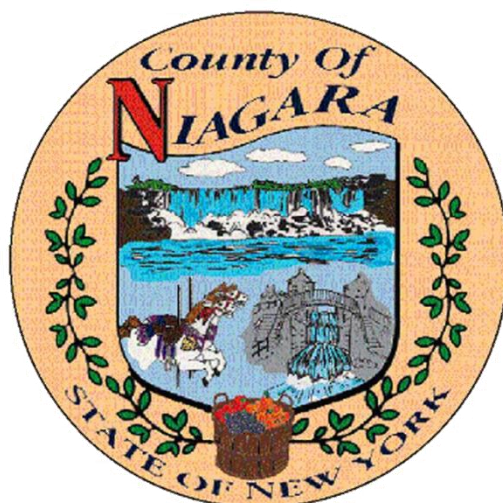


**Niagara County
Health Department
Children with Special Needs Division**



**Medicaid Compliance
Plan**

Updated March 2025

Purpose of Medicaid Compliance Program

Effective April 2020, for New York State (NYS) Social Services Law (SSL) §363-d, and effective December 28, 2022, for the corresponding regulations at 18 New York Codes, Rules and Regulations (NYCRR) Subpart 521-1, NYS Medicaid providers shall adopt, implement, and maintain effective compliance programs aimed at detecting fraud, waste, and abuse in the NYS Medicaid program. All NYS Medicaid providers subject to the provisions of Public Health Law (PHL) Articles 28 or 36, providers subject to the provisions of Mental Hygiene Law (MHL) Articles 16 or 31, Medicaid Managed Care (MMC) providers of Managed Long Term Care (MLTC) Plans [collectively, Medicaid Managed Care Organization (MMCOs)], and those providers for which the NYS Medicaid program "constitutes a substantial portion of business operations," are required to have an effective compliance program.

The Office of the Medicaid Inspector General (OMIG) defines "substantial portion of business operations" as claiming or receiving \$1,000,000 or more in the aggregate in a consecutive 12-month period, directly or indirectly, from the NYS Medicaid program. OMIG has the responsibility under SOS §363-d and Subpart 521-1 to determine if compliance programs meet the requirements of the law and regulation. An "effective" compliance program is defined in Subpart 521-1 as a compliance program adopted and implemented by the required provider that, at a minimum, satisfies the requirements of Subpart 521-1 and that is designed to be compatible with the provider's characteristics.

A compliance program should include, at a minimum, the following seven elements:

1. written policies and procedures;
2. the designation of a compliance officer and compliance committee;
3. compliance training and education;
4. lines of communication to the provider's compliance officer or compliance function;
5. disciplinary policies to encourage good faith participation in the compliance program;
6. auditing and monitoring compliance risk areas; and
7. responding to compliance issues.

Effective compliance programs, in meeting the above seven elements, are expected to establish systemic checks and balances to detect and prevent inaccurate billing and inappropriate practices in the NYS Medicaid program; address the requirement to self-disclose, explain, and repay identified overpayments; address the responsibility of the provider to check for excluded persons who may be involved in the provision of NYS Medicaid services; and other obligations that may be specific to the size, complexity, resources, and culture of the provider. The OMIG Bureau of Compliance regularly conducts reviews of providers to ensure they have a compliance program, if required, and that the compliance program is effective.

Required providers who fall under the requirements of the regulation are required to certify upon enrollment and annually using the eMedNY/Medicaid Management Information System – Certification Statement for Provider Billing Medicaid form (EMEDNY 490601). Each year, approximately 45 to 60 days before the enrollment anniversary of a provider, the NYS Department of Health (DOH) mails a package of information and materials to the provider, which includes the EMEDNY 490601 form. This form must be completed and returned by the enrollment anniversary date. Failure to adopt, implement, and maintain an effective compliance program may result in sanctions or penalties, including, but not limited to, the revocation of the provider's agreement to participate in the NYS Medicaid program.

Additional guidance and information on compliance requirements can be found on the OMIG website.

The Niagara County Health Department, Children with Special Needs(CWSN) Division has developed a Medicaid Compliance Program as required by Social Services Law 363-d. Our Early Intervention and Preschool Supportive Health Services programs bill Medicaid in excess of \$1,000,000 annually.

The purpose of the Niagara County Health Department, Children with Special Needs (CWSN) Division Medicaid Compliance Program, is to clearly articulate the division's commitment and obligation to to comply with all applicable federal and state standards, along with implementing policies and procedures that are designed to preserve the integrity and safeguard assets of the Medicaid program and identify internal controls and procedures that promote adherence to statutes and regulations applicable to Federal Healthcare Programs and private insurance requirements. The subsequent policies, forms and documents provide guidance to all affected individuals, including direct Niagara County employees, independent and agency contractors that provide preschool services for Niagara County families and the Niagara County Board of Health (Health Department's governing body), regarding the operation of the Medicaid Compliance Program and the available mechanisms through which compliance issues are identified and ways in which they can and should be reported.

Affected Individuals

Niagara County Employees/Internal staff- This description includes the providers of service, billing staff, support staff and supervisors, including the Chief Executive/Public Health Director, who are directly employed by Niagara County and work within the Department of Health/CWSN Division. These employees have roles and/or provide services through the Preschool Supportive Health Services Program (PSSHSP) and/or the Early Intervention Program (EIP). In addition to the general Medicaid Compliance Program, Niagara County employees must comply with policy and procedures directly related to either the PSSHSP and/or EIP, which are both found in this compliance program.

Contracted Providers-This includes agencies and individual/independent providers who have entered in contract with Niagara County to provide services under the of Preschool Supportive Health Services Program. These providers contractually through our reassignment of benefits, fall under the division's Medicaid Compliance Program in the same way as our own division employees. Contracted Providers are trained annually with the division's own employees regarding their responsibilities under the program and must comply with the strict documentation policy and procedures put in place to protect the integrity of the Medicaid system. Any agencies who contract with Niagara County are obligated to disseminate this plan and train any and all employees who provide services for Niagara County children. Specific information about the compliance program as related to the Early Intervention Program is shared with agencies who have a provider agreement in place with the NYSDOH/Bureau of Early Intervention Program (EIP) and service children residing in Niagara County but since individual counties no longer contract with provider for the EIP each agency/ independent provider is responsible for their own policies and procedures surrounding billing and claiming Medicaid funds in the EIP.

Niagara County Board of Health(BOH)- This includes all active BOH members, Public Health Director and Niagara County Attorney. As the governing body of the Niagara County Department of Health, the BOH is made aware of and trained in their responsibilities regarding Medicaid Compliance. All elements of the program are shared at least annually including: Identifying the current Medicaid Compliance Officer, outlining lines of communication within the division, and the system to respond to issues. Also shared are written policies regarding training and education, disciplinary and non-intimidation policies, and routine identification of compliance risk areas.

