Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

New York State Department of Health
Docket No. A-14-104
Decision No. 2637
May 19, 2015

DECISION

The New York State Department of Health (New York) appeals a decision by the Centers for Medicare & Medicaid Services (CMS) to disallow $68,407,132 in federal financial participation (FFP) claimed for New York's Medicaid program. New York claimed FFP for expenditures it made to non-hospital providers for continuing day treatment (CDT) services provided from January 1, 2005 through December 31, 2008. CMS determined that the claims were unallowable under the federal cost principle stating that to be allowable, costs must be authorized or not prohibited by state or local laws or regulation. Based on an audit performed by the Department of Health and Human Services Office of the Inspector General (OIG), CMS determined that 48 claims in a sample of 100 claims for CDT services did not comply with requirements for CDT services in State regulations. CMS calculated the disallowance by projecting the sample results to the universe of claims.

For the reasons explained below, we reverse the disallowance with respect to nine sample claims and uphold the disallowance with respect to 39 sample claims. CMS should determine the amount attributable to the nine sample claims and reduce the disallowance accordingly.

Background

Under Medicaid, a program created under title XIX of the Social Security Act (Act), federal grants are available to states for medical assistance to persons with low income and resources. *See* Act §§ 1901, 1902(a)(10);[1] 42 C.F.R. § 430.0. "Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures." 42 C.F.R. § 430.0. A State is

[1] The current version of the Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp. Table.

eligible to receive FFP for a percentage of its expenditures for program services under a State plan approved by the Secretary of HHS. Act § 1903(a); 42 C.F.R. § 433.10(a). "Payments for services are made directly by the State to the individuals or entities that furnish the services to program recipients." 42 C.F.R. § 430.0. Such services include "clinic services furnished by or under the direction of a physician." Act § 1905(a)(9). "Clinic services" are defined as "preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients." 42 C.F.R. § 440.90.

New York State elected to provide Medicaid coverage of CDT services, a form of clinic services. NY Br., Ex. 1 (OIG's "Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State," dated October 2011)[2] at i. The Office of Mental Health in what was then the New York Department of Mental Hygiene promulgated regulations for outpatient programs, including CDT programs, which appear at title 14 of the New York Codes, Rules and Regulations (NYCRR).

Title 14 NYCRR, Part 587, captioned "Operation of Outpatient Programs," provides, in section 587.10, captioned "Continuing day treatment programs":

> (a) A continuing day treatment program shall provide active treatment designed to maintain or enhance current levels of functioning and skills, to maintain community living, and to develop self-awareness and self-esteem through the exploration and development of strengths and interests.
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> (b) Eligibility for admission to a continuing day treatment program shall be based on a designated mental illness diagnosis and a dysfunction due to mental illness.
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> (c) A continuing day treatment program shall provide assessment and health screening services to all recipients. Treatment planning and discharge planning services shall be provided in accordance with section 587.16 of this Part.
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> (d) A continuing day treatment program shall offer each of the following services, to be consistent with recipients' conditions and needs: (1) medication therapy; (2) medication education; (3) case management; (4) health referral; (5) rehabilitation readiness development; (6) psychiatric rehabilitation readiness determination and referral; and (7) symptom management.

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[2] We refer to this document below as "OIG Report."

> (e) A continuing day treatment program may also provide the following additional services: (1) supportive skills training; (2) activity therapy; (3) verbal therapy; (4) crisis intervention services; and (5) clinical support services.
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Section 587.16 of 14 NYCRR, to which section 587.10(c) refers, is captioned “Treatment planning for…continuing day treatment programs…” and provides:

> (a) Treatment planning shall be an ongoing assessment process carried out by the professional staff in cooperation with the recipient and his or her family and/or other collaterals, as appropriate, which results in a treatment plan. The treatment plan shall be updated or revised as necessary to document changes in the recipient’s condition or needs and the services and treatment provided.
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> (b) Treatment planning shall be based on an assessment of the recipient’s psychiatric, physical, social, and/or psychiatric rehabilitation needs which result in the identification of the following: (1) the recipient’s designated mental illness diagnosis; (2) the recipient’s problems and strengths; (3) the recipient’s treatment goals…; (4) the specific objectives and services necessary to accomplish goals.
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> (e) The treatment plan shall include, but need not be limited to, the following: (1) the signature of the physician involved in the treatment; (2) the recipient’s designated mental illness diagnosis; (3) the recipient’s treatment goals, objectives and related services; (4) plan for the provision of additional services to support the recipient outside of the program; and (5) criteria for discharge planning.
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> (f) Progress notes shall be recorded by the clinical staff member(s) who provided services to the recipient. Such notes shall identify the particular services provided and the changes in goals, objectives and services, as appropriate. Progress notes shall be recorded within the following intervals:…(2) continuing day treatment programs—at least every two weeks[.]
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Section 588.7 of 14 NYCRR, captioned “Standards pertaining to reimbursement for continuing day treatment programs,” in turn provides in pertinent part:[3]

[3] The provision quoted below now appears in section 588.7(k). The other NYCRR provisions quoted here have remained unchanged since the period for which the claims at issue here were made.

> (d) The treatment plan required pursuant to section 587.16 of this Title shall be completed prior to the 12th visit after admission or within 30 days of admission, whichever occurs first. Review of the treatment plan shall be every three months.

Section 587.18 of NYCRR, captioned "Case records," provides in pertinent part:

> (b) The case record…shall include the following information:
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> (7) record and date of all on-site and off-site face to face contacts with the recipient, the type of service provided and the duration of contact[.]

The New York State Department of Social Services also promulgated regulations that apply to CDT programs. These regulations appear at 18 NYCRR § 505.25, captioned "Ambulatory care for recipients with mental illness."[4] This section provides in pertinent part:

> (d) *Standards which shall be met by programs in order to bill under the Medical Assistance Program.*
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> (1) All programs must meet the standards set forth by 14 NYCRR Parts 579 and 585, as revised on April 1, 1991, by the addition of 14 NYCRR Parts 587 and 588.
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> *****
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> (h) *Reimbursement.*
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> (1) State reimbursement shall be available for expenditures made in accordance with the provisions of this section and when the following conditions are met:
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> (ii) documentation that at least one Medicaid reimbursable service has been delivered for each billable occasion of service;
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The OIG conducted an audit to determine whether New York claimed federal Medicaid reimbursement for CDT services in accordance with federal and State requirements. The OIG reviewed claims submitted by 95 CDT providers in the State for the period January 1, 2005 through December 31, 2008. Each claim is for an amount based on the total hours of service delivered to an individual recipient on a particular date. The OIG selected a simple random sample of 100 claims and reviewed the CDT provider's documentation for each claim. OIG Report at 3. The OIG found that all 100 claims complied with federal requirements for CDT services but that 57 of these claims did not

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[4] Section 505.25(a)(1) states that "[f]or the purposes of the Medical Assistance Program, *ambulatory care for eligible recipients with mental illness* means any arrangement or therapeutic environment for the delivery of medical care, health care, or services meeting the criteria … of the Mental Hygiene Law, as implemented by appropriate sections of 14 NYCRR Parts 579 and 585."

comply with State requirements.[5] The OIG identified several types of deficiencies, each representing noncompliance with a provision of either title 18 or title 14 NYCRR. The most prevalent deficiency found by the OIG was noncompliance with 18 NYCRR 505.25(h)(1)(ii), which the OIG referred to as "Type of services not documented."[6] *Id.* at 4. Based on the sample results, the OIG estimated that New York improperly claimed $84,866,929 in federal Medicaid reimbursement during the audit period. *Id.* at 7.

