

# Compliance News

NYSARC, Inc.

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## Office of Medicaid Inspector General (OMIG) 2009-2010 Work Plan

The Office of Medicaid Inspector General (OMIG) released its 2009-2010 work plan on April 24, 2009. A copy of the complete work plan can be found on the OMIG's web page. Highlights from the work plan include:

- **Compliance Officers.** The OMIG states that it expects the Compliance Officer to (1) be a senior management position; (2) be afforded the support and assistance of the Board and senior management; (3) be provided adequate resources (staff & budget); and (4) granted access to relevant documents and other information. *Page 5.*
- **Board Oversight.** When the OMIG identifies a "significant compliance or control weakness" at a provider, the OMIG will look into the Board's actions in assuring that compliance systems are in place and whether the Board exercised reasonable oversight. In "appropriate circumstances" the OMIG may sanction individual members of the Board for significant failures to comply with their duties with respect to compliance and oversight. *Page 6.*
- **OMRDD.** OMRDD plans to conduct 124 field audits of voluntary providers. These field audits will be in addition to desk reviews of claims and audits/investigations conducted where a provider self discloses an issue or an issue is reported to OMRDD by an external source. OMRDD will also be conducting desk audits of At Home Residential Habilitation claims. In addition, for the first time, OMRDD will also be auditing its own DDSOs.

Specific areas of audit focus by the OMIG will be:

- o **Case Management.** The OMIG will be looking to ensure that (1) procedural requirements for the provision of services are met; (2) that services are billed correctly; and (3) providers have supporting documentation for units billed.
- o **Ninety - Day Billing Exceptions.** Claims for services must be submitted within 90 days of the date of service or discharge unless an exception applies. The OMIG will begin reviewing claims submitted after 90 days to determine if the claims were submitted with an invalid exception code. The review period will cover July 1, 2003 – December 31, 2005 and providers will be asked to supply documentation to support the claims more than 90 days old.

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**OMIG 2009-2010 Work Plan** *(Continued from Page 1)*

- o Waiver Services. The OMIG will conduct audits and reviews of providers identified by OMRDD as having failed a first stage Limited Fiscal Review audit. *Pages 33, 34, & 40.*
- Article 28 Clinics. The OMIG will look at documentation of services, coding, medical necessity, the qualifications of the service provider, whether claims for payment were submitted within 90 days, review plans of care for rehabilitation services and determine the appropriateness of payments for physical, speech and occupational therapy services. *Page 17.*
- Early Intervention. The OMIG believes that some children are receiving “excessive daily services” and some providers under contract with the county lack documentation to support their claims. The OMIG intends to separate EI claims into categories and audit a sample of claims delivered by the largest (in terms of claim volume) providers. If the OMIG audits reveal significant issues, the results will be turned over to the county(ies) for audits of additional providers.
- Traumatic Brain Injury Programs (TBI). TBI audits will include a look at issues such as lack of documentation for services, billing for TBI provider services not included in the service plan, billing for more hours than documented, service plans that have not been updated on a timely basis, and the provision of services by staff that do not have the necessary qualifications. The OMIG will also be reviewing claims submitted more than 90 days after the service was provided.
- Office of Mental Health. It is the policy of OMH to refer all matters relating to suspected Medicaid fraud, waste, or abuse to the OMIG for investigation. Topics of concern addressed in the work plan include:
  - o Clinic Restructuring.
  - o Continuing Day Treatment Reimbursement Methodology.
  - o Community Residence Rehab Services. Services will be reviewed for compliance with regulations relating to service authorization and adherence to program documentation and staffing requirements.
  - o Case Management. The OMIG will be looking to ensure that (1) procedural requirements for the provision of service are met; (2) that services are billed correctly; and (3) providers have supporting documentation for units billed.
  - o Ninety - Day Billing Exceptions. Claims for services must be submitted within 90 days of the date of service or discharge unless an exception applies. The OMIG will begin reviewing claims submitted after 90 days to determine if the claims were submitted with an invalid exception code. *Pages 29-32.*

**Did You Know?**

At one time or another, every provider has faced a situation where an individual receiving services refuses to participate or work on his/her program goal(s). In some cases these service refusals pose a problem for the provider who is undergoing a Limited Fiscal Review where the auditor wants to deny payment. During the course of disputing its draft Limited Fiscal Review findings, one Chapter received the following clarification on the service refusal issue:

*“For the first month that the consumer refuses multiple times, a specific service for the month, and the provider can show that an attempt or action took place to try and deliver that service, we will count those “failed service deliveries” toward the total countable days. If after the first month, if this repeated sequence of failed deliveries continues, we will not allow the “failed services” to count toward the countable days when services were delivered.”*

## Downstate HCBS/TBI Provider Faces Harsh Reality of Numbers by Extrapolation

In a recent audit by the NYS Office of the Medicaid Inspector General (OMIG), the Center for Family Support learned what others have previously and painfully discovered – the power of algorithmic sanctions.

