DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

MAR 25 2013

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson Daniel R. Levinson
Inspector General

SUBJECT: New York Improperly Claimed Medicaid Reimbursement for Family-Based Treatment Rehabilitation Services (A-02-10-01024)

Attached, for your information, is an advance copy of our final report on Medicaid Family-Based Treatment Rehabilitation Services in New York. We will issue this report to the New York State Department of Health within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through email at James.Edert@oig.hhs.gov. Please refer to report number A-02-10-01024.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION II
JACOB K. JAVITS FEDERAL BUILDING
26 FEDERAL PLAZA, ROOM 3900
NEW YORK, NY 10278

MAR 26 2013

Report Number: A-02-10-01024

Nirav R. Shah, M.D., M.P.H.
Commissioner
New York State Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Shah:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *New York Improperly Claimed Medicaid Reimbursement for Family-Based Treatment Rehabilitation Services.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at https://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Kevin W. Smith, Audit Manager, at (518) 437-9390, extension 232, or through email at Kevin.Smith@oig.hhs.gov. Please refer to report number A-02-10-01024 in all correspondence.

Sincerely,

James P. Edert

James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations (CMCHO)
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK IMPROPERLY CLAIMED MEDICAID REIMBURSEMENT FOR FAMILY-BASED TREATMENT REHABILITATION SERVICES

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Daniel R. Levinson
Inspector General

March 2013
A-02-10-01024

Office of Inspector General

https://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer Medicaid. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers Medicaid. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Section 1905(a)(13) of the Act authorizes optional rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

In New York State (the State), the Department of Health (State agency) administers Medicaid. The State elected to include, under a program administered by its Office of Mental Health (OMH), Medicaid coverage of family-based treatment (FBT) rehabilitation services provided to recipients between the ages of 5 and 19. FBT rehabilitation services include training and assistance with daily living skills; medication management; and socialization, counseling, family support, and health services.

State requirements for Medicaid reimbursement of FBT rehabilitation services state, in part, that: (1) providers must have at least 11 qualifying face-to-face contacts with the recipient for a monthly claim or 6 qualifying face-to-face contacts for a semimonthly claim; (2) each contact must be at least 15 minutes in duration; (3) an initial authorization for services must include a physician's face-to-face assessment of the recipient; (4) a physician must renew authorizations every 6 months and have a face-to-face contact with the recipient; (5) reauthorization for services must be based on a review of a summary of the recipient's 3-month service plan review or a review of the complete case record of the recipient; (6) authorized staff must record monthly progress notes based on daily logs that trained professional parents keep, and the service provider must review them weekly; (7) an eligible recipient must be in residence for at least 21 days in a calendar month for a monthly claim; (8) a contact that occurs while a recipient is a hospital inpatient or while residing in any other residential facility is not a reimbursable contact; (9) a qualified mental health staff person must prepare a note when the recipient is admitted; (10) the provider must develop a service plan within 4 weeks of admission to the FBT program; and (11) the recipient must be between the ages of 5 and 19.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for FBT rehabilitation services in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency did not claim Federal Medicaid reimbursement for FBT rehabilitation services in accordance with Federal and State requirements. Of the 100 claims in our random sample, 16 claims complied with Federal and State requirements, but 84 claims did not.

Of the 84 noncompliant claims, 58 contained more than 1 deficiency:

- For each of 39 claims, the recipient did not receive the required minimum number of face-to-face contacts and/or services with an authorized staff person for a monthly or semimonthly claim.

- For each of 37 claims, documentation did not demonstrate that the rehabilitation contact was at least 15 minutes in duration.

- For each of 29 claims, the physician's reauthorization was not based on a review of the recipient's service plan or case record.

- For each of 26 claims, the physician's reauthorization did not include a face-to-face contact with the recipient.

- For each of 26 claims, the professional parents' daily logs did not indicate that the provider's authorized staff reviewed them.

- For each of nine claims, the recipient was not in residence for the minimum number of days required for a monthly claim.

- For each of six claims, the physician's initial authorization did not include a face-to-face assessment of the recipient.

- For each of five claims, the physician's reauthorization was not performed timely.

- For each of three claims, the recipient resided outside of the FBT home.

- For one claim, the provider could not document that FBT rehabilitation services were provided.

- For one claim, there was no initial physician's authorization.

- For one claim, a qualified mental health staff person did not prepare the admission note.

- For one claim, the service plan was not developed within 4 weeks of the recipient's admission to the program.

- For one claim, the recipient exceeded the program's age requirements.

These deficiencies occurred because: (1) FBT rehabilitation providers did not fully comply with State regulations, (2) authorizing physicians were not familiar with applicable State regulations and program requirements, and (3) the State did not adequately monitor the program for compliance with certain Federal and State requirements.

Using our sample results, we estimate that the State agency improperly claimed $27,467,320 in Federal Medicaid reimbursement during our January 1, 2005, through December 31, 2009, audit period.

RECOMMENDATIONS

We recommend that the State agency refund $27,467,320 to the Federal Government.

If the State agency does not close the FBT program by March 31, 2013—a date it has set as a deadline for closing the program—we further recommend that it:

- work with OMH to provide guidance to the provider community on State regulations for FBT rehabilitation services,

- work with OMH to provide guidance to physicians on State regulations and program requirements authorizing FBT rehabilitation services, and

- improve its monitoring and oversight of the FBT program to ensure compliance with Federal and State requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our first recommendation (financial disallowance) and stated that it will evaluate the practicality of "reissuing guidance to the provider community and physicians" (second and third recommendations) given that the State is eliminating the FBT program. Regarding our fourth recommendation, the State agency stated that if any ways to improve its monitoring and oversight activities are identified in the process of its closing the FBT program, it will implement such changes.