In a March 11, 2014 letter to New York, CMS gave notice that it was disallowing $68,407,132 in FFP as a result of the OIG Report. NY Br., Ex. 3. CMS stated that it had reviewed the audit findings and "concurs with the decision," but that it had reduced the original questioned amount after reviewing additional case documentation provided by New York and determining that nine of the 57 claims the OIG found did not comply with State regulations were allowable. *Id.* at 1. CMS identified as the basis for the disallowance the cost principle that states, "To be allowable under Federal awards, costs must meet the following general criteria:…c. Be authorized or not prohibited by state or local laws or regulations." *Id.* at 2, citing Office of Management and Budget (OMB) Circular A-87, Attachment A, Section C.1.c., made applicable to the Medicaid program by 45 C.F.R. § 92.22(b).[7] CMS also cited "Title 14 §§ 587-588 and Title 18 § 505.25" of NYCRR, which it stated "establish requirements for Medicaid reimbursement for the CDT program, as well as standards for CDT care and treatment planning." *Id.* In addition, CMS cited two Board decisions as holding that "in order for costs to be allowable…under federal awards, they must not be prohibited by state or local laws or regulations." *Id.*, citing *New York Dep't of Social Servs.*, DAB No. 1112 (1989) and *New York State Dep't of Social Servs.*, DAB No. 1235 (1991).

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[5] The OIG found that 10 of the 57 sample claims included more than one deficiency. OIG Report at 4. The claims we find are allowable had only one deficiency finding.

[6] The OIG audit workpapers for each of the sample claims found unallowable on this basis state that because "[n]o documentation was provided to indicate the nature (type) of services rendered on the service date or during the 2 week progress note period[,]…we cannot make a determination" regarding whether the case met audit criteria #18 (Was reimbursement made only for services identified and provided in accordance with an individual treatment plan or psychiatric rehabilitation service plan?); or #19 (Were only allowable services included in the hours billed to Medicaid?); or, for some sample claims, #9 (Were the progress notes recorded by a clinical staff member who provided at least one service to the recipient?). Thus, the OIG said, it "will only footnote these categories at this time." *See* last page of OIG Provider Worksheet for each affected sample claim. CMS did not state that it was basing the disallowance on these criteria.

[7] In 2005, OMB Circular A-87 was codified in appendices to 2 C.F.R. Part 225. *See* 70 Fed. Reg. 51,910 (Aug. 31, 2005). In 2013, OMB consolidated the content of OMB Circular A-87 and eight other OMB circulars into one streamlined set of uniform administrative requirements, cost principles, and audit requirements for federal awards, currently published in 2 C.F.R. Part 200. 78 Fed. Reg. 78,590 (Dec. 26, 2013); *see also* 79 Fed. Reg. 75,871, 75,875 (Dec. 19, 2014) (promulgating regulations in 45 C.F.R. Part 75 which make the cost principles and other requirements published in 2 C.F.R. Part 200 applicable, with certain amendments, to HHS programs).

As permitted by section 1116(e) of the Act, New York requested reconsideration of CMS's March 11, 2014 disallowance. NY Br., Ex. 4. CMS affirmed the disallowance by letter dated July 18, 2014. *Id*., Ex. 5. This appeal followed. The record made in the appeal includes New York's October 31, 2014 brief (NY Br.) with Exhibits 1-6; New York's December 2, 2014 supplemental brief (NY Supp. Br.) with Exhibits 1-6; CMS's January 30, 2015 response brief (CMS Br.); New York's March 18, 2015 reply brief (NY Reply Br.) with Exhibits 1-22;[8] and the OIG audit workpapers for all 48 sample claims on which CMS based its disallowance (supplied by CMS at the Board's request). The workpapers include provider documents and the "OIG Provider Worksheet" for each sample claim.[9]

<u>Analysis</u>

New York takes the position that all 34 of the sample claims CMS found unallowable based on the OIG's deficiency finding "Type of services not documented" were supported by adequate documentation. New York also takes the position that CMS erred in finding a total of 14 sample claims unallowable based on the deficiency findings "Progress notes not properly recorded"; "Duration of recipient's contact with staff not indicated"; "Treatment plan not completed in a timely manner"; or "Treatment plan incomplete." New York argues that the State regulations on which the deficiency findings for the 14 sample claims are based do not impose requirements for reimbursing an individual claim for services. New York argues in the alternative that the documentation for five of these 14 sample claims shows that the deficiency findings are incorrect.

In section I below, we address the 34 sample claims involving the deficiency finding "Type of services not documented," concluding that nine of these claims are allowable and 25 are unallowable. We first explain our general rationale for determining the allowability of these claims and then discuss each sample claim. In section II, we address the 14 sample claims involving the other deficiency findings. We first explain why we reject New York's argument that the State regulations on which the deficiency findings for all 14 claims are based do not impose requirements for reimbursing an individual

[8] New York filed a total of 34 exhibits with its three briefs but did not continue the same numbering sequence for exhibits submitted with its last two briefs. Exhibits 1-5 submitted with New York's brief are identical to Exhibits 1-5 submitted with New York's supplemental brief.

[9] New York asserted in its notice of appeal and in its initial brief that it was unable to "defend its claims" because CMS had failed to identify the nine sample claims questioned by the auditors that CMS found allowable after reviewing additional documentation. NY ltr. dated 8/14/14, at 1; NY Br. at 17. The Board provided an opportunity for New York to file a supplemental brief once CMS provided this information. App. Div. ltr. dated 11/5/14. CMS provided the information in a letter dated November 7, 2014. CMS stated in that letter that the "CMS auditor" had provided this information in a package sent to New York on October 3, 2014, but that since "[t]here appears to be a mix-up," it was providing the information again. CMS ltr. dated 11/7/14, at 1.

claim for services. We then discuss individually the five of these 14 sample claims that New York maintains met the applicable requirements, concluding that these five claims, as well as the nine claims conceded by New York, are unallowable. In section III, we address New York's argument that CMS improperly based the disallowance on its own interpretation of New York's regulations instead of giving deference to New York's interpretation and explain why we conclude that this argument has no merit.

I. Claims CMS found unallowable based on State regulations requiring documentation of the type of CDT service

State regulations in effect during the period at issue provided that "reimbursement [for CDT services] shall be available …when the following conditions are met: … (ii) [there is] documentation that at least one Medicaid reimbursable service has been delivered for each billable occasion of service.…" 18 NYCRR § 505.25(h)(1). Based on the OIG Report and its own further review, CMS agreed with the OIG's finding for 34 sample claims that the CDT provider could not document that at least one CDT service "was delivered on the date of the sampled service," i.e., that "the provider could document only the duration of the visit…, but not the type of CDT service provided." OIG Report at 5; CMS Response Br. at 6.