Agents-Niagara County works with James P. McGuinness and Associates utilizing a variety of their software systems to record, pay and bill for services under the Preschool Supportive Health Services Program. The county contract includes "Full Service Medicaid" (FSM), McGuinness staff complete most aspects of Medicaid auditing and billing for dates of service beginning September 1, 2024. As part of this service McGuinness offers Annual and ongoing training to all service providers and county staff on targeted compliance areas throughout the year. McGuinness works with contractors to ensure documentation meets the Medicaid billing requirements.

The division considers this plan a fluid document and changes will be made throughout the year as needed. A formal review of the written policies and procedures and standards of conduct is completed and documented by the Medicaid Compliance officer/committee, at least annually. In addition, the Medicaid Compliance Plans and Programs are certified annually using the *eMedNY/Medicaid Management Information System – Certification Statement for Provider Billing Medicaid* form (EMEDNY 490601). Training for staff, contracted providers and the BOH is addressed later in this plan.

This plan was established to fulfill the Division's legal responsibility to submit accurate claims to Medicaid and other payors, to identify and prevent illegal conduct and to minimize losses from false claims, to prevent unwanted events from occurring, and to help the Division learn about these events before they occur and if the event occurs without the Division learning about it first, this plan will help mitigate or reduce negative effects by demonstrating that these events are exceptions.

Each affected individual working for or with the Niagara County Health Department-CWSN program is responsible for adhering to the standards and the policies of the Medicaid Compliance Program.

Code of Conduct

Niagara County has an established Code of Ethics. This Code of Ethics is enacted pursuant to Article 18 of the General Municipal Law. It is the purpose of this Code to encourage public trust and to establish minimum standards of ethical conduct for County officers, employees, and other appointed officials, to afford them clear guidance, and to ensure that County government is so free from improper influence as to assure public confidence. Employees can access the current [Niagara County Code of Ethics](#) by clicking on the text, or through the county network Intranet.

In keeping with its ethics code, the Niagara County Health Department CWSN Division has developed a Medicaid Compliance Plan to reaffirm the commitment of this Division to abide by high legal and ethical standards in connection with the delivery of health care services by division employees and contractors who provide our services. Reportable incidents based on the Medicaid Compliance Plan include:

- Any employee or contractor who acquires information that gives him or her reason to believe that another employee or contractor is engaged in or plans to engage in conduct prohibited by the Medicaid Compliance Plan
- Any information indicating that any other person or entity associated with Niagara County Health Department CWSN Division plans to violate the standards of conduct or the policies and procedures contained in the Medicaid Compliance Plan or any other policies and procedures;
- Anyone who is instructed, directed, or requested to engage in conduct prohibited by the Medicaid Compliance Plan;
- Any other issues about which employees or contractors believe involve questionable activity;

Employees, contractor, agents or BOH members aware of any incidents, which fit the description above, must immediately refer to the Medicaid Compliance Plan section on Reporting Requirements and take action. Failure to take action is a violation of this compliance plan and may result in disciplinary actions.

Medicaid Compliance Officer(MCO)

The Niagara County Public Health Director appoints the Medicaid Compliance Officer. Documentation of this appointment is maintained in the division compliance manual. The CWSN Director, an employee of the Niagara County Department of Health, is currently the appointed MCO for the CWSN Division. The Director will consult with the Public Health Director, County Attorney and Board of Health, as needed.

The County Attorney shall be required to render all legal opinions; advise the Compliance Officer on developments and changes in the laws, regulations and policies that effect the Medicaid Compliance Plan; and advise on any enforcement or discipline pertaining to reports of misconduct, in conjunction with Human Resources.

The Compliance Officer's primary responsibilities include:

- Overseeing and monitoring the adoption, implementation and maintenance of the compliance program and evaluating its effectiveness;
- Drafting, implenting and updating no less frequently than annually or, as otherwise necessary, to conform to changes to Federal and State laws, rules, regualtions, policies and standards, a compliance work plan which shall outline the required provider's proposed strategy for meeting requirement of the compliance program;
- Reviewing and revising the compliance program, the written policies and procedures and standards of conduct, to incorporate changes based on the required provider's organizational experience and promptly incorporate changes to Federal and State laws, rules, regulations, policies and standards;
- Reporting directly, on a regular basis, but no less frequently than quarterly, to the required provider's governing body, chief executive, and compliance committee on the progress of adopting, implementing, and maintaining the compliance program;
- Assisting the required provider in establishing methods to improve the required provider's efficiency, quality of services, and reducing the required provider's vulnerability to fraud, waste and abuse;
- Investigating and independently acting on matters related to the compliance program, including designing and coordinating internal investigations and documenting, reporting, coordinating, and pursuing any resulting corrective action with all internal departments, contractors, and the State; and
- Coordinating the implementation of the fraud, waste, and abuse prevention program.

Medicaid Compliance Committee

The CWSN Compliance Committee consists of division leadership, Director/ MCO, Supervisor and Administrative Assistant as well as various Account Clerical staff responsible for day to day operations. All compliance personnel have access to all records, documents, information facilities and Affected Individuals that are relevant to their compliance responsibilities.

Division Director acts as chairperson of the committee and is responsible for reporting directly to Public Health Director and/or Board of Health, as governing body (see illustration below).

Responsibilities of the Compliance Committee include:

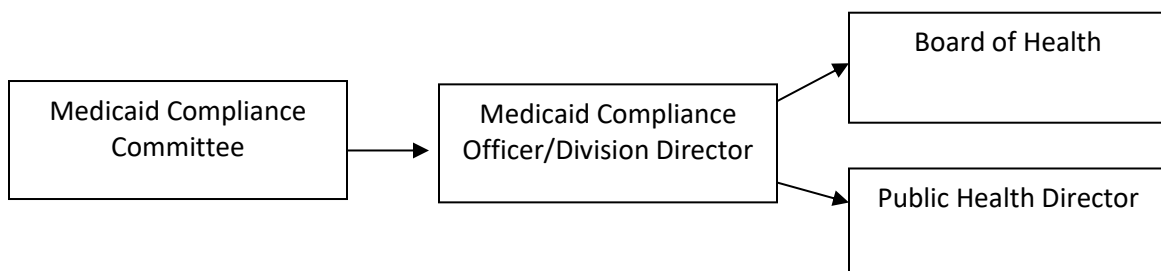
- Coordinating with the compliance officer to ensure that all written policies and procedures, and standards of conduct are current, accurate and complete.
- Coordinating with the compliance officer to ensure communication and cooperation by affected individuals on compliance related issues, including internal or external reviews.
- Advocating for the allocation of sufficient funding, resources and staff for the compliance officer to fully perform responsibilities.
- Ensuring the required provider has effective systems and processes in place to identify compliance program risks, overpayments and other issues, and effective policies and procedures for correcting and reporting such issues.
- Advocating for adoption and implementation of required modifications to the compliance program.

The compliance committee will meet at least quarterly each year, more often if indicated, to review the compliance plan and address any issues identified through day-to-day implementation of the compliance plan. Committee may share information via e-mail correspondence to expedite decision making when appropriate. Meeting attendance and minutes will be recorded and distributed for each compliance committee meeting.

Each Compliance Committee member plays an integral role in identifying necessary changes to the Medicaid Compliance plan, which may be identified through billing audits, review of guidance materials or information shared from oversight entities.

