



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

REVIEW OF UNION-ENDICOTT CENTRAL SCHOOL DISTRICT
CLAIMS FOR SCHOOL SUPPORTIVE HEALTH SERVICES
PROGRAM SERVICES
PAID FROM
JANUARY 1, 2010 – DECEMBER 31, 2010

FINAL AUDIT REPORT
AUDIT #11-3006

James C. Cox
Medicaid Inspector General

March 6, 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 6, 2014

[REDACTED]
Union-Endicott Central School District
1100 East Main Street
Endicott, New York 13760

Re: Final Audit Report
Audit #: 11-3006
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 Union-Endicott Central School District" (Provider) paid claims for School Supportive Health Services Program services covering the period January 1, 2010, through December 31, 2010.

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 January 21, 2014. The mean point estimate overpaid is \$118,038. The lower confidence limit of the amount overpaid is \$95,212. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the lower confidence limit of \$95,212.

[REDACTED]
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March 6, 2014

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 11-3006 in all correspondence.

Sincerely,

[REDACTED]

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

[REDACTED]
Enclosure

cc: [REDACTED]

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 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, 2010, through December 31, 2010.

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 \$34,041.75 in Medicaid payments. Of the 100 claims in our random sample, 41 claims had at least one error and did not comply with state requirements. Of the 41 noncompliant claims, 17 contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
No Recommendation or Written Order	26
No Documentation of Supervision	18
No Signed, Dated Evaluation Report	1
No Progress Note That Covers the Service Month	1
No Service Report	1
No Documentation of Group Size (Corrective Action)	14

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$16,672 in sample overpayments with an extrapolated point estimate of \$118,038. The lower confidence limit of the amount overpaid is \$95,212.

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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 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;
- student 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, 2010, through December 31, 2010. Our audit universe consisted of 708 claims totaling \$254,667.74.

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 708 paid School Supportive Health Services Program claims, totaling \$254,667.74;
- selected a random sample of 100 claims from the population of 708 claims; and,
- estimated the overpayment paid in the population of 708 claims.

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

- Medicaid electronic claim information
- Student 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)

AUDIT FINDINGS

This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated January 21, 2014.

The attached Bridge Schedule (Attachment D) indicates any financial changes to the findings as a result of your response.

FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2010, through December 31, 2010, identified 41 claims with at least one error, for a total sample overpayment of \$16,672 (Attachment C).

1. No Recommendation or Written Order

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 19*

The Medicaid Claiming/Billing Handbook states, "Physical 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*

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 student's 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, pages 15-16*

Physician's written order required. (1) Rehabilitation services must be supported by a written order of a qualified physician and must be carried out under his or her medical direction. The written order constitutes medical direction of the physician.

(2) Such written order must include a diagnostic statement and purpose of treatment.

(3) Such written order is required prior to treatment.

18 NYCRR Section 505.11(e)(1)(2)(3)

In 26 instances pertaining to 15 students, there was no order signed by a physician, a physician's assistant, nurse practitioner or speech language pathologist. This finding applies to Sample #'s 2, 10, 13, 14, 19, 23, 24, 26, 56, 62, 63, 66, 71, 82, 84, 88 (OT); Sample #'s 9, 20, 25, 40, 52, 90 (PT); and 3, 48, 53 and 94 (ST).

2. No Documentation of Supervision

No Documentation of Supervision–Occupational Therapy

No Documentation of Supervision and Direction by Availability to Therapist for Consultation

No Documentation of Supervision and Direction by Meeting with Therapist

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 CFR § 440.110(a)(1)(b)(1)(c)(1)
Subpart 76.6*

The direct supervision required by section 7906(6) of the Education Law shall include meeting with and observing the occupational therapy assistant on a regular basis to review the implementation of treatment plans and to foster professional development.

NYS Education Department Commissioner's Regulations

To claim Medicaid reimbursement, providers must abide by the following: There should be at least quarterly progress notes prepared by the service provider and signed by the NYS licensed occupational therapist (updated 10/17/05). We recommend use of the progress notes sent home to parents (Part 200 of the Regulations of the Commissioner of Education).

*Medicaid Claiming/Billing Handbook
Update #6, page 19*

In 3 instances pertaining to 2 students, a claim was billed while there was insufficient documentation regarding direct supervision by the licensed professional.