The State agency disagreed with the legal basis of our findings and stated that they are based solely on our interpretation of State regulations. The State agency described our interpretation as overly technical and contrary to the meaning and intent of the regulations.

In addition, the State agency stated that, for each of the 29 sampled claims for which the authorizing physician did not review the recipient's service plan or case record, we ignored documentation of the authorizing physician's knowledge of the recipient. Regarding each of the nine sampled claims for which we determined that the recipient was not in residence for the minimum number of days for a monthly claim, the State agency stated that we counted weekend visits to a family home as not being "in residence."

In followup emails, an official with OMH stated that the program was scheduled to be phased out and closed by March 31, 2013.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments and the OMH official's emails, we maintain that our findings and recommendations are valid. We continue to recommend a refund of $27,467,320. In addition, if the State agency does not close the FBT program by its target date, we continue to recommend that it work with OMH to provide guidance and improve its monitoring and oversight of the program.

The plain language of the State's regulations (repealed after our audit period) provided that a physician's authorization "be based on a review of the beneficiary's service plan or entire case record." This requirement addressed two subject areas—medical necessity and coordination of care—that are not wholly technical. Regarding those claims for which we determined that the recipient did not meet the minimum number of days for a monthly claim, our calculations of when a recipient was "in residence" did not include days in which the recipient was hospitalized, was at summer camp, was not in the program, or did not receive a reimbursable service while at the family home.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer Medicaid. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers Medicaid. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In New York State (the State), the Department of Health (State agency) administers Medicaid. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

Federal Requirements for Family-Based Treatment Rehabilitation Services

Section 1905(a)(13) of the Act and 42 CFR § 440.130(d) authorize optional rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

Principles and standards for determining allowable costs incurred by State and local governments under Federal awards are established by 2 CFR part 225 (Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*). Pursuant to 2 CFR § App. A,C.1.c, to be allowable, costs must be authorized or not prohibited by State or local laws and regulations.

New York State's Program for Family-Based Treatment Rehabilitation Services

The State elected to include, under a program administered by its Office of Mental Health (OMH), Medicaid coverage of family-based treatment (FBT) rehabilitation services for recipients between the ages of 5 and 19.[1] The program provides care and treatment to children and youths with serious emotional disturbances who reside in State-operated housing programs (known as FBT homes). The primary goal of the program is to return children and youths to a permanent family-like setting and to prepare them for successful independent living. A physician or other licensed practitioner of the healing arts determines program eligibility. Physicians' authorizations are valid for up to 6 months for recipients in FBT homes. FBT providers maintain records, develop admission notes, develop service plans, provide services,

[1] Although OMH administers the FBT program, FBT rehabilitation providers submit claims for payment through the MMIS. The State agency then seeks Federal reimbursement for these claims through the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

monitor recipient progress, review daily logs maintained by "professional parents,"[2] and periodically review the status of recipients.[3] FBT rehabilitation services include training and assistance with daily living skills; medication management; and socialization, counseling, family support, and health services. Medicaid reimbursement is based on monthly or semimonthly rates.[4]

State Requirements for Family-Based Treatment Rehabilitation Services

Title 14, parts 593 and 594 of the New York Compilation of Codes, Rules, & Regulations (NYCRR) establishes standards for Medicaid reimbursement of FBT rehabilitation services. Parts 593 and 594 also establish standards for service planning and review that FBT rehabilitation providers must follow.[5] These regulations state, in part, that: (1) providers must have at least 11 qualifying face-to-face contacts with the recipient for a monthly claim or 6 qualifying face-to-face contacts for a semimonthly claim;[6] (2) each contact must be at least 15 minutes in duration; (3) an initial authorization for services must include a physician's face-to-face assessment of the recipient; (4) a physician must renew authorizations every 6 months and have a face-to-face contact with the recipient; (5) reauthorization for services must be based on a review of a summary of the recipient's 3-month service plan review or a review of the complete case record of the recipient; (6) authorized staff must record monthly progress notes based on daily logs that trained professional parents keep, and the service provider must review them weekly; (7) an eligible recipient must be in residence for at least 21 days in a calendar month for a monthly claim; (8) a contact that occurs while a recipient is a hospital inpatient or while residing in any other residential facility is not a reimbursable contact; (9) a qualified mental health staff person (QMHS) must prepare a note when the recipient is admitted; (10) the provider must develop a service plan within 4 weeks of admission to the FBT program; and (11) the recipient must be between the ages of 5 and 19.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for FBT rehabilitation services in accordance with Federal and State requirements.

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[2] Professional parents are trained to maintain and service children and youths in their homes and to work intensively with the children's and youths' families.

[3] Authorized staff include family specialists who perform these duties, as well as "professional parents."

[4] For our audit period, the average monthly payment to FBT rehabilitation providers was $4,321 per recipient.

[5] In February 2010, which is after our audit period, OMH revised some of its requirements for Medicaid reimbursement of FBT rehabilitation services. Among its changes to the program, the State repealed 14 NYCRR § 593.6(g) and revised 14 NYCRR § 593.6(b) to allow reauthorizations for services to be signed by a physician, physician assistant, or nurse practitioner in psychiatry.

[6] Contacts with authorized staff are defined as contacts involving the performance of at least one service indicated in the recipient's service plan.

Scope

Our review covered 16,574 FBT rehabilitation services claims, totaling $70,490,871 ($35,249,719 Federal share), submitted by 34 FBT rehabilitation providers in the State for the period January 1, 2005, through December 31, 2009.

During our audit, we did not review the overall internal control structure of the State agency, OMH, or the Medicaid program. Rather, we reviewed only the internal controls directly related to our objective.