Members of the Medicaid Compliance Committee also conduct an Annual Compliance Program Self-Assessment to drive updates and changes to the Compliance Plan.

Compliance Committee Reporting Structure



Education and Training on Medicaid Compliance Plan

The initial training for new employees (all CWSN staff), the Niagara County Public Health Director, Niagara County Attorney, and new BOH members shall include, at a minimum, review of the Medicaid Compliance Plan and the applicable federal and state regulatory requirements relating to the provision of Medicaid services by Niagara County Health Department CWSN division. This initial training is completed during the orientation period. Each new CWSN staff member will be required to review and indicate understanding of these requirements and the Medicaid Compliance Plan. Completion of this training will be monitored by the MCO, and kept in each employees personnel file. New contracted providers and new members of the Board of Health that will be working with the division will also receive this initial training as part of their orientation.

Thereafter, ongoing training is provided to all staff as needed, but no less than yearly. Each employee will then be required annually to affirm that he/she has completed Compliance Training and agrees to abide by the standards of conduct and policies and procedures contained in this Medicaid Compliance Plan. Compliance issues will be a regular topic at division staff meetings, to keep staff members informed of any changes in policies and procedures.

All preschool contractors (including agencies and individual/independent providers) that furnish direct patient care services for the CWSN division or that provide billing services for the division must review and agree to abide by the standards of conduct, policies, and procedures contained in this Medicaid Compliance Plan annually, indicating the contractor:

- Has reviewed the Medicaid Compliance Plan with their staff
- Will require compliance with such standards of conduct and policies and procedures by all staff who provide services under the Children with Special Needs division on behalf of such contractor.

Contracted preschool providers will be required to participate in training programs relating to the Niagara County Health Department CWSN Division Medicaid Compliance Plan and any interim changes, at least annually. These trainings may be in- person training or web based depending on the need. Each contracted provider is required to complete an attestation of training. Agency director attestation includes notification that all affected individuals within the agency are appropriately trained.

The Board of Health is on the Medicaid Compliance program and any associated updates annually. The Medicaid Compliance program is also available on the Niagara County Website for providers to reference, as needed.

The MCO will distribute in writing any modifications of or amendments to the Medicaid Compliance Plan to all employees and/or preschool contractors.

The MCO also will provide employees and /or preschool contractors with written explanations of substantial changes in the applicable laws pertaining to Medicaid. If the MCO determines that written materials are not sufficient to familiarize employees with the amendments to the Medicaid Compliance Plan, or changes in the applicable law, then interim training sessions will be conducted.

Beginning in 2024, and contracting for the Full Service Medicaid Program with James P. McGuinness and Associates, affected individuals are expected to participate in and review as needed training materials

provided by the FSM staff. Recordings and resources are available through the Knowledge Base available at: <https://support.cpseportal.com/Main/>

Training Topics offered by James P. McGuinness and Associates/Full Service Medicaid include:

- Medicaid-Compliant Written Orders
- Medicaid-Compliant Session Notes
- OPRA
- Digital Speech Recommendations
- Supervision

Effectiveness of training is evaluated by review of the results of paper audits; please see that attached Paper Audit policy.

Reporting Requirements

All employees and contracted preschool providers of the CWSN division, as well as members of our governing body (BOH) have a duty to report suspected misconduct, in connection with alleged unethical or illegal behavior relating to Medicaid billing and the Medicaid Compliance Plan, without fear of retaliation or breach of confidentiality.

If the reporter wishes to remain anonymous, they can report suspected Medicaid fraud or abuse directly to the Office of the Medicaid Inspector General. The toll-free New York State hotline (1-877-873-7283) will be conspicuously posted in each office for staff or other concerned parties to report suspected fraud or abuse. Allegations can also be filed online at <https://omig.ny.gov/>. The form to file an allegation is also available to staff as an attachment to this manual. Other ways to contact OMIG include by telephone at 1-877-87 FRUAD (1-877-873-7283) by email- bmfa@omig.ny.gov, or by mail to NYS OMIG – Bureau of Medicaid Fraud Allegations, 800 North Pearl Street, Albany, NY 12204. A copy of the “Blow the Whistle on Medicaid Fraud” handout is in each office of the CWSN division.

Individuals wishing to report a concern may also approach the MCO directly, or by phone (716)439-7463. If an individual wishes, they may submit, in writing, their cause for concern regarding the suspected misconduct. This could be completed through interoffice mail or regular mail service, sent directly to the MCO, and therefore not traceable to the individual who has the concern. In addition, an anonymous hotline is also available through the department at (716)278-1935. A message may be left for the MCO with appropriate response forthcoming.

All attempts to keep the reporter’s identity confidential will be made and the form may be submitted anonymously. All affected individuals under this plan, may utilize any of these avenues to report possible compliance violations. All interaction with the MCO will be logged and a report will be made on each incident. The MCO will be responsible to ensure appropriate follow-up for each incident and will maintain records to track the nature, topic, and source of calls. If the identity of the reporter is known, the MCO will contact the reporter within 7 days to provide the opportunity to discuss any additional information known by the reporter regarding the subject matter of the incident.

After the preliminary investigation, the MCO will consult with the Public Health Director and/or Niagara County Attorney as needed, in order to determine the direction of any further investigation, enforcement or discipline. (Please see section on Investigations) All responses to incidents and follow-up will be documented and maintained by the MCO. The CWSN Division will not permit any retaliation against any employee or contractor for reporting compliance issues.

As a result of reporting by individuals and subsequent investigations, the MCO will assess the necessity for amendments to the Medicaid Compliance Plan, as well as any changes in policy and procedure that may be needed.

Employees or contractors reporting compliance issues may be covered and/or protected under various provisions in both State and Federal law. Most notably the “qui tam” or “whistleblower” provisions of the False Claims Act address these issues. Other federal and state laws also incorporate so-called “whistleblower” provisions. For a listing of some of these applicable laws, please refer to the back of this manual.

Investigations and Corrective Action

Upon receiving report of a known or suspected violation of the Medicaid Compliance Plan, the MCO will notify the Public Health Director, and provide updates as the investigation continues.

The MCO will promptly investigate the matter to determine whether a violation of the Medicaid Compliance Plan, has in fact occurred. In no instance, will a person coming forward in an investigation, in good faith, be made to feel intimidated by the process, the MCO or by others involved in the investigation. The MCO will have use of any available resources necessary for a thorough investigation of alleged violations of the Medicaid Compliance Plan. The investigation may include:

- Interviews of relevant personnel. Personnel are expected to cooperate in any investigation to assist in resolution
- A review of relevant documents
- Engagement of outside counsel or experts as needed (under the direction of the Public Health Director/County Attorney)

At the conclusion of any investigation by the MCO, a written report will be prepared, and if appropriate under the direction of the county attorney for the Public Health Director and the Board of Health (BOH). The report will describe:

- The substance of the allegations.
- The evidence uncovered by the investigation.
- The MCO's findings.

