



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

REVIEW OF BUFFALO FEDERATION
OF NEIGHBORHOOD CENTERS
CLAIMS FOR OMH REHABILITATIVE SERVICES
PAID FROM
JULY 1, 2003 - JUNE 30, 2007

FINAL AUDIT REPORT
AUDIT #09-1701

James C. Cox
Medicaid Inspector General

March 18, 2014



STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
584 Delaware Avenue
Buffalo, New York 14202

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

March 18, 2014

[REDACTED]
Buffalo Federation of Neighborhood Centers
97 Lemon Street
Buffalo, New York 14204-1224

Re: Final Audit Report
Audit #: 09-1701
Provider ID #: [REDACTED]
FEIN: [REDACTED]
NPI #: [REDACTED]

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Buffalo Federation of Neighborhood Centers" (Provider) paid claims for OMH rehabilitative services covering the period July 1, 2003, through June 30, 2007.

In the attached final audit report, the OMIG has detailed our 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 revised draft audit report dated June 24, 2013. The adjusted mean point estimate overpaid is \$761,777. The adjusted lower confidence limit of the amount overpaid is \$507,150. 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 adjusted lower confidence limit of \$507,150.

[REDACTED]
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If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED] or through email at [REDACTED].
[REDACTED] Please refer to report number 09-1701 in all correspondence.

Sincerely,

[REDACTED]
Division of Medicaid Audit, Buffalo
Office of the Medicaid Inspector General

[REDACTED]
Enclosure

Ver-5.0

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to assess 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 assess 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 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 for OMH rehabilitative services provided by residential programs that are licensed in accordance with the provisions of Article 31 of the Mental Hygiene Law. Residential programs primarily have a rehabilitative focus and provide an array of rehabilitative and supportive services to individuals diagnosed with severe and persistent mental illness. The purpose of these programs is to provide varied services which support and assist individuals with their goal of integration into the community.

OMH rehabilitative services provided by residential programs are based upon a comprehensive client assessment and must have the written authorization of a physician. Providers must implement an individualized written service plan for each resident identifying the specific services to be offered. These services are intended to focus on improving or maintaining resident skills that enable a resident to remain living in community housing. The specific standards and criteria for OMH Rehabilitative services within residential programs are outlined in Title 14 NYCRR Parts 593 and 595. The Provider Manual pertaining to OMH Certified Rehabilitation Services also provides program guidance in claiming Medicaid reimbursement for OMH Rehabilitative services.

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OMH rehabilitative services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to OMH rehabilitative services, this audit covered services paid by Medicaid from July 1, 2003, through June 30, 2007.

SUMMARY OF FINDINGS

We inspected a random sample of 100 services with \$141,698.54 in Medicaid payments. Of the 100 services in our random sample, 34 services had at least one error and did not comply with state requirements. Of the 34 noncompliant services, some contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
<u>Extrapolated Findings</u>	
Failure to Document Four Different Rehabilitative Services For a Full Month Claim	8
Missing Documentation of Rehabilitative Service	6
Missing Service Plan/Service Plan Review	3
Service Plan/Service Plan Review Not Reviewed and Signed by a Qualified Mental Health Staff Person (QMHSP)	1
Recipient Not in Residence 21 Days in Month	1
Failure to Perform Rehabilitative Services on Different Days	1
Billing Medicaid for Unlicensed Residence	1
<u>Not Extrapolated Findings</u>	
Missing Renewal/Reauthorization of Authorization	14
Rehabilitative Service Provided Not Included in Service Plan	5

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$39,993.17 in sample overpayments with an extrapolated adjusted point estimate of \$761,777. The adjusted lower confidence limit of the amount overpaid is \$507,150.

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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 OMH rehabilitative services 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 OMH Rehabilitative Services Program

OMH rehabilitative services provided by residential programs are based upon a comprehensive client assessment and must have the written authorization of a physician. Providers must implement an individualized written service plan for each resident identifying the specific services to be offered. These services are intended to focus on improving or maintaining resident skills that enable a resident to remain living in community housing. The specific standards and criteria for OMH rehabilitative services within residential programs are outlined in Title 14 NYCRR Parts 593 and 595. The Provider Manual pertaining to OMH Certified rehabilitation services also provides program guidance in claiming Medicaid reimbursement for OMH rehabilitative services.