We conducted fieldwork at OMH's offices in Albany, New York; offices of the MMIS fiscal agent in Rensselaer, New York; offices of 18 FBT rehabilitation providers throughout the State; and physicians' offices throughout the State.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State regulations and requirements;

- held discussions with OMH officials to gain an understanding of the program for FBT rehabilitation services;

- ran computer programming applications at the MMIS fiscal agent that identified a sampling frame of 16,574 claims for FBT rehabilitation services, totaling $70,490,871 ($35,249,719 Federal share), submitted by 34 FBT rehabilitation providers;

- selected a simple random sample of 100 claims (98 monthly claims and 2 semimonthly claims) from the sampling frame of 16,574 claims,[7] and for each of these 100 claims, we:

    - reviewed the corresponding FBT rehabilitation provider's supporting documentation;

    - reviewed the professional credentials of the FBT rehabilitation provider's authorized staff person(s) who prepared the admission note and reviewed and signed the recipient's applicable service plan;

    - interviewed officials at the corresponding FBT rehabilitation provider to gain an understanding of the provider's policies and procedures for obtaining authorizations for FBT rehabilitation services; and

[7] Forty-eight authorizing physicians were associated with the 100 sampled claims. (Some physicians authorized two or more claims). For various reasons (e.g., retirement, relocation), we were able to interview only 38 of the 48 physicians (representing 78 claims).

- interviewed the physician (if available) who authorized FBT rehabilitation services to determine the physician's knowledge of the program requirements; and

- estimated the unallowable Federal Medicaid reimbursement paid in the population of 16,574 claims.

Appendix A contains the details of our sample design and methodology.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

FINDINGS AND RECOMMENDATIONS

The State agency did not claim Federal Medicaid reimbursement for FBT rehabilitation services in accordance with Federal and State requirements. Of the 100 claims in our random sample, 16 claims complied with Federal and State requirements, but 84 claims did not. Of the 84 claims, 58 contained more than 1 deficiency. The table below summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Table: Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Unallowable Claims[8]
Claim not supported by required number of services	39
Services not at least 15 minutes in duration	37
Physician reauthorized services without review of service plan or case record	29
Physician's reauthorization did not include a face-to-face contact	26
Professional parents' daily logs not reviewed by provider's authorized staff	26
Recipient not in residence for required minimum number of days	9
Physician's initial authorization did not include a face-to-face assessment	6
Physician's reauthorization not performed timely	5
Recipient did not reside in home	3
Services not documented	1
No initial physician's authorization	1
Admission note not prepared by a qualified staff person	1
Service plan not developed within 4 weeks	1
Recipient exceeded program's age requirements	1

[8] The total exceeds 84 because 58 claims contained more than 1 deficiency.

These deficiencies occurred because: (1) FBT rehabilitation providers did not fully comply with State regulations, (2) authorizing physicians were not familiar with applicable State regulations and program requirements, and (3) the State did not adequately monitor the program for compliance with certain Federal and State requirements.

Using our sample results, we estimate that the State agency improperly claimed $27,467,320 in Federal Medicaid reimbursement during our January 1, 2005, through December 31, 2009, audit period.

CLAIM NOT SUPPORTED BY REQUIRED NUMBER OF SERVICES

Pursuant to 14 NYCRR § 593.7(b), Medicaid reimbursement for FBT rehabilitation services is based on monthly or semimonthly rates. For FBT providers to bill for a monthly claim, a recipient must receive at least 11 face-to face contacts with an authorized staff person, at least 3 of which must be provided by authorized staff other than the professional parents, and at least 4 different rehabilitation services must be provided. For FBT providers to bill for a semimonthly claim, a recipient must receive at least six face-to-face contacts with an authorized staff person, at least two of which must be provided by authorized staff other than the professional parents, and at least two different rehabilitation services must be provided.

For each of 39 of the 100 claims in our sample, the recipient did not receive the minimum number of contacts and/or services. Of these, 22 contained more than 1 error. Specifically:

- For each of 33 monthly claims, the recipient did not receive at least 11 face-to-face contacts.

- For each of 16 monthly claims, the recipient did not receive at least 3 contacts with authorized staff other than the recipient's professional parents.

- For each of 16 monthly claims, the recipient did not receive at least 4 different rehabilitation services.

- For one semimonthly claim, the recipient did not receive at least six face-to-face contacts with authorized staff and two contacts with authorized staff other than the recipient's professional parents.

SERVICES NOT AT LEAST 15 MINUTES IN DURATION

Pursuant to 14 NYCRR § 593.7(b)(3), each face-to-face contact must be at least 15 minutes in duration.

For each of 37 of the 100 claims in our sample, the FBT rehabilitation provider's documentation did not demonstrate that the rehabilitation contact was at least 15 minutes in duration.

PHYSICIAN REAUTHORIZED SERVICES WITHOUT REVIEW OF SERVICE PLAN OR CASE RECORD

Pursuant to 14 NYCRR § 593.6(b)(1), the physician's authorization must be renewed every 6 months for residents in FBT homes. A summary of the service plan review prepared immediately preceding the expiration date of the physician's authorization, signed by a QMHS, must be submitted to the physician before the physician reauthorizes rehabilitation services. The physician may reauthorize the services on the basis of the summary of the 3-month service plan review or, if necessary, may request the complete case record of the individual (14 NYCRR § 593.6(g)). The service plan review is developed by qualified staff of the program and identifies the recipient's service goals and objectives, the services to be provided, proposed time periods, and efforts to coordinate services with other providers.

For each of 29 of the 100 claims in our sample, the physician reauthorized FBT rehabilitation services without reviewing the summary of the 3-month service plan review or the complete case record. For 21 of these claims, the FBT rehabilitation providers stated that they did not submit any documentation (e.g., service plan review, assessment, summary of service plan review) to the physician who reauthorized FBT rehabilitation services.[9] For seven other claims, providers made this documentation available; however, physicians stated in interviews that they did not review the documentation before reauthorizing FBT rehabilitation services. For the remaining claim, provider officials said they were uncertain if the documentation was made available to the physician; however, the physician stated that he did not review the documentation before reauthorizing FBT rehabilitation services.

