



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

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

May 17, 2012

[REDACTED]
Soundview Health Center
731 White Plains Road
Bronx, New York 10473

Final Audit Report

Audit #08-3883

Provider ID [REDACTED]

Dear [REDACTED]

This letter will serve as our final audit report for the completed review of payments made to Soundview Health Center under the New York State Medicaid Program.

The New York State Department of Health is responsible for the administration of the Medicaid program. As part of this responsibility, the Office of the Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)] and the Medicaid Management Information System (MMIS) Provider Manuals.

A diagnostic and treatment center is a medical facility with one or more health services which is not part of an inpatient hospital facility or vocational rehabilitation center. It is primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician or dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition. A diagnostic and treatment center is certified in accordance with Article 28 of the NYS Public Health Law and/or Article 31 of the Mental Hygiene Law to provide such services on an outpatient basis. The specific standards and criteria for diagnostic and treatment center services are principally found in various parts of 10 NYCRR Chapter V and 18 NYCRR Chapter II, as well as the MMIS Provider Manual for Clinics.

A review of payments to Soundview Health Center for diagnostic and treatment center services paid by Medicaid from January 1, 2004, through December 31, 2007, was completed. During the audit period, \$8,170,738.18 was paid for 69,656 services rendered. This review consisted of a random sample of 200 services with Medicaid payments of \$24,040.92. The purpose of the audit was to ensure 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 Department regulations and the Provider Manuals for Clinics.

In response to the revised draft audit report dated December 22, 2009, you identified specific audit findings with which you disagreed. Your comments have been considered (see Attachment A) and the report has been revised accordingly. Consideration of your comments resulted in a reduction of \$424,121.00 to the adjusted mean per unit point estimate and a reduction of \$330,231.00 to the adjusted lower confidence limit.

Soundview Health Center's failure to comply with Title(s) 10, 14 and/or 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) and the MMIS Provider Manual for Clinics resulted in a total sample overpayment of \$10,878.55.

The statistical sampling methodology employed allows for extrapolation of the sample findings to the universe of services (18 NYCRR Section 519.18). The adjusted mean per unit point estimate of the amount overpaid is \$423,891.00. The adjusted lower confidence limit of the amount overpaid is \$211,587.00. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit (Exhibit I). This audit may be settled through repayment of the adjusted lower confidence limit of \$211,587.00.

The following detailed findings reflect the results of our audit.

DETAILED FINDINGS

In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."
18 NYCRR Section 504.3

Regulations state: "All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing . . . ; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment . . . ; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided. . . ."

18 NYCRR Section 540.7(a)

Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake."
18 NYCRR Section 518.1(c)

Regulations state: "An unacceptable practice is conduct by a person which is contrary to: . . . (2) the published fees, rates, claiming instructions or procedures of the department" and "(3) the official rules and regulations of the Departments of Health, Education and Mental Hygiene. . . ."
18 NYCRR Section 515.2(a)

Furthermore, according to regulations, all providers must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. In addition, the provider must keep, for a period of six years, all records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply. This information is subject to audit for a period of six years and must be furnished, upon request.
18 NYCRR Section 517.3(b)

1. Incorrect Servicing Provider on Claim

Regulations state, "By enrolling the provider agrees . . . that the information provided in relation to any claim for payment shall be true, accurate and complete; and . . . comply with the rules, regulations and official directives of the department."
18 NYCRR Section 504.3(h)(i)

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

Medicaid Update, June 2002, Volume 17, Number 6, Page 3

In 91 instances pertaining to 90 patients, the servicing practitioner was not accurately identified. The servicing practitioner's name on the 91 claims did not match the name of the practitioner who provided the service. This resulted in a sample overpayment of \$9,689.27 (Exhibit II).

2. Medical Entry Not Signed

Regulations state, "The operator shall . . . ensure that entries in the medical record are current, legible, signed and dated by the person making the entry."
10 NYCRR Section 751.7(f)

In 4 instances pertaining to 3 patients, the practitioner did not sign the entry in the medical record. This resulted in a sample overpayment of \$456.28 (Exhibit III).

3. Missing Documentation

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 also require that bills for medical care, services and supplies contain a certification that such records as are necessary to disclose fully the services provided to individuals under

the New York State Medicaid program will be kept for a period of not less than six years. These records must be furnished to the Department upon request.