The documentation submitted to the OIG for each of the sample claims in most cases consists of the following: a weekly schedule (not always dated) prepared by the CDT provider for the recipient which shows a particular CDT service for each time slot on each weekday the recipient was scheduled to attend the CDT program; progress notes for the recipient covering a two-week period including the DOS; a daily sign-in/out sheet or attendance sheet for the DOS showing what time the recipient arrived and departed the CDT program; and a treatment plan for the recipient (containing different levels of detail about what services the recipient was to receive and with what frequency). The OIG found that the sign-in/out sheets documented "only the duration of the visit[.]"[10] OIG Report at 5. The OIG also found that the weekly schedules "did not document that services were actually performed," but only what services were planned, and in many cases "did not include the date (month or year) of the planned services." *Id.* at 8. In addition, the OIG found that the biweekly progress notes "were often just a summation of the prior 2 weeks without any specific information regarding a particular day, including our sampled date of service." *Id.*

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[10] Services provided by day treatment programs are billed based on the length of a "visit," i.e., the total number of hours the recipient was at the program on the DOS. *See* 18 NYCRR §§ 505.25(b)(2) and 505.25(h)(2). However, evidence of simply visiting the CDT program on a particular day is, as we discuss, not sufficient to establish that some service was provided to the recipient during the visit.

New York does not dispute that section 505.25(h)(1)(ii) requires that, in order to be reimbursed, a claim be supported by documentation that both specifically identifies one or more group or individual therapeutic CDT services scheduled for the recipient for the DOS and shows that the recipient attended at least one such service on the DOS. Nor does New York dispute the OIG's findings that certain documents submitted in support of the sample claims were insufficient. However, New York takes the position that the "totality of the documentation" for each of the 34 sample claims meets the regulatory requirement. NY Reply Br. at 3; *see also* NY Br. at 6-8; NY Supp. Br. at 8-10. New York relies on documentation submitted to the OIG as well as letters from three CDT providers explaining the procedures the provider had in place to ensure that, after signing into the CDT program, a recipient attended each CDT service for which the recipient was scheduled that day. NY Reply Br. at 4, 10-11; *Id*., Exs. 1, 11, and 17, at 26.[11] New York summarizes its position that the documentation for each of the sample claims meets the requirement in section 505.25(h)(1)(ii) as follows:

> The billable services that were rendered on the date of service are outlined in the client's therapeutic services/group schedule and treatment plan and discussed in the bi-weekly progress note. The group schedule and the sign in and out sheets correspond with the dates of attendance on the bi-weekly progress notes. The bi-weekly progress note lists the dates the client was in attendance and his or her progress on treatment goals. To verify that the client was in attendance each day and was following his group schedule, each CDT program was able to provide a sign in and sign out sheets for the date of service. Additionally, attendance in groups was monitored by staff members. The bi-weekly progress note also outlines the client's participation in groups, comments on mental status and whether or not he or she is meeting his treatment goals….[A]ll of this documentation provides conclusive evidence that the client received Medicaid reimbursable services on the date of service.

NY Reply Br. at 15.

Although we agree with New York that it is appropriate to consider the "totality of the documentation" for each sample claim, doing so does not establish that all of the sample claims at issue here met the requirement in section 505.25(h)(1)(ii). We find that nine sample claims are allowable because the documentation for each of those claims both specifically identifies a CDT service scheduled for the DOS and shows that the recipient attended that service. However, we find that 25 sample claims are unallowable. The documentation for almost all of the 25 sample claims either 1) fails to specifically

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[11] New York mentions only two of these letters in its reply brief and in comments to CMS on the OIG Report (NY ltr. dated 4/17/12, NY Br., Ex. 2), but we assume New York intended to rely on the third letter as well.

identify any CDT service scheduled for the recipient for the DOS or 2) specifically identifies one or more such services but does not show that the recipient attended any of those services. The documentation for the few remaining sample claims affirmatively indicates that the recipient did not attend any services on the DOS.

We first explain our approach to evaluating the types of documentation on which New York primarily relies and then proceed to discuss the sample claims individually.

A. Whether the documentation identifies at least one CDT service scheduled for the DOS

New York takes the position that weekly schedules, treatment plans and/or progress notes in the record for each sample claim identify at least one CDT service scheduled for the recipient for the DOS.

1. Weekly schedules

Our review of the record shows that the weekly schedules in the claims at issue before us are either undated or are dated before or after the DOS. (And, for some sample claims, the record contains no weekly schedule at all.) As explained in our discussion of the individual sample claims, we do find that the weekly schedules for two sample claims were in effect on the DOS because they are dated the same week as the DOS. Thus, the CDT services scheduled for the DOS are those shown on the weekly schedule for the day of the week corresponding to the DOS. If other documentation in the record shows that the recipient attended one of these services on the DOS, then the claim is allowable.

For the weekly schedules in the record that are either undated or dated outside the week of the DOS, New York nevertheless maintains, for the most part without any explanation, that these weekly schedules were in effect on the DOS.[12] For some sample claims, a summary of the supporting documentation, apparently prepared by the provider, simply asserts that the weekly schedule was followed on the DOS. *See, e.g.*, NY Ex. 15, 1st page discussing sample #75). However, in the absence of any explanation for this assertion, much less an identification of its author, we do not give it any weight.

For other sample claims, the summary of the supporting documentation states, "Although the weekly schedule is undated, it can serve as a sample of the groups [the recipient] attended." *See, e.g.*, NY Ex. 3, 2nd page (discussing sample #13). However,

[12] For samples #20 and 67, New York offers a rationale for finding that the weekly schedule was in effect on the DOS. We discuss later why we do not accept New York's rationale for sample #67. We do not address New York's rationale for sample #20 (at NY Reply Br. at 5-6) since we do not need to rely on the weekly schedule to find the claim allowable.

section 505.25(h)(1)(ii) requires documentation that a CDT service was actually received by the recipient on the DOS. Thus, a schedule that was not in effect on the DOS is irrelevant.

New York argues that the Board's decision in *New York Department of Social Services*, DAB No. 1112 (one of the Board decisions CMS cited in its disallowance letter) provides support for finding that a weekly schedule with a date "proximate to" the DOS of a sample claim was in effect on the DOS. NY Reply Br. at 2-3. That decision is clearly inapposite here. The issue presented there was whether certain outpatient mental health services qualified as "crisis services" that were not subject to the general rule that providers may bill for only one visit per patient per day. The Board rejected the State's argument that CMS's predecessor agency, the Health Care Financing Administration (HCFA), improperly relied on progress notes for dates other than the DOS to show that the recipient was not in constant crisis but was improving, stating: "The State's objection to HCFA's reliance on progress notes for dates proximate to the date in question is ill founded. If such information is reasonably probative of what was occurring on the date in question, it is relevant." DAB No. 1112, Appendix at 8. Read in context, the quoted statement means that progress notes showing what occurred on a date other than the DOS were relevant to whether the claim was allowable, not that such progress notes showed what occurred on the DOS. Since only weekly schedules that show what was scheduled to occur on the DOS are relevant to whether the sample claims at issue here are allowable, New York's reliance on this Board decision is misplaced.