No Documentation of Supervision – Physical Therapy

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

No Documentation of Supervision and Direction by Meeting with Therapist

No Documentation of Supervision and Direction by Review of Therapist's Progress Notes

No Documentation of Supervisor Review of IEP/Schedule

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 CFR § 440.110(a)(1)(b)(1)(c)(1)

For purposes of this subdivision "continuous supervision" shall be deemed to include: i. the licensed physical therapist's setting of the goals, establishing a plan of care, determining on an initial and ongoing basis whether the patient is appropriate to receive the services of a physical therapist assistant, determining the frequency of joint visits with the patient by both the supervising licensed physical therapist and the physical therapist assistant, except that in no instance shall the interval, between joint visits, be more than every ninety calendar days, subject to the licensed physical therapist's evaluation; ii. an initial joint visit with the patient by the supervising licensed physical therapist and physical therapist assistant; iii. periodic treatment and evaluation of the patient by the supervising licensed physical therapist as indicated in the plan of care and as determined in accordance with patient need, except that in no instance shall the interval between such treatment exceed every twelfth visit or thirty days which ever occurs first; and iv. Notification of the supervising licensed physical therapist by the physical therapist assistant whenever there is a change in status, condition or performance of the patient.

8 NYCRR § 6738(d)(1)

To claim Medicaid reimbursement, providers must abide by the following:

- The licensed physical therapist must sign all service provider sheets, whether delivering the service directly, or providing supervision to a PTA (Article 136).
- There should be at least quarterly progress notes prepared by the service provider and signed by the NYS licensed physical therapist.

We recommend use of the progress notes sent home to parents (Part 200 of the Regulations of the Commissioner of Education). Refer to page 12 for documentation requirements.

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

In 3 instances pertaining to 1 student, a claim was billed while there was insufficient documentation regarding direct supervision by the licensed professional.

No Documentation of Services Provided Under the Direction of a Therapist – Speech Therapy

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

No Documentation of Supervisor Availability

No Documentation of Supervision and Direction by Meeting with Therapist

No Documentation of Supervisor Review of Progress Notes

No Documentation of Supervisor Review of IEP/Schedule

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 CFR § 440.110(a)(1)(b)(1)(c)(1)

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*

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*

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 12 instances pertaining to 8 students, a claim was billed while there was insufficient documentation regarding direct supervision by the licensed professional.

There are a total of 18 instances where claims are disallowed for Missing Documentation of Supervision.

In 18 instances pertaining to 11 students, a claim was billed while there was insufficient documentation regarding direct supervision by the licensed professional. This finding applies to Sample #'s 14, 62 and 63 (OT); Sample #'s 31, 52 and 64 (PT); and Sample #'s 3, 33, 45, 48, 50, 51, 59, 60, 67, 72, 74 and 98 (ST).

3. No Signed, Dated Evaluation Report

Evaluation means procedures that are used to determine whether a child has a disability and the nature and extent of the special education and related services that the child needs. *34 CFR 300.15*

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 Part 200.4(d)

School districts shall ensure that 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 Part 200.4(b)(vii)*

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 an SLP, Physician, Physician's Assistant or a Nurse Practitioner is required whenever a formal speech evaluation is conducted.

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

In 1 instance, there was no evaluation demonstrating the need for speech therapy services. This finding applies to Sample #15.

4. No Progress Note that Covers the Service Month

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 Part 200.4(d)(2)(iii)(c)*

All providers, who are not paid at rates or fees approved by the State Director of the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor, including any prescription or fiscal order for the service or supply, must be kept by the provider for a period of six years from the date of care, services or supplies were furnished or billed, whichever is later. *18 NYCRR Section 517.3(b)(1)*

Documentation requirements necessary to claim Medicaid for the provision of Health Related Support Services include 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 the 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*

Progress notes are completed, at a minimum quarterly, by the service provider. They indicate performance level of the student, the progress that the student is making toward meeting projected outcomes of goals, and/or objectives of health related services as specified on the IEP. This may be part of the service delivery documentation. Progress notes are now required, under IDEA and Part 200 of the Commissioner's Regulations, for each reporting period. An annual review that contains progress notes by appropriate providers qualifies as one progress note.

*Medicaid Claiming/Billing Handbook
Update #6, Appendix A, Page 2*

In 1 instance, there was no indication of a progress note being completed by a Speech Language Pathologist. This finding applies to Sample #15.

