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

REVIEW OF AIM SERVICES, INC
CLAIMS FOR TRAUMATIC BRAIN INJURY SERVICES
PAID FROM
OCTOBER 1, 2004 – DECEMBER 31, 2008

FINAL AUDIT REPORT

James G. Sheehan
Medicaid Inspector General

November 17, 2010

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

DAVID A. PATERSON
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

November 17, 2010

[redacted]
Aim Services, Inc.
3257 Route 9
Saratoga Springs, NY 12866-6203

Re: Final Audit Report
Audit #: 10-2060

Dear [redacted]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Aim Services, Inc" (Aim Services) paid claims for traumatic brain injury services covering the period October 1, 2004 through December 31, 2008.

In the attached final 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 audit report incorporates consideration of any additional documentation and information presented in response to the draft report dated September 15, 2010. The mean point estimate overpaid is $436,960. The lower confidence limit of the amount overpaid is $330,760. 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 $330,760.

If Aim Services has any questions or comments concerning this report, please contact [redacted] at [redacted] or through email at [redacted]
Please refer to report number 10-2060 in all correspondence.

Sincerely,

[redacted]
Director of Provider Audit
Bureau of Fee for Service Audit
Office of the Medicaid Inspector General

[redacted]
Enclosure

CERTIFIED MAIL #[redacted]
RETURN RECEIPT REQUESTED

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 ensure 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 ensure 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 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] and the Medicaid Provider Manuals.

The Home and Community Based Services Waiver for Traumatic Brain Injury (HCBS/TBI) is administered by the New York State Department of Health (DOH) through the Regional Resource Development Centers (RRDC) and Specialists (RRDS) who serve specific counties throughout the State. Waiver services are available to persons with traumatic brain injury who meet certain eligibility criteria. The Waiver uses Medicaid funding to provide support and services to assist an individual with a traumatic brain injury (TBI) toward successful inclusion in the community. The services focus on the community repatriation of New York State TBI individuals who may reside in high cost institutionalized settings or choose to participate in the waiver to prevent institutional placement. The Waiver is funded under the Medicaid Program and the costs are shared by the Federal, State and local governments.

The HCBS/TBI Waiver Provider is generally subject to Title XIX of the Federal Social Security Act and Article 27-CC of the New York State Public Health Law. The specific standards and criteria for HCBS/TBI waiver services are outlined in The HCBS/TBI Provider Manual, the MMIS Provider Manual, various administrative directives issued by the Department, and the contractual agreement with the Department for the HCBS/TBI Waiver. The HCBS/TBI Provider Manual also provides program guidance for claiming Medicaid reimbursement for TBI services.

OBJECTIVE AND SCOPE

The objective of our audit was to ensure Aim Services' compliance with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to traumatic brain injury services, our audit covered services paid by Medicaid from October 1, 2004 through December 31, 2008.

SUMMARY OF FINDINGS

We inspected a random sample of 100 services with $18,020.45 in Medicaid payments. Of the 100 services in our random sample, forty-five services had at least one error and did not comply with state requirements. Of the 45 noncompliant services, some contained more than one deficiency. Specifics are as follows:

Error Description	Number of Errors
No Documentation of Service	16
Billed More Hours than Documented	16
TBI Training Not Completed – Home and Community Support Services	10
TBI Training Not Completed – Independent Living Skills Training and Development Staff	9
Partial Service Hours Were Billed Incorrectly	3
Billed Service Not Included in Service Plan	1

Based on the procedures performed, the OMIG has determined Aim Services was overpaid $5,792.15 in sample overpayments with an extrapolated point estimate of $436,960. The lower confidence limit of the amount overpaid is $330,760.

TABLE OF CONTENTS

	PAGE
INTRODUCTION	
Background	
Medicaid Program	1
New York State's Medicaid Program	1
New York State's Home and Community Based Services Traumatic Brain Injury Waiver Program	1
Objective, Scope, and Methodology	
Objective	2
Scope	2
Methodology	2-3
LAWS, REGULATIONS, RULES AND POLICIES	4-5
DETAILED FINDINGS	6-10
PROVIDER RIGHTS	11
REMITTANCE ADVICE	
ATTACHMENTS:	
A – SAMPLE DESIGN AND METHODOLOGY	
B – SAMPLE RESULTS AND ESTIMATES	
C – DETAILED AUDIT FINDINGS	

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 traumatic brain injury service 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 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] and the Medicaid Provider Manuals.