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OMH rehabilitative 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 OMH rehabilitative services paid by Medicaid from July 1, 2003, through June 30, 2007. Our audit universe consisted of 3,302 claims totaling \$4,700,841.30.

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 OMH rehabilitative services program;
- ran computer programming application of claims in our data warehouse that identified 3,302 paid OMH rehabilitative services claims, totaling \$4,700,841.30;
- selected a random sample of 100 services from the population of 3,302 services; and,
- estimated the overpayment paid in the population of 3,302 services.

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

- Medicaid electronic claim information
- Recipient record, including, but not limited to:
 - Service Plans and Service Plan Reviews
 - Rehabilitative Service Documentation
 - Authorizations and Reauthorizations
 - Personnel Records of Staff who make entries in the Record
- 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)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, Title 18 NYCRR Section 540.6, and 14 NYCRR Parts 593 and 595.
- 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: "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)

AUDIT FINDINGS

This audit report incorporates consideration of any additional documentation and information presented in response to the Revised Draft Audit Report dated June 24, 2013. The attached Bridge Schedule (Attachment D) indicates any changes to the findings as a result of your response.

FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from July 1, 2003, through June 30, 2007, identified 34 claims with at least one error, for a total sample overpayment of \$39,993.17 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Revised Draft Audit Report dated June 24, 2013. Appropriate adjustments were made to the findings.

1. Failure to Document Four Different Rehabilitative Services For a Full Month Claim

Regulations state: "Service definitions for programs serving adults.

- (1) Assertiveness/self-advocacy training...
- (2) Community integration...
- (3) Daily living skills training...
- (4) Health services ...
- (5) Medication management and training ...
- (6) Parenting training...
- (7) Rehabilitation counseling...
- (8) Skill development services...
- (9) Socialization...
- (10) Substance abuse services...
- (11) Symptom management..."

14 NYCRR Section 593.4(b)

Regulations require that, "At least four different community rehabilitative services must have been provided" in order to be reimbursed for a full monthly rate.

14 NYCRR Section 593.7(b)(1)

In 8 instances pertaining to 8 residents, the record did not document four different community rehabilitative services provided in the month claimed. This finding applies to Sample #'s 18, 28, 29, 33, 34, 54, 92 and 100.

2. Missing Documentation of Rehabilitative Service

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. . . ."

18 NYCRR Section 504.3(a)

Regulations state, "There shall be a complete case record maintained for each resident. Such case record shall be maintained in accordance with recognized and acceptable principles of recordkeeping...."

14 NYCRR Section 595.14(a)

Regulations state: "The case record shall ... include the following information...(8) documentation of the type of service provided, the date it was provided, its duration and the name of the person rendering the service;"

14 NYCRR Section 595.14(b)(8)

In 6 instances pertaining to 4 residents, the record did not document that any rehabilitative services was provided. This finding applies to Sample #'s 70, 72, 73, 88, 94 and 97.

3. Missing Service Plan/Service Plan Review

Regulations state, "Community rehabilitation services shall be provided in accordance with a service plan developed within four weeks of admission to the program."

14 NYCRR Section 593.6(c)

Regulations also state, "The service plan shall be reviewed at least every three months with the initial review occurring three months from the date of admission."

14 NYCRR Section 593.6(f)

Regulations require Medicaid providers to develop "an individualized written service plan which shall be based upon psychiatric rehabilitation principles of participation and individual resident choice."

14 NYCRR Section 595.1(b)

Regulations state, "The individualized written service plan shall be reviewed at least once every three months, with the initial review occurring three months from the date of admission."

14 NYCRR Section 595.11(d)

In addition, Regulations state, "Services provided within a residential program... shall be provided in accordance with a service plan developed within four weeks of admission to the program."

14 NYCRR Section 595.11(a)

Medicaid policy states, "A written service plan for each client in any Licensed Residential/Housing Program is required."

*Office of Mental Health Rehabilitation In Community Residences,
Policy Guidelines, Version 2006-1, Section I*

In 3 instances pertaining to 2 residents, the record did not contain a service plan or the required service plan review. This finding applies to Sample #'s 15, 35 and 38.