If, as a result of the investigation, the MCO determines that a provision of the Medicaid Compliance Plan has been violated, then the MCO's report will recommend to the Public Health Director the corrective solution warranted under the circumstances. This may include reporting to the Board of Health, in executive session, as needed.

With the assistance of the MCO, and in conjunction with any necessary outside parties (i.e. Niagara County Human Resources Department, County Attorney, OMIG, BOH etc.), corrective action will be implemented, including:

- Any necessary disciplinary action. For County employees, Article 9 of the CSEA employee contract should be reviewed regarding disciplinary actions and discharge. For contracted preschool providers and other affected individuals, disciplinary action may result in contract termination of the individual and/or agency.
- Communications to employees and preschool contractors, regarding any amendments or modifications to the Medicaid Compliance Plan
- Voiding any identified claims and overpayments, disclosing the overpayment in accordance with the required OMIG procedure.

Disciplinary Procedures for all Affected Individuals

The CWSN division shall consistently enforce through appropriate disciplinary mechanisms, the Medicaid Compliance Plan.

Disciplinary procedures for violation of the division's Medicaid Compliance Plan, by an employee, will follow the provisions of the applicable collective bargaining agreement and personnel policies of the County (please see current contract for details). Disciplinary actions up to and including termination, will be determined on a case-by-case basis, in conjunction with the Human Resources Department, the County Attorney and CSEA representatives, as needed.

Discipline may also involve direction from outside parties (i.e. OMIG, law enforcement, NYSDOH, NYSED) for further investigation and/or prosecution.

Disciplinary action will be taken against employees who either:

- Authorize or participate directly in a violation of the Medicaid Compliance Plan.
- Deliberately fail to report a violation.
- Deliberately withhold relevant and material information concerning a violation of the Medicaid Compliance Plan
- Report a compliance issue if an investigation reveals that he/she violated or participated in a violation of the Medicaid Compliance Plan.

Disciplinary action may be taken against the violator's manager or supervisor, to the extent that the circumstances of the violation reflect inadequate training, leadership or a lack of diligence. Appropriate action will also take place to prevent recurrence.

Agency and Independent Preschool Contractors of the CWSN Division are held to the same standards regarding the Division's Medicaid Compliance Plan as employees. Reasons for disciplinary action are listed above.

Violations may result in termination of any agreement pursuant to the terms thereof, depending on the circumstances of each violation. In addition, the matter may be referred to an outside agency (i.e. OMIG, NYSDOH, NYSED, DOE, etc.) for further investigation and/or prosecution.

Disciplinary policies will be firmly and fairly enforced for all affected individuals.

**Niagara County Department of Health
Children with Special Needs Division
Billing and Claiming
Policies and Procedures**

Billing Compliance

Niagara County Health Department CWSN Division only bills for medically reasonable, necessary and/or appropriate health care items and services rendered or provided to eligible infants, toddlers and preschoolers with a disability. These services are based on the child's individual needs that are identified through the Early Intervention or Preschool Supportive Health Services Programs. The Division must comply with specific billing requirements for government programs (i.e. Medicaid), any third party payers and the State of New York.

Employees and preschool contractors of the Division have an obligation to ensure that all bills submitted to the County for payment are accurate and complete. All invoices, bills, claims, records and reports submitted should be clear and accurate and should provide sufficient information and documentation to substantiate:

- The medical necessity of such services provided
- The cost for such services
- The identity of the health care professional(s) involved in the rendering of such services
- Any other information deemed necessary by the County to substantiate Medicaid claims or meet program requirements

The Early Intervention and Preschool Supportive Health Services Programs each have specific billing rules related to claiming for Medicaid eligible services. There are significant differences in what each program requires to document a Medicaid claim. The specific process for each program is detailed later in this section; however, no claim for a service provided by CWSN division staff or PSSHSP Contracted providers is submitted to Medicaid until the Division has made every effort to ensure accuracy in billing. **Contracted preschool providers who also have a provider agreement to service children in the Early Intervention Program are responsible for the accuracy of their own Early Intervention claims billed through the State Fiscal Agent.**

For Preschool Services the department relies on publications and information from Medicaid in Education, including the Preschool Medicaid Handbook.

- Medicaid in Education Website: <https://www.oms.nysed.gov/mcicaid/>

Early Intervention requirements are identified through sources such as the New York State Bureau of Early Intervention (BEI) and the specific OMIG protocol for Early Intervention.

- BEI Website: https://www.health.ny.gov/community/infants_children/early_intervention/
- Early Intervention OMIG Protocol: <https://omig.ny.gov/media/document/62256>

Quality Assurance

The CWSN Division, as part of their Division Policy Manual, maintains a planned and systematic process for monitoring and assessing the quality and appropriateness of patient care and clinical performance. (Please refer to this section in the Division Policy Manual for more information).

Billing Personnel

The CWSN Division requires all billing personnel to be knowledgeable regarding the billing policies and procedures, established by Medicaid, relating to services associated with the Early Intervention Program and the Preschool Supportive Health Services Program.

The CWSN Division is committed to providing and authorizing involvement in training and in-service opportunities for billing personnel to help keep them up to date on billing policies and procedures. This includes any training sponsored by the State Education Department, for billing personnel, MCO, and the Chief Financial Officer.

All questions regarding billing requirements for Medicaid should be directed to supervisory staff in the program, in conjunction with the MCO. Medicaid may be contacted directly for additional information and/or clarification regarding the appropriate billing requirements. All requests for additional information and/or clarification of the Medicaid billing requirements will be documented. CWSN Billing personnel work closely with James P. McGuinness and Associates utilizing their Full Service Medicaid program for all Medicaid billing as of dates of service 9/1/2024.

General Policies

The CWSN Division maintains a database (through Preschool software) of physicians and SLP's prescribing Medicaid eligible services to ensure that they are qualified professionals under Medicaid regulations and to assure they have not been excluded from the Medicaid program. Information on Internal employees and all preschool contractor, credentials and necessary information is maintained through billing staff created databases and an attestation system through the CPSE Portal. Additionally, all providers are checked through monthly Medicaid exclusion lists, using the K-checks program. The Division collects and keeps on file the following for all internal staff service providers and contractors:

- Current licensure/registration information
- National Provider Identification #
- Medicaid billing or non-billing provider# (if applicable)
- Check of the restricted and excluded Medicaid provider lists through a software program from Kinney and Associates (K-Checks). This is checked at hire and monthly thereafter for all rendering and ordering providers. Sites included in the monthly check: https://apps.omig.ny.gov/exclusions/ex_search.aspx, www.oig.hhs.gov , <https://sam.gov/> as well as exclusion lists from several other states.
- All employees and preschool related service contractors hired after July 1, 2013, are cleared through the Staff Exclusion List (SEL) at the NYS Justice Center for the Protection of People with Special Needs, and yearly thereafter for internal providers.
- All County employees, and independent/individual contractors are cleared through the State Central Registry for child abuse

- Supervision plans, which are updated on a yearly basis for all employees and preschool contracted staff, who work under the direction of a supervising therapist (such as COTAs , PTAs, TSSH/TSLDs or CFYs).

