In July 2009, the United States Department of Justice, on behalf of the Office of Inspector General (OIG) of the Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS) entered into a Settlement Agreement (Settlement Agreement) with the State of New York, the City of New York, and the Board of Education of the City School District of the City of New York to end litigation related to the New York State School Health Services Program (Program). In addition to the Settlement Agreement CMS entered into Program Compliance Agreement (Compliance Agreement) with New York State Department of Health (DOH), New York State Department of Education and the New York State Office of the Medicaid Inspector General (OMIG) with respect to the Program's compliance with all rules and regulations applicable to this program. Under the terms of the Program Compliance Agreement, the OMIG must conduct payment audits of the Program's compliance with all applicable federal laws and regulations regarding claims for federal Medicaid participation. The payment audits will focus on program physical therapy, occupational therapy, speech therapy, audiological evaluations, evaluations for all available services, nursing services, psychological services, transportation, medical evaluations, targeted case management services, initial individual education plan (IEP), triennial IEP, annual IEP, requested or amended IEP and ongoing service coordination.

The OMIG is required to perform separate payment Program claim audits for the New York City School District and for school districts and Counties in the rest of the State. The results of these audits must be provided to CMS.

### **PURPOSE, SCOPE, AND METHODOLOGY**

#### **Purpose**

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for Preschool and School Supportive Health Services complied 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 the Provider for School Supportive Health Services Program services paid by Medicaid from January 1, 2009, through December 31, 2009. Our audit universe consisted of 274 claims totaling \$114,337.

During our audit, we did not review the overall internal control structure of the Provider. 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 the Provider's management personnel to gain an understanding of the School Supportive Health Services Program;
- ran computer programming application of claims in our data warehouse that identified 274 paid School Supportive Health Services Program claims, totaling \$114,337;
- selected a random sample of 100 claims from the population of 274 claims; and,
- estimated the overpayment paid in the population of 274 claims.

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

- Medicaid electronic claim information
- Patient record, including, but not limited to:
  - Individualized Education Program (IEP)
  - CSE Meeting Minutes
  - Invitation to parent/guardian to attend a CSE meeting and notification of the outcome
  - Service reports
  - Progress notes
- Any additional documentation deemed by the Provider 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)], and State Education Department [Title 8 of the Official Compilation of Codes, Rules and Regulations of the State of New York (8 NYCRR Part 200)].
- Medicaid Management Information System and eMedNY Provider Manual, including applicable updates by the New York State Department of Health with the New York State Education Department.
- Specifically, Title 18 NYCRR Section 540.6, and other applicable program regulations, for example, 14 NYCRR Part 822.

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: "Fee-for-service providers.(1) All providers . . . must prepare and maintain contemporaneous records demonstrating their right to receive payment . . . 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)*

Regulations require that bills for medical care, services and supplies contain patient name, case number and date of service; itemization of the volume and specific types of care, services and supplies provided; the unit price and total cost of the care, services and supplies provided; and a dated certification by the provider that the care, services and supplies itemized have been in fact furnished; that the amounts listed are in fact 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)*

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)*

Regulations state: "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*

Regulations state: "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)*

Regulations state: "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)*

Regulations state: "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)*

## DETAILED FINDINGS

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2009, through December 31, 2009, identified 84 claims with at least one error, for a total sample overpayment of \$24,410 (Attachment C).

### Sample Selection

#### 1. No Recommendation or Written Order

The Medicaid Claiming/Billing Handbook states, "A written medical recommendation for speech services must be completed. The recommendation must be completed using one of the following three alternatives:

1. A written medical recommendation is signed and completed by a physician, physician's assistant, nurse practitioner, or a New York State registered and licensed ~~or ASHA-certified~~ (updated 2/6/07) SLP for speech services only, dated on or before the initiation of the speech services.

2. A written medical recommendation is signed and completed for all health related support services indicated on the students IEP by a physician, physician's assistant, or nurse practitioner in accordance with the frequency and duration indicated on the student's IEP. However, School Districts may no longer claim a medical evaluation for a physician's, nurse practitioner or a registered physician's assistant's sign-off on all related services indicated on the student's IEP.