PHYSICIAN'S REAUTHORIZATION DID NOT INCLUDE A FACE-TO-FACE CONTACT

Pursuant to 14 NYCRR § 593.6(b)(1), the physician's reauthorization must be renewed every 6 months for children and youths and must include a face-to-face contact between the physician and the recipient.

For each of 26 of the 100 claims in our sample, the physician's reauthorization did not include a face-to-face contact between the recipient and the physician. Specifically, we could not find any documentation in the providers' files to indicate that the physician met face-to-face with the recipient prior to renewing the reauthorization.

PROFESSIONAL PARENTS' DAILY LOGS NOT REVIEWED BY PROVIDER'S AUTHORIZED STAFF

Pursuant to 14 NYCRR § 593.6(e), an authorized staff member must record, at least monthly, progress notes that specify the types of services provided; significant events that occurred; and, if applicable, recommendations for changes to the recipient's service plan goals and objectives. For FBT program services, providers must base their progress notes on the professional parent's daily logs that authorized staff review weekly (14 NYCRR § 594.10(c)).

[9] In interviews, all of the physicians associated with the 21 claims (except 3 whom we were unable to interview) confirmed this information.

For each of 26 of the 100 claims in our sample, the professional parents' daily logs did not indicate that authorized staff (e.g., a family specialist)[10] had reviewed them.

RECIPIENT NOT IN RESIDENCE FOR REQUIRED MINIMUM NUMBER OF DAYS

Pursuant to 14 NYCRR § 593.7(b)(1), a monthly rate is paid for services provided to eligible recipients residing in FBT homes for at least 21 days in a calendar month.

For each of 9 monthly claims in our sample, the FBT provider did not document that the recipient resided in the FBT home for 21 days in a calendar month.[11] The nine recipients resided in FBT homes from 0 to 17 days during the sampled month.

PHYSICIAN'S INITIAL AUTHORIZATION DID NOT INCLUDE A FACE-TO-FACE ASSESSMENT

Pursuant to 14 NYCRR § 593.6(a)(1), the physician's initial authorization must be based on appropriate clinical information and assessment of the individual and must include a face-to-face assessment of the recipient.

For each of 6 of the 100 claims in our sample, the physician's initial authorization did not include a face-to-face assessment of the recipient. We interviewed five of the six physicians who signed the initial authorizations[12] and reviewed all six recipients' records and found no evidence of a face-to-face assessment between the physician and recipient applicable to the date of the initial authorization.

PHYSICIAN'S REAUTHORIZATION NOT PERFORMED TIMELY

Pursuant to 14 NYCRR § 593.6(b)(1), the physician's authorization must be renewed every 6 months for residents in FBT homes.

For each of 5 of the 100 claims in our sample, the physician signed a reauthorization for FBT rehabilitation services before or after the 6-month reauthorization period applicable to the date of our sampled claim. Specifically, for three claims, physicians signed reauthorizations 14 to 18 months before the date of our sampled claim; as of the end of our fieldwork, no reauthorizations

[10] For the remaining 74 claims, the family specialist initialed or signed the daily logs, either on each page or on the last page, to certify that he/she reviewed the logs.

[11] FBT rehabilitation providers generally documented the number of days a recipient was in residence using medication logs, daily logs, or progress notes. We allowed claims for which the provider recorded that the recipient occupied a bed in an OMH-approved FBT home for 21 days in a calendar month.

[12] We could not interview the remaining physician because he was hospitalized during our fieldwork.

had been signed after the date of those three sampled claims. For the remaining two claims, physicians signed reauthorizations 1 to 4 months after the date of our sampled claim.[13]

RECIPIENT DID NOT RESIDE IN HOME

Pursuant to 14 NYCRR § 593.7(b)(5), a contact that occurs while a recipient is a hospital inpatient or is residing in any other residential facility is not a reimbursable contact.

For each of 3 of the 100 claims in our sample, the provider received Medicaid reimbursement for FBT rehabilitation services during a period for which the recipient resided outside of the FBT home. For two claims, the recipients were hospital inpatients for most of the service month. For the remaining claim, the recipient was discharged from the program 4 days into the service month to a group home dedicated to young adults.

SERVICES NOT DOCUMENTED

Pursuant to 42 CFR § 433.32, services claimed for Federal Medicaid reimbursement must be documented. Pursuant to 18 NYCRR § 504.3(e), by enrolling in the State's Medicaid program, a provider agrees to submit claims for payment only for services actually provided to Medicaid recipients. Pursuant to 14 NYCRR § 593.6, in order to receive reimbursement for rehabilitation services to an individual, documentation must be retained as a part of the individual's case record.

For 1 of the 100 claims in our sample, the provider did not provide any documentation to support the claim because the recipient's case record was inadvertently shredded when the recipient moved to another county.

NO INITIAL PHYSICIAN'S AUTHORIZATION

Pursuant to 14 NYCRR § 593.6(a), to receive reimbursement for providing rehabilitation services, providers must ensure that a physician authorizes in writing a resident's admission to the program before that admission.

For 1 of the 100 claims in our sample, the provider received Medicaid reimbursement for FBT rehabilitation services provided to a recipient who was not authorized by a physician to receive FBT rehabilitation services prior to or upon the recipient's admission to the FBT program. For this claim, the provider could not produce an initial authorization for the recipient.

