Office of the
Medicaid Inspector
General

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

Audit of Claims for OMH Outpatient Mental Health Services

Final Audit Report
Audit #: 19-4575

Metropolitan Center for Mental Health

Provider ID #: 00244335
NPI #: 1275695371

Office of the Medicaid Inspector General

KATHY HOCHUL
Governor

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

April 7, 2022

Metropolitan Center for Mental Health
160 West 86th Street
New York, New York 10024

Re: Final Audit Report
Audit #: 19-4575
Provider ID #: 00244335

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Metropolitan Center for Mental Health (Provider).

In accordance with Sections 30, 31 and 32 of the New York State Public Health Law, and Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York (NYCRR) Parts 504 and 517, OMIG performed an audit of OMH outpatient mental health services claims paid to the Provider from January 1, 2014, through December 31, 2016. The audit universe consisted of 100,132 claims totaling $12,604,167.75. The audit consisted of a random sample of 100 claims with Medicaid payments totaling $11,795.95 (Attachment A).

OMIG has attached the sample detail for the paid claims determined to be in error. This Final Audit Report incorporates consideration of any additional documentation and information presented in the Provider's October 1, 2021 response to the Draft Audit Report dated July 28, 2021. The point estimate overpaid is $1,778,364. The lower confidence limit of the amount overpaid is $1,075,096. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the lower confidence limit of $1,075,096.

If you have any questions or comments concerning this report, please contact [redacted] or through email at [redacted]. Please refer to audit number 19-4575 in all correspondence.

Division of Medicaid Audit
Office of the Medicaid Inspector General

Attachments
Certified Mail Number: 7015-0640-0003-2856-4485
Return Receipt Requested

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Background, Objective, and Audit Scope

Background

The New York State Department of Health (DOH) is the single state agency responsible for the administration of the Medicaid program. As part of its responsibility as an independent entity within DOH, 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 assessing provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth in New York Public Health Law, New York Social Services Law, the regulations of DOH (Titles 10 and 18 of the New York Codes Rules and Regulations), the regulations of the Office of Mental Hygiene (Title 14 of the New York Codes Rules and Regulations), the regulations of the Education Department (Title 8 of the New York Codes Rules and Regulations), DOH's Medicaid Provider Manuals and *Medicaid Update* publications.

The purpose of outpatient mental health programs is to diagnose and treat mentally ill adults and children on an ambulatory basis. Outpatient mental health programs are offered at hospital-based, freestanding, or state operated Psychiatric Centers. There are five categories of outpatient mental health programs: clinic treatment, continuing day treatment, day treatment serving children, intensive psychiatric rehabilitation treatment, and partial hospitalization. The specific standards and criteria for mental health clinics are outlined in Title 14 NYCRR Parts 587, 588, 599, 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.

Objective

The objective of this audit was to assess Metropolitan Center for Mental Health's (Provider) adherence to applicable laws, regulations, rules and policies governing the New York State Medicaid program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate codes were billed for services rendered;
- recipient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with applicable rules and requirements.

Audit Scope

A review of OMH outpatient mental health services claims paid to the Provider by Medicaid for payment dates included in the period beginning January 1, 2014, and ending December 31, 2016, was completed.

The audit universe consisted of 100,132 claims totaling $12,604,167.75. The audit sample consisted of 100 claims totaling $11,795.95 (Attachment A).

Regulations of General Application

Each audit finding is supported by relevant regulations, policy statements and manuals. In addition, the audit findings in this audit are supported by regulations of general application to the Medicaid program. These regulations are provided below.