3. The SLP can sign and date the formal speech evaluation or assessment (both of which identify the recommendation with frequency and duration).

**Note: The recommendation must include the frequency and duration of the service or state that the service must be provided as per frequency and duration as indicated on the IEP. The New York State Health Department (DOH) defines a medical recommendation as an order."**

*Medicaid Claiming / Billing Handbook  
Update #6, page 15*

The Medicaid Claiming/Billing Handbook states, "Skilled nursing services must be supported by a written order signed and dated by a NYS licensed and registered physician, a physician assistant, or

4, 5, 6, 9, 10, 11, 14, 16, 18, 20, 22, 23, 24, 25, 27, 30, 32, 33, 36, 38, 43, 49, 56, 57, 58, 59, 66, 68, 69, 74, 79, 80, 81, 82, 83, 85, 86, 87, 88, 89, 90, 92, 93, 94, 96, 98, 99

a licensed nurse practitioner within the scope of their practice. Orders are required when the student enters school for the first time during the school year and new orders are required when there are any significant changes in the student's condition."

*Medicaid Claiming / Billing Handbook  
Update #6, page 20*

The Medicaid Claiming/Billing Handbook states, "Occupational therapy orders must be signed and dated by a NYS licensed and registered physician, physician's assistant or nurse practitioner and must indicate that services should be delivered as indicated on the IEP. Orders exist for the life of the IEP (see Appendix A)."

*Medicaid Claiming / Billing Handbook  
Update #6, page 18*

In 47 instances pertaining to 19 patients, the claim was billed while there was no documentation of a written order.

**2. No Provider Agreement and Statement of Reassignment**

1, 2, 3, 12, 13, 15, 17, 21, 26, 28, 31, 34, 35, 37, 39, 40, 45, 47, 52, 54, 55, 63, 72, 73, 75, 77, 78, 83, 91, 95, 100

The Medicaid Claiming/Billing Handbook states, "In order for school districts, §4201 schools or counties to claim Medicaid reimbursement for services, they must have all private agencies or service providers with whom they contract, sign a Provider Agreement Form and a Statement of Reassignment. Specifically, if a School District, §4201 school or county contracts directly for a service such as transportation or speech therapy with an agency or person who is not an employee of the county or BOCES, that provider must have signed the Provider Agreement Form and the Statement of Reassignment."

*Medicaid Claiming / Billing Handbook  
Update #6, page 10*

In 31 instances pertaining to 6 patients, the claim was billed with no documentation of a provider agreement and statement of reassignment.

This finding is being treated as a compliance issue in the current audit of the New York School for the Deaf. A corrective action is assigned.

## Sample Selection

### 3. No Documentation of Supervision and Direction by Meeting with Child Prior to Services and Periodically

4, 7, 18, 27, 32, 33, 41, 44, 46, 56, 57, 58, 67, 69, 74, 76, 81, 82, 84, 85, 90, 92, 94

Regulations state, "Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law."

*42 C. F. R. §440.110*

*United States Code of Federal Regulations*

The Medicaid Claiming/Billing Handbook states, "Documentation needed for face-to-face contact: Documentation must show that the SLP has seen the beneficiary at the beginning of and periodically during treatment, be familiar with the treatment plan as recommended by the referring physician or other licensed practitioner, have continued involvement in the care provided, and review the need for continued services throughout the treatment (updated 2/6/07)."

*Medicaid Claiming / Billing Handbook  
Update #6, page 14*

P/SSHSP policy states, "No services provided by the Teacher of the Speech and Hearing Handicapped (TSHH) before the first meeting between the qualified SLP and the child are reimbursable by Medicaid."

*Medicaid in Education Alert Issue 08-04  
NYS OMIG SSHSP/PSHSP  
Medicaid in Education Unit*

In 23 instances pertaining to 9 patients, the claim was billed while there was no documentation of supervision and direction by meeting with child prior to services and periodically.