ADMISSION NOTE NOT PREPARED BY A QUALIFIED STAFF PERSON

Pursuant to 14 NYCRR §§ 593.6(c) and 594.10(a), a QMHS must prepare an admission note at the time of admission that specifies, at a minimum, a description of the needs of the recipient and a brief description of the rehabilitation services necessary to meet those needs during the initial period after admission.

[13] The previous reauthorizations for these two claims were signed 12 to 17 months before the dates of our sampled claims.

For 1 of the 100 claims in our sample, the admission note was prepared by a staff person who possessed an associate's degree, a degree that does not meet the QMHS criteria for this type of program.

SERVICE PLAN NOT DEVELOPED WITHIN 4 WEEKS

Pursuant to 14 NYCRR §§ 593.6(c) and 594.10(a), rehabilitation services provided within the program must be provided in accordance with a service plan developed within 4 weeks of admission to the program.

For 1 of the 100 claims in our sample, the initial service plan was not developed within 4 weeks of the recipient's admission to the program. The plan was developed over 5 weeks after the recipient was admitted.

RECIPIENT EXCEEDED PROGRAM'S AGE REQUIREMENTS

Pursuant to 14 NYCRR § 594.8(b)(1), FBT program recipients must be between the ages of 5 and 19. Recipients may remain in the program for up to 1 year following their 18th birthdays, if clinically appropriate (14 NYCRR § 594.8(i)).

For 1 of the 100 claims in our sample, the recipient exceeded the program's age requirements by more than 9 months.

CAUSES OF UNALLOWABLE CLAIMS

Family-Based Treatment Rehabilitation Providers Did Not Fully Comply With State Regulations

None of the 18 FBT rehabilitation providers included in our sample fully complied with State regulations. Specifically, 13 of the providers associated with 54 sampled claims did not comply with State regulations on the minimum number and length of rehabilitation services required for Medicaid reimbursement. In addition, 11 of the 18 providers associated with 32 sampled claims did not ensure that physicians performed face-to-face assessments of recipients before authorizing services. Further, authorized staff (e.g., a family specialist) at 10 providers associated with 26 sampled claims did not review the professional parents' daily logs documenting services provided to recipients. Finally, 6 providers associated with 21 sampled claims did not provide any documentation to the recipient's physician for use in determining the reauthorization of rehabilitation services.

Authorizing Physicians Not Familiar With State Regulations and Program Requirements

Forms used by physicians to authorize rehabilitation services for recipients in the FBT program vary slightly throughout the State. However, each form requires the physician to declare that the authorization or reauthorization for FBT services is based on a review of the recipient's assessments and a determination that the recipient would benefit from services defined in

14 NYCRR part 593. However, 33 of the 38 physicians interviewed (87 percent) stated that they were not familiar with these regulations. Thirty-one physicians stated that they did not practice in an FBT rehabilitation program setting and were familiar with the recipient for whom they authorized rehabilitation services only through a different program, such as an outpatient mental health clinic, primary care physician, or private psychiatric practice.

For each of the 29 claims that we determined were in error, the physician's reauthorization for services was not based on a review of the summary of a recipient's 3-month service plan review (or the actual service plan review) or a review of the complete case record, as required. The service plan identifies the recipient's service goals and objectives, the services to be provided, proposed time periods, and efforts to coordinate services with other providers. We interviewed 17 physicians who signed 25 of the 29 authorizations, to determine the basis for their signatures on the authorization.[14] For 13 of the 25 claims, the physician did not see the recipient prior to authorizing FBT rehabilitation services. The 10 physicians associated with the remaining 12 claims stated that they authorized FBT rehabilitation services based on their familiarity with the recipient from other programs the recipient attended, not their own knowledge of the FBT program.

Finally, of the 38 total physicians interviewed, 22 did not assess the recipients face-to-face or have contact with them before signing the authorization.

Inadequate Monitoring by State Agencies

The State agency did not provide adequate oversight to ensure that OMH effectively monitored FBT providers throughout the State for compliance with certain Federal and State requirements. Although OMH conducts periodic monitoring visits at program providers to review case records for compliance with applicable State regulations, OMH's monitoring program did not ensure that providers complied with Federal and State requirements. Of the 18 providers in our sample, OMH cited 16 in its monitoring outcome reports for instances of noncompliance similar to those discussed above. Despite these monitoring outcome reports and recommended corrective actions, the providers continued to submit improper claims for Federal Medicaid reimbursement.

ESTIMATE OF THE UNALLOWABLE AMOUNT

Of the 100 claims for FBT rehabilitation services that we sampled, 84 were not claimed in accordance with Federal and State requirements. Using our sample results, we estimate that the State improperly claimed $27,467,320 in Federal Medicaid reimbursement during our January 1, 2005, through December 31, 2009, audit period. Appendix B contains our sample results and estimates.

[14] We did not interview the physicians who authorized services for recipients in 4 of the 29 unallowable claims because either the physicians were retired or we could not locate them. However, provider officials stated that they did not provide the summaries of the service plan reviews or the complete case records to the physicians for the four claims.

RECOMMENDATIONS

We recommend that the State agency refund $27,467,320 to the Federal Government.

If the State agency does not close the FBT program by March 31, 2013—a date it has set as a deadline for closing the program—we further recommend that it:

- work with OMH to provide guidance to the provider community on State regulations for FBT rehabilitation services,

- work with OMH to provide guidance to physicians on State regulations and program requirements authorizing FBT rehabilitation services, and

- improve its monitoring and oversight of the FBT program to ensure compliance with Federal and State requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our first recommendation (financial disallowance). As to our other recommendations, the State agency noted that because OMH is closing the FBT program, it will evaluate the practicality of "reissuing guidance to the provider community and physicians" (second and third recommendations) and will implement improvements in its monitoring and oversight (fourth recommendation) that it identifies before the program closes. The State agency's comments appear in their entirety as Appendix C.