"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*

"Fee-for-service providers. (1) All providers ... must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor ... must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department ... for audit and review." *18 NYCRR Section 517.3(b)*

"All bills for medical care, services and supplies shall contain: (1) patient name, case number and date of service; (2) itemization of the volume and specific types of care, services and supplies provided (including for a physician, his final diagnosis, and for drugs, the prescription filled); (3) the unit price and total cost of the care, services and supplies provided; . . . and (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)(1)-(3) and (8)*

"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)*

"Vendor payments for medical care and other items of medical assistance shall not be made unless such care or other items of assistance have been furnished on the basis of the appropriate authorization prescribed by the rules of the board and regulations of the department."
18 NYCRR Section 540.1

"The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim."
18 NYCRR Section 518.3(a)

"The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished...." *18 NYCRR Section 518.3(b)*

"Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record." *18 NYCRR Section 518.3(b)*

Audit Findings

OMIG issued a Draft Audit Report to the Provider on July 28, 2021. This Final Audit Report incorporates consideration of any additional documentation and information presented in the Provider's October 1, 2021 response to the Draft Audit Report dated July 28, 2021. The attached Bridge Schedule (Attachment D) indicates any financial changes to the findings as a result of the Provider's response. A description of each finding, regulations, and the list of samples supporting each finding, appear below. Each sample may contain more than one error, and may be listed in more than one category of finding. A sample may only be disallowed once in an audit, however, each sample is subject to disallowance based on a single error.

Summary of Audit Findings

Error Description	Number of Errors
Incorrect Use of the Modifier Adjustment	21
No Explanation of Benefits (EOB) / Documentation for Medicare Covered Service	4
Incorrect Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) Service Classification	3
Duration of Service Not Documented	3
Brief Visit Billed as Regular/Extended Clinic Visit	3
Group Clinic Visit Billed as Regular Clinic Visit	2
Missing Physician Signature on Individual Treatment Plan or Treatment Plan Review	2
No EOB for Third Party Health Insurance (TPHI) Covered Service (Excluding Medicare)	2
Failure to Meet Group Clinic Visit Duration Requirements	1

Audit Findings Detail

OMIG's review of Medicaid claims paid to the Provider from January 1, 2014, through December 31, 2016, identified 35 claims with at least one error, for a total sample overpayment of $1,776.02 (Attachment C).

1. Incorrect Use of the Modifier Adjustment

"Modifiers means payment adjustments made to Medicaid fees for specific reasons such as billing for services in languages other than English and services delivered after hours.

14 NYCRR Section 599.4(aj)

"The treatment plan shall include, where applicable, documentation of the need for the provision of off-site services, special linguistic arrangements, or determination of homebound status."

14 NYCRR Section 599.10(h)

"Clinics may bill the physician modifier when psychiatrists, nurse practitioners in psychiatry or physicians approved pursuant to Section 599.9 of this Part spend at least 15 minutes serving the recipient during the time of the initial assessment is being conducted by another licensed practitioner." *14 NYCRR Section 599.14(d)(1)(i)(c)*

"Modifiers. Billing modifiers, including modifiers paid as supplementary rates to visits, are available pursuant to this section as indicated in the modifier chart included in this subdivision...." *14 NYCRR Section 599.14(e)*

In 21 instances pertaining to 19 recipients, the need for a modifier adjustment was not identified in the recipient record or there lacked documentation that the modifier adjustment was provided. The APG portion of the claim was reduced by the percentage of the modifier. This finding applies to Sample #s 5, 9, 12, 15, 16, 19, 28, 30, 38, 47, 48, 53, 56, 57, 66, 69, 73, 76, 85, 94 and 96.

2. No Explanation of Benefits (EOB) / Documentation for Medicare Covered Service

"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*

"No claim for reimbursement shall be submitted unless the provider...(i) investigated to find third-party resources....(ii) sought reimbursement from liable third parties."

18 NYCRR Section 540.6(e)(2)

Medicaid policy 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.

NYS Medicaid Program, Information For All Providers, Policy Guidelines, Version 2011-1 & 2, Section I

In 4 instances pertaining to 4 recipients, no Explanation of Medical Benefits (EOB) was found for a Medicare eligible recipient who received services covered by Medicare. This finding applies to Sample #s 24, 56, 59 and 99.

3. Incorrect Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) Service Classification

"Medicaid claims for individuals who have been admitted to a clinic treatment program shall include...the procedure code or codes corresponding to the procedure or procedures provided....[] The Provider must also comply with the requirements associated with any procedure code being billed." *14 NYCRR Section 599.14(a)*

New York State's OMH Interpretive/Implementation guidance states, "All fee-for-service Medicaid claims require the submission of the appropriate CPT code for the procedure provided and the appropriate rate code."