4. Service Plan/Service Plan Review Not Reviewed and Signed by Qualified Mental Health Staff Person (QMHSPP)

Regulations define a Qualified Mental Health Staff Person (QMHSPP) as a NYS licensed:

- (i) a physician...
- (ii) a psychologist...
- (iii) a social worker...
- (iv) a registered nurse...
- (v) a creative arts therapist...
- (vi) a marriage and family therapist...
- (vii) a mental health counselor...
- (viii) a psychoanalyst...
- (ix) a nurse practitioner...
- (x) an individual having education, experience and demonstrated competence, as defined below:
 - (a) a master's or bachelor's degree in a human services related field;
 - (b) an associate's degree in a human services related field and three years' experience in human services;
 - (c) a high school degree and five years' experience in human services; or...
- (xi) other professional disciplines which receive the written approval of the Office of Mental Health."

14 NYCRR Section 595.4(a)(10)

Regulations state, "The service plan must be reviewed and signed by a qualified mental health staff person."
14 NYCRR Section 593.6(d)

Regulations also state, "The service plan shall be reviewed and signed by a qualified mental health staff person."
14 NYCRR Section 595.11(b)

Regulations require the service plan review to consist of a "review of the service plan and signed approval by a qualified mental health staff person."
14 NYCRR Section 593.6(f)(3)

Medicaid policy states, "All plans must be reviewed and signed by a Qualified Mental Health Staff person."
*Office of Mental Health Rehabilitation In Community Residences,
Policy Guidelines, Version 2006-1, Section I*

In 1 instance, the service plan or service plan review was signed by an individual who did not meet the regulatory definition of a Qualified Mental Health Staff Person. This finding applies to Sample # 46.

5. Recipient Not in Residence 21 Days in Month

Regulations state, "A full monthly rate will be paid for services provided to an eligible resident in residence for at least 21 days in a calendar month..."
14 NYCRR Section 593.7(b)(1)

In 1 instance, a full monthly rate was paid for services provided to a client in residence less than 21 days. This finding applies to Sample # 98.

6. Failure to Perform Rehabilitative Services on Different Days

Regulations state, "Only one contact can be counted each day and such contact shall be at least 15 minutes in duration."
14 NYCRR Section 593.7(b)(3)

In 1 instance, the community rehabilitative services provided were not performed on different days of the month. This finding applies to Sample # 99.

7. Billing Medicaid for Unlicensed Residence

Regulations state, "An operating certificate, valid for a period not to exceed three years, will be issued to residential programs which comply with the requirements stated in this Part."
14 NYCRR Section 595.5(a)

Regulations also state, "The current operating certificate shall be available to be shown to anyone upon request."
14 NYCRR Section 595.5(e)

In addition, regulations state, "In order to receive reimbursement for community rehabilitation services pursuant to this Part, each program operated by a provider of service shall have a valid operating certificate issued by the Office of Mental Health as well as a contract to provide services."
14 NYCRR Section 593.5(a)

In 1 instance, services were claimed while the resident was housed in an unlicensed site. This finding applies to Sample # 96.

8. Missing Renewal/Reauthorization of Authorization

Regulations state, "Physician's authorizations must be renewed as follows:

- (1) every six months for individuals residing within congregate residences...;
- (2) every 12 months for individuals residing within an apartment program; and
- (3) upon transfer to a different category of adult program (i.e., congregate to apartment or apartment to congregate). The authorization renewal must, in the case of a transfer from congregate to apartment, occur upon the expiration date of the current authorization or in the case of a transfer from apartment to congregate, within six months of admission to the new program or the expiration of the current authorization, whichever comes first."

14 NYCRR Section 593.6(b)

Medicaid policy states, "For adults living in CR congregate settings, re-authorization is required at least every six months. For adults living in apartments, re-authorization is required once a year."

*Office of Mental Health Rehabilitation
In Community Residences,
Policy Guidelines, Version 2006-1, Section I*

In 14 instances pertaining to 12 residents, the record did not contain the required reauthorization signed by a physician at the time rehabilitative services were delivered. This finding applies to Sample #'s 6, 10, 13, 16, 20, 24, 26, 30, 41, 48, 57, 70, 72 and 94.

9. Rehabilitative Service Provided Not Included in Service Plan

Regulations state, "For reimbursement purposes, a contact shall involve the performance of at least one of the services indicated in the resident's current service plan."
14 NYCRR Section 593.7(b)(4)

Regulations also state, "The individualized written service plan shall be a mutually agreed upon plan which, at a minimum, identifies the following:...(5) identification of the services to be provided;"
14 NYCRR Section 595.11(b)(5)

In 5 instances pertaining to 4 residents, the community rehabilitative services provided were not specified on the service plan. This finding applies to Sample #'s 2, 15, 20, 29 and 91.