2. Treatment plans

New York maintains that a treatment plan that was in effect on the DOS can specifically identify CDT services scheduled for the DOS. Some of the treatment plans in the record do not specifically identify any CDT services. Other treatment plans specifically identify one or more CDT services but do not include any information about how frequently each service is to be provided. However, we find numerous sample claims for which the treatment plan indicates that a particular CDT service is to be provided on a daily basis, by describing the frequency either as "daily" or in terms of the number of times per week where that number is the same as the number of days each week the recipient is to attend the CDT program (e.g., five times weekly for a recipient who is to attend the CDT program five days a week). By doing so, the treatment plan in essence specifically identifies a CDT service scheduled for the DOS. If other documentation in the record shows that the recipient attended that service on the DOS, then the claim is allowable.

3. Bi-weekly progress notes

New York points out that many of the progress notes specifically identify one or more CDT services that the recipient attended during the two-week period covered by the progress notes. However, that is not sufficient to establish that the service was scheduled for or provided on the DOS since the recipient could have attended the service on a day other than the DOS.

B. Whether the documentation shows that the recipient attended at least one of the CDT services identified as scheduled for the DOS

New York takes the position that the sign-in/out sheet, bi-weekly progress notes, and/or the provider's letter (where applicable) show that the recipient attended at least one of the CDT services identified as scheduled for the DOS.

1. Sign-in/out sheets

A CDT program generally schedules a recipient for several group or individual therapeutic services each day. Thus, the sign-in/out sheet or attendance sheet for the DOS simply indicates that the recipient was at the CDT program on the DOS for a certain number of hours, not that the recipient attended all of the services or a particular service identified as scheduled for the DOS. It is undisputed that the recipient was at the CDT program on the DOS for each of the sample claims at issue. However, for some sample claims, the sign-in/out sheet or attendance sheet shows that the recipient was only at the CDT program for so brief a time on the DOS that we find it implausible that the recipient attended a service that was specifically identified as scheduled for the DOS.

2. Bi-weekly progress notes

Progress notes that do not specifically identify a CDT service scheduled for the DOS could nevertheless establish that the recipient attended a service identified elsewhere in the record as a service scheduled for the DOS. For example, we would accept a statement in the progress notes to the effect that the recipient attended all services on the DOS as sufficient evidence that at least one specific service was received on the DOS. Furthermore, a statement in the progress notes to the effect that the recipient attended all scheduled services during the two-week period would be acceptable evidence of the same thing, if accompanied by a weekly report or treatment plan that showed at least one service was scheduled for each day the recipient was scheduled for the CDT program.

We find no such statement in the progress notes on which we can rely, however.[13] Some of the progress notes state that the recipient attended the program every day or regularly or that the recipient's attendance was good, but these statements at most show that the recipient was at the CDT program on the DOS, not that scheduled services were actually delivered during those visits.

3. Provider letters

The record includes letters from three CDT providers—New York Psychotherapy and Counseling Center (NYPCC), New Horizon Counseling Center, and The Pederson-Krag Center—written in 2011 in response to New York's request for evidence that recipients attended each of the CDT services for which they were scheduled on the DOS. We conclude that NYPCC's letter, but not The Pederson-Krag Center's letter, is adequate to establish that a recipient in its CDT program attended at least one service scheduled for the DOS. Since we find that the documentation for the sample claims for which New Horizon Counseling Center was the provider does not identify any services scheduled for the DOS, we need not consider whether the letter from that provider would be sufficient to establish attendance at such a service.[14]

In NYPCC's letter, the Director of Program Operations and General Counsel provided the following information about NYPCC's "policies and procedures for the period 2005-2008:"

> ...NYPCC ran three continuing day treatment (CDT) programs….[R]ecipients were signed in and out of those program[s] by staff members, who noted the time the recipients entered the building in the morning and the time they left in the afternoon. Also…, it was NYPCC practice to assign recipients receiving treatment at our CDT programs to therapeutic groups—5 each day – depending on the specific goals and objectives in their treatment plans. Recipients were given a copy of their weekly schedule, so that they knew the groups to which they were assigned. It was not, at that time, our policy to sign recipients in or out of their assigned groups.

[13] According to New York, the progress notes for one sample claim state "pt. attends all assigned groups." NY Reply Br. at 6-7 (discussing sample #34). The progress notes actually state that the recipient reported in his Goal Discussion Group that he attends all of his assigned groups. NY Ex. 5, at 6. We need not consider the probative value of this statement since there is other evidence of attendance for this sample claim.

[14] NYPCC was the provider for samples #6, 13, 20, 34, 35, 44, 61, 87, and 100. NY Reply Br. at 4. New Horizon Counseling Center was the provider for samples #33, 58, 67, 75, and 80. *Id*. at 10. The Pedersen-Krag Center was the provider for sample #85. *Id*. at 14. The providers for the other sample claims are identified in the OIG Provider Worksheet for each claim.

> In order to ensure that recipients were in the groups to which they were assigned, each facilitator was charged with the responsibility of knowing the clients assigned to their groups, and were provided with group rosters. We also had employees known as Monitors whose job it was to walk through the halls while groups were being run, making sure that no recipients were "wandering in the halls". In the event that a Monitor found a recipient out of their group, they would either ask the recipient for their group schedule or, if they did not have a copy with them, bring the recipient to the clerical office where a duplicate set of group schedules were kept. The Monitor would then escort the client to the group to which they were assigned during that time. The same was true if a facility found that a recipient not enrolled in their group was in the room – they would call a Monitor.

NY Reply Br., Ex. 1.

CMS notes with respect to each of the disputed sample claims for which NYPCC was the provider that this letter "states that it was not [NYPCC's] policy to sign beneficiaries in or out of group attendance." CMS Response Br. at 8-14, 16-18. To the extent CMS meant to suggest that sign-in/out sheets for each group would be necessary to establish that a recipient attended that group, we disagree. We conclude that the use of the policies and procedures described in the second paragraph quoted above would have made it highly likely that a recipient went to all of the services identified in the recipient's weekly schedule or treatment plan as scheduled for the DOS. Although the letter acknowledges that recipients may at times have been in the hallway or in the wrong group, the letter attests that procedures were followed to get them to their groups. In addition, we can reasonably infer that NYPCC's Director of Program Operations and General Counsel was in a position to know what policies and procedures were in effect were during the period at issue, and CMS does not argue otherwise.[15] Accordingly, we conclude that this letter provides sufficient assurance that a recipient who was at NYPCC's CDT program on the DOS for what appears to be a full day or close to a full day attended at least one CDT service identified in the recipient's weekly schedule or treatment plan as scheduled for that date.

However, we conclude that the letter from The Pederson-Krag Center, signed by the Clinical Director, provides no such assurance with respect to the one sample claim (sample #85) involving that provider. The letter states in pertinent part:

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[15] The letter's author does not make clear whether he held the same positions during the period at issue, but CMS does not object to it on this basis.