In followup emails, an official with OMH stated that the program was scheduled to be phased out and closed by March 31, 2013.

After reviewing the State agency's comments and the OMH official's emails, we maintain that our findings and recommendations are valid. We continue to recommend a refund of $27,467,320. In addition, if the State agency does not close the FBT program by its target date, we continue to recommend that it work with OMH to provide guidance and improve its monitoring and oversight of the program.

Application of State Regulations

State Agency Comments

The State agency stated that we misapplied State regulations and ignored "alternative enforcement actions" provided in State regulations. It stated that even if our sampled services violated State regulations, other State regulations (14 NYCRR § 593.8) exist that "would have resulted in the State agency taking alternative enforcement actions" provided for in those regulations. Among OMH's means of monitoring and enforcing provider compliance with program standards are: (1) requiring providers to submit a plan of corrective action addressing

program deficiencies; (2) imposing fines; (3) limiting, suspending, or revoking a provider's license; and (4) increasing the frequency of program inspections.

The State agency stated that we misapplied 14 NYCRR § 593.6 and that our interpretation of it was "overly technical."

Office of Inspector General Response

We maintain that the plain language of the State's regulations at 14 NYCRR § 593.6 provides clear requirements for Medicaid providers to be paid. The section begins, "In order to receive reimbursement for the provision of … services to an individual …" (emphasis added). Pursuant to 2 CFR part 225, *Cost Principles for State, Local, and Indian Tribal Governments* (Office of Management and Budget Circular A-87), to be allowable under Federal awards, costs must "[b]e authorized or not prohibited under State or local laws or regulations." Therefore, we may conduct an audit to determine whether Federal payments have been made in violation of State laws and regulations and recommend disallowances of Federal funding on the findings of such an audit.

Documentation of Authorizing Physicians' Knowledge of Recipients

State Agency Comments

The State agency stated that, for each of the sampled claims for which the authorizing physician did not review the recipient's service plan or case record, we "ignored documentation of the authorizing physicians' knowledge of the patients for whom services were being authorized." The State agency cited eight sampled claims[15] for which it asserted that physicians' responses to a questionnaire used during our review indicated that the authorizing physician was "familiar with the needs of the individuals."

Office of Inspector General Response

We maintain that the plain language of the State's regulations at 14 NYCRR § 593.6(g) (repealed after our audit period) provided that a physician's authorization be based on a review of the beneficiary's service plan or entire case record. This requirement addressed two subject areas—medical necessity and coordination of care—that are not wholly technical. For each of the sampled claims cited by the State agency, the physician reauthorized FBT rehabilitation services without reviewing a summary of the 3-month service plan review or the complete case record. Specifically:

- For each of six sampled claims (numbers 14, 20, 52, 53, 69, and 70), the authorizing physician saw the recipient only for medication management—not FBT services. For one of these claims (number 53), the physician stated that she was unaware that the recipient was receiving FBT services and did not clearly understand what services she was authorizing.

[15] The eight sampled claims that the State agency cited are: Numbers 14, 20, 52, 53, 69, 70, 76, and 94.

- For one sampled claim (number 76), the authorizing physician was not provided the applicable service plan or case record prior to reauthorizing FBT services.

- For one sampled claim (number 94), the authorizing physician saw the recipient in a clinical setting—not for FBT services. In addition, the applicable service plan or case record was not provided to the physician prior to her signing the reauthorization.

Claims Not Supported by Required Number of Services

State Agency Comments

Regarding our finding that for nine sampled claims the recipient was not in residence for the minimum number of days for a monthly claim, the State agency stated that reimbursable contacts can occur at the family home and indicated that we did not count days for which a recipient was in the family home as being in residence.

Office of Inspector General Response

Our calculations of when a recipient was "in residence" did not include days in which the recipient was hospitalized, was at summer camp, was not in the program, or did not receive a reimbursable service while at the family home. For 9 monthly claims in our sample, the FBT provider did not document that the recipient resided in the FBT home for the required 21 days in a calendar month. Specifically:

- For two claims, the recipient was hospitalized for at least 21 days during the month.

- For one claim, the recipient was at summer camp for 19 days during the month.

- For one claim, the recipient was in the FBT program for only 4 days before moving to a different program.

- For one claim, the recipient did not enter the FBT program until the 8th day of the month. The recipient then spent 9 of the remaining 23 days at the family home.

- For one claim, the provider could document that the recipient was in the FBT program for only a total of 17 days during the month.

- For three claims, the recipient spent at least 14 days during the month at his/her family home without a reimbursable FBT service being provided by the parent—days that should not count toward the minimum number of days needed to bill for a monthly claim. As the State agency stated in its comments, "In residence means currently admitted to and residing in a family based treatment program …."

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was family-based treatment (FBT) rehabilitation claims submitted by 34 providers in the State during our January 1, 2005, through December 31, 2009, audit period that the New York State Department of Health claimed for Federal Medicaid reimbursement.

SAMPLING FRAME

The sampling frame was a computer file containing 16,574 detailed paid claims for FBT rehabilitation services submitted by 34 providers in the State during our audit period. The total Medicaid reimbursement for the 16,574 claims was $70,490,871 ($35,249,719 Federal share). The Medicaid claims were extracted from the claims' files maintained at the Medicaid Management Information System fiscal agent.

SAMPLE UNIT

The sample unit was an individual Federal Medicaid claim.

SAMPLE DESIGN

We used a simple random sample to evaluate the population of Federal Medicaid claims.