New York State's Home and Community Based Services Traumatic Brain Injury Waiver Program

The Home and Community Based Services Waiver for Traumatic Brain Injury (HCBS/TBI) is administered by the New York State Department of Health (DOH) through the Regional Resource Development Centers (RRDC) and Specialists (RRDS) who serve specific counties throughout the State. Waiver services are available to persons with traumatic brain injury who meet certain eligibility criteria. The Waiver uses Medicaid funding to provide support and services to assist an individual with a traumatic brain injury (TBI) toward successful inclusion in the community. The services focus on the community repatriation of New York State TBI individuals who may reside in high cost institutionalized settings or choose to participate in the waiver to prevent institutional placement. The Waiver is funded under the Medicaid Program and the costs are shared by the Federal, State and local governments.

The HCBS/TBI Waiver Provider is generally subject to Title XIX of the Federal Social Security Act and Article 27-CC of the New York State Public Health Law. The specific standards and criteria for HCBS/TBI waiver services are outlined in The HCBS/TBI Provider Manual, the MMIS Provider Manual, various administrative directives issued by the Department, and the contractual agreement with the Department for the HCBS/TBI Waiver. The HCBS/TBI Provider Manual also provides program guidance for claiming Medicaid reimbursement for TBI services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to ensure Aim Services' compliance 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 Aim Services for traumatic brain injury services paid by Medicaid from October 1, 2004, through December 31, 2008. Our audit universe consisted of 7,544 claims totaling $1,514,049.21.

During our audit, we did not review the overall internal control structure of Aim Services. 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 Aim Services management personnel to gain an understanding of the Home and Community Based Services Traumatic Brain Injury Waiver program;
- ran computer programming application of claims in our data warehouse that identified 7,544 paid traumatic brain injury service claims, totaling $1,514,049.21;
- selected a random sample of 100 services from the population of 7,544 services; and,
- estimated the overpayment paid in the population of 7,544 services.

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

- Medicaid electronic claim information
- Patient record, including, but not limited to:
    - Notice Of Decisions (NOD's)
    - Initial/Revised Service Plans (ISP's/RSP's), and Addendums
    - Individual Service Reports (ISR's)
    - Case/Progress Notes

- Staff Qualifications and Training Files
- Training Manuals
- Payroll Records
- Federal Form 990
- Any additional documentation deemed by Aim Services 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:

- Department of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].

- Medicaid Management Information System and eMedNY Provider Manual.

- Specifically, HCBS/TBI Waiver Provider Manual, HCBS/TBI Waiver Program Manual (June 2006), and applicable DOH Medicaid Updates

-

- 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)*

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 Aim Services from October 1, 2004 through December 31, 2008 identified 45 claims with at least one error, for a total sample overpayment of $5,792.15 (Attachment C).

Sample Selection

1. No Documentation of Service

1, 5, 23, 29, 36, 50, 52, 57, 62, 79, 85, 86, 87, 88, 90, 97

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..."

The DOH Medicaid Update states: "all Medicaid claims for reimbursement must be supported with a record of services provided. At a minimum, this should include: the participant's name; the date of service; the start and end time of each session; a description of the activities performed during the session; and the participant's service plan goals that are being worked on and the participant's progress toward attaining those goals."

The HCBS/TBI Waiver Provider Manual states: "Providers of HCBS/TBI waiver services... shall maintain adequate records which include:... billing records which reflect the date service was provided, who provided the service, and where and when it was provided."

The HCBS/TBI Waiver Program Manual states: "Record keeping to document Medicaid billing is required of all Medicaid providers. The need to maintain the necessary records is discussed in the Provider Agreement, the eMedNY Provider Manual and in this Program Manual. It is the responsibility of the provider to have clear and accurate documentation to support all Medicaid claims."