New York State OMH Interpretive/Implementation Guidance, 14 NYCRR Part 599, "Clinic Treatment Programs" 01-04-2012, Section X, p. 35

In 3 instances pertaining to 3 recipients, an incorrect CPT or HCPCS procedure code was billed which resulted in a higher reimbursement than indicated in the fee schedule for the appropriate procedure code. The CPT or HCPCS procedure code(s) billed must be consistent with the services documented in the treatment note for the visit. The claim was adjusted to reflect payment based on the correct procedure code for the documented service or visit. This finding applies to Sample #s 4, 55 and 65.

4. Duration of Service Not Documented

"Progress notes shall be recorded by the clinical staff member(s) who provided services to the recipient upon each occasion of service. ... The progress notes shall also document the date and duration of each service provided..." *14 NYCRR Section 599.10(k)*

In 3 instances pertaining to 3 recipients, the record did not indicate the duration of the billed service. This finding applies to Sample #s 13, 69 and 99.

5. Brief Visit Billed as Regular/Extended Clinic Visit

"A psychiatric assessment of at least 30 minutes of documented face-to-face interaction between the recipient and the psychiatrist or nurse practitioner in psychiatry shall be billed as a brief psychiatric assessment." *14 NYCRR Section 599.14(d)(1)(ii)(b)*

"A psychiatric assessment of at least 45 minutes of documented face-to-face interaction between the recipient and the psychiatrist or nurse practitioner in psychiatry shall be billed as an extended psychiatric assessment." *14 NYCRR Section 599.14(d)(1)(ii)(c)*

"brief individual psychotherapy service requires face-to-face service with the recipient of a minimum duration of 30 minutes." *14 NYCRR Section 599.14(d)(6)(i)(a)*

"extended individual psychotherapy service requires documented face-to-face service with the recipient of a minimum duration of 45 minutes. For school-based services, the duration services may be that of the school period provided the school period is of a duration of at least 40 minutes." *14 NYCRR Section 599.14(d)(6)(i)(b)*

In 3 instances pertaining to 3 recipients, a regular/extended clinic visit rate was billed when a brief visit was documented. The regular/extended clinic visit rate was reduced to a brief visit rate. This finding applies to Sample #s 40, 83 and 86.

6. Group Clinic Visit Billed as Regular Clinic Visit

Regulations describe the requirements for each level of billable psychotherapy service.
14 NYCRR Section 599.14(d)(6)

In 2 instances pertaining to 2 recipients, a regular clinic visit was billed when a group clinic visit was documented. The regular clinic visit fee was reduced to the group clinic visit fee. This finding applies to Sample #s 2 and 28.

7. Missing Physician Signature on Individual Treatment Plan or Treatment Plan Review

"Services required for ambulatory care for mental illness when certified by a physician to be medically necessary and appropriate, are covered services under the Medical Assistance Program." *18 NYCRR Section 505.25(e)(1)*

"State reimbursement shall be available for expenditures made in accordance with the provisions of this section and when the following conditions are met: (i) documentation by a physician that treatment is appropriate and necessary." *18 NYCRR Section 505.25(h)(1)(i)*

"The treatment plan for recipients receiving services reimbursed by Medicaid on a fee-for-service basis shall be signed by a psychiatrist or other physician, ..."
14 NYCRR Section 599.10(c)

"The periodic review of the treatment plan shall include the following: (4) For recipients receiving services reimbursed by Medicaid on a fee-for service basis, the signature of the physician..."
14 NYCRR Section 599.10(j)(4)

In 2 instances pertaining to 2 recipients, the treatment plan or review lacked the required physician signature. This finding applies to Sample #s 3 and 17.

8. No EOB for Third Party Health Insurance (TPHI) Covered Service (Excluding Medicare)

"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*

"No claim for reimbursement shall be submitted unless the provider... ...(i) investigated to find third-party resources....(ii) sought reimbursement from liable third parties."
18 NYCRR Section 540.6(e)(2)

Medicaid policy 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.
NYS Medicaid Program, Information For All Providers, Policy Guidelines, Version 2011-1 & 2, Section I

In 2 instances pertaining to 2 recipients, no Explanation of Medical Benefits (EOB) was found for a recipient who received services covered by third party health insurance. This finding applies to Sample #s 17 and 58.