Providers whose credential information is not up to date will not be able to submit billing for rendered services until this information is current in the CPSE Portal System and approved by Full Service Medicaid staff. Once information is updated and approved, providers are able to submit all billing for payment.

Required Documentation

Each spring division staff send out an annual documentation e-mail to all preschool service providers, which includes links to all current forms as well as any specific reminders that are applicable for the coming service/school year. Contact information for the FSM Team is included with this “annual start-up” e-mail. Forms and documents referenced throughout this plan are available on the Niagara County Children with Special Needs Website in the “For Providers” section:

https://www.niagaracounty.gov/departments/a-f/children_with_special_needs/for_providers.php

Early Intervention Specific Information

Like all providers across the State, Niagara County CWSN division has a Provider Agreement in place with NYSDOH, to provide services to children in our County. Niagara County is no longer in direct contract with other agencies or individuals that provide Early Intervention services and therefore is not responsible for the accuracy of Early Intervention claims billed through the SFA by other Early Intervention providers operating in the County.

Internally, services include service coordination, speech therapy and special instruction. Claims for services are entered into a state sponsored data system. The State Fiscal Agent (SFA) then extracts information from the data system and uses it to create claims for each associated payer. As of January 1, 2022 with the passage of the Covered Lives legislation, claims are no longer billed directly to third party insurance. Claims go to Medicaid, when applicable, with any balance paid through county funded escrow accounts. Payments from Medicaid or Escrow will come directly to the County (as service provider) by either check or electronic fund transfer (EFT).

In addition to these billing procedures, the Division has procedures in place to accurate documentation to substantiate claims for Medicaid billing. These include:

- For each child in the program, insurance information is obtained and checked through emedny and private insurance websites as available. This information is updated monthly in conversation with the family by their ongoing service coordinator (OSC).
- If a child has Medicaid, initial eligibility is checked and the New York State Department of Health places a Code 35 on that child’s Medicaid. Division staff also work with local DSS to resolve any conflicts.

- A prescription for every medical service authorized, is obtained from the child's primary physician and/or speech language pathologist. For any change in service (increase, decrease, etc.), a new prescription is obtained. The scripts should be signed and dated prior to service delivery.
- Per Early Intervention Regulations, the Individual Family Service Plan (IFSP) serves as documentation for medical necessity under the program.
- IFSP meetings are held at least annually, service plans are updated every six months or more frequently, if it is in the best interest of the child.
- Therapists in the division are required to complete and submit with their billing, a monthly log sheet verifying time in/time out for each date of service with parent signature and a corresponding daily case note for that date of service, these documents constitute the complete session note. Logs and case notes are reviewed and audited monthly by billing and supervisory staff. Initial and ongoing service coordinators will keep adequate time records and case notes to substantiate any billable claims to Medicaid or the County escrow account.

Monthly billing for therapists and service coordinators are subject to a series of programmatic and fiscal audits. Before any therapist claims are entered into the NYEIS system for payment, monthly log sheets are audited for accuracy, please see the Monthly Therapist Checklist. Billing may be rejected for a series of reasons including: unauthorized or excessive services, duplicate records, inaccurate physician/SLP prescription or missing information on the monthly log. Service coordination billing also goes through a vigorous peer review before claiming as part of the Billing Audit Policies for Early Intervention.

Preschool Supportive Health Services

Selected medical preschool services are covered costs under Medicaid as part of Medicaid-in-Education. Regulations in the preschool program require municipalities administering preschool special education services to pay for program costs up front and then seek reimbursement through Medicaid and the New York State Department of Education. It is our expectation that contracted staff are familiar with laws and regulations pertaining to Medicaid in Education.

There are several resources at the State level to assist Counties and providers with Medicaid billing. They include:

SSHSP Medicaid Policy and Claiming Questions-DOH - #518-472-2160, SSHSP@health.ny.gov
 Medicaid In Education Unit-NYSED - #518-474-7116, medined@nysed.gov
 New York State Compliance Office- #518-473-3782 or information@omig.ny.gov

The CWSN Division uses the McGuinness software systems to complete all aspects of billing and claiming of preschool services, including billing Medicaid for accurate and appropriate services. McGuinness offers regular trainings that are conducted live, and recorded for future viewing to support staff and contractors in meeting Medicaid requirements. Information is available through the website knowledge base available at this link: <https://support.cpseportal.com/Main/>. There are a number of checks and audits provided by the McGuinness systems prior to claims being submitted for Medicaid payment, including the following:

- Providers should refer to SPA#09-61 for Preschool Services for any questions regarding who is qualified to provide preschool supportive health services and specific documentation required for each discipline. It is ultimately the provider's responsibility to make sure all these critical steps are in place. State Education also provides the Medicaid -in -Education Handbook #10 for provider reference with a companion, Q &A document available to providers through the Medicaid in Education website. Preschool Contractors are bound by contractual language to meet all Medicaid Rules and Regulations.
- A prescription must be in place for all Medicaid eligible services. Prescriptions, which are obtained by the provider for any Medicaid eligible service, will be uploaded to the CPSE portal. McGuinness has a template prescription that all providers are expected to use which must be signed and dated **by a Medicaid eligible provider**, before the start of services.
 - Full Service Medicaid (FSM) Team and county staff will monitor to ensure prescriptions for service do not have stamped signatures as this is clearly indicated as not allowable under the Medicaid Program. SLP's are able to use the CPSE Portal system to create a digital order with an electronic signature that meets Medicaid Requirements.
- Parental consent for release of information for Medicaid funding is in place at the initiation of preschool services. The County requests that evaluators obtain this consent at initial meeting and/or that rendering providers obtain it at the beginning of services. Once the parental consent is initially signed, the County billing office will notify parents of their rights concerning Medicaid consent in each subsequent school year that the child receives services.
- The County receives the evaluation results, with the ICD-10 code attached to the individual evaluations, and the IEP, which outlines the frequency, duration and location of services to be delivered to the child from the child's home school district.
- For make-up sessions, please refer to the Preschool Make-up Policy.
- With the use of the CPSE Portal, all daily sessions notes will be documented and electronically signed through the CPSE portal. Each rendering provider will have a separate login and password to the CPSE Portal, and a private pin number used to validate their electronic signatures. These processes meet all Medicaid requirements for electronic signature per James McGuinness and Associates. Daily session notes must be signed contemporaneously, no later than 45 days after the date of service.
- Providers of Preschool service who provide Related Service Only or Special Education Itinerant Services are required to complete and submit with their billing, a preschool confirmation of delivery form for each date of service with parent/or other third party signature. **The preschool confirmation of delivery form can be obtained on the CPSE Portal and should not be modified by providers.** The provider should under no circumstances, sign their own daily session verification log to indicate that the session took place. Preschool confirmation of delivery forms for center-based services are no longer required.