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

The source of the random numbers was the Office of Audit Services' statistical software, RAT-STATS. We used the random number generator for our sample.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the 16,574 detailed claims. After generating 100 random numbers, we selected the corresponding frame items. We created a list of 100 sample items.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We used the lower limit at a 90-percent confidence level to estimate the overpayment associated with the unallowable claims.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Unallowable Claims	Value of Unallowable Claims (Federal Share)
16,574	$35,249,719	100	$212,781	84	$179,732

Estimated Unallowable Costs
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$29,788,810
Lower Limit	$27,467,320
Upper Limit	$32,110,299

APPENDIX C: STATE AGENCY COMMENTS

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

August 29, 2012

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-10-01024

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the U.S. Department of Health and Human Services, Office of Inspector General's draft audit report A-02-10-01024 on "New York Improperly Claimed Medicaid Reimbursement for Family-Based Treatment Rehabilitation Services."

Thank you for the opportunity to comment.

Sincerely,

Robert W. Locicero, Esq.
Deputy Director for Administration

enclosure
cc: Courtney Burke
Kristin Riley
Jason Helgerson
James C. Cox
Diane Christensen
Stephen Abbott
Stephen La Casse
James Russo
Irene Myron
John Brooks
Ronald Farrell
Michelle Contreras

New York State Department of Health Comments on the U.S. Department of Health and Human Services Office of Inspector General Draft Audit Report A-02-10-01024 on "New York Improperly Claimed Medicaid Reimbursement for Family-Based Treatment Rehabilitation Services"

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services Office of Inspector General (OIG) Draft Audit Report A-02-10-01024 on "New York Improperly Claimed Medicaid Reimbursement for Family-Based Treatment Rehabilitation Services."

Overview of the Family Based Treatment Program:

The New York State Family-Based Treatment (FBT) Program is a component of the system of care for children and youth with serious emotional disturbances (SED). FBT targets children who meet SED criteria, can function in a family setting, and are at risk for restrictive settings. It provides, through a careful matching process, a placement in a family home for children who are able to live in the community under the supervision, and with the support, of surrogate parents. These surrogate parents receive special training in behavior management and other related aspects of caring for youth with SED. Additional supports, including clinical services, are arranged through community mental health programs and other community agencies.

Recommendation #1:

The Department should refund $27,467,320 to the Federal Government.

Response #1:

This recommendation resulted from OIG's review of a sample of 100 claims out of 16,574 claims submitted by 34 providers during the period January 1, 2005 through December 31, 2009. Of the 100 claims sampled, OIG determined 84 claims were non-reimbursable. The Department and the New York State Office of Mental Health (OMH) strongly disagree with the recommendation for the State to refund $27,467,320 to the Federal Government on the basis that OIG's underlying audit methodology is flawed.

OIG is recommending this punitive disallowance based upon findings of alleged technical violations of New York State program regulations. This recommendation is being made despite the fact there is no finding that the services provided were not medically necessary, were not in fact provided or were provided to individuals who were not Medicaid-eligible. Preliminary analyses of the OIG audit workpapers reveals the OIG auditors did not take into consideration all other available documentation enabling a reasonable person to conclude an appropriate service was delivered to a Medicaid-eligible person.

The auditors ignored the appropriateness of remedies other than disallowance for alleged regulatory violations

The type of violations alleged by the OIG, even had they been violative of the regulatory provisions cited, would not have rendered the services non-reimbursable under the same regulations being applied by the OIG. Rather, they would have resulted in alternative enforcement actions by the State, which are specifically provided for in the regulations in question.

OMH maintains various means of monitoring and enforcing provider compliance with program standards. Among these are requiring providers to submit a plan of corrective action (POCA) addressing program deficiencies, increasing the frequency of program inspections, the imposition of fines and the limitation, suspension or revocation of a provider's license. Section 593.8 of the regulation in question, "Enforcement Standards and Procedures," makes this explicit. This section specifically provides that where OMH determines a provider of service is not exercising due diligence in complying with the State regulatory requirements pertaining to this program, OMH will give notice of the deficiency to the provider, and may also either request the provider to prepare a POCA, or OMH may provide technical assistance. If the provider fails to prepare an acceptable POCA within a reasonable time, or if it refuses to permit OMH to provide technical assistance or effectively implement a plan of correction, then it will be determined to be in violation of the program regulations. Such a determination, as well as a failure to comply with the terms of the provider's operating certificate or with the provisions of any applicable statute, rule or regulation, subjects the provider to a possible revocation, suspension or limitation of the provider's operating certificate, or the imposition of a fine.

Thus, the OIG has issued a recommended disallowance based entirely upon its interpretation and application of State regulations. In so doing, however, it has ignored specific and relevant provisions of the regulation it is purporting to enforce. As detailed below, the OIG then compounds this error by misapplying these regulations, resulting in a determination of violations based upon behaviors the State would have found to be compliant.

The OIG applied an inappropriate and overly technical interpretation of New York State's program regulations that is contrary to the meaning and intent of these regulations

The draft OIG audit report relies on an overly technical interpretation of State regulations. OIG recommends a disallowance of over $27 million based upon a review of a sample of 100 claims from a universe of 16,574 claims. Of the 100 claims sampled, OIG found 84 claims so flawed as to render such claims non-reimbursable. Of those 84 claims, 29 were found to violate the State's requirement for service reauthorization, which states that at the service plan review immediately preceding the expiration date of the physician's authorization, a summary of the review must be submitted to the physician, and the physician may authorize the services based upon the summary of the three month review or, if necessary, may request the complete case record of the individual. For these 29 claims, OIG states the provider did not submit the review summary to the physician.

The services in question are provided to children with SED who are residing with surrogate families. OMH, in designing program standards, intended to ensure that there was physician involvement in the determination of need for services, and in periodic reauthorizations.