9. Failure to Meet Group Clinic Visit Duration Requirements

"Psychotherapy - multi-recipient group requires documented face-to-face services with a minimum of two recipients and a maximum of 12 recipients for services of a minimum duration of 60 minutes. For school-based services, the duration of such services may be that of the school period provided the school period is of a duration of at least 40 minutes."

14 NYCRR Section 599.14(d)(6)(iv)

In 1 instance, a clinic group therapy visit of less than 60 minutes or school based group therapy service of less than 40 minutes was billed. This finding applies to Sample # 28.

Repayment Options

In accordance with 18 NYCRR Part 518, which regulates the collection of overpayments, your repayment options are described below.

Option #1: Make a full payment by check, money order, or OMIG's Online Payment Portal within 20 days of the date of the Final Audit Report.

- The check should be made payable to the New York State Department of Health, should include the audit number on the memo line, and be mailed with the attached remittance advice to:

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

- If you elect to pay electronically through OMIG's Online Payment Portal, please visit or contact OMIG's Bureau of Collections Management by telephone or email, at the above number or address.

Option #2: Enter into a repayment agreement with OMIG. If your repayment terms exceed 90 days from the date of the Final Audit Report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. OMIG's acceptance of a repayment agreement is based on your repaying the Medicaid overpayment as agreed. OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days, by telephone or email, as provided above.

Should you fail to select a payment option above within 20 days of the date of this Report, OMIG will initiate recoupment by withholding all or a part of your payments otherwise payable, in accordance with 18 NYCRR 518.6. Additionally, OMIG reserves the right to use any remedy allowed by law to collect the amount due. Pursuant to the State Finance Law Section 18(5), a collection fee equal to twenty two percent (22%) of the amount due, including interest, may be added to the amount owed.

Hearing Rights

If you choose not to settle this audit through repayment of the lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where OMIG would seek and defend the point estimate of $1,778,364. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, NY 12204

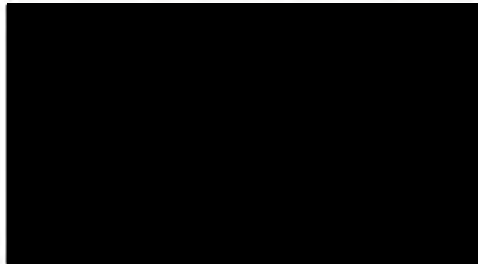
Questions regarding the request for a hearing should be directed to Office of Counsel, at [redacted]

In accordance with 18 NYCRR Section 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply along with your hearing request a signed authorization permitting that person to represent you at the hearing; you may call witnesses and present documentary evidence on your behalf.

For a full listing of hearing rights please see 18 NYCRR Part 519.

Contact Information



Office Address:

New York State
Office of the Medicaid Inspector General
Division of Medicaid Audit
90 Church Street, 14th Floor
New York, New York 10007

Mission

The mission of the Office of the Medicaid Inspector General is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care.

Vision

To be the national leader in promoting and protecting the integrity of the Medicaid program.

Office of the
Medicaid Inspector
General

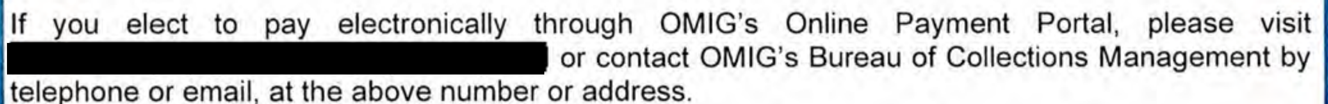
REMITTANCE ADVICE

Metropolitan Center for Mental Health **160 West 86th Street** **New York, New York 10024**	**Provider ID #: 00244335** **Audit #: 19-4575**
Amount Due: $1,075,096	**Audit Type** ☐ **Managed Care** ☒ **Fee-for-Service** ☐ **Rate**

Checklist

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

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



If you elect to pay electronically through OMIG's Online Payment Portal, please visit or contact OMIG's Bureau of Collections Management by telephone or email, at the above number or address.