18 NYCRR Section 540.7(a)(8) and Section 517.3

In 3 instances pertaining to 3 patients, the services were not documented. This resulted in a sample overpayment of \$367.16 (Exhibit IV).

4. No EOB for Medicare Covered Services

Regulations state, "The Department . . . will seek reimbursement for any payments for care and services it makes for which a third party is legally responsible."

18 NYCRR Section 360-7.2

The MMIS Manual requires that providers must bill all applicable insurance sources, including Medicare, before submitting claims to Medicaid. The Manual also states, "Providers must maintain appropriate financial records supporting their . . . receipt of funds and application of monies received. Such records must be readily accessible. . . for audit purposes."

MMIS Provider Manual for Clinics, Section 2.1.9

In 3 instances pertaining to 3 patients, no Explanation of Medical Benefits (EOB) was found for a Medicare eligible patient. In this case, Medicare was not billed for specific services paid by Medicaid. This resulted in a sample overpayment of \$365.84 (Exhibit V).

Total sample overpayments for this audit amounted to \$10,878.55.

Additional reasons for disallowance exist regarding certain findings. These findings are identified in Exhibit VI.

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 \$211,587.00, 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 2266
 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 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 meanpoint estimate of \$423,891.00. 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 [REDACTED], 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.

Should you have any questions, please contact [REDACTED] at [REDACTED].

Thank you for the cooperation and courtesy extended to our staff during this audit.

Sincerely,

A large black rectangular redaction box covering the signature of the sender.

Division of Medicaid Audit, White Plains
Office of the Medicaid Inspector General

A small black rectangular redaction box covering the subject line.

Enclosures

cc:

A large black rectangular redaction box covering the list of recipients in the cc field.

CERTIFIED MAIL # 
RETURN RECEIPT REQUESTED

Ver-31.4
Fin-8.0

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

NAME AND ADDRESS OF AUDITEE

Soundview Health Center
731 White Plains Road
Bronx, New York 10473

AMOUNT DUE: \$211,587.00

PROVIDER ID [REDACTED]

AUDIT #08-3883

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, B.A.M.
GNARESP Corning Tower, Room 2266
File #08-3883
Albany, New York 12237

Thank you for your cooperation.

**SOUNDVIEW HEALTH CENTER - AUDIT #08-3883
PROVIDER DRAFT REPORT COMMENTS AND OMIG RESPONSE**

The following details the disposition of final report adjustments after consideration of the provider's March 22, 2010, response to the revised draft audit report.

Incorrect Servicing Provider on Claim

Provider Comment

Not applicable

OMIG Comment

This finding has been revised to include the secondary findings for the following samples:

<u>Sample #</u>	<u>Amount</u>
73	\$123.54
105	126.30
136	120.31

It was necessary to defer to the secondary findings for these claims due to the elimination of audit adjustment #2 of the revised draft audit report, Claims Submitted 90 Days or More After Date of Service (See Exhibit II).

Disposition: Draft audit report disallowances of \$9,319.12 are increased by \$370.15 to \$9,689.27 to reflect the above.

Claims Submitted Over 90 Days from Date of Service

OMIG Comments

Based on documentation provided in response to the revised draft audit report, this finding has been deleted.

SOUNDVIEW HEALTH CENTER
 DIAGNOSTIC AND TREATMENT CENTER AUDIT
 AUDIT #08-3883
 AUDIT PERIOD: 01/01/04 - 12/31/07

EXTRAPOLATION OF SAMPLE FINDINGS

Total Sample Overpayments	\$ 10,878.55
Less Overpayments Not Projected*	<u>(9,689.27)</u>
Sample Overpayments for Extrapolation Purposes	\$ 1,189.28
Services in Sample	200
Overpayments Per Sampled Service	\$ 5.9464
Services in Universe	69,656
Meanpoint Estimate	\$ 414,202.00
Add Overpayments Not Projected*	<u>9,689.00</u>
Adjusted Meanpoint Estimate	<u>\$ 423,891.00</u>
Lower Confidence Limit	\$ 201,898.00
Add Overpayments Not Projected*	<u>9,689.00</u>
Adjusted Lower Confidence Limit	<u>\$ 211,587.00</u>

* The actual dollar disallowance for *Finding #1-Incorrect Servicing Provider on Claim* was subtracted from the total sample overpayment and added to the Meanpoint Estimate and the Lower Confidence Limit. The dollars associated with this finding were not used in the extrapolation.