## 4. No Referral for a Formal Evaluation

4, 30, 33, 58, 76

**Medical Referral for Speech Evaluation**

Effective July 1, 1998 a **written medical referral** signed by a physician, physician's assistant or nurse practitioner or NYS licensed ~~and/or ASHA-certified~~ (updated 2/6/07) SLP is required for a **formal speech evaluation only**, dated on or before the initiation of the evaluation. **A formal evaluation requires parental permission each time it is conducted.** An assessment does not require a medical referral. A speech referral is any document that indicates that the child should be reviewed for need of speech services signed and dated by an appropriate health practitioner. A speech referral may include multiple students (a manageable list is acceptable)

**Formal Evaluation**

If the school district CSE/CPSE or parent determines that a formal evaluation is required, IDEA requires parental consent for the evaluation. A formal evaluation is the administration of a standardized test to the student to determine the need for services. **A medical referral from a SLP, Physician, Physician's Assistant or a Nurse Practitioner is required whenever a formal speech evaluation is conducted.**

Progress assessment reviews of the Speech Services provided take place during the scheduled Speech Therapy sessions. These progress assessments measure progress in meeting current IEP goals and are provided to the Committee on Special Education (CSE) during a review process. They may be done at any time and are done usually at Annual Review. **These assessments do not require a medical referral.** In these instances, a formal evaluation may not be required.

*Medicaid Claiming / Billing Handbook  
Update #6, Page 15  
42 CFR Section 440.110*

In 5 instances pertaining to 4 patients, the claim was billed while there was no referral for a formal evaluation.

**5. No Signed Service Report**

7, 47, 55, 75

The Medicaid Claiming/Billing Handbook states, "Monthly service reports to include date of service, service provided, service provider signature and the date signed."

*Medicaid Claiming / Billing Handbook  
Update #6, page 12*

The Medicaid Claiming/Billing Handbook states, "Services provided and billed must be documented, signed and dated by the service provider."

*Medicaid Claiming / Billing Handbook  
Update #6, page 13*

The Medicaid Claiming/Billing Handbook states, "The NYS licensed OT must sign all service provider sheets, whether delivering the service directly or providing supervision to an OTA."

*Medicaid Claiming / Billing Handbook  
Update #6, page 18*

Regulations state, "(2) All required fiscal and statistical reports are subject to audit for a period of six years from the date of their filing or from the date when such reports were required to be filed, whichever is later. This limitation does not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this Part. Where reports and documentation have been submitted pursuant to a rate appeal of a provisional rate, such reports and documentation will likewise be subject to audit for a period of six years from the submission of material in support of such appeal or two years following certification of any revised rate resulting from such appeal, whichever is later."

*18 NYCRR Section 517.3(2)  
New York Codes, Rules and Regulations*

In 4 instances pertaining to 2 patients, the claim was billed while there was no documentation of a signed service report.

**6. No Child/Therapist Attendance Records**

16, 26, 44, 45

Regulations state, "(2) All required fiscal and statistical reports are subject to audit for a period of six years from the date of their filing or from the date when such reports were required to be filed, whichever is later. This limitation does not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this Part. Where reports and documentation have been submitted pursuant to a rate appeal of a provisional rate, such reports and documentation will likewise be subject to audit for a period of six years from the submission of material in support of such appeal or two years following certification of any revised rate resulting from such appeal, whichever is later."

*18 NYCRR §517.3(2)*

*New York Codes, Rules and Regulations*

In 4 instances pertaining to 4 patients, the claim was billed while there was no documentation of child and/or therapist attendance records.

This finding is being treated as a compliance issue in the current audit of the New York School for the Deaf. A corrective action is assigned.

**7. No Signed Progress Note for Date of Service**

22, 43

The Medicaid Claiming/Billing Handbook states, "Progress notes signed and dated by service provider. A minimum of quarterly progress notes is required for each service except skilled nursing being claimed. The progress notes must address the goals and/or objectives indicated in the student's IEP and copies need to be maintained in accordance with existing document retention requirements. In the alternative, consistent with SED regulations, schools will inform the parents of children with disabilities of their child's progress in meeting annual goals, at least as often as student's without special needs. The notification must include an assessment of sufficient progress to enable the student to achieve the goals by the end of the year. Supporting documentation must be retained in accordance with existing documentation retention requirements."

