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COUNTY MANAGER
CAYUGA COUNTY

STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
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Syracuse, New York 13202

ANDREW M. CUOMO
GOVERNOR

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ACTING MEDICAID INSPECTOR GENERAL

September 8, 2011

Thomas G. Squires
Cayuga County Administrator
160 Genesee Street, 6th Floor
Auburn, New York 13021

Draft Audit Report

Audit #: 08-3044
Provider ID #: 00357268

Dear Mr. Squires:

This letter will serve as our draft audit report of the recently completed review of payments made to Cayuga County Community Services Board 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.

Outpatient mental health programs are offered at hospital-based, freestanding, or state operated Psychiatric Centers. The purpose of these programs is to diagnose and treat mentally ill adults and children on an ambulatory basis. There are four categories of outpatient programs: clinic treatment, continuing day treatment, intensive psychiatric rehabilitation treatment, and partial hospitalization. The specific standards and criteria for mental health clinics are outlined in Title 14 NYCRR Parts 579, 585, 587, 588, and Title 18 NYCRR Section 505.25. The MMIS Provider Manual for Clinics also provides program guidance for claiming Medicaid reimbursement for mental health clinic services.

A review of payments to Cayuga County Community Services Board for outpatient mental health services paid by Medicaid from January 1, 2006, through December 31, 2007, was recently completed. During the audit period, $6,457,070.37 was paid for services rendered to 1,681 patients. This review consisted of a random sample of 100 patients with Medicaid payments of $337,151.30. 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.

Cayuga County Community Services Board'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 $100,540.11.

The statistical sampling methodology employed allows for extrapolation of the sample findings to the universe of cases (18 NYCRR Section 519.18). The adjusted mean per unit point estimate of the amount overpaid is $710,672.00. The adjusted lower confidence limit of the amount overpaid is $285,981.00. We are 95% certain that the actual amount of the overpayment is greater than the adjusted lower confidence limit (Exhibit I).

The following detailed findings reflect the results of our audit and were presented to you at our exit conference. This audit report incorporates consideration of any additional documentation and information presented since that time.

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 therefor, 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. Improper Billing for Case Management Service

Regulations state, "Case management services are the process of linking the individual to the service system and monitoring the provision of services with the objective of continuity of care and service. Case management includes the following components: (i) Linking. The process of referring the individual to all required services and supports as specified in the individual service plan. (ii) Case-specific advocacy. The process of interceding on behalf of the individual to gain access to needed services and supports. (iii) Monitoring. The process of observing the individual to assure that needed services and supports are received."
14 NYCRR Section 587.4(c)(3)

Regulations also state, "Only covered services which are actually delivered to eligible recipients shall be reimbursed." *18 NYCRR Section 505.25(f)(1)*

In addition, "All reimbursable billings shall only be for a documented, definable medical service of face-to-face professional exchange between provider and client. . . ."
18 NYCRR Section 505.25(e)(5)

In 476 instances pertaining to 18 patients, medical records did not document a service meeting the definition of a case management service. In 476 instances, the medical record documented a transportation service only which did not meet the components of linking, case-specific advocacy, and monitoring. In 160 instances, the transportation services provided by the case manager involved transporting the client to scheduled medical appointments. In 170 instances, the transportation only services by the case manager involved personal errands such as grocery shopping, laundry, banking, appearing in Family Court, and appointments at housing agencies. We found 101 billings for collateral service that involved the case manger transporting the client as needed then babysitting the client's child(ren). In 45 instances, the case manager transported the client on a trip that involved both a scheduled medical appointment and a personal errand. This resulted in a sample overpayment of $61,746.59 (Exhibit II).

2. Missing Physician Signature on Treatment Plan

Regulations state, "The treatment plan shall include, . . . the signature of the physician involved in the treatment." *14 NYCRR Section 587.16(e)(1)*

In addition, "A periodic review of the treatment plan shall include . . . the signature of the physician involved in the treatment." *14 NYCRR Section 587.16(g)(5)*

In 109 instances pertaining to 19 patients, the treatment plan or review lacked the required physician signature. In 32 instances the treatment plan lacked the physician's signature. In addition, treatment plan reviews lacked a physician's signature in 77 instances. This resulted in a sample overpayment of $12,795.38 (Exhibit III).