> For each period of time that classes are held, we have a staff member designated to be the Float person. This individual's primary purpose is to help prompt individuals to attend their scheduled activity. Since every client has a schedule, the Float person, or any staff member, can help a client find the room that their class is being held. In addition to the Float person, all staff are trained to observe individuals who might be presenting distress and to alert senior staff or individual contact person. Every participant at program is assigned a Contact Person (Treatment coordinator) who they work with to formulate goals and objectives geared towards recovery. Clients are also routinely discussed at daily staff meetings such that certain clients who are not adhering to their schedules would be highlighted for all to observe. Ultimately the Contact Person is informed when there is an issue. There is usually more than one staff person walking through the facility at any given time so monitoring for nonattendance is constant and consistent. There are also monthly client activity sheets that are generated denoting all the service activities an individual took part in. These reports give us a birds eye view as to the involvement of each program participant.

NY Reply Br., Ex. 17, at 26.[16] Nothing in this letter indicates that the procedures the provider had in place succeeded in getting recipients to attend the services scheduled for the DOS, or even actively attempted to ensure that every recipient attended all their planned activities. To the contrary, the letter states that it designated a staff member "to help prompt individuals to attend" a scheduled activity and admits that the provider identified certain recipients who were "not adhering to their schedules[.]" Moreover, although staff members are expected to notice and report recipients in distress, there is no indication that they are instructed to take any action when a recipient is not in a group activity or is in an activity which they are not scheduled to attend. Thus, we conclude that the procedures described in this letter do not provide sufficient assurance that the recipient in sample #85 attended at least one of the CDT services identified in her weekly schedule as scheduled for that date. The letter also claims that the provider generated monthly "activity sheets" that show "all the service activities an individual took part in" but does not explain how the provider determined what those activities were in the absence of procedures that ensured attendance at all scheduled activities. For that reason and others we discuss later, we find that the activities report for sample #85 does not identify CDT services the recipient attended on the DOS.

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[16] The first two sentences and the last three sentences quoted are largely obscured by what appears to be highlighting that shows up as a black line on the record copy. We have deciphered them to the best of our ability.

C. The individual sample claims

Below, we set out the relevant facts for each of the 34 sample claims and our rationale for determining that the claim is or is not allowable. We note preliminarily that New York submitted documentation for only 15 sample claims "as exemplars" and discussed only these sample claims in its briefing. New York Reply Br. at 3-15.[17] Since CMS's findings are dependent on the specific facts of each sample claim, New York cannot show that all sample claims met the documentation requirement in section 505.25(h)(1)(ii) by relying on these examples. However, as noted above, at the Board's request, CMS provided the OIG audit workpapers. Accordingly, we have reviewed the documentation in the workpapers for the 19 sample claims for which New York itself submitted no documentation directly to the Board.[18] Although the workpapers for many of these sample claims do not include some of the types of documentation that New York said was furnished to the OIG, New York had ample opportunity to submit to the Board any documentation not in the workpapers on which it intended to rely.

Sample #6

This claim is for services delivered to A.M. on 12/29/06. A treatment plan for A.M. dated 10/18/06, and reviewed on 12/21/06 without any changes, was still in effect on the DOS since the next treatment plan review was conducted after the DOS, on 3/16/07. NY Ex. 2, at 18-19. The treatment plan lists "Goal Discussion Group" as a service to be provided to A.M. five times a week. *Id*. at 13-16. Progress notes covering the DOS do not note any change in the scheduled services. *Id*. at 4. The progress notes also show that A.M. was scheduled for the CDT program five days a week and was there for a full day on the DOS. *Id*. Since NYPCC was the provider, its letter documents that A.M. attended all scheduled CDT services on the DOS. It is reasonable to infer from these facts that the CDT service Goal Discussion Group was delivered to A.M. on the DOS. We therefore **reverse** CMS's finding that this claim is unallowable.

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[17] The sample claims for which New York submitted documentation are: #6, 13, 20, 34, 35, 44, 61, 87, 100, 33, 58, 67, 75, 80, and 85. We list them in the order that New York discussed them in its reply brief, which grouped the sample claims based on who the CDT provider was. *See* NY Reply Br. at 4-14. All New York exhibits cited below with respect to these claims were submitted with New York's reply brief.

[18] We review the OIG audit workpapers for the following sample claims: #2, 11, 16, 18, 25, 28, 29, 30, 39, 40, 47, 52, 60, 66, 83, 93, 94, 97, and 99. The workpapers are on a CD that contains separate files, listed by claim number, for each of the 48 sample claims on which the disallowance was based. We do not cite to page numbers since the documents to which we refer can be easily located without them.

Sample #13

This claim is for services delivered to A.B. on 8/11/05. A treatment plan for A.B. updated on 9/18/05 lists Goal Discussion Group as a service to be provided five times a week. NY Ex. 3, at 15-16. The schedule for this service was continued from the treatment plan for 3/18/05 and was therefore in effect on the DOS. *Id.* Progress notes covering the DOS do not note any change in the scheduled services and show that A.B. was scheduled for the CDT program five days a week. *Id.* at 4. The progress notes as well as the attendance sheet for the DOS indicate that A.B. was at the CDT program for a full day on the DOS (although she arrived slightly later and left slightly earlier than on some other days). *Id.* at 4, 13; *compare id.* at 5-12, 14. Since NYPCC was the provider, its letter documents that A.B. attended all scheduled CDT services on the DOS. It is reasonable to infer from these facts the CDT service Goal Discussion group was delivered to A.M. on the DOS. We therefore **reverse** CMS's finding that this claim is unallowable.

Sample #20

This claim is for services delivered to C.A. on 2/8/05. A treatment plan for C.A. dated 1/3/05 was still in effect on the DOS since the next treatment plan review was conducted after the DOS, on 3/30/05. NY Ex. 4, at 15, 20. The treatment plan lists Goal Discussion Group and Community Meeting as services to be provided five times a week. *Id.* at 16-18. Progress notes covering the DOS do not appear to note any change in the scheduled services and show that C.A. was scheduled for the CDT program five days a week and was there for a full day on the DOS.[19] *Id.* at 3. Since NYPCC was the provider, its letter documents that C.A. attended all scheduled CDT services on the DOS. It is reasonable to infer from these facts that the CDT services Goal Discussion Group and Community Meeting were delivered to C.A. on the DOS. We therefore **reverse** CMS's finding that this claim is unallowable.

Sample #34

This claim is for services delivered to R.R. on 6/21/06. A treatment plan for R.R. dated 7/25/06 lists Goal Discussion Group as a service to be provided five times a week. NY Ex. 5, at 17-18. The schedule for this service was continued from the treatment plan for 2/23/06 and was therefore in effect on the DOS. Progress notes covering the DOS do not note any change in the scheduled services and show that R.R. was scheduled for the CDT program five days a week and was there for a full day on the DOS. *Id.* at 6. Since NYPCC was the provider, its letter documents that R.R. attended all scheduled CDT services on the DOS. It is reasonable to infer from these facts that the CDT service Goal Discussion Group was delivered to R.R. on the DOS. We therefore **reverse** CMS's finding that this claim is unallowable.

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[19] The text of the progress notes is barely legible.