18 NYCRR Section 504.3(a);
DOH Medicaid Update January 2005, Vol. 20, No. 1;
HCBS/TBI Waiver Provider Manual – Page 65, Section D(2); and
HCBS/TBI Waiver Program Manual Effective June 2006 – Page 78

In 16 instances pertaining to 8 participants, the services were not documented. Of these services, we found in 14 instances pertaining to 8 participants, Home and Community Support Services (HCSS) were not documented. In 2 instances pertaining to 2 participants, Independent Living Skills Training (ILST) and Development services were not documented.

Sample Selection

2. Billed More Hours than Documented

3, 4, 9, 11, 24, 27, 28, 49, 68, 74, 77, 80, 82, 93, 96, 100

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..."

The DOH Medicaid Update states: "all Medicaid claims for reimbursement must be supported with a record of services provided. At a minimum, this should include: the participant's name; the date of service; the start and end time of each session; a description of the activities performed during the session; and the participant's service plan goals that are being worked on and the participant's progress toward attaining those goals."

The HCBS/TBI Waiver Provider Manual states: "Providers of HCBS/TBI waiver services... shall maintain adequate records which include:... billing records which reflect the date service was provided, who provided the service, and where and when it was provided."

18 NYCRR Section 504.3(a);
DOH Medicaid Update January 2005, Vol. 20, No. 1; and
HCBS/TBI Waiver Provider Manual – Page 65, Section D(2)

In 16 instances pertaining to 4 participants, the number of Home and Community Support Service (HCSS) hours billed exceeded the number of hours provided as documented in the Agency's records.

3. TBI Training Not Completed – Home and Community Support Services

3, 7, 33, 51, 66, 74, 88, 90, 93, 100

The HCBS/TBI Waiver Provider Manual states: "The individual who provides these services must: (1) Be at least 18 years old; (2) Be able to follow written and verbal instructions; (3) Have the ability and skills necessary to meet the waiver participant's needs which are to be addressed through this service; (4) Complete training concerning traumatic brain injury. This training will be provided by the agency employing this individual and will be completed prior to the provision of the service."

Sample Selection

The HCBS/TBI Waiver Program Manual states: "There are three components of required training for Waiver Service Providers: (1) Basic Orientation Training, (2) Service Specific Training, and (3) Annual Training. An approved provider agency is responsible for: developing a written training curriculum to meet the requirements identified in this section, ensuring that individuals providing the training meet the qualifications specified in this section; providing Basic Orientation Training and the appropriate Service Specific Training to all waiver providers prior to any unsupervised contact with a waiver participant; providing required annual training to all service providers; and documenting all training in the employee file, including all related TBI training, seminars and conferences attended, whether offered by the provider or other entities."

The HCBS/TBI Waiver Program Manual states: "All HCBS/TBI waiver service provider agencies are required to provide to their staff annual training which includes, at a minimum, the following information: 1. HCBS/TBI Incident Reporting Policy; 2. Review of all new policies and/or procedures required by the HCBS/TBI waiver; 3. Review of HCBS/TBI Participant Rights and Responsibilities; and 4. Additional topics relating to findings of satisfaction surveys, incident reports and additional training."

HCBS/TBI Waiver Provider Manual – Page 30; and
HCBS/TBI Waiver Program Manual Effective June 2006 – Page 84 & 90

In 10 instances pertaining to 5 participants, the Home and Community Support Services (HCSS) staff did not comply with the training requirements regarding the traumatic brain injury waiver.

4. TBI Training Not Completed – Independent Living Skills Training and Development Staff

20, 42, 44, 55, 56, 67, 81, 83, 95

The HCBS/TBI Waiver Program Manual states: "There are three components of required training for Waiver Service Providers: (1) Basic Orientation Training, (2) Service Specific Training, and (3) Annual Training. An approved provider agency is responsible for: developing a written training curriculum to meet the requirements identified in this section, ensuring that individuals providing the training meet the qualifications specified in this section; providing Basic Orientation Training and the appropriate Service Specific Training to all waiver providers prior to any unsupervised contact with a waiver participant; providing required annual training to all service providers; and documenting all training

in the employee file, including all related TBI training, seminars and conferences attended, whether offered by the provider or other entities."