*Medicaid Claiming / Billing Handbook*

*Update #6, page 12*

The Medicaid Claiming/Billing Handbook states, "Progress notes must be maintained. (Refer to page 12 for requirements)"

*Medicaid Claiming / Billing Handbook  
Update #6, page 13*

Regulations state, "(2) All required fiscal and statistical reports are subject to audit for a period of six years from the date of their filing or from the date when such reports were required to be filed, whichever is later. This limitation does not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this Part. Where reports and documentation have been submitted pursuant to a rate appeal of a provisional rate, such reports and documentation will likewise be subject to audit for a period of six years from the submission of material in support of such appeal or two years following certification of any revised rate resulting from such appeal, whichever is later."

*18 NYCRR Section 517.3(2)  
New York Codes, Rules and Regulations*

Regulations state, "(c) The IEP shall identify when periodic reports on the progress the student is making toward the annual goals (such as through the use of quarterly or other periodic reports that are concurrent with the issuance of report cards) will be provided to the student's parents."

*8 NYCRR Section 200.4 (d)(2)(iii)(c)  
New York Codes, Rules and Regulations*

In 2 instances pertaining to 2 patients, the claim was billed while there was no signed documentation of a progress note.

**8. No Documentation of Supervision and Direction by Availability to Therapist for Consultation** 44, 58

Regulations state, "Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified

occupational therapist. Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law".

*42 C. F. R. Section 440.110  
United States Code of Federal Regulations*

P/SSHP policy states, "To ensure the availability of adequate supervisory direction, supervising speech pathologists must ensure that individuals working under their direction have contact information to permit them direct contact with the supervising speech pathologist as necessary during the course of treatment."

*Medicaid Reimbursement Billing Requirements –  
SSHSP/PSHSP New York State Education  
Department Memorandum February 6, 2007.*

The Medicaid Claiming/Billing Handbook states, "Documentation Requirements for 'Under the Direction Of 2. Signed statement by the SLP with license # or ASHA certification (updated 2/6/07) listing the TSHH for whom direction is being provided as well as a statement of how accessibility will be provided. Examples of this are:

team meetings, access by telephone on a scheduled basis, regularly scheduled meetings with teachers, sign-off on progress notes, or any other method where accessibility is demonstrated.

This documentation should be on file in the school district or county office."

*Medicaid Claiming / Billing Handbook  
Update #6, page 14*

In 2 instances pertaining to 2 patients, the claim was billed while there was no documentation of supervision and direction by availability to therapist for consultation.

**9. No Documentation of Supervision and Direction by Meeting with Therapist** 44, 58

Regulations state, "Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law."

*42 C. F. R. Section 440.110  
United States Code of Federal Regulations*

The Medicaid Claiming/Billing Handbook states, "When providing direction to a TSHH, the licensed SLP is responsible for documenting the following four major criteria: 3. a. The SLP should be available, as needed, to the TSHH for assistance and consultation but need not be on the premises; and b. The SLP must have regular scheduled meetings with the TSHH [Effective July 1, 2005]."

*Medicaid Claiming / Billing Handbook  
Update #6, page 13*

In 2 instances pertaining to 2 patients, the claim was billed while there was no documentation of supervision or direction by meeting with the therapist.

**10. No Individualized Education Program (IEP)** 58, 99

Regulations state, "Services provided under subparagraph (c)(1)(iv) of this section may be made available only if a physician, registered nurse, nurse practitioner, physical therapist, occupational therapist, or speech pathologist, who is acting within the scope of his or her practice under New York

State law, recommends the medical assistance recipient for such services and the services are part of an individualized education program or an interim or final individualized family services plan."

*18 NYCRR Section 505.11(a)*

The Medicaid Claiming/Billing Handbook states, "Services must be listed on the Individualized Education Program (IEP)."

*Medicaid Claiming / Billing Handbook  
Update #6, pages 13, 18, 19*

In 2 instances pertaining to 1 patient, the claim was billed while there was no documentation of an Individualized Education Program (IEP).