The OMIG's Final Audit Report of January, 2009, summarizes the audit conducted last summer, covering the period 2005 through 2006. Two hundred claims, with total payments amounting to \$30,506.00, were selected for review.

Most of the citations listed in the report are, from a provider's standpoint, fairly benign and not indicative of deliberate fraud. Nine errors in billing were cited, as noted below.

1. Service Coordinator, in four instances, did not review the service plan within the six-month period. Overpayment: \$851.00
2. In eight instances staff did not document the program participant's progress toward their goals. Overpayment: \$874.80.
3. TBI/Waiver staff, in five instances, did not meet all of the Waiver standards required for ILST position. Overpayment: \$672.00.
4. ILST services are reimbursed on an hourly basis. The service time is not allowed to be "rounded up". If less than a billable claim is provided the previous service time may be added on to the next service. In four instances partial service hours were rounded up. Overpayment: \$101.10.
5. HCBS/TBI Waiver staff, in 3 instances, did not comply with the service plan (in regard to either the amount, frequency, duration or all). Overpayment: \$289.70.
6. HCBS/TBI Waiver provider, in one instance, did not have supporting documentation for all of the hours billed. Overpayment: \$194.70.
7. HCBS/TBI Waiver provider, in one instance, was unable to provide documentation for services that overlapped between two staff. Overpayment: \$35.40.
8. Either the start or the end time, in one instance, was not recorded. Overpayment: \$96.00.

Total overpayment from the universe of 200 claims reviewed:  
\$3,114.70.

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### Questions From the Field

**Question:** Our compliance plan calls for the Board of Directors to designate a member and an alternate to serve on the compliance committee. In reality, no Board member attends the meeting and is unlikely to unless I push the issue. I give face-to-face and written reports to the Board every month, so information is communicated.

Is there a requirement that a Board member serve on the compliance committee, or may I revise the policy to indicate that a Board designee will be named and copied with agendas and meeting minutes for each meeting whether they attend the meeting or not?

**Answer:** Having a Board member on the committee is a best practice that is indicative of top-level buy-in to a Chapter's compliance program. There is no legal requirement that a Board member attend compliance committee meetings. You may revise your policy to reflect that a designee will be named and kept informed. However, in general, and certainly in the current environment, it is not advisable to be a passive designee.

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## NYSARC, Inc.'s 2nd Annual Corporate Compliance Conference

On May 5, 2009, NYSARC, Inc. and Cerebral Palsy Association of NYS presented the 2<sup>nd</sup> Annual Conference for Providers Serving Individuals with Disabilities. Marc Brandt opened the conference titled: *Audits, Investigations & Self-Disclosures* and Robert Hussar, First Deputy, NYS OMIG, presented on *Trends in Medicaid Enforcement*. This was followed by two break-out sessions. Judy Trent, Nassau County Arc, and Laura Wells, Center for Disability Services, presented *Audits & Self-Disclosures*. Brian Flood, Managing Director, KPMG (formerly Texas Inspector General for Health & Human Services), presented *Federal Perspective: Regulatory and Enforcement Issues*.



The afternoon sessions commenced with Michael Koenig, Partner with Greenberg Traurig, presenting on *When the Government Comes Calling: How to Respond to Government Inquiries & Investigations*. Roy Snell, CEO, Health Care Compliance Association, concluded the conference with a presentation on compliance and ethics: *Leading Leadership – The Perfect Storm & The Compliance Profession*.

Conference speakers were invited based on their knowledge base, as well as relevance to our field. Additionally, some national speakers were invited in order to expose the attendees to compliance issues in related fields and of national significance.

Audience responses were very positive. More than fifty-six Arc staff attended with thirty-eight Chapters represented. In all, more than one hundred and seventy-six people attended the conference. Mr. Snell was amazed at the turnout and credited it to the organizers developing a professional product and attention to detail. He expressed how remarkable it was that so many people attended a conference on audits, investigations and disclosures. It was no doubt an opportunity for the CEO of a national compliance training and resource organization to learn about an industry that he had no experience with thus far.

## Downstate HCBS/TBI Provider Faces Harsh Reality... (Continued from page 3)

How does extrapolation work? As follows:

Sample overpayment divided by the universe times the total amount received as reimbursement for the universe of claims being reviewed, or

$3,114.70 \div 200 \times \$30,506 = \$475,085.00$  (called the Mean Point Average)

The OMIG does have a Lower Confidence Limit – in this case: \$294,091.00, which they offer as an option if none of their claims are disputed and the liability is paid within their scheduled time-frame. Payment or an agreed upon payment plan is due within 20 days of the final audit report.

Using this as a training tool may help Chapter employees understand why compliance officers appear to get hung up about “little things.” Using this formula, even in instance #7 (overpayment \$35.40) the Mean Point Average owed to the OMIG is \$5,400. One small error that results in a payback fifteen times the original error!