- In the case of a provider who must be supervised under the regulations (this includes COTA, PTA, TSLD, TSHH, CFY), each daily case note must be cosigned by the supervisor of record, as well as the daily session verification form in the case of related services. **All rendering provider and supervisory signatures must be completed within 45 days of the date of service.**
- In all cases of supervision, supervisory case notes should be sent with monthly billing voucher by the supervisor, indicating initial and periodic visits with the child, correspondence and meetings with the provider of service, and documentation of any meetings, changes to the child's plan or testing completed or reviewed.
- Due to regulations governing the supervision of COTA's by OT's, and in an attempt to document what supervision is taking place across **all disciplines that require supervision**, a supervisory plan should be filled out at the beginning of each school year or whenever the supervisor changes and sent to the County.
- In the case of group services, the # of children served in a group cannot exceed five children (or what is indicated on the IEP) and should be indicated on the daily session note in the CPSE Portal. In the event a group of one (1) is delivered, the case note in CPSE Portal should indicate "group of 1" and no CPT code available.
- If the child's setting of service changes after the IEP has been developed, the provider should contact the school district to have the IEP amended to reflect that change. If a child is seen in more than one setting, the IEP should also reflect that (for instance home/daycare). The CPSE Portal requires the rendering provider to indicate the setting the service took place (for instance home or preschool) **as well as the actual location or physical address of the service delivery on each case note in the system.**
- As of January 1, 2019, provider billing will be uploaded to the Division, on a monthly basis (but no later than quarterly per contracts) with a County Voucher and any other required documentation (such as parent signatures, supervision information, etc.). Once these steps are completed, the County will pay the provider and then attempt to recover funds from Medicaid and the State. **Due to the need for the County to complete a Medicaid cost report yearly, it is imperative that contracted providers bill the County in a timely manner.**

Fiscal Audit

Audit protocols are in place for internal Early Intervention billing, as well as Preschool services for the entire County. Current software systems utilized by the County, including the Early Intervention data system and CPSE Portal have internal audits built into the system, to assure there is no double billing or overlapping visits.

Please see the "Monthly Therapist Checklist", "Preschool Monthly Medicaid Audit Checklist" and the "Post Billing Audit" forms for specific audits completed for internal and contracted preschool providers, beyond what the software systems offer.

Every effort is made to assure all claims billed to Medicaid meet the specific requirements for each program. An additional audit of 50 claims per billed month is completed after payment is made. This audit looks at all required components to ensure accuracy of billing and identify any untoward errors were made. These audits confirm that our compliance plan is working or provide opportunity for improvement if concerns or errors are noted. Any claims that do not meet Medicaid requirements identified from this audit are voided if necessary, and reported to Medicaid via the self-disclosure process (see <https://omig.ny.gov/provider-resources/self-disclosure> for the most up to date forms and processes associated with self-disclosure).

Medicaid Billing Flow (Preschool)

Beginning September 1, 2024 James P. McGuinness and Associates will complete Medicaid billing for all preschool claims as part of the Full Service Medicaid.

Daily (ongoing)

- Mail is processed daily.
- Medicaid eligibility is checked as children's information is sent to the county from school districts. The CIN for any child with active Medicaid is entered into the Preschool system.
- CPSE Portal invoices are downloaded, processed and paid based on the first in/first out process with the "in" determined by when the county receives the provider's paper invoice and any other documents that are required on paper based on service type (i.e.- session signature sheets, monthly supervision notes, etc.)
- At the time of payment, an initial audit is conducted to review some claim information and ensure sufficient documentation is provided to substantiate claims.

Weekly

- Supervisory billing staff person checks for any updated Medicaid remits including pending files, downloads and prints remits, also completes ACH deposit forms to be sent to treasurer's office.

Monthly

- Once per month, after Medicaid Payments are received and remittances are available, at least 50 random claims will be selected from Medicaid Payment remittance for a full paper audit (see Paper Audit Policy).

Twice Yearly (January and June)

- Staff will check the Medicaid status of any children who were not indicated as having Medicaid during the school year, this is completed by running the "Children without a CIN Report" (Medicaid Tab→ Service Bureau Eligibility→ Children without a CIN).
- If children are identified as having active Medicaid, which was previously not entered into Preschool system, staff will pull info and do a complete audit of the sessions. Any claims, which do not meet Medicaid billing requirements, will be indicated and marked as do not bill Medicaid.

Early Intervention-Billing Procedures

Services

- At month end, all therapist documentation (session verification, daily case notes, etc.) is submitted to supervisor for quality audits.
- A copy of billing documents are provided to Account Clerical/Billing staff to begin billing/data entry into the data system.
- Once supervisor completes quality audit the original billing documents will be used to complete a data entry audit of NYEIS invoice prior to submission. The person who completes the data entry of the invoice will not audit his or her own work.
- At this point, any claims identified by supervisor as not billable will be deleted from invoice.
- Once data entry audit is completed voucher will be submitted, staff will follow-up on voucher to make sure all claims were approved and research/correct if possible any denied claims.
- Processing of actual payments (Medicaid, Escrow) is completed by PCG the eibilling module is available for claim research and reports.
- On at least a monthly basis Admin Assist logs into the billing module to check for claims with problems or any claims that need to be addressed so that payment process can continue.

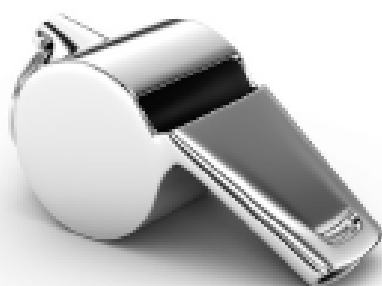
Service Coordination

- Service Coordinators complete audits of their case records and billing documentation each month, these audits are completed with the rendering provider and a co-worker.
- Division clerical staff then complete data entry into EI billing system.
- Billing staff/Account Clerical I collects all completed data entry and will conduct a brief data entry audit for claim accuracy before submitting vouchers.
- Staff will follow-up on voucher to make sure all claims were approved and research/correct if possible any denied claims.
- Processing of actual payments (Medicaid, Escrow) is completed by PCG, the billing module is available for claim research and reports
- At least every 2 months a quality/compliance audit is completed. Account Clerical/billing staff will randomly select 10% of the total number of claims approved for this audit. Any claims identified as not meeting billing requirements may be voided pending results of this audit with any systemic errors resulting in additional training, form revisions, etc.
- On at least a monthly basis Admin Assist logs into the billing module to check for claims with problems or any claims that need to be addressed so that payment process can continue (code 35, code 22, etc.).



Office of the
Medicaid Inspector
General

BLOW THE WHISTLE ON MEDICAID FRAUD



Report Medicaid fraud, waste
or abuse to the **Office of the
Medicaid Inspector General**
Toll Free: **877-87-FRAUD**
877-873-7283

Medicaid fraud is not a victimless crime and can occur along with waste and abuse in many different ways. Below are some examples of Medicaid fraud, waste, and abuse.

