



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

REVIEW OF UCP OF ULSTER COUNTY
CLAIMS FOR DAY TREATMENT SERVICES
PAID FROM
JANUARY 1, 2009 – MARCH 31, 2010

FINAL AUDIT REPORT
AUDIT #10-8210

James C. Cox
Medicaid Inspector General

July 11, 2013



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

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

July 11, 2013

[REDACTED]
UCP of Ulster County Day Treatment
P.O. Box 1488
Kingston, NY 12402

Re: Final Audit Report
Audit #: 10-8210

Dear [REDACTED]:

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of UCP of Ulster County Day Treatment" (the Provider) paid claims for day treatment services covering the period January 1, 2009, through March 31, 2010.

In the attached final audit report, the OMIG has detailed our scope, procedures, laws, regulations, rules and policies, sampling technique, findings, provider rights, and statistical analysis.

The OMIG has attached the sample detail for the paid claims determined to be in error. This final audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report dated October 17, 2011. The mean point estimate overpaid is \$1,162,084. The lower confidence limit of the amount overpaid is \$994,359. 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 \$994,359.

[REDACTED]
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July 11, 2013

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED] at [REDACTED] or through email at [REDACTED]. Please refer to report number 10-8210 in all correspondence.

Sincerely,

[REDACTED]

Coordinator, Medicaid Facilities Audit
Division of Medicaid Audit, Albany Office
Office of the Medicaid Inspector General

[REDACTED]
Enclosure

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

Ver-3.0

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to assess compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to assess the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

DIVISION OF MEDICAID INVESTIGATIONS

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and state governments jointly fund and administer the Medicaid program. In New York State, the Department of Health (DOH) administers the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

Outpatient services provided to persons with developmental disabilities are offered at programs licensed by the Office for People with Developmental Disabilities (OPWDD). The purpose of these programs is to offer a comprehensive system of services, which has as its primary purposes the promotion and attainment of independence, inclusion, and productivity for persons with mental retardation and developmental disabilities. These services are furnished at clinic and day treatment facilities, and through a home and community based Federal waiver program. The waiver program, established under the authority of section 1915 [c] of the Social Security Act, is intended for persons with mental retardation and developmental disabilities who would otherwise need the level of care provided in an intermediate care facility. The specific standards and criteria for OPWDD services are outlined in Title 14 NYCRR Parts 671, 679, and 690.

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for day treatment services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to day treatment services, this audit covered services paid by Medicaid from January 1, 2009, through March 31, 2010.

SUMMARY OF FINDINGS

We inspected a random sample of 100 claims with \$35,304.51 in Medicaid payments. Of the 100 claims in our random sample, 69 claims had at least one error and did not comply with state requirements. Of the 69 noncompliant claims, most contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Missing Physician Review of Individual Treatment Plan	227
Missing Progress Note	15
Incorrect Rate Code Billed	14
Duration of Service Not Documented	6
Missing Record of Attendance	5
No Documentation of Service	5
Failure to Meet Minimum Duration	5
No Documentation of Allowable Service	5
Missing Comprehensive Functional Assessment	5

Based on the procedures performed, the OMIG has determined that the Provider was overpaid \$23,278.92 in sample overpayments with an extrapolated point estimate of \$1,162,084. The lower confidence limit of the amount overpaid is \$994,359.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including day treatment claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

New York State's Day Treatment Program

Outpatient services provided to persons with developmental disabilities are offered at programs licensed by the Office for People with Developmental Disabilities (OPWDD). The purpose of these programs is to offer a comprehensive system of services, which has as its primary purposes the promotion and attainment of independence, inclusion, and productivity for persons with mental retardation and developmental disabilities. These services are furnished at clinic and day treatment facilities, and through a home and community based Federal waiver program. The waiver program, established under the authority of section 1915 [c] of the Social Security Act, is intended for persons with mental retardation and developmental disabilities who would otherwise need the level of care provided in an intermediate care facility. The specific standards and criteria for OPWDD services are outlined in Title 14 NYCRR Parts 671, 679, and 690.

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for day treatment complied with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;

- patient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

Scope

Our audit period covered payments to the Provider for day treatment services paid by Medicaid from January 1, 2009, through March 31, 2010. Our audit universe consisted of 4,992 claims totaling \$1,721,097.60.

During our audit, we did not review the overall internal control structure of the Provider. Rather, we limited our internal control review to the objective of our audit.

Methodology

To accomplish our objective, we:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with the Provider's management personnel to gain an understanding of the day treatment services program;
- ran computer programming application of claims in our data warehouse that identified 4,992 paid day treatment claims, totaling \$1,721,097.60;
- selected a random sample of 100 claims from the population of 4,992 claims; and,
- estimated the overpayment paid in the population of 100 claims.