The intent of the regulatory provision that the program supply the physician with a summary of the service plan review, and the language stating the physician may authorize additional services based upon that review, was to ensure physicians not otherwise familiar with the individual would be provided with sufficient information to make an informed clinical judgment. Furthermore, the regulation was not intended to require the physician to base his or her recommendation on that summary, rather than his or her own informed clinical judgment. In fact, an interpretation that would require a physician to base a recommendation for continued services on a summary prepared by others, rather than his or her informed clinical judgment and actual knowledge of the patient, would be clinically inappropriate.

The OIG auditors ignored documentation of the authorizing physicians' knowledge of the patients for whom services were being authorized

Despite having ample documentation that the physicians providing the service reauthorization in question were familiar with the needs of the individuals as a result of the physicians' own personal knowledge, the OIG repeatedly disallowed services based upon its reading of a regulation intended to ensure that such reauthorizations be provided by informed physicians, because those physicians did not base the reauthorization on a written summary prepared by others. Specifically, in the FBT programs, the physician was very familiar with the child's needs as he or she was one of the primary treating practitioners and usually saw the child on a monthly basis for medication management.

In a questionnaire used by the OIG auditors, the physicians were asked whether they reauthorized services based upon a review of the summary of the three month service plan review, the actual service plan review or the complete case record, and to explain. In case after case, when the "no" box was marked, the explanation given was the physician was personally familiar with the patient and had been seeing the child along with his or her caretaker at least on a monthly basis.

Examples from OIG questionnaires supporting physician familiarity and knowledge of a child's needs include the following:

Sample 14:

The doctor told the investigators that the reauthorization is based on knowledge of the patient and what is being reported to the physician. There is a group meeting with the family specialist where the physician receives information about the patient.

Sample 20:

The doctor had been seeing the child every one or two months for at least two years based on need. The doctor stated that when he reauthorized services he interviewed the child and if he felt the child was emotionally disturbed he would base the reauthorization on that fact.

Sample 52:

The doctor saw the child for approximately six months primarily for medication management. The doctor stated there are team meetings in which the therapist discusses how the child is doing at home and school. The doctor also stated he received constant feedback regarding the child's progress.

Sample 53:

The doctor stated he had treated the child for approximately four years primarily for medication management on a monthly basis, and more often if needed. The doctor stated it never occurred to her to ask for the service plan as she knew the child and the type of treatment he was receiving.

Sample 69:

The doctor stated she had treated the patient for approximately a year and a half and she saw him once a month primarily for medication management. The doctor stated she signed the reauthorization based on her own clinical opinion and knowledge of the child's needs. She also considered the assessments and opinions of the child's family specialist, case worker and his therapist.

Sample 70:

The doctor stated he signed the reauthorization based on his own knowledge of the patient and the information reported to him by the child's other treatment providers.

Sample 76:

The doctor treated the patient for two years and during that time saw the patient on a monthly basis. Prior to signing the reauthorization, the doctor reviewed the case specialist's notes which he described as very thorough. It was the doctor's opinion the case specialist knew the child best out of all the treatment providers.

Sample 94:

The doctor said she saw the patient on a monthly basis. She stated she did not review the FBT chart but she usually pulls the clinic chart to review. She also stated she sees the family of the child.

The above examples are representative of the cases determined by the OIG auditors to be noncompliant with the State's requirement, despite it being clear that service reauthorization was made by physicians based upon an informed decision of clinical need. The recommendation of a disallowance based upon a narrow reading of only a portion of the applicable regulations is a misinterpretation and misapplication of those regulations which is unwarranted and excessive.

Claim not supported by required number of services

The OIG disallowed 9 claims alleging the recipient was not in residence for the minimum number of days required for a monthly claim.

"In residence" means currently admitted to and residing in a family based treatment program and not on leave as an inpatient of any hospital for any reason, or temporarily residing in any other licensed residential facility. For a family based treatment program, a reimbursable contact may occur at or away from the program, except a reimbursable service may not occur at the site for a licensed mental health program. As such, reimbursable contacts can occur at the family home. Best practice requires family based treatment providers to frequently arrange for the youth to go home to a parent and or guardian for weekend visits. These days do not constitute discharge, but in some cases, the OIG auditors counted these days as the youth not being "in residence."

Independent review

The State has hired an independent company, Behavioral Organizational Consulting Associates (BOCA) which is a consulting firm that has conducted evaluations, inspections and reviews in behavioral health care since 1988, to review all of the cases that were audited by the OIG. As such, BOCA will be reviewing all of the charts reviewed by OIG and interviewing the FBT programs involved in the audit. Therefore, the State reserves the right to raise additional concerns and to introduce further supporting documentation to refute these disallowances.

Recommendation #2:

The Department should work with OMH to provide guidance to the provider community on State regulations for FBT rehabilitation services.

Recommendation #3:

The Department should work with OMH to provide guidance to physicians on State regulations and program requirements authorizing FBT rehabilitation services.

Recommendation #4:

The Department should improve its monitoring and oversight of the FBT program to ensure compliance with Federal and State requirements.

Response to Recommendations #2, #3, & #4:

OMH is currently in the process of closing the FBT Program. This process began in April of 2011 and as of July 18, 2012, only 47 slots remained of the 470 once open. It is anticipated that all slots will be closed by March, 2013.

In the past, OMH has provided guidance documents concerning State regulations and program requirements. Given the program is now nearing elimination, OMH and the Department will evaluate the practicality of reissuing guidance to the provider community and physicians.

OMH's Bureau of Inspection and Certification will continue its ongoing monitoring and oversight of the program until the remaining beds are closed. If during that time any ways for improvement can be identified by OMH and the Department, they will of course be implemented.

Summary:

The recommended disallowance is based upon a misapplication of State regulations. The majority of the OIG's findings are based on alleged violations of the State's program regulations, which would not have rendered the services non-reimbursable. It is only when a provider of service does not meet the State's reimbursement rules and regulations that OMH would make a referral to the Department for the recovery of an overpayment.