Medical Identity Theft	Using another person's medical information to obtain money, items, or services.
Upcoding/Unbundling	Billing for services at a level of complexity that is higher than the service actually provided or documented, or using multiple codes for services covered by a single code.
Services or Supplies Not Rendered	Billing for services or supplies not provided to a beneficiary, services not documented correctly, or both.
Kickbacks	Soliciting or receiving remuneration (in kind or in cash) in return for referring individuals, goods, or services that may be paid under the Medicaid program.
Excluded Individuals	Employing or contracting with any excluded individual or entity for the provision of items or services that are reimbursable, directly or indirectly, by any Federal health care and/or State Medicaid program.
Drug Diversion	Illegally prescribing, distributing, abusing, or overusing prescription drugs.
Beneficiary Fraud	Eligibility fraud, card sharing, doctor shopping, and drug diversion.
Quality of Care/ Patient Abuse/ Neglect	Abusing, neglecting, or exploiting Medicaid patients, including committing physical and mental abuse, withholding medically necessary services, or neglecting to provide appropriate or adequate care.
General Fraud and Abuse	Billing in ways inconsistent with sound financial management or professional standards; or payment/billing is fraudulent when done intentionally and abusive if unintentional.
Waste	Over utilizing Medicaid benefits, such as prescribing inappropriate or unnecessary drugs, medical equipment and supplies, or medical services.

If you suspect fraud or abuse, contact the
Office of the Medicaid Inspector General

www.omig.ny.gov

Facebook  and Twitter  @nysomig

877-87-FRAUD / 877-873-7283

www.omig.ny.gov/medicaid-fraud/file-allegation



Office of the
Medicaid Inspector
General

Kathy Hochul, Governor

Frank T. Walsh, Jr., Acting Medicaid Inspector General

New York State Office of the Medicaid Inspector General - Bureau of Medicaid Fraud Allegations (BMFA)
800 North Pearl Street, Albany, NY 12204
Email: BMFA@omig.ny.gov Phone: 877-873-7283 FAX: 518-408-0480

Allegation Date: _____

YOUR INFORMATION: *I would like to be considered:*

☐ **CONFIDENTIAL** (Your information is kept private, but your identity is known to OMIG. This allows OMIG to contact you to obtain additional information or clarify your allegation.)

☐ **ANONYMOUS** (no personal information is provided/known to OMIG-BMFA)

Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: () _____ Email: _____ MEDICAID ID#: _____

THE ALLEGATION IS AGAINST :

☐ **Provider**

☐ **MEDICAID Recipient**

Name: _____ Provider ID/License# *or* MEDICAID ID# _____

Address: _____ City: _____ State: _____ ZIP: _____

County: _____ DOB: _____ SS# _____

Phone: () _____ Email: _____

ALLEGATION: _____

FIGHTING FRAUD ○ IMPROVING INTEGRITY AND QUALITY ○ SAVING TAXPAYER DOLLARS

MEDICAID COMPLAINT LOG

Received by _____

[illegible][illegible]

Complaint Medicaid 11/16

Monthly Therapy Checklist

Therapist: _____

Month: _____

[illegible]

**NIAGARA COUNTY DEPARTMENT OF HEALTH
CHILDREN WITH SPECIAL NEEDS**

Early Intervention Program

BILLING AUDIT POLICIES FOR SERVICE COORDINATION

Policy

It shall be the policy of the Children with Special Needs division to perform audits of all Service Coordinator billing sheets and case notes across the Early Intervention Program.

Purpose

To significantly reduce or eliminate any billing errors to State Health Department, Niagara County, Medicaid and/or third party insurances.

Procedures

ISC/OSC role

- Each SC will have their monthly billing sheet completed no later than the second Monday of the following month
- Each SC will in pairs with an identified co-worker to complete an audit of their monthly billing, audit to include review of the following:
 1. Units billed are listed on the billing sheet for the same day as the related activity and that the units billed can be substantiated by activities noted in the case note
 2. Each case note lists the date, activity, amount of time spent on the activity (time began, time ended), your name, role (ISC, OSC, EIOD) and signature.
 3. While completing the peer review audit, if for whatever reason the ISC/OSC/EIOD finds that a note was not entirely completed and cannot remember the circumstances, the note will be crossed off, and initialed – review of the billing sheet will occur to determine that work done on that day which cannot be substantiated will not be billed.
 4. If an ISC/OSC cannot remember what date they did an activity but ARE certain that the activity was completed, they may enter the activity in the case record but CANNOT bill for the activity since the work cannot be verified. Please put a “0” or “NB”-no bill, next to the case note so that supervisory staff will know that you do not intend to bill for that activity.
 5. If the ISC/OSC has ANY questions regarding billable activities, they can consult the ISC/OSC Billing Guidance Document or check with supervisory staff for clarification. Any billing under question will be removed from the SC billing log
- Once the ISC/OSC has completed the above steps, data entry of claims will begin.

Quality/Compliance Audit

- Account Clerical/Billing will randomly review 10% of approved SC billing claims at least once every 2 months, during this audit the following items are reviewed:
 1. Match case notes with units billed to determine if activity substantiates billing
 2. Match dates of units billed to ensure that a case note is in the record which substantiates the billing for each date
 3. Ensure that SC units were not billed for leaving/receiving recorded messages
 4. Ensure that SC units were not billed for preparing/mailling letters
 5. Ensure that SC units were not billed for completing/mailling forms, including IFSP amendments
 6. Ensure that SC units were not billed for reviewing documents such as session notes, IFSPs, medical records, evaluations, etc.
 7. That each case note billed has a time began, time ended listed on the case note.
 8. In consultation with department supervisors billing claims not meeting any of the above criteria may be voided.
- Disciplinary action (as delineated under the CSEA agreement) may be required based on severity of actions for any SC who is unable to follow EI billing rules and regulations as identified in (3) consecutive audits.
- Supervisory staff will continuously review the SC Guidance Document regarding EI billing rules and regulations and will seek assistance from the BEI if direction is needed in any content area. The EIO and/or EIO (M) will conduct regular staff meetings, agenda items include billing related topics as identified through the monthly audits. Topics may include:
 - Common identified billing errors
 - Remediation of common identified billing errors
 - Review of billable ISC functions
 - Review of non-billable ISC functions
 - Review of billable OSC functions
 - Review of non-billable OSC functions
- Results of audits are shared at division Quality Assurance meetings and recommendations are made by that team for any necessary changes in processes and documentation.

**NIAGARA COUNTY DEPARTMENT OF HEALTH
CHILDREN WITH SPECIAL NEEDS**

Preschool Make-up Policy

Policy

It shall be the policy of the Children with Special Needs Division- Education of Handicapped Children to allow and encourage make-up visits when State Education and Medicaid requirements are met.

Purpose

To best meet the individual needs of a child based on the IEP developed by the Committee on Preschool Special Education.