[http://www.omig.state.ny.us/data/images/stories/audit\\_reports/Batch22508mix/07-4084.pdf](http://www.omig.state.ny.us/data/images/stories/audit_reports/Batch22508mix/07-4084.pdf)

## Calculation of Interest on OMIG Recoveries

When a provider has been the subject of an OMIG audit, interest on any monetary recoveries will be assessed. In the very near future, interest will also be imposed on paybacks that result from OMRDD Limited Fiscal Reviews. Interest will be calculated in the following manner:

### From the Date of Overpayment to the Date of Notice of Audit Findings

Interest will be assessed beginning on the date of overpayment through the date of the final report; The rate of interest will be the prime rate and will adjust any changes to the prime rate over the period at issue;

If a random sample of claims is used for the audit, interest will be assessed from the end of the audit period to the date of the audit report;

If individual specified claims are used to calculate an overpayment (instead of a sample), interest will be calculated from the individual dates of payment to the date of the audit report; and

Interest will also be charged during the time period from the issuance of the draft audit report until the issuance of the final audit report.

### From the Date of Notice of Audit Findings to the Date of Repayment

If full repayment is made within 90 days of the final audit report, no additional interest will be imposed.

If full repayment is not made within 90 days, interest at the rate of prime plus two percentage points will be charged beginning on day 91.

## New York's Medicaid Fraud Control Unit Considered Top in the Nation

Attorney General Andrew M. Cuomo announced that New York's Medicaid Fraud Control Unit (NYMFCU) has been selected as the top Medicaid Fraud Control Unit in the country by the Department of Health and Human Services Office of the Inspector General (HHS-OIG) for 2008. According to NYMFCU's 2008 Annual Report, the Unit obtained nearly 150 convictions last year in cases of Medicaid provider fraud and patient abuse, recovering over \$263 million in civil damages and criminal restitution. In HHS-OIG's announcement of the honor, which is being awarded to NYMFCU for the first time ever during the more than thirty years the unit has been in existence, HHS-OIG noted that the NYMFCU obtained a "return of investment of approximately \$6.64 for every Federal dollar expended."

For full report: [http://www.oag.state.ny.us/media\\_center/2009/may/may6b\\_09.html](http://www.oag.state.ny.us/media_center/2009/may/may6b_09.html)



## Questions from the Field: *(Continued from Page 3)*

The purpose of Board participation and oversight arises from the need for good governance. Therefore, would the designee want to be in the position of "designee" if there is a major compliance inquiry? At such time it might carry little weight for a designee to state that their role was in fact perfunctory. In fairness to the designee this should be explained to him or her. From a compliance standpoint, we always recommend that Board members play an active role on the committee so that in times of crisis, not just in routine affairs, they have real knowledge of the issues and are able to respond appropriately.

**Question:** Our Executive Director received a call from a woman at the OMIG's office last Friday afternoon. She indicated that there will be a "routine" federal audit of one record from our agency. The Executive Director was told that the audit would be conducted by CMS or a contractor, Lavanta, and that we would be receiving a fax/letter from them regarding the audit. We have yet to receive the fax/letter and are not aware when the audit will be conducted. Is there anything that we should be doing prior to the audit? I'm assuming that we should determine a room in which they can conduct the audit, but other than that, is there anything that we should be doing to prepare? Are you familiar with this type of audit or Lavanta? Any advice/assistance you can provide would be greatly appreciated!

**Answer:** Don't worry, this is an easy one. It appears as if one of your Agency's claims has been selected for a "PERM" audit. PERM stands for Payment Error Rate Measurement and it is an audit where the Feds look at State Medicaid claims. A Medicaid claim from any type of provider may be randomly selected (e.g., hospital, pharmacy, DME, long term care, etc). You will receive a letter from the contractor, Lavanta, that asks for specific information. Some of the documents requested may not exist in our world, so you will provide the closest equivalent. Also, a PERM audit is a desk audit. You will be asked to send the information (most likely by fax) to a certain person or department. No one should show up in person at your agency. You will also be providing a copy of all of the information you send to Lavanta to the OMIG. If all goes well, you will not hear from Lavanta after your data has been submitted -in other words, you will not receive an audit report or results. No news is good news.

### "Quotes of the Quarter"

"The OMIG is particularly interested in two kinds of whistleblower cases; First, those in which the whistleblower can demonstrate that the issues which are the basis of the action was raised internally through a health care providers' existing compliance program, and not addressed. Secondly, those cases where a whistleblower raised the issues which are the basis of the action and was retaliated against by the employer or other employees." OMIG 2009-2010 Work Plan, page 56.

"Always do right--this will gratify some and astonish the rest." Mark Twain: Message to Young People's Society, Greenpoint Presbyterian Church, Brooklyn, New York, February 16, 1901.