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

- Medicaid electronic claim information
- Individual Day Treatment record, including, but not limited to:
 - Annual Physical
 - Individual Program Plan
 - Individual Treatment Plan
 - Comprehensive Functional Assessment
 - Documentation demonstrating licensed physician of the individual treatment plan
 - Physical Therapy Documentation
 - Occupational Therapy Documentation
 - Speech Therapy Documentation
 - Progress notes
 - Treatment Notes
 - Census Records
- Any additional documentation deemed by the Provider necessary to substantiate the Medicaid paid claim

LAWS, REGULATIONS, RULES AND POLICIES

The following are applicable Laws, Regulations, Rules and Policies of the Medicaid program referenced when conducting this audit:

- Departments of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, Title 14 NYCRR Part 690 and Title 18 NYCRR Parts 360, 504 and 540.
- OPWDD Administrative Memorandum #2008-02
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."
18 NYCRR Section 504.3

Regulations state: "All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing . . . ; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment . . . ; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided. . . ."
18 NYCRR Section 540.7(a)

Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake."
18 NYCRR Section 518.1(c)

Furthermore, according to regulations, all providers must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. In addition, the provider must keep, for a period of six years, all records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply. This information is subject to audit for a period of six years and must be furnished, upon request.

18 NYCRR Section 517.3(b)

DETAILED FINDINGS

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2009, through March 31, 2010, identified 69 claims with at least one error, for a total sample overpayment of \$23,278.92 (Attachment C).

Sample Selection

1. Missing Physician Review of the Individual Treatment Plan

Regulations require that each day treatment facility have a licensed physician responsible for "reviewing each person's treatment plan or any substantial revisions within 30 days of its implementation, and indicating by signature that said treatment plan . . . is appropriate and not medically contraindicated."

14 NYCRR Section 690.5(b)(3)(ii)

In 227 instances pertaining to 28 recipients, the treatment plan or substantial revisions lacked the required physician signature.

2. Missing Progress Note

Regulations state, "OPWDD shall verify that individual program plans of persons admitted to the day facility include: (1) progress notes describing the person's response in terms of the established objectives."

14 NYCRR Section 690.6(s)(1)

In 15 instances pertaining to 5 recipients, the required progress note was missing.

3. Incorrect Rate Code Billed

Regulations state, "Persons provided day treatment services in a free-standing certified site or approved satellite . . . site, will attend for periods in excess of three hours if reimbursement is to be claimed. A reimbursable half-day visit covers a period of three to five hours. A full-day reimbursable visit covers a period of five hours or more."

14 NYCRR Section 690.1(d)(1)

In 14 instances pertaining to 10 recipients, an incorrect rate code was billed which resulted in a higher reimbursement than indicated for the proper rate code.

1, 2, 3, 4, 7, 8, 10, 12, 13, 15, 17, 18, 19, 20, 21, 22, 25, 27, 28, 29, 32, 33, 34, 36, 37, 38, 41, 42, 43, 44, 45, 47, 48, 49, 50, 51, 52, 54, 55, 57, 61, 62, 64, 66, 67, 69, 71, 72, 77, 78, 79, 80, 81, 83, 85, 88, 90, 92, 93, 96, 97, 98

8, 31, 35, 65, 69

15, 29, 32, 33, 36, 39, 48, 67, 73, 77, 97, 98, 99

4. Duration of Service Not Documented

65, 69

Regulations state, "The administrator shall maintain or cause to be maintained . . . a daily census record, including daily census and cumulative census for each month and year, accompanied by records which document and fully detail the extent of services provided and the length of each service"

14 NYCRR Section 690.5(b)(2)(xv)(b)

Regulations state, "OPWDD shall verify that individual program plans of persons admitted to the day facility include . . . an activity and attendance schedule."

14 NYCRR Section 690.6(s)(4)

In 6 instances pertaining to 2 recipients, the duration of the day treatment service was not documented.

5. Missing Record of Attendance

8

Regulations state, "The administrator shall maintain . . . a daily census record, including daily census and cumulative census for each month and year, accompanied by records which document and fully detail the extent of services provided and the length of each service."

14 NYCRR Section 690.5(b)(2)(xv)(b)

Regulations state, "OPWDD shall verify that individual program plans of persons admitted to the day facility include . . . an activity and attendance schedule."

14 NYCRR Section 690.6(s)(4)

In 5 instances pertaining to 1 recipient, no daily census record was available.

6. No Documentation of Service

8

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

18 NYCRR Section 504.3(a)

Regulations also require that bills for medical care, services and supplies contain a certification that such records as are necessary to disclose fully the services provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years. These records must be furnished to the Department upon request.

18 NYCRR Section 540.7(a)(8)

Regulations state, "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, the Secretary of the United States Department of Health and Human Services, the Medicaid Fraud Control Unit or the New York State Department of Health for audit and review."

18 NYCRR Section 517.3(b)(2)

In 5 instances pertaining to 1 recipient, the records did not document that a service was provided.

7. Failure to Meet Minimum Duration Requirements for Non-Collocated Day Treatment Services 11, 36, 48, 54, 73

Regulations state, "Persons provided day treatment services in a free-standing certified site or approved satellite . . . site, will attend for periods in excess of three hours if reimbursement is to be claimed."