3. <u>Missing Progress Note</u>

Regulations state: "Progress notes shall be recorded by the clinical staff member(s) who provided services to the recipient. Such notes shall identify the particular services provided and the changes in goals, objectives and services, as appropriate. Progress notes shall be recorded within the following intervals: (1) clinic treatment programs—each visit and/or contact; (2) continuing day treatment programs—at least every two weeks; and (3) partial hospitalization programs—each visit and/or contact." *14 NYCRR Section 587.16(f)*

In 81 instances pertaining to 29 patients, the required progress note was missing. This resulted in a sample overpayment of $9,535.46 (Exhibit IV).

4. <u>Missing Treatment Plan for Clinic Treatment Program</u>

Regulations state, "All services shall be delivered in accordance with a written individual treatment plan." *18 NYCRR Section 505.25(d)(2)*

In addition, regulations require that for clinic treatment programs, the treatment plan schedule is as follows: "The treatment plan...shall be developed prior to the fourth visit after admission or within 30 days of admission, whichever comes first. Review of the treatment plan shall be every three months. . . ." *14 NYCRR Section 588.6(g)*

In 57 instances pertaining to 15 patients, the medical record did not contain a treatment plan or required treatment plan review. In 7 instances the treatment plan was not found in the medical record, while in 50 instances the treatment plan review was missing. This resulted in a sample overpayment of $7,306.17 (Exhibit V).

5. <u>Claims Submitted Over 90 Days From the Date of Service</u>

Regulations state: "Claims for payment for medical care, services or supplies furnished by any provider under the medical assistance program must be initially submitted within 90 days of the date the medical care, services or supplies were furnished to an eligible person to be valid and enforceable against the department or a social services district, unless the provider's submission of the claims is delayed beyond 90 days due to circumstances outside of the control of the provider. Such circumstances include but are not limited to attempts to recover from a third-party insurer, legal proceedings against a responsible third-party or the recipient of the medical care, services or supplies or delays in the determination of client eligibility by the social services district. All claims submitted after 90 days must be accompanied by a statement of the reason for such delay and must be submitted within 30 days from the time submission came within the control of the provider, subject to the limitations of paragraph (3) of this subdivision. Also, any claim returned to a provider due to data insufficiency or claiming errors may be resubmitted by the provider upon proper completion of the claim in accordance with the claims processing requirements of the department within 60 days of the date of notification to the provider advising the provider of such insufficiency or invalidity. Any returned claim not correctly

resubmitted within 60 days or on the second resubmission is neither valid nor enforceable against the department or a social services district."

18 NYCRR Section 540.6(a)(1) and (2)

The MMIS Provider Manual states: "Medicaid regulations require that claims for payment of medical care, services, or supplies to eligible enrollees be initially submitted within **90 days of the date of service** to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider."

MMIS Provider Manual Information for All Providers
General Billing, Page 6

In 24 instances pertaining to 14 patients, the claims were submitted more than 180 days after the date of service without the valid use of an exception code as the reason for late submission of claims. Regulations require a claim to be submitted within 90 days of the date of service; however, the OMIG disallowed claims submitted more than 180 days after the date of service without supporting documentation. This is in keeping with general industry standards. This resulted in a sample overpayment of $2,814.71 (Exhibit VI).

6. **Incorrect Rate Code Billed**

Regulations provide, "State reimbursement shall be available, at fees approved by the New York State Director of the Budget, for ambulatory care for eligible recipients with mental illness. . . ." *18 NYCRR Section 505.25(h)(2)*

Regulations also state that reimbursement under the medical assistance program for non-State operated continuing day treatment programs licensed pursuant to article 31 of the Mental Hygiene Law and Part 587 of this Title shall be in accordance with the fee schedule detailed in Part 588. Such reimbursement shall be adjusted pursuant to Part 579.7 of this Title.

14 NYCRR Section 588.13(a)(3)

In 123 instances pertaining to 9 patients, the incorrect rate code was billed which resulted in higher reimbursement than indicated in the fee schedule for the proper rate code. This resulted in a sample overpayment of $1,406.24 (Exhibit VII).

7. **Insufficient Duration for Collateral Billings**

Regulations state, "Collateral visit: Shall be reimbursed for clinical support services of at least 30 minutes in duration of face-to-face interaction between one or more collaterals and one therapist with or without a recipient." *14 NYCRR Section 588.6(a)(5)*

In 8 instances pertaining to 7 patients, the duration of the collateral session was less than 30 minutes. This resulted in a sample overpayment of $928.60 (Exhibit VIII).

