



STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
221 South Warren Street, Suite 410
Syracuse, New York 13202

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

May 7, 2012

[REDACTED]
Fulton City School District
167 South Fourth Street
Fulton, New York 13069

Re: Final Audit Report
Audit #: 10-2679

Dear [REDACTED]:

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

In the attached final audit report, the OMIG has detailed our objectives 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 February 18, 2011. The mean point estimate overpaid is \$196,472.00. The lower confidence limit of the amount overpaid is \$111,744.00. 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 \$111,744.00.

[REDACTED]
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May 7, 2012

If the Fulton City School District has any questions or comments concerning this final audit report, please contact [REDACTED] at [REDACTED] or through email at [REDACTED]. Please refer to report number 10-2679 in all correspondence.

Sincerely,

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

cc: [REDACTED]
Enclosure

CERTIFIED MAIL #: [REDACTED]
RETURN RECEIPT REQUESTED



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

REVIEW OF FULTON CITY SCHOOL DISTRICT
CLAIMS FOR SCHOOL SUPPORTIVE HEALTH SERVICES
PROGRAM SERVICES
PAID FROM
JANUARY 1, 2009 – DECEMBER 31, 2009

FINAL AUDIT REPORT

James C. Cox
Medicaid Inspector General

May 7, 2012

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 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 Fulton City School District's claims for Medicaid reimbursement for School Supportive Health Services Program complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to (Preschool) School Supportive Health Services Program, our audit covered services paid by Medicaid from January 1, 2009, through December 31, 2009.

SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM COMPLIANCE AGREEMENT

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

transportation, medical evaluations, targeted case management services, initial individual education plan (IEP), triennial evaluations, annual IEP, requested or interim 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 \$29,182.44 in Medicaid payments. Of the 100 claims in our random sample, 14 claims had at least one error and did not comply with state requirements. Of the 14 noncompliant claims, 3 contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
No Documentation Services Provided Under the Direction of a SLP	7
No Written Referral for Evaluation	3
No Signed, Dated Evaluation Report	3
No Documentation of Group Size or Group Size Exceeded Five Students	3
No Documentation of Two Services During Month	1
No Signed Service Report	1
No Documentation that the Contacts Meet the SSHSP Criteria	1
Service Encounter Records do not Substantiate the Related Health Services Rendered that Month	1

Based on the procedures performed, the OMIG has determined the Fulton City School District was overpaid \$5,320.13 in sample overpayments with an extrapolated point estimate of \$196,472.00. The lower confidence limit of the amount overpaid is \$111,744.00.

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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, and Part 200 of the Regulations of the Commissioner of the New York State Education Department.

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 evaluations, annual IEP, requested or interim 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 Fulton City School District's claims for Medicaid reimbursement for School Supportive Health Services Program 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 Fulton City School District for School Supportive Health Services Program services paid by Medicaid from January 1, 2009, through December 31, 2009. Our audit universe consisted of 3,693 claims totaling \$1,032,674.51.

During our audit, we did not review the overall internal control structure of the Fulton City School District. 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 management personnel at the Fulton City School District to gain an understanding of the School Supportive Health Services Program;
- ran computer programming application of claims in our data warehouse that identified 3,693 paid School Supportive Health Services Program claims, totaling \$1,032,674.51;
- selected a random sample of 100 claims from the population of 3,693 claims; and,
- estimated the overpayment paid in the population of 3,693 claims.

In determining the propriety of the claims for the sample selection, the following documents were inspected, where applicable and/or available:

- Medicaid electronic claim information
- Individualized Education Program (IEP)
- CSE Meeting Minutes
- Invitation to parent/guardian to attend a CSE meeting and notification of the outcome
- Any additional documentation deemed by the Fulton City School District necessary to substantiate the Medicaid paid claim

Each Medicaid claim in the sample was compared to the corresponding documentation in the recipient's record to ascertain the propriety of services paid. Additional supportive documentation was requested as necessary.

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.
- 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)

DETAILED FINDINGS

The OMIG's review of Medicaid claims paid to the Fulton City School District from January 1, 2009, through December 31, 2009, identified 14 claims with at least one error, for a total sample overpayment of \$5,320.13 (Attachment C).

Sample Selection

1. **No Documentation Services Provided Under the Direction of a Speech Language Pathologist** 27, 35, 47, 62, 66, 87, 100

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

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

Documentation Requirements for "Under the Direction Of" 2. Signed statement by the SLP with license # ~~or ASHA certification~~ (updated 2/6/07) listing the TSHH for whom direction is being provided as well as a statement of how accessibility will be provided. Examples of this are: team meetings, access by telephone on a scheduled basis, regularly scheduled meetings with teachers, sign-off on progress notes, or any other method where accessibility is demonstrated. This documentation should be on file in the school district or county office.

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

In 7 instances pertaining to 6 patients, the signature and signature date by the SLP on the Under the Direction Of (UDO) Service Log was not contemporaneous.

2. **No Written Referral for Evaluation** 27, 66, 87

Effective July 1, 1998 a **written medical referral** signed by a physician, physician's assistant or nurse practitioner ~~or NYS licensed and/or ASHA certified~~ (updated 2/6/07) SLP is required for a **formal speech evaluation only**, dated on or before the

initiation of the evaluation. **A formal evaluation requires parental permission each time it is conducted.** An assessment does not require a medical referral. A speech referral is any document that indicates that the child should be reviewed for need of speech services signed and dated by an appropriate health practitioner. A speech referral may include multiple students (a manageable list is acceptable).

Formal Evaluation

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

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

*Update # 6, page 15
42 CFR 440.110*

In 3 instances pertaining to 2 patients, a referral from a SLP, Physician, Physician's Assistant, or Nurse Practitioner for a formal speech evaluation was not provided.