SOUNDVIEW HEALTH CENTER
Audit Number: 08-3883
Audit Period: 1/1/2004 to 12/31/2007

Summary of Findings

Finding Description	Total Cases with Error	Total Services	Total \$ Disallowance	Exhibit
Incorrect Servicing Provider on Claim	90	91	\$9,689.27	II
Medical Entry Not Signed	3	4	\$456.28	III
Missing Documentation	3	3	\$367.16	IV
No EOB for Medicare Covered Services	3	<u>3</u>	<u>\$365.84</u>	V
		<u>101</u>	<u>\$10,878.55</u>	

SOUNDVIEW HEALTH CENTER

Provider Number: [REDACTED]

Audit Number: 08-3883

Exhibit: II

Page 1 of 5

Incorrect Servicing Provider on Claim

Sample #	Date of Service	Proc/Rate Code	Amount Disallowed
2	11/17/2005	1610	\$35.64
6	1/18/2005	1610	\$120.31
8	9/22/2004	1610	\$114.07
9	11/17/2004	1610	\$117.01
12	12/21/2004	1610	\$117.01
15	4/4/2006	1610	\$35.93
17	10/23/2007	1610	\$134.61
18	11/23/2004	1610	\$120.01
19	11/2/2004	1610	\$117.01
22	2/19/2004	1610	\$34.21
23	10/5/2002	1610	\$31.17
24	11/23/2004	1610	\$31.75
27	10/19/2007	1610	\$131.61
30	3/8/2005	1610	\$120.31
31	6/25/2004	1610	\$117.07
37	6/23/2005	1610	\$32.41
38	6/3/2004	1610	\$28.81
39	1/12/2006	1610	\$38.40
40	2/27/2004	1610	\$114.07
41	5/18/2005	1610	\$32.41
42	10/21/2005	1610	\$35.64
46	7/28/2005	1610	\$120.31

SOUNDVIEW HEALTH CENTER

Provider Number: [REDACTED]

Audit Number: 08-3883

Exhibit: II

Page 2 of 5

Incorrect Servicing Provider on Claim

Sample #	Date of Service	Proc/Rate Code	Amount Disallowed
47	9/27/2004	1610	\$28.81
50	4/14/2006	1610	\$129.30
54	12/27/2004	1610	\$120.01
55	12/9/2005	1610	\$123.54
56	3/30/2005	1610	\$120.31
60	9/15/2006	1610	\$126.30
61	1/22/2007	1610	\$132.30
64	12/3/2004	1610	\$120.01
66	1/6/2004	1610	\$31.21
68	1/27/2004	1610	\$114.07
72	6/21/2004	1610	\$114.07
73	12/5/2005	1610	\$123.54
74	8/12/2004	1610	\$114.07
76	5/4/2006	1610	\$126.30
78	2/23/2004	1610	\$117.07
79	4/19/2004	1610	\$117.07
81	12/19/2005	1610	\$123.54
84	4/9/2005	1610	\$35.41
85	9/22/2005	1610	\$123.31
86	2/23/2006	1610	\$126.30

SOUNDVIEW HEALTH CENTER

Provider Number: [REDACTED]

Audit Number: 08-3883

Exhibit: II

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Incorrect Servicing Provider on Claim

Sample #	Date of Service	Proc/Rate Code	Amount Disallowed
87	10/20/2004	1610	\$31.75
88	3/30/2005	1610	\$120.31
89	6/18/2004	1610	\$114.07
90	1/3/2005	1610	\$123.31
91	10/14/2004	1610	\$117.01
97	3/16/2006	1610	\$126.30
99	6/7/2006	1610	\$126.30
102	8/30/2006	1610	\$35.93
103	1/25/2007	1610	\$129.30
105	8/16/2006	1610	\$126.30
107	11/17/2005	1610	\$123.54
110	6/8/2005	1610	\$123.31
115	12/22/2004	1610	\$120.01
116	5/7/2004	1610	\$114.07
118	7/19/2005	1610	\$123.31
122	7/30/2004	1610	\$114.07
125	4/14/2004	1610	\$117.07
127	3/9/2007	1610	\$129.30
129	9/16/2005	1610	\$123.31
130	8/1/2006	1610	\$35.93