Sample #35
This claim is for services delivered to J.G. on 4/1/08. A treatment plan dated 7/31/07 reflects an update on 4/28/08, after the DOS, and was therefore in effect on the DOS. NY Ex. 6, at 14-17. The treatment plan lists Goal Discussion Group and Token Economy as services to be provided five times a week. *Id*. Progress notes covering the DOS do not note any change in the scheduled services and show that J.G. was scheduled for the CDT program five days a week and was there for a full day on the DOS. *Id*. at 3. Since NYPCC was the provider, its letter documents that J.G. attended all scheduled CDT services on the DOS. It is reasonable to infer from these facts that the CDT services Goal Discussion Group and Token Economy were delivered to J.G. on the DOS. We therefore **reverse** CMS's finding that this claim is unallowable.

Sample #44
This claim is for services delivered to D.T. on 12/4/08. A treatment plan established 10/30/08 reflects an update on 4/28/09, after the DOS, and was therefore in effect on the DOS. NY Ex. 7, at 14-15. The treatment plan lists Goal Discussion Group as a service to be provided five times a week. *Id*. Progress notes covering the DOS do not note any change in the scheduled services and show that D.T. was scheduled for the CDT program five days a week and was there for a full day on the DOS. *Id*. at 4. Since NYPCC was the provider, its letter documents that D.T. attended all scheduled CDT services on the DOS. It is reasonable to infer from these facts that the CDT service Goal Discussion Group was delivered to D.T. on the DOS. We therefore **reverse** CMS's finding that this claim is unallowable.

Sample #61
This claim is for services delivered to B.B. on 6/7/06. A treatment plan established 12/2/05 reflecting an update on 5/10/06 was still in effect on the DOS since the next review was conducted on 8/3/06. NY Ex. 8 at 17-18. The treatment plan lists Goal Discussion Group and Community Meetings as services to be provided five times a week. *Id*. at 15-16. Bi-weekly progress notes for the period covering the DOS do not note any change in the scheduled services and show that B.B. was scheduled for the CDT program five days a week and was there for a full day on the DOS. *Id*. at 3. Since NYPCC was the provider, its letter documents that B.B. attended all scheduled CDT services on the DOS. It is reasonable to infer from these facts that the CDT services Goal Discussion Group and Community Meetings were delivered to B.B. on the DOS. We therefore **reverse** CMS's finding that this claim is unallowable.

Sample #87
This claim is for services to M.A. on 10/31/07. A treatment plan dated 5/14/07 reflects an update on 11/1/07, after the DOS, and was therefore in effect on the DOS. NY Ex. 9, at 18-19. The treatment plan lists Goal Discussion Group and Community Meeting as services to be provided five times a week. *Id*. Progress notes covering the DOS do not note any change in the scheduled services and show that M.A. was scheduled for the

CDT program five days a week and was there for a full day on DOS. *Id*. at 5. Since NYPCC was the provider, its letter documents that M.A. attended all scheduled CDT services on the DOS. It is reasonable to infer from these facts that the CDT services Goal Discussion Group and Community Meeting were delivered to M.A. on the DOS. We therefore **reverse** CMS's finding that this claim is unallowable.

Sample #100

This claim is for services to J.C. on 11/5/08. The weekly schedule is dated 11/3/08, a Monday.[20] NY Ex. 10, at 2. Since the DOS fell on Wednesday of the same week, it follows that the weekly schedule was still in effect on the DOS. (In addition, two CDT services on the weekly schedule, Socialization and Community Meeting, are listed as services to be provided five days a week on a treatment plan that was still in effect on the DOS. NY Ex. 10, at 18-21.) Progress notes for the period covering the DOS show that J.C. was at the CDT program for a full day on the DOS. *Id*. at 5. Since NYPCC was the provider, its letter documents that J.C. attended all scheduled CDT services on the DOS. It is reasonable to infer from these facts that the CDT services shown on the weekly schedule were delivered to J.C. on the DOS. We therefore **reverse** CMS's finding that this claim is unallowable.

Sample #33

This claim is for services to H.B. on 1/11/05. The weekly schedule is dated 10/26/04, more than two months before the DOS. NY Ex. 12, at 11. The treatment plan does not identify any CDT service. *Id*. at 4-8, 13. Progress notes covering the DOS state that H.B. went to a "Core Group party" but do not indicate that it was on the DOS. *Id*. at 13. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #58

This claim is for services to W.B. on 8/26/08. The weekly schedule is dated 8/2/08, more than two weeks before the DOS. NY Ex. 13, at 11. The treatment plan does not identify any CDT services. *Id*. at 5-8. Progress notes covering the DOS identify several groups W.B. attended, including Problem Solving, Anger Management, and Therapeutic Community. *Id*. at 12. However, the progress notes do not indicate that W.B. attended any of these services on the DOS or even that they were scheduled for the DOS. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

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[20] We take judicial notice of the day of the week here and in our discussion of other sample claims based calendars available on the internet. *See, e.g.*, http://www.timeanddate.com/calendar/generate.html.

Sample #67
This claim is for services to S.B. on 12/7/05. The weekly schedule is dated 11/16/05, three weeks before the DOS. NY Ex. 14, at 14. New York asserts that this weekly schedule was still in effect on the DOS because a "treatment plan review [that] took place just prior to the" DOS indicated that S.B.'s "groups and treatment goals remain the same from the previous period[.]" NY Reply Br. at 12-13. However, even if the CDT services on the weekly schedule had not changed as of the DOS, it does not necessarily follow that the services would have been scheduled for the same days of the week as shown on the 11/16/05 schedule. In addition, neither the treatment plan nor the progress notes identify any CDT services. *Id.* at 8-11, 15. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #75
This claim is for services to M.B. on 9/2/05. The weekly schedule is dated 6/29/05, more than two months before the DOS. NY Ex. 15, at 16. Neither the treatment plan nor the progress notes identify any CDT services. *Id.* at 10-13, 18. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that the sample claim is unallowable.

Sample #80
This claim is for services to A.T. on 4/12/06. The weekly schedule is dated 2/06, at least one month before the DOS.[21] NY Ex. 16, at 12. Neither the treatment plan nor the progress notes identify any CDT services. *Id.* at 6-9, 11. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #85
This claim is for services to A.M. on 07/8/05. The weekly schedule is dated 7/5/05. NY Ex. 17, at 4.[22] The record shows that 7/5/05 was a Tuesday. *Id.* at 6. Since the DOS fell on Friday of the same week, it follows that the weekly schedule was still in effect on the DOS. However, nothing in the record establishes that A.M. attended any of the CDT services scheduled for the DOS. The sign-in/out sheet for the DOS merely shows that A.M. was at the CDT program on the DOS. New York points to a progress note entry on the DOS stating that A.M. was seen by a staff member and an LPN for a fall on that date; however, nothing in that entry indicates that A.M. went to any scheduled CDT services.

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[21] We are unable to read the complete date on this document.

[22] The date on the weekly schedule is partially obscured by a black line that appears to be highlighting; however, the provider's summary identifies the date as 7/5/05. *Id.* at 1st page (unnumbered).