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 adjusted lower confidence limit amount of \$507,150, 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:


New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #09-1701
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 50% withhold after 20 days until the agreement is established. 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. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

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


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 adjusted point estimate of \$761,777. 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**

NAME AND ADDRESS OF AUDITEE

Buffalo Federation of Neighborhood
Centers
97 Lemon Street
Buffalo, New York 14204-1224

AMOUNT DUE: \$507,150

PROVIDER ID [REDACTED]

AUDIT #09-1701

AUDIT	<input checked="" type="checkbox"/> PROVIDER
	<input type="checkbox"/> RATE
	<input type="checkbox"/> PART B
TYPE	<input type="checkbox"/> 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
GNARESP Corning Tower, Room 2739
File #09-1701
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN

The sample design used for Audit #09-1701 was as follows:

- Universe - Medicaid claims for OMH rehabilitative services paid during the period July 1, 2003, through June 30, 2007.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for OMH rehabilitative services paid during the period July 1, 2003, through June 30, 2007.
- Sample Unit - The sample unit is a Medicaid claim paid during the period July 1, 2003, through June 30, 2007.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 services.

SAMPLE RESULTS AND ESTIMATES

Audit Statistics

Universe Size	3,302
Sample Size	100
Sample Value	\$ 141,698.54
Sample Overpayments	\$ 39,993.17
Net Financial Error Rate	28.2%
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	\$ 39,993.17
Less Overpayments Not Extrapolated*	<u>\$ (17,451.53)</u>
Sample Overpayments for Extrapolation Purposes	\$ 22,541.64
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	\$ 225.4164
Universe Size	3,302
Point Estimate of Total Dollars	\$ 744,325
Add Overpayments Not Extrapolated*	<u>\$ 17,452</u>
Adjusted Point Estimate of Total Dollars	<u>\$ 761,777</u>
Lower Confidence Limit	\$ 489,698
Add Overpayments Not Extrapolated*	<u>\$ 17,452</u>
Adjusted Lower Confidence Limit	<u>\$ 507,150</u>

* The actual dollar disallowance for the following findings was subtracted from the total sample overpayment and added to the Point Estimate and Lower Confidence Limit:

- **Finding #8 – Missing Renewal/Reauthorization of Authorization**
- **Finding #9 – Rehabilitative Service Provided Not Included in Service Plan**

The dollar disallowance associated with these findings was not used in the extrapolation. However, this does not apply if an extrapolated finding was also identified for a sampled claim

FINAL DISPOSITION FOR SAMPLED SELECTIONS CHANGED FROM DRAFT TO FINAL AUDIT REPORT

BUFFALO FEDERATION OF NEIGHBORHOOD CENTERS
OMH REHABILITATIVE SERVICES AUDIT

AUDIT #09-1701

AUDIT PERIOD: 07/01/03 - 06/30/07

BRIDGE SCHEDULE

SAMPLE #	FINDING	DRAFT REPORT AMOUNT DISALLOWED	FINAL REPORT AMOUNT DISALLOWED	CHANGE
25	Recipient Not in Residence 21 Days in Month	\$723.21	\$0.00	(\$723.21)
37	Rehabilitative Service Provided Not Included in Service Plan	\$723.21	\$0.00	(\$723.21)
42	Missing Renewal/Reauthorization of Authorization	\$1,560.77	\$0.00	(\$1,560.77)
49	Failure to Document Four Different Rehabilitative Services For a Full Month Claim	\$776.18	\$0.00	(\$776.18)
69	Missing Service Plan/Service Plan Review	\$1,385.87	\$0.00	(\$1,385.87)
71	Service Plan/Service Plan Review Not Reviewed and Signed by a QMHSP	\$1,385.87	\$0.00	(\$1,385.87)
81	Failure to Document Four Different Rehabilitative Services For a Full Month Claim	\$750.19	\$0.00	(\$750.19)
98	Recipient Not in Residence 21 Days in Month	\$1,446.42	\$723.21	(\$723.21)
99	Failure to Perform Rehabilitative Services on Different Days	\$1,446.42	\$723.21	(\$723.21)
TOTAL		\$10,198.14	\$1,446.42	(\$8,751.72)

Note: The adjustments shown above only reflect those that were revised as a result of the provider's response. All other financial adjustments remain the same as shown in the Draft Audit Report.