8. **No Documentation of Service**

Regulations require that the Medicaid provider agrees, "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years . . . all records necessary to disclose the nature and extent of services furnished. . . ." *18 NYCRR Section 504.3(a)*

Regulations 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 8 instances pertaining to 7 patients, patient records did not document a clinical service. This resulted in a sample overpayment of $825.45 (Exhibit IX).

9. Duration of Visit Not Documented

Regulations state, "Clinic treatment programs shall receive reimbursement for the following types of visits: (1) Brief visit: Shall be reimbursed for services of at least 15 minutes in duration but not more than 29 minutes of face-to-face interaction between one recipient and one therapist. (2) Regular visit: Shall be reimbursed for services of at least 30 minutes in duration of face to face interaction between one recipient and one therapist."

14 NYCRR Section 588.6(a)(1) and (2)

Regulations require that case records include the record and date of all on-site and off-site face to face contacts with the recipient, the type of service provided and the duration of the contact.

14 NYCRR Section 587.18(b)(7)

In 22 instances pertaining to 15 patients, the record did not indicate the duration of the visit. The regular clinic visit rate was reduced to a brief visit rate. This resulted in a sample overpayment of $733.14 (Exhibit X).

10. Excessive Preadmission Visit

Regulations require that "Reimbursement for preadmission visits shall be . . . limited to a maximum of three visits. . . ." *14 NYCRR Section 588.5(k)(4)*

In 4 instances pertaining to 2 patients, more than three preadmission visits were billed. This resulted in a sample overpayment of $543.26 (Exhibit XI).

11. No EOB for Medicare Covered Service

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 requires that 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 5 instances pertaining to 2 patients, no Explanation of Medical Benefits (EOB) was found for a Medicare eligible patient who received services covered by Medicare. This resulted in a sample overpayment of $530.66 (Exhibit XII).

12. No Documented Medical Service

Regulations state, "Only covered services which are actually delivered to eligible recipients shall be reimbursed." *18 NYCRR Section 505.25(f)(1)*

In addition, "All reimbursable billings shall only be for a documented, definable medical service of face-to-face professional exchange between provider and client. . . ."

18 NYCRR Section 505.25(e)(5)

In 3 instances pertaining to 2 patients, medical records did not document a medical service. In two instances the record stated the patient did not appear at the scheduled visit. The third instance involved a telephone call rather than a face-to face exchange. This resulted in a sample overpayment of $406.42 (Exhibit XIII).

13. <u>Brief Visit Billed as Regular Clinic Visit</u>

Regulations state, "Clinic treatment programs shall receive reimbursement for the following types of visits: (1) Brief visit: Shall be reimbursed for services of at least 15 minutes in duration but not more than 29 minutes of face-to-face interaction between one recipient and one therapist. (2) Regular visit: Shall be reimbursed for services of at least 30 minutes in duration of face-to-face interaction between one recipient and one therapist."

14 NYCRR Section 588.6(a)(1) and (2)

In 10 instances pertaining to 6 patients, a regular clinic visit rate was billed when a brief visit was documented. The regular clinic visit rate was reduced to a brief visit rate. This resulted in a sample overpayment of $334.12 (Exhibit XIV).

14. <u>No EOB for the Third Party Health Insurance Covered Service (Excluding Medicare)</u>

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 before submitting claims to Medicaid. The Manual also requires that 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 2 patients, no Explanation of Medical Benefits (EOB) was found for a patient who received services covered by third party health insurance. This resulted in a sample overpayment of $220.11 (Exhibit XV).

15. <u>Failure to Meet Preadmission Duration Requirements</u>

Regulations state, "Reimbursement for preadmission visits shall be . . . a minimum of 30 minutes for a clinic treatment program." *14 NYCRR Section 588.5(k)(1)*

In 2 instances pertaining to 2 patients, preadmission visits of less than 30 minutes were billed. This resulted in a sample overpayment of $200.32 (Exhibit XVI).

16. <u>Failure to Meet Group Clinic Visit Duration Requirements</u>

Regulations state, "Group therapy visits: shall be reimbursed for services of at least 60 minutes duration provided to from 2 to 12 recipients and a therapist(s)."