5. No Service Report

Documentation necessary to claim Medicaid for the provision of Health Related Support Services includes Monthly Service Reports which must contain the date of service, service provided, service provider signature, and the date signed.

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

In 1 instance, there was no service report. This finding applies to Sample #53 (ST).

6. No Documentation of Group Size

When a related service is provided to a number of students at the same time, the number of students in the group shall not exceed five students per teacher.

*New York State Education Law
Section 200.6(b)(e)(3)*

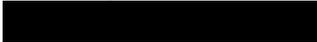
In 14 instances pertaining to 8 students, documentation of group size was missing. This finding refers to Sample #'s 2, 10, 13, 14, 19, 23, 24, 47, 57 and 88 (OT); Sample #'s 20, 25 and 52 (PT) and Sample #15 (ST).

This finding is being treated as a compliance issue in the current audit of the Union-Endicott Central School District. There has been no monetary disallowance taken.

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 \$95,212, 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 #11-3006
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


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 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 \$118,038. 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

Union-Endicott Central School District
1100 East Main Street
Endicott, New York 13760

PROVIDER ID [REDACTED]

AUDIT #11-3006

AMOUNT DUE: \$95,212

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
GNARESP Corning Tower, Room 2739
File #11-3006
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, 2010, through December 31, 2010.
- 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, 2010, through December 31, 2010.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2010, through December 31, 2010.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 claims.

SAMPLE RESULTS AND ESTIMATES**Audit Statistics**

Universe Size	708
Sample Size	100
Sample Value	\$ 34,041.75
Sample Overpayments	\$ 16,672.00
Net Financial Error Rate	48.97%
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	\$ 16,672.00
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	\$ 166.7200
Universe Size	708
Point Estimate of Total Dollars	\$ 118,038
Lower Confidence Limit	\$ 95,212

OFFICE OF THE MEDICAID INSPECTOR GENERAL
UNION-ENDICOTT CENTRAL SCHOOL DISTRICT
REVIEW OF SCHOOL SUPPORTIVE HEALTH SERVICES
PROJECT NUMBER: 11-3006
REVIEW PERIOD: 01/01/10 - 12/31/10

Sample Number	Date of Service	Rate Code		Amount		Over Payment		DETAILED AUDIT FINDINGS						
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. No Recommendation or Written Order	2. No Documentation of Supervision	3. No Signed, Dated Evaluation Report	4. No Progress Note that Covers the Service Month	5. No Service Report	6. No Documentation of Group Size (Corrective Action)	
1	03/01/09	5496	5496	\$ 90.84	\$ 90.84	\$ -	\$ -							
2	10/01/08	5330	5496	422.00	-	422.00	422.00	X						X
3	02/01/09	5326		432.00	-	432.00	432.00	X	X					
4	02/01/09	5330	5330	422.00	422.00	-	-							
5	11/01/08	5496	5496	181.68	181.68	-	-							
6	08/01/08	5496	5496	45.42	45.42	-	-							
7	01/01/09	5496	5496	295.23	295.23	-	-							
8	06/01/09	5330	5330	422.00	422.00	-	-							
9	06/01/09	5328		430.00	-	430.00	430.00	X						X
10	12/01/08	5330		422.00	-	422.00	422.00	X						
11	03/01/08	5328	5328	430.00	430.00	-	-							
12	01/01/09	5496	5496	204.39	204.39	-	-							
13	12/01/08	5330		422.00	-	422.00	422.00	X						X
14	10/01/08	5330		422.00	-	422.00	422.00	X	X					X
15	03/01/08	5326		432.00	-	432.00	432.00			X	X			X
16	08/01/08	5496	5496	113.55	113.55	-	-							
17	11/01/08	5330	5330	422.00	422.00	-	-							
18	10/01/08	5326	5326	432.00	432.00	-	-							
19	02/01/09	5330		422.00	-	422.00	422.00	X						X
20	10/01/08	5328		430.00	-	430.00	430.00	X						X
21	10/01/08	5494	5494	520.00	520.00	-	-							
22	09/01/08	5496	5496	45.42	45.42	-	-							
23	09/01/08	5330		422.00	-	422.00	422.00	X						X
24	02/01/09	5330		422.00	-	422.00	422.00	X						X
25	02/01/09	5328		430.00	-	430.00	430.00	X						X