**11. No Documentation of Two Services During Month of Service** 1

The Medicaid Claiming/Billing Handbook states, "Monthly Service Delivery Documentation These are notes and/or reports, which demonstrate the attendance of the provider and the student on the day of the service. The service provider must sign this document. In order to bill, there must be two billable services within the calendar month."

*Medicaid Claiming / Billing Handbook  
Update #6, page A-2.*

In 1 instance, the claim was billed while there was no documentation of two services being performed during the month

**12. No Signed, Dated Evaluation Report** 58

The Medicaid Claiming/Billing Handbook states, "If the school district CSE/CPSE or parent determines that a formal evaluation is required, IDEA requires parental consent for the evaluation. A formal evaluation is the administration of a standardized test to the student to determine the need for services. A medical referral from a SLP, Physician, Physician's Assistant or a Nurse Practitioner is required whenever a formal speech evaluation is conducted. Progress assessment reviews of the Speech Services provided take place during the scheduled Speech Therapy sessions. These progress assessments measure progress in meeting current IEP goals and are provided to the Committee on Special Education (CSE) during a

review process. They may be done at any time and are done usually at Annual Review.

These assessments do not require a medical referral. In these instances, a formal evaluation may not be required."

*Medicaid Claiming / Billing Handbook  
Update #6, page 15*

Regulations state, "(2) Individualized education program (IEP). If the student has been determined to be eligible for special education services, the committee shall develop an IEP. In developing the recommendations for the IEP, the committee must consider the results of the initial or most recent evaluation;"

*8 NYCRR Section 200.4 (d)  
New York Codes, Rules and Regulations*

Regulations state, "Individual evaluation and reevaluation... (6) School districts shall ensure that:... (vii) the student is assessed in all areas related to the suspected disability, including, where appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, vocational skills, communicative status and motor abilities;"

*8 NYCRR Section 200.4 (b)  
New York Codes, Rules and Regulations*

In 1 instance, the claim was billed with no documentation of a signed, dated evaluation report.

## 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 \$59,164, 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:

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
File #10-3736  
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 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  
[REDACTED]

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 \$66,883. 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 Office of Counsel, at [REDACTED]

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**

[REDACTED]  
New York School for the Deaf  
555 Knollwood Road  
White Plains, New York 10603

PROVIDER ID [REDACTED]

AUDIT #10-3736

AMOUNT DUE: \$59,164

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]  
New York State Department of Health  
Medicaid Financial Management, B.A.M.  
GNARESP Corning Tower, Room 2739  
File #10-3736  
Albany, New York 12237

*Thank you for your cooperation.*

## **SAMPLE DESIGN AND METHODOLOGY**

Our sample design and methodology are as follows:

- **Universe** - Medicaid claims for School Supportive Health Services Program services paid during the period January 1, 2009, through December 31, 2009.
- **Sampling Frame** - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for School Supportive Health Services Program services paid during the period January 1, 2009, through December 31, 2009.
- **Sample Unit** - The sample unit is a Medicaid claim paid during the period January 1, 2009, through December 31, 2009.
- **Sample Design** – Simple sampling was used for sample selection.
- **Sample Size** – The sample size is 100 claims.
- **Source of Random Numbers** – The source of the random numbers was the OMIG statistical software. We used a random number generator for selecting our random sampling items.
- **Characteristics to be measured** - Adequacy of documentation received supporting the sample claims.
- **Treatment of Missing Sample Services** - For purposes of appraising items, any sample service for which the Provider could not produce sufficient supporting documentation was treated as an error.
- **Estimation Methodology** – Estimates are based on the sample data using per unit estimates.

**SAMPLE RESULTS AND ESTIMATES**

Universe Size	274
Sample Size	100
Sample Book Value	\$42,021.00
Sample Overpayments	\$24,410.00
Net Financial Error Rate	58%
Mean Dollars in Error	\$244.10
Standard Deviation	212.97
Point Estimate of Total Dollars	\$66,883
Confidence Level	90%
Lower Confidence Limit	\$59,164