NY Reply Br. at 14; NY Ex. 17, at 8.[23] The next progress note entry, dated 7/15/05, states. "Last week, client did participate in groups," but this does not show that A.M. attended any groups on the DOS. NY Ex. 17, at 9. A report for A.M. captioned "Patient Activities" lists certain dates in each of four consecutive weeks and, for each date including the DOS, lists all of the CDT services shown on the weekly schedule for the day of the week corresponding to that date. NY Reply Br., Ex. 17, at 6. The activities report lists three dates in the first week (including the DOS), one date in the second week, three dates in the third week, and four dates in the fourth week. *Id.* Since the weekly schedule shows that A.M. was scheduled to attend the CDT program four days a week, the fact that some dates are missing from the activity report indicates that the dates that are listed are the dates A.M. attended the CDT program. However, nothing on the face of the report indicates that the services listed for each date are services A.M. attended and not simply services scheduled for her on that date. (If, for example, even one of the scheduled services for any date listed had not been not included, that would have tended to show that the services that are listed are services that A.M. actually attended.) The letter from the provider, The Pedersen-Krag Center, states that "monthly client activity sheets [were] generated denoting all the service activities an individual took part in." *Id.* at 26. However, as discussed above, this letter is not sufficient to establish that the provider followed procedures to ensure that recipients attended scheduled services when they were at the CDT program or that the activities report in fact shows services attended. Since the documentation does not show that A.M. attended any CDT services identified as scheduled for the DOS, we **uphold** CMS's finding that this sample claim was unallowable.

Sample #2

This claim is for services to T.C. on 11/3/05.[24] The audit workpapers include an individualized treatment plan signed by the physician on 11/2/05 that lists CDT services including group verbal therapy five times a week. The sign-in sheet for the DOS indicates that T.C. was at the CDT program most of the day, but there are no progress notes or other documents in the record that might show that T.C. attended the therapy service on the DOS. Since the documentation does not show that T.C. attended the CDT service identified as scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

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[23] We rely mostly on New York's description since the progress note is partially illegible.

[24] CMS incorrectly identified the DOS as 12/29/06. CMS Br. at 8.

Sample #11
This claim is for services to R.B. on 6/9/06. The OIG audit workpapers include progress notes covering the DOS stating that R.B. "does not attend groups[.]" In addition, the OIG Provider Worksheet at page 8 states that C.N., an employee of the provider, stated that "it does not appear" from the progress notes "that therapy services were rendered to [R.B.] on the sample service date under review." Since the documentation shows that R.B. did not attend a CDT service on the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #16
This claim is for services to P.D. on 4/19/05. The OIG audit workpapers do not include a weekly schedule or a treatment plan. Progress notes covering the DOS are recorded on a form that lists specific CDT services scheduled for P.D., but the form does not indicate that any of these services were scheduled for the DOS. The text of the progress notes does not identify a CDT service. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #18
This claim is for services to V.C. on 8/12/05. The OIG audit workpapers include a weekly schedule dated 7/28/05, two weeks before the DOS. The only specific reference to a service in the progress notes is in an entry dated 8/17/05 signed by the art therapist stating that V.C. "fell asleep, slept most of the morning," and "could not participate in art room project[.]" This identifies art therapy as a CDT service, but there is no indication that it was scheduled for the DOS as well as 8/17/05. The treatment plan does not identify a CDT service. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #25
This claim is for services to S.V. on 1/3/05. The OIG audit workpapers do not include a weekly schedule. The progress notes do not identify any CDT services. The treatment plan lists "Individual therapy," "Healthy Living," and "Good Humor-good health" as services to be provided one time each per week, but does not include any information which might indicate that at least one of these services was scheduled for the DOS. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #28
This claim is for services to G.B. on 9/21/06. A treatment plan dated 8/10/06 indicates that the next review was scheduled for 11/9/06 and was thus in effect on the DOS. The treatment plan specifies that G.B. was to attend "Advocacy Meetings daily." Although the treatment plan thus identifies "advocacy" as a CDT service that was scheduled for the

DOS, nothing in the record establishes that G.B. attended this service on the DOS. A 9/27/06 entry in the progress notes that may cover the DOS states that G.B. "does make a point of voicing how he feels in advocacy," but neither this statement nor anything else in the record indicates that G.B. attended this service on the DOS. Since the documentation does not show that G.B. attended the CDT service specifically identified as scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #29
This claim is for services to A.B. on 9/15/06. The OIG audit workpapers do not include a weekly schedule or a treatment plan. Progress notes covering the DOS are recorded on a form that lists specific CDT services for A.B., but the form does not indicate that any of these services were scheduled for the DOS. The text of the progress notes states that A.B. "attends Community Meeting and Recovery Circle" but contains no indication that A.B. attended either service on the DOS or even that one of these services was scheduled for the DOS. There is no treatment plan in the record. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #30
This claim is for services to G.W. on 9/23/05. The OIG audit workpapers include a weekly schedule showing that is for "2005." Progress notes for the period covering the DOS identify services including "Client Gov't," "smoke cessations grp," "comm. Meeting" and "memory grp," but contain no indication that G.W. attended any of these services on the DOS or even that one of these services was scheduled for the DOS. (The progress notes state that G.W. "[a]ttends smoke cessations grp on Tues AM," but the DOS was on a Friday.) There is no treatment plan in the record. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #39
This claim is for services to G.C. on 7/31/06. The OIG audit workpapers do not include a weekly schedule. The treatment plan is dated 8/24/06, after the DOS, and does not indicate what services were scheduled for G.C. prior to that date. An 8/2/06 entry in the progress notes that may cover the DOS state that G.C. "is invited to join advocacy daily" and "often refuses." Although this identifies advocacy as a CDT service that was scheduled for G.C. for the DOS, it indicates that G.C. may not have attended this service on the DOS. Since the documentation does not show that G.C. attended the CDT service identified as scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #40
This claim is for services to R.B. on 8/17/07. The OIG audit workpapers include progress notes covering the DOS that note that R.B. did not attend any groups on the DOS. In addition, the OIG Provider Worksheet at page 8 states: "Provider official [T.G.] confirmed that the recipient received no services on our service date and that billing Medicaid for that day was an 'error.' [T.G.] stated that the recipient worked at the CDT that day [at a provider-operated store] and was subsequently paid on a stipend." Since the documentation shows that R.B. did not attend a CDT service on the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #47
This claim is for services to J.T. on 11/14/06. The OIG audit workpapers include only an attendance sheet for the DOS. A note in the workpapers states that there "was a calendar showing the groups the recipient was scheduled for," but that "[t]here is no documentation for what services were provided on the" DOS. Even if the OIG meant that it saw a calendar that was in effect on the DOS, the documentation does not show that J.T. attended any of the services identified as scheduled for the DOS. We therefore **uphold** CMS's finding that this claim is unallowable.