14 NYCRR Section 588.6(a)(4)

In 1 instance, a clinic group therapy visit of less than 60 minutes was billed. This resulted in a sample overpayment of $133.98 (Exhibit XVII).

17. Failure to Meet Minimum Duration Requirements

Regulations state, "Continuing day treatment visits shall be reimbursed on the basis of duration of hours provided as follows: (1) Reimbursement shall be provided for visits of at least one hour duration." *14 NYCRR Section 588.7(a)(1)*

In 4 instances pertaining to 3 patients, continuing day treatment visits of less than one hour were billed. This resulted in a sample overpayment of $79.50 (Exhibit XVIII).

Total sample overpayments for this audit amounted to $100,540.11.

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

This audit may be settled through repayment of the adjusted lower confidence limit amount, which has been reduced to reflect the Comprehensive Outpatient Program (COPS) and Community Service Program (CSP) allowances. As shown on Exhibit I, the amount due for an adjusted lower confidence limit settlement is $285,981.00. Settling at this amount will eliminate the need for an administrative action where the OMIG would seek and defend the adjusted meanpoint estimate of $710,672.00, which has also been reduced to reflect the COPS and CSP allowances. The final audit report will advise you of the repayment options.

Please note that the amount of the disallowance resulting from the OMIG's audit does not include any COPS/CSP related adjustments which may be recovered by the Office of Mental Health (OMH). (See Exhibit I, which shows COPS/CSP as a reduction to the amount disallowed by the OMIG). Any applicable COPS/CSP related adjustments that may result in disallowances will be reviewed by OMH and may result in an additional recovery.

As allowed by state regulations, we are giving you the opportunity to submit documentation and written arguments in objection to the determination and proposed action. Your submission must be sent to Terry Dulac at the above address within 30 days of receipt of this draft audit report. Receipt of this notice is presumed to be five days after the date of this draft audit report.

Your objections must include a written statement detailing the specific items in this draft audit report to which you object. Issues raised at administrative hearing will be limited to those contained in your objections. Your failure to submit, in a timely manner, documentation or written arguments in objection to this draft audit report, may, at the sole discretion of the OMIG's audit staff, result in the issuance of this draft audit report as the final agency action.

If you have any questions, or should you wish to make arrangements to settle this audit, please contact Terry Dulac at (315) 423-2039.

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

Sincerely,

James R. Kaiser, Director
Division of Medicaid Audit, Syracuse
Office of the Medicaid Inspector General

cc: Katherine O'Connell, Director – Cayuga County Department of Mental Health

CERTIFIED MAIL#: 7010 3090 0003 0689 0336
RETURNED RECEIPT REQUESTED

EXHIBIT I

CAYUGA COUNTY COMMUNITY SERVICES BOARD
OUTPATIENT MENTAL HEALTH SERVICES AUDIT
AUDIT #: 08-3044
AUDIT PERIOD: 01/01/06 - 12/31/07

EXTRAPOLATION OF SAMPLE FINDINGS

	SAMPLE OVERPAYMENTS	COPS/CSP BREAKOUT
Total Sample Overpayments	$ 49,188.01	$ 51,352.10
Less Overpayments Not Projected*	(7,348.42)	(6,723.36)
Sample Overpayments for Extrapolation Purposes	$ 41,839.59	$ 44,628.74
Patients in Sample	100	100
Overpayments Per Sampled Patient	$ 418.3959	$ 446.2874
Patients in Universe	1,681	1,681
Meanpoint Estimate	$ 703,324.00	$ 750,209.00
Add Overpayments Not Projected*	7,348.00	6,723.00
Adjusted Meanpoint Estimate	$ 710,672.00	$ 756,932.00
Lower Confidence Limit	$ 278,633.00	$ 305,348.00
Add Overpayments Not Projected*	7,348.00	6,723.00
Adjusted Lower Confidence Limit	$ 285,981.00	$ 312,071.00

* As discussed at our Exit Conference, the actual dollar disallowance for ***Finding # 2 – Missing Physician Signature on Treatment Plan, Finding # 9 – Duration of Visit Not Documented, and Finding # 10 – Excessive Preadmission Visit*** were subtracted from the total sample overpayment and added to the Meanpoint Estimate and the Lower Confidence Limit. The dollars associated with these findings were not used in the extrapolation. However, in future audits, disallowances for these findings will be extrapolated.