3. No Signed, Dated Evaluation Report

27, 66, 87

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

Sample Selection

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

*Update # 6, page 15
42 CFR 440.110*

In 3 instances pertaining to 2 patients, a formal speech evaluation with test results was not provided.

4. No Documentation of Group Size or Group Size Exceeded Five Students 3, 4, 54

Regulations state, "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 or specialist except that, in the city school district of the city of New York, the commissioner shall allow a variance of up to 50 percent rounded up to the nearest whole number from the maximum of five students per teacher or specialist."

*8 NYCRR Section 200.6 (e) (3)
New York Codes, Rules and Regulations*

In 3 instances pertaining to 3 patients, no documentation of group size was provided

5. No Documentation of Two Services During Month 18

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

18 NYCRR Section 504.3

In 1 instance, the claim was based on three services provided during the month; the patient was absent on one of the claimed dates of service, and the therapist was absent part of another of the dates of

service. Insufficient documentation was provided to substantiate when the service occurred on the day the therapist was partially absent.

6. No Signed Service Report

44

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

Update # 6, page 13

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

18 NYCRR Section 517.3(2)

In 1 instance, no signature was found on the service report.

7. No Documentation of 2 Contacts per Month

75

The Medicaid Claiming/Billing Handbook states, "The service coordinator or case manager must document all contacts relating to service coordination. The contact notes will serve as documentation that the service was provided. (See examples on Page 34)."

Update # 6, page 33

In 1 instance, the Service Coordinator's signatures for the contact notes were not contemporaneous.

8. Service Encounter Records do not Substantiate the Related Health Services Rendered that Month 98

The Medicaid Claiming/Billing Handbook states, "Provider attendance sheets for the Medicaid covered service other than the transportation must be on file".

Update #6, page 27

In 1 instance, the provided bus attendance logs substantiated only two of the five round-trip services.

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 \$111,744.00, 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


If within 20 days, you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to recover payment and liquidate the lower confidence limit amount, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of \$196,472.00. 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.

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

FULTON CITY SCHOOL DISTRICT
167 SOUTH FOURTH STREET
FULTON, NEW YORK 13069

PROVIDER ID #: [REDACTED]

AUDIT #:10-2679

SCHOOL SUPPORTIVE
HEALTH SERVICES
PROGRAM

PROVIDER
 RATE
 PART B
 OTHER

AMOUNT DUE: \$111,744.00

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 1237
File #: 10-2679
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN AND METHODOLOGY

Our sample design and methodology are as follows:

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

SAMPLE RESULTS AND ESTIMATES

Universe Size	3,693
Sample Size	100
Sample Book Value	\$29,182.44
Sample Overpayments	\$5,320.13
Net Financial Error Rate	18.2%
Mean Dollars in Error	\$53.20
Standard Deviation	140.12
Point Estimate of Total Dollars	\$196,472.00
Confidence Level	90%
Lower Confidence Limit	\$111,744.00

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 FULTON CITY SCHOOL DISTRICT
 REVIEW OF SAMPLE SELECTION
 PROJECT NUMBER: 10-2679
 REVIEW PERIOD: 01/01/2009 - 12/31/2009

Sample Number	Date of Service	Rate Code		Amount		Over Payment	1. No Documentation Services Provided UDC a SLP	2. No Written Referral for Evaluation	3. No Signed, Dated Evaluation Report	4. No Documentation of Group Size or Group Size Exceeded Five Students	5. No Documentation of Two Services During Month	6. No Signed Service Report	7. No Documentation of 2 Contacts per Month	8. Service Encounter Records do not Substantiate the Related Health Services Rendered that Month
		Billed	Derived	Paid	Derived									
76	12/01/08	5496	5496	\$227.10	\$227.10	-								
77	03/01/09	5493	5493	\$492.00	\$492.00	-								
78	06/01/09	5495	5495	\$100.00	\$100.00	-								
79	02/01/09	5495	5495	\$100.00	\$100.00	-								
80	03/01/09	5326	5326	\$432.00	\$432.00	-								
81	06/01/09	5328	5328	\$430.00	\$430.00	-								
82	11/01/08	5326	5326	\$432.00	\$432.00	-								
83	01/01/09	5328	5328	\$430.00	\$430.00	-								
84	05/01/09	5492	5492	\$265.00	\$265.00	-								
85	04/01/09	5495	5495	\$100.00	\$100.00	-								
86	12/01/08	5494	5494	\$520.00	\$520.00	-								
87	04/01/08	5326	-	\$432.00	\$0.00	432.00	X	X	X					
88	05/01/09	5495	5495	\$100.00	\$100.00	-								
89	11/01/08	5495	5495	\$100.00	\$100.00	-								
90	04/01/09	5330	5330	\$422.00	\$422.00	-								
91	06/01/09	5326	5326	\$432.00	\$432.00	-								
92	06/01/09	5495	5495	\$100.00	\$100.00	-								
93	12/01/08	5495	5495	\$100.00	\$100.00	-								
94	03/01/09	5326	5326	\$432.00	\$432.00	-								
95	02/01/09	5495	5495	\$100.00	\$100.00	-								
96	06/01/09	5495	5495	\$100.00	\$100.00	-								
97	05/01/09	5495	5495	\$100.00	\$100.00	-								
98	02/01/09	5496	5496	\$113.55	\$45.42	68.13								X
99	04/01/09	5326	5326	\$432.00	\$432.00	-								
100	03/01/09	5326	-	\$432.00	\$0.00	432.00	X							
				\$29,182.44	\$23,862.31	\$ 5,320.13	7	3	3	3	1	1	1	1