OFFICE OF THE MEDICAID INSPECTOR GENERAL
UNION-ENDICOTT CENTRAL SCHOOL DISTRICT
REVIEW OF SCHOOL SUPPORTIVE HEALTH SERVICES
PROJECT NUMBER: 11-3006
REVIEW PERIOD: 01/01/10 - 12/31/10

Sample Number	Date of Service	Rate Code		Amount		Over Payment		DETAILED AUDIT FINDINGS						
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. No Recommendation or Written Order	2. No Documentation of Supervision	3. No Signed, Dated Evaluation Report	4. No Progress Note that Covers the Service Month	5. No Service Report	6. No Documentation of Group Size (Corrective Action)	
76	11/01/08	5496	5496	\$ 90.84	\$ 90.84	\$ -	\$ -							
77	03/01/09	5492	5492	265.00	265.00	-	-							
78	08/01/08	5326	5326	432.00	432.00	-	-							
79	03/01/09	5496	5496	181.68	181.68	-	-							
80	04/01/09	5496	5496	204.39	204.39	-	-							
81	03/01/09	5328	5328	430.00	430.00	-	-							
82	11/01/08	5330	5330	422.00	422.00	-	422.00	X						
83	06/01/09	5496	5496	340.65	340.65	-	-							
84	05/01/09	5330	5330	422.00	422.00	-	422.00	X						
85	06/01/09	5492	5492	265.00	265.00	-	-							
86	10/01/08	5496	5496	317.94	317.94	-	-							
87	11/01/08	5326	5326	432.00	432.00	-	-							
88	01/01/09	5330	5330	422.00	422.00	-	422.00	X						X
89	11/01/08	5496	5496	90.84	90.84	-	-							
90	01/01/09	5328	5328	430.00	430.00	-	430.00	X						
91	05/01/09	5496	5496	204.39	204.39	-	-							
92	02/01/09	5494	5494	520.00	520.00	-	-							
93	05/01/08	5328	5328	430.00	430.00	-	-							
94	01/01/09	5326	5326	432.00	432.00	-	432.00	X						
95	01/01/09	5496	5496	317.94	317.94	-	-							
96	04/01/09	5496	5496	22.71	22.71	-	-							
97	09/01/08	5496	5496	113.55	113.55	-	-							
98	03/01/08	5326	5326	432.00	432.00	-	432.00		X					
99	09/01/08	5330	5330	422.00	422.00	-	-							
100	06/01/09	5326	5326	432.00	432.00	-	-							
Totals				\$ 34,041.75	\$ 17,369.75	\$ 16,672.00	\$ -	26	18	1	1	1	1	14

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

UNION-ENDICOTT CENTRAL SCHOOL DISTRICT
 SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM SERVICES

AUDIT #11-3006

AUDIT PERIOD: 01/01/10-12/31/10

BRIDGE SCHEDULE

SAMPLE #	FINDING	DRAFT REPORT		FINAL REPORT		CHANGE
		AMOUNT DISALLOWED	AMOUNT DISALLOWED	AMOUNT DISALLOWED	AMOUNT DISALLOWED	
32	No Recommendation or Written Order-Finding Eliminated	\$422.00	\$0.00	\$0.00	\$0.00	(\$422.00)
68	No Recommendation or Written Order-Finding Eliminated	\$432.00	\$0.00	\$0.00	\$0.00	(\$432.00)
68	No Documentation of Supervision-Finding Eliminated	See #68 Above	\$0.00	\$0.00	\$0.00	
68	No Signed, Dated Evaluation Report-Finding Eliminated	See #68 Above	\$0.00	\$0.00	\$0.00	
70	No Recommendation or Written Order-Finding Eliminated	\$432.00	\$0.00	\$0.00	\$0.00	(\$432.00)
70	No Signed, Dated Evaluation Report-Finding Eliminated	See #70 Above	\$0.00	\$0.00	\$0.00	
87	No Recommendation or Written Order-Finding Eliminated	\$432.00	\$0.00	\$0.00	\$0.00	(\$432.00)
87	No Written Referral for Evaluation-Finding Eliminated	See #87 Above	\$0.00	\$0.00	\$0.00	
100	No Recommendation or Written Order-Finding Eliminated	\$432.00	\$0.00	\$0.00	\$0.00	(\$432.00)
TOTALS		<u>\$2,150.00</u>	<u>\$0.00</u>	<u>\$0.00</u>	<u>\$0.00</u>	<u>(\$2,150.00)</u>

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.