14 NYCRR Section 690.1(d)(1)

In 5 instances pertaining to 3 recipients, day treatment services of less than three hours were billed.

8. No Documented Allowable Service 8

Regulations state, "The day treatment facility is required to provide . . . a planned combination of diagnostic, treatment and habilitation services . . . Allowable services . . . include: independent living services; medical oversight services; nursing services; nutrition services; occupational therapy services; physical therapy services; psychology services; self-care services; social work services; speech pathology services; and therapeutic recreational services."

14 NYCRR Section 690.3(a)(1)(i-xi)

In 5 instances pertaining to 1 recipient, the record did not document at least one of the required services.

9. Missing Comprehensive Functional Assessment 25, 34, 64

Regulations state, "Within the 21 working days after the date of admission, the following shall have been completed . . . a comprehensive functional assessment."

14 NYCRR Section 690.5(d)(5)(iii)(b)

Regulations state, "At least annually, the interdisciplinary treatment team shall meet to review and evaluate each person's individual program plan . . ."

14 NYCRR Section 690.5(d)(9)(ii)

In 5 instances pertaining to 1 recipient, the required comprehensive functional assessment was missing.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the lower confidence limit amount of \$994,359, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order within 20 days of the date of the final audit report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #10-8210
Albany, New York 12237

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final audit report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 15% withhold after 20 days until the agreement is established.

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

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

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

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of \$1,162,084. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

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

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

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing you have the right to:

- a) be represented by an attorney or other representative, or to represent yourself;
- b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
- c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

██████████
UCP of Ulster County Day Treatment
P.O. Box 1488
Kingston, New York 12402

PROVIDER ID ██████████

AUDIT #10-8210

AMOUNT DUE: \$994,359

AUDIT

TYPE

PROVIDER
 RATE
 PART B
 OTHER:

CHECKLIST

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

██████████
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File #10-8210
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN AND METHODOLOGY

Our sample design and methodology are as follows:

- **Universe** - Medicaid claims for day treatment services paid during the period January 1, 2009, through March 31, 2010.
- **Sampling Frame** - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for day treatment services paid during the period January 1, 2009, through March 31, 2010.
- **Sample Unit** - The sample unit is a Medicaid claim paid during the period January 1, 2009, through March 31, 2010.
- **Sample Design** – Simple sampling was used for sample selection.
- **Sample Size** – The sample size is 100 claims.
- **Source of Random Numbers** – The source of the random numbers was the OMIG statistical software. We used a random number generator for selecting our random sampling items.
- **Characteristics to be measured** - Adequacy of documentation received supporting the sample claims.
- **Treatment of Missing Sample Services** - For purposes of appraising items, any sample service for which the Provider could not produce sufficient supporting documentation was treated as an error.
- **Estimation Methodology** – Estimates are based on the sample data using per unit estimates.

SAMPLE RESULTS AND ESTIMATES

Universe Size	4,992
Sample Size	100
Sample Book Value	\$35,304.51
Sample Overpayments	\$23,278.92
Net Financial Error Rate	65.938%
Mean Dollars in Error	\$232.7892
Standard Deviation	204.46
Point Estimate of Total Dollars	\$1,162,084
Confidence Level	90%
Lower Confidence Limit	\$994,359

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 UCP of ULSTER COUNTY
 REVIEW OF DAY TREATMENT SERVICES
 PROJECT #10-8210
 REVIEW PERIOD:
 01/01/09 - 03/31/10

Sample Number	Date of Service	Rate Code		Amount		Over Payment	DETAILED AUDIT FINDINGS											
		Billed	Derived	Billed	Derived		1. MISSING PHYSICIAN REVIEW OF ITP	2. MISSING PROGRESS NOTE	3. INCORRECT RATE CODE BILLED	4. Duration of Service Not Documented	5. MISSING RECORD OF ATTENDANCE	6. NO DOCUMENTATION OF SERVICE DURATION	7. FAILURE TO MEET MINIMUM SERVICE	8. NO DOCUMENTATION OF ALLOWABLE FUNCTIONAL ASSESSMENT				
98	08/20/09	4170		\$ 99.16	\$ -	\$ 99.16	X											
	08/21/09	4170		99.16	-	99.16	X											
	02/17/09	4170		98.21	-	98.21	X											
	02/18/09	4170		98.21	-	98.21	X											
	02/19/09	4170		98.21	-	98.21	X		X									
	02/20/09	4170		98.21	-	98.21	X											
99	09/08/09	4170	4171	99.16	49.58	49.58				X								
	09/09/09	4170		99.16	99.16	-												
	09/10/09	4170		99.16	99.16	-												
	09/11/09	4170		99.16	99.16	-												
100	11/12/09	4170	4170	99.16	99.16	-												
	11/13/09	4170	4170	99.16	99.16	-												
Totals				\$35,304.51	\$11,926.63	\$23,278.92	227	15	14	6	5	5	6	6	6	5		