Procedures

1. Make-up sessions must be provided within the beginning and ending dates of each child's IEP, unless a request is made to the CPSE to extend the ending date to the end of the school year (June 30th)
2. Make-up sessions cannot be provided on legal holidays.
3. There is no County requirement for make-up sessions to only be provided based on the school district calendar. However, providers must deliver sessions based on the authorization dates, frequency and duration developed on the IEP.
4. Make-up visits for the same discipline on the same day will be allowed, if the parent agrees and a child can tolerate it. CPSE Portal has a check that will exclude the second session from moving forward to Medicaid billing, if applicable
5. Sessions delivered in excess of the # of sessions on the script, in a week, will also be excluded from Medicaid billing by the Preschool system.
6. Make-up sessions cannot exceed the total number of sessions authorized by the CPSE and identified on the child's IEP. Make-up sessions are not meant to increase the number of sessions provided to the student based on the IEP.
7. Make-up sessions can be provided prior to a scheduled session, as in the case of a planned medical leave.
8. Make-up sessions when agreed upon by the parent and provider can be made up on weekends.



Service Month

Child's Name	DOB	Type of Service	Frequency & Duration	
Agency Name	NPI #	School District		
Name of Individual Service Provider	Profession	License	NPI	

[illegible]

I certify that on the dates above, the above named child received the services noted and that documentation exists and is maintained on file verifying the delivery of said services in accordance with all relevant federal, state and local laws and regulations governing the Medicaid process.

Therapist Signature _____ **Date:** _____

12



Required Documentation for Niagara County Preschool Provider Claims	
Niagara County Provider Insurance Requirements	
Must have Current/Up to date copies of the following <u>ON FILE</u> with Niagara County:	
Professional Liability Insurance	
General Liability Insurance	
Auto Liability	
Workers' Compensation	
Disability Benefits	
Script Needed (PT, OT, ST) upload in Portal	
Child name and DOB on script and correct	
Signed (No Stamps) and dated by doctor/SLP (SLP OPRA enrolled)	
Electronic signature agreement on file	
NPI on script and is correct	
Includes necessary ICD code(s)-most specific when applicable	
Frequency and duration is on script and matches IEP	
New script for changes in service level	
Session Verification/Billing Logs (RS and SEIS)	
Child name, DOB correct	
Time in/time out completed for each date	
Authorized signature completed at each visit	
Provider signed at the end of the service month	
Provider license number and NPI are correct	
Daily Session Notes	
Completed contemporaneously	
One note for each date on session verification form, dates/times match	
At least one ICD code matches script	
CPT Code and Units recorded correctly	
Service is provided per IEP (I/G, setting, location, frequency)	
Setting-matches IEP (contact district if amendment is needed)	
Location of service is indicated and specific per Medicaid Q&A #164	
Frequency does not match IEP-contact district to send amendment to county	
Group Service-if child seen in G1 consistently contact district to discuss/amend IEP	
Providers	
Current license on file-actual copy of license needed for PT/OT/ST (TEACH printout acceptable for teachers)	
UDO/USO (if applicable)	
Current license on file for supervisor	
Supervision plan (using Niagara County form) in place at the beginning of employment and updated yearly (need a different plan for each supervisor)	
Documented face to face visits, minimally at the beginning of 2 month and 10 month services	
Monthly supervisory notes	
Sign off on each case note and session verification/billing log (within 45 days of service)	
Medicaid Consent Needed (upload in Portal)	

Paper Audit Policy

It shall be the policy of the Niagara County Department of Health, Children with Special Needs division to verify the accuracy of claims submitted electronically to Medicaid. This will be completed through a monthly random selection of claims to go through a full paper audit.

Niagara County uses the James P. McGuinness, Preschool, CPSE Portal and Full Service Medicaid programs to facilitate Preschool Supportive Health Services Medicaid billing. James P. McGuinness and Associate's also operates as the Niagara County Medicaid Service Bureau. Full Service Medicaid staff complete all necessary documentation audits and ensure claims are accurate and meet all billing requirements prior to submission. The paper audit will function to affirm that all audits checks, which are stated to be completed by these programs, are functioning correctly and meet the requirements of the Medicaid Program. Any errors found in the system will be immediately reported to the Medicaid Compliance Officer and to James P. McGuinness and Associate's for correction. Should there be a non-functional aspect of the Preschool or CPSE Portal systems, the Medicaid Compliance Officer will be notified and a corrective action plan will be implemented. Any claims paid by Medicaid, which do not meet Medicaid billing requirements, will be voided.

Procedure

1. Full Service Medicaid team will submit batches to Medicaid on a regular basis.
2. Once per month, the Medicaid Compliance Officer will randomly select at least 50 Medicaid paid claims, from the remittance report to go through a full paper audit.
3. Claims will be assigned to Preschool billing staff for audit; all staff will use the "Preschool Post Billing Audit" tool to verify all billing requirements are in place for the claim date.
4. Billing staff will print a copy of the actual payment information directly from the Medicaid website (<https://mmis.online.emedny.ny.gov/eMedNYPhaseII/login.jsp>) and review the actual claim information for accuracy according to the audit tool.
5. Any claims, which do not meet Niagara County Medicaid billing requirements, will be reported to the Medicaid Compliance Officer, and the claim will be voided.
6. The claims will be reported to Medicaid via the self-disclosure process.
7. Should there be systemic issues found in multiple claims, the Medicaid Compliance Officer and/or supervisory staff will be consulted to ensure the accuracy of all claims submitted as part of that audit batch. If necessary, more claims may be indicated for the post billing/paper audit.
8. Systemic issues will also result in notification to James P. McGuinness and Associate's, if the issue was part of their electronic verification process. Corrective action plans and steps will be put in place, which may include suspending Medicaid billing until a resolution is in place.

Preschool Monthly Medicaid Audit Checklist

Child Name: _____

School Year: _____

DOB: _____

2 MO

10 MO

☐ Medicaid Consent on File

PT

OT

ST

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
Current and Valid Prescription	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Setting Matches IEP _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Location (other than Home) is filled in	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Telehealth (X if Yes): Informed Consent ____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
UDO/USO: Rendering Provider: _____ Supervisor: _____												
Supervision Plan in Place (Check-off month completed once per year)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Face 2 Face (write date completed)												
Monthly Supervision Note (check each month)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Notes												
Audit Completed By (Initials)												

*The items listed are manually checked each month when paying bills, any dates of service not meeting requirements will be removed from Medicaid Billing.

False Claims Act Information

(Click on text for more information)

[Federal False Claims Act](#)

[Federal Administrative remedies for false claims and statement](#)

[NYS False Claims Act](#)

[NYS laws pertaining to criminal liabilities and penalties for false claims and statements](#)

[Federal Whistleblower Protections](#)

[NYS Whistleblower Protections](#)

Important Websites and Links

Niagara County CWSN “For Providers”: https://www.niagaracounty.gov/departments/a-f/children_with_special_needs/for_providers.php

CPSE Portal Knowledge Base: <https://support.cpseportal.com/Main/>

Medicaid In Education: <https://www.oms.nysed.gov/medicaid/>

Bureau of Early Intervention:
https://www.health.ny.gov/community/infants_children/early_intervention/

Office of the Medicaid Inspector General:
<https://omig.ny.gov/>

OMIG Early Intervention Protocol: <https://omig.ny.gov/media/document/62256>

OMIG Self-Disclosure Information: <https://omig.ny.gov/provider-resources/self-disclosure>

Medicaid Fraud Online Report: <https://apps.omig.ny.gov/bmfa/bmfa.aspx>