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July 22, 2014

Kerry A. Delaney
Acting Commissioner
New York State Office for People with Developmental Disabilities
44 Holland Avenue
Albany, New York 12229

Re: NYS IG 0252-031-2012

Dear Acting Commissioner Kelley:

The Office for People with Developmental Disabilities (OPWDD) notified the Inspector General that discrepancies were identified in reports written by OPWDD Medicaid Service Coordinator [redacted] related to services billed to Medicaid. I am writing to advise you of the results of our review of this matter.

As a Medicaid Service Coordinator assigned to the Finger Lakes Developmental Disabilities Services Office, [redacted] provided service coordination to developmentally disabled people in that region. [redacted] was responsible for providing this coordination to approximately 40 individuals residing in state-operated facilities, volunteer-operated facilities, family care homes, and individuals living on their own at home.

As you know, many Medicaid Service Coordinators' contacts with these individuals are billed to Medicaid, and Medicaid requires submission of the specified number of contacts and maintenance of supporting documentation. The Medicaid Service Coordinators prepare a report of reimbursable contacts which is forwarded to the OPWDD billing office, which in turn submits them for Medicaid reimbursement.

As per OPWDD policy, Medicaid Service Coordinators are required to document – generally in the form of a Medicaid Service Coordinator note – visits or other contacts with individuals receiving services. The notes must be submitted to an OPWDD supervisor by the 15th

day of the month following the contact. Failure to document services provided is a violation of OPWDD policy and may result in denial of Medicaid reimbursement.

In late November 2011, [redacted] took medical leave. Prior to the leave, her supervisor instructed that she complete and submit all her required paperwork, including Medicaid Service Coordinator notes. While [redacted] was on medical leave, employees who were covering her workload noticed that Medicaid Service Coordinator notes were missing from a number of files.

As a result, [redacted], [redacted] of the Finger Lakes Developmental Disabilities Services Office's Medicaid Service Coordination Program, reviewed [redacted]'s assignments from January 1, 2011, to the date [redacted] medical leave commenced. [redacted] became [redacted] supervisor after she went on medical leave. [redacted]'s review found 19 instances where [redacted] reported a service contact for billing to Medicaid, but failed to create the required Medicaid Service Coordinator note documenting the contact. [redacted] then reviewed other paperwork, including facility sign-in sheets, mileage logs, and time records, in an attempt to corroborate the contacts claimed by [redacted]. [redacted] found some documentation in six of the 19 cases. However, in 13 cases she was unable to find any corroboration of the contacts claimed by [redacted]. As a result of [redacted] findings, OPWDD placed [redacted] on administrative leave upon her return from medical leave in January 2012.

OPWDD determined that [redacted] conduct may have constituted a fraud and appropriately notified my office. We then conducted an independent review of this matter that confirmed that [redacted] failed to properly document service visits and/or contacts as required by OPWDD policy. [redacted]'s contacts with individuals who receive services from OPWDD included personal visits, telephone calls, or communication with others associated with the individual, i.e., family members or service providers. However, given the absence of any documentation and the various possible types of contacts, it was not feasible to determine with certainty that these contacts had not occurred; thus, no finding of fraud could be reached. When [redacted] returned to work from administrative leave in December 2012, OPWDD assigned her to a position that does not involve the documentation of Medicaid services. Despite the findings of OPWDD, confirmed by my office, that [redacted]'s conduct violated agency policy, OPWDD did not initiate disciplinary action against her.

When questioned recently by my office, [redacted] advised that [redacted]'s failure to file the Medicaid Service Coordinator notes was only discovered because other employees noticed their absence while she was on leave; the errors were not discovered as part of an established review process. Asked if supervisors review Medicaid Service Coordinator notes in any systemic manner, [redacted] advised us that there has never been in place a procedure for supervisory review of the notes as they are completed. She stated that staffing levels were insufficient to accomplish such a task. [redacted] further explained that, in the western region, supervisors typically reviewed one or two files of each Medicaid Service Coordinator a month to ensure compliance with all requirements including notes. These reviews were not, however, documented.

[redacted] for OPWDD, advised my investigators that OPWDD normally informs the Office of the Medicaid Inspector General when such non-compliance issues arise and conducts a comprehensive audit to determine if additional Medicaid

charges should be voided. OPWDD, however, did not initially do that in this case because it believed that it should take no action pending the Inspector General's review. Upon [redacted] return, OPWDD did conduct a comprehensive audit of [redacted] 2011 work and found additional billings in which the required documentation was not properly completed by [redacted]. OPWDD advised the Office of the Medicaid Inspector General of these deficiencies and voided over $40,000 of charges.

OPWDD further advised us that it is in the process of transferring many of the active state-operated Medicaid service coordination cases in the Finger Lakes Region to voluntary, not-for-profit providers, and that most of the Medicaid Service Coordinators have been transferred to other functions. As a result, potential problems such as those raised by [redacted] conduct may be significantly less likely to occur in the future. However, given that [redacted] failures were not discovered until months after they occurred, and may never have been discovered but for her leave, I recommend that OPWDD strengthen its internal controls and documentation system for Medicaid Service Coordinators to avoid this type of situation in the future. Specifically, OPWDD should implement formal procedures requiring that the supervisors of Medicaid Service Coordinators review a sampling of notes and other required documentation each month and document that review. Such review should be heightened for any employee with a history of failing to properly complete the appropriate documentation. Supervisors and staff should be trained in these new procedures.

It is requested that within 30 days you provide a detailed response to this recommendation, including a copy of new procedures. If you have any questions regarding this matter, you can contact me at (518) 474-1010.

Sincerely,

[redacted]

Catherine Leahy Scott
Inspector General