SOUNDVIEW HEALTH CENTER

Provider Number: [REDACTED]

Audit Number: 08-3883

Exhibit: II
Page 4 of 5

Incorrect Servicing Provider on Claim

Sample #	Date of Service	Proc/Rate Code	Amount Disallowed
133	7/6/2004	1610	\$114.07
135	4/19/2005	1610	\$32.41
136	9/9/2005	1610	\$120.31
138	3/29/2006	1610	\$126.30
139	8/23/2005	1610	\$32.41
142	10/26/2004	1610	\$31.75
146	9/15/2006	1610	\$129.30
148	6/15/2005	1610	\$120.31
150	3/2/2005	1610	\$123.31
153	9/18/2006	1610	\$126.30
154	10/24/2007	1610	\$131.61
156	7/24/2006	1610	\$126.30
159	5/16/2006	1610	\$129.30
160	12/15/2004	1699	\$220.34
161	5/10/2004	1610	\$117.07
162	3/11/2005	1610	\$123.31
164	1/3/2007	1610	\$129.30
167	8/6/2004	1610	\$114.07
173	4/13/2006	1610	\$129.30
174	1/16/2007	1610	\$129.30
176	5/17/2004	1610	\$114.07

SOUNDVIEW HEALTH CENTER
Provider Number: [REDACTED]
Audit Number: 08-3883

Exhibit: II
Page 5 of 5

Incorrect Servicing Provider on Claim

Sample #	Date of Service	Proc/Rate Code	Amount Disallowed
177	7/22/2004	1610	\$114.07
182	4/5/2005	1610	\$120.31
188	8/27/2005	1610	\$120.31
192	11/20/2006	1610	\$394.01
193	5/25/2004	1610	\$114.07
195	7/20/2006	1610	\$126.30
197	12/22/2005	1610	\$35.64
200	9/19/2005	1610	<u>\$123.31</u>
Total Services:	91		<u>\$9,689.27</u>

SOUNDVIEW HEALTH CENTER

Provider Number: [REDACTED]

Audit Number: 08-3883

Exhibit: III

Page 1 of 1

Medical Entry Not Signed

Sample #	Date of Service	Proc/Rate Code	Amount Disallowed
1	1/6/2004	1610	\$114.07
101	3/31/2004	1610	\$114.07
134	6/7/2004	1610	\$114.07
141	6/3/2004	1610	\$114.07
Total Services:	4		<u>\$456.28</u>

SOUNDVIEW HEALTH CENTER
Provider Number: [REDACTED]
Audit Number: 08-3883

Exhibit: IV
Page 1 of 1

Missing Documentation

<u>Sample #</u>	<u>Date of Service</u>	<u>Proc/Rate Code</u>	<u>Amount Disallowed</u>
63	8/5/2005	1610	\$120.31
168	2/4/2005	1610	\$123.31
194	10/24/2005	1610	\$123.54
Total Services:	<u>3</u>		<u>\$367.16</u>

SOUNDVIEW HEALTH CENTER
Provider Number: [REDACTED]
Audit Number: 08-3883

Exhibit: V
Page 1 of 1

No EOB for Medicare Covered Services

Sample #	Date of Service	Proc/Rate Code	Amount Disallowed
92	2/22/2005	1610	\$120.31
180	1/27/2004	1610	\$119.23
183	1/7/2006	1610	<u>\$126.30</u>
Total Services:	<u>3</u>		<u>\$365.84</u>

SOUNDVIEW HEALTH CENTER

Provider Number: [REDACTED]

Audit Number: 08-3883

Audit Period: 1/1/2004 to 12/31/2007

Exhibit: VI

Page 1 of 1

Additional Findings Pertaining to Sampled Items

Sample #	Date of Service	Primary Finding	Other Findings Pertaining to Sampled Item
92	2/22/2005	No EOB for Medicare Covered Services	Incorrect Servicing Provider on Claim
101	3/31/2004	Medical Entry Not Signed	Threshold Visit Billed for Non-Reimbursable Service
134	6/7/2004	Medical Entry Not Signed	Review of Plan of Care for Rehabilitation Services Not Completed
183	1/7/2006	No EOB for Medicare Covered Services	Incorrect Servicing Provider on Claim