The HCBS/TBI Waiver Program Manual states: "All HCBS/TBI waiver service provider agencies are required to provide to their staff annual training which includes, at a minimum, the following information: 1. HCBS/TBI Incident Reporting Policy; 2. Review of all new policies and/or procedures required by the HCBS/TBI waiver; 3. Review of HCBS/TBI Participant Rights and Responsibilities; and 4. Additional topics relating to findings of satisfaction surveys, incident reports and additional training."

HCBS/TBI Waiver Program Manual Effective June 2006 – Page 84 & 90

In 9 instances pertaining to 4 participants, the Independent Living Skills Training (ILST) and Development staff did not meet the training requirements as documented.

5. Partial Service Hours Were Billed Incorrectly 3, 90, 97

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."

The Medicaid Update states with regard to billing for TBI services: "Service of less than one hour should be carried forward to the next service date and combined to accumulate billable time in whole hours. This practice should be fully documented."

The HCBS/TBI Waiver Provider Manual states: "All Home and Community Support Services must be documented in the Service Plan, and provided by agencies approved as a provider of this waiver service by the State Department of Social Services. This service will be reimbursed on an hourly basis."

18 NYCRR, Section 518.1(c);
DOH Medicaid Update January 2005, Vol. 20, No. 1; and
HCBS/TBI Waiver Provider Manual - Page 29

In 3 instances pertaining to 3 participants, partial service hours for Home and Community Support Services (HCSS) were rounded up to the next whole hours rather than carried forward to the next service date.

6. Billed Service Not Included in Service Plan 20

The HCBS/TBI Waiver Program Manual states: "The waiver is a prior approval program. No services can be provided without written prior approval from the RRDS [Regional Resource Development Specialists]. Services provided without RRDS approval are not eligible for reimbursement."

The HCBS/TBI Waiver Program Manual states: "ILST must be provided by a DOH approved provider and must be included in the Service Plan to be reimbursed. ILST is provided on an individual, hourly basis…"

HCBS/TBI Waiver Program Manual Effective June 2006 – Page 36, 37, &51

In 1 instance, Independent Living Skills Training (ILST) and Development services were provided that were not included in the Service Plan.

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 $330,760, 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 report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[redacted]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 1237
Albany, New York 12237-0048

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 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 report, the OMIG will impose a 15% withhold after 20 days until the agreement is established.

Furthermore, the OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. The OMIG will notify you no later than 5 days after initiating such action. If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

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

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

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of $436,960. 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

NAME AND ADDRESS OF AUDITEE

[redacted]
Aim Services, Inc.
3257 Route 9
Saratoga Springs, NY 12866-6203

AMOUNT DUE: $330,760

PROVIDER ID # [redacted]

AUDIT #10-2060

AUDIT TYPE	[X] PROVIDER [ ] RATE [ ] PART B [ ] OTHER:

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

[redacted]
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 1237
File #10-2060
Albany, New York 12237-0048

Thank you for your cooperation.

Attachment "A"

SAMPLE DESIGN AND METHODOLOGY

Our sample design and methodology are as follows:

- Universe - Medicaid claims for traumatic brain injury services paid during the period October 1, 2004, through December 31, 2008.

- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Aim Services' claims for traumatic brain injury services paid during the period October 1, 2004, through December 31, 2008.

- Sample Unit - The sample unit is a Medicaid claim paid during the period October 1, 2004, through December 31, 2008.

- Sample Design – Simple sampling was used for sample selection.

- Sample Size – The sample size is 100 services.

- 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 Aim Services could not produce sufficient supporting documentation was treated as an error.

- Estimation Methodology – Estimates are based on the sample data using per unit estimates.

Attachment "B"

SAMPLE RESULTS AND ESTIMATES

Universe Size	7,544
Sample Size	100
Sample Book Value	$18,020.45
Sample Overpayments	$5,792.15
Net Financial Error Rate	32.14%
Mean Dollars in Error	$57.9215
Standard Deviation	85.37
Point Estimate of Total Dollars	$436,960
Confidence Level	90%
Lower Confidence Limit	$330,760