Sample #52
This claim is for services to S.M. on 6/21/08. In addition to a sign-in/out sheet, the OIG audit workpapers include only "Master" schedules that show all of the groups that were available on each day of the week, not S.M.'s individual schedule. Since the documentation does not specifically identify a CDT service even scheduled for S.M. for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #60
This claim is for services to P.S. on 5/12/08. The OIG audit workpapers include an undated weekly schedule and do not include a treatment plan. Progress notes covering the DOS mention P.S.'s attendance at "stress reduction, wellness self management groups" but contain no indication that P.S. attended any of these services on the DOS or even that one of these services was scheduled for the DOS. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #66
This claim is for services to D.A. on 10/3/06. The OIG audit workpapers do not include a weekly schedule or progress notes. A treatment plan dated 8/8/06 was still in effect on the DOS since the next review was scheduled for 10/25/06, after the DOS. The treatment plan identifies advocacy, medication management, and group therapy as CDT services

that are each to be provided daily. However, there is no documentation showing that D.A. attended any of these services on the DOS. Since the documentation does not show that D.A. attended any of the CDT services identified as scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #83

This claim is for services to S.C. for 8/26/05. The OIG audit workpapers do not include a weekly schedule. A treatment plan dated 8/11/05 was still in effect on the DOS since the next review was scheduled for 11/11/05. The treatment plan states that S.C. "will attend the following: ADL & Anger management" but does not include any information about the frequency which might indicate that at least one of these services was scheduled for the DOS. Progress notes covering the DOS state that: S.C. "attended stress management sessions," the social worker "had an individual session with" S.C., and S.C. "attended ADL group session," but do not indicate that S.C. attended any of these services on the DOS or even that they were scheduled for the DOS. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #93

This claim is for services to J.D. on 4/18/05. The OIG audit workpapers include a weekly schedule dated 4/7/05, more than a week before the DOS. Progress notes covering the DOS do not identify any CDT services. A treatment plan dated 1/21/05 was still in effect on the DOS since the next review was scheduled for 4/21/05. The treatment plan provides for "Adv[ocacy] and Senior Citizens group" "1x per week." The treatment plan also indicates that the Senior Citizens group was on a Tuesday, but the DOS fell on a Thursday. There is no documentation showing that Advocacy was scheduled for the DOS, much less during the one hour the attendance sheet shows J.D. was at the CDT program on the DOS. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #94

This claim is for services to R.L. on 6/21/05. The OIG audit workpapers do not include a weekly schedule. A treatment plan dated 5/15/15 was still in effect on the DOS since the next review was scheduled for 8/12/05. The treatment plan identifies "Individual Supportive Therapy" as a service to be provided "wkly" but there is no indication that this service was scheduled for the DOS, much less during the 80 minutes the attendance sheet shows R.L. was at the CDT program on the DOS. Progress notes covering the DOS state that R.L. "helped out in the boutique and attended some groups at times." However, there is no indication that working in the boutique constituted a CDT service, much less that it was scheduled for the DOS. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #97

This claim is for services to D.S. on 6/30/08. The OIG audit workpapers include an attendance report for the DOS showing that D.S. signed in at 9:00 a.m. and out at 9:30 a.m. A progress report dated 7/3/08 states that D.S. "attended CDT on …6/30…but did not attend any groups." Since the documentation shows that D.S. did not attend any CDT services on the DOS, we **uphold** CMS's finding that this claim is unallowable.

Sample #99

This claim is for services to S.C. on 12/15/05. The OIG audit workpapers include a weekly schedule for S.C. dated 11/10/05, more than a month before the DOS. Progress notes covering the DOS do not identify any CDT services. A treatment plan dated 11/10/05 was still in effect on the DOS since the next review was scheduled for 2/10/06, after the DOS. The treatment plan states that S.C. "participates in D.B.T. groups, symptom management and verbal therapy" but does not include any information about the frequency which might indicate that at least one of these services was scheduled for the DOS. Since the documentation does not specifically identify a CDT service even scheduled for the DOS, we **uphold** CMS's finding that this claim is unallowable.

For the foregoing reasons, we conclude that nine of the 34 sample claims discussed above are allowable— samples #6, 13, 20, 34, 35, 44, 61, 87, and 100—and that the remaining 25 sample claims are unallowable.

II. Claims CMS found unallowable based on other State regulations that applied to the CDT program

CMS found 14 sample claims unallowable based on one of four other deficiency findings made by the OIG: 1) progress notes were not properly recorded; 2) the duration of the recipient's contact with staff was not indicated; 3) the treatment plan was not completed timely; and 4) the treatment plan was not complete. New York argues that the State regulations on which these deficiency findings are based, which appear in Parts 587 and 588 of 14 NYCRR, do not impose requirements for reimbursing an individual claim for CDT services. According to New York, only section 505.25(h)(1)(i)-(v) of 18 NYCRR sets forth conditions that each individual claim must meet in order to be eligible for reimbursement.[25] NY Supp. Br. at 22-23. New York states that the remaining State regulations on which the OIG based its deficiency findings—

[25] In addition to the requirement in section 505.25(h)(1)(ii) at issue here, section 505.25(h)(1) lists the following: (i) documentation by a physician that treatment is appropriate and necessary; (iii) services are provided by staff designated as appropriate by regulations of the Office of Mental Health; (iv) except for crisis services, the location of service is documented in the recipient's record and off-site service is justified; and (v) utilization review policies and procedures, acceptable to the Office of Mental Health, are operative.

> are the standards for how the *entire program* is operated. If a program does not operate in accordance with these standards, it is not qualified to bill under the Medical Assistance Program. These standards are not intended to be applied as indispensable requirements for each specific claim.

Id. at 22 (italics in original), citing 18 NYCRR § 505.25(d).

New York's argument is not supported by the language of its own regulations read as a whole. The regulatory provision on which New York relies, section 505.25(d) of 18 NYCRR, applies to programs providing ambulatory care for recipients with mental illness, such as clinic programs, and states in pertinent part: "*Standards which shall be met by programs in order to bill under the Medical Assistance Program.* (1) All programs must meet the standards set forth by…14 NYCRR Parts 587 and 588." Parts 587 and 588 include the requirements that New York argues were not a proper basis for the OIG's deficiency findings. In particular, Part 587 includes the requirements that the treatment plan include criteria for discharge planning (section 587.16(e)(5)), that progress notes shall be recorded by the clinical staff member(s) who provided services to the recipient (section 587.16(f)), and that the duration of the recipient's contacts with staff be indicated in the case record (section 587.18(b)(7)). Part 588 includes the requirement that the treatment plan shall be completed prior to the 12th visit after admission or within 30 days of admission, whichever occurs first (section 588.7(d)).

As New York argues, under 18 NYCRR § 505.25(d)(1), Parts 587 and 588 of 14 NYCRR set out standards a CDT **program** must meet in order to qualify to bill Medicaid for services to recipients. Consistent with this provision, section 587.1 of 14 NYCRR "sets certification standards" for outpatient programs including CDT programs. 14 NYCRR § 587.1(c). Section 587.1(d) states:

> The Office of Mental Health issues operating certificates to programs which meet the standards set forth in this Part [Part 587]. Certification in and of itself does not confer eligibility to receive financial support from any governmental source. In order to qualify for reimbursement under the medical assistance program, outpatient programs must also comply with the standards specified in Part 588 of this Title.

In addition, section 587.22 provides that once an operating certificate is issued, a provider "shall exercise due diligence in complying with the requirements of this Part." 14 NYCRR § 587.22(c). Section 587.22 also provides in part that the Office of Mental Health "may revoke, suspend or limit the provider's operating certificate or impose fines" if the provider does not exercise such due diligence and "fails to promptly or effectively implement a plan of correction[.]" 14 NYCRR § 587.22(c)-(e). Thus, a CDT program that does not comply with standards in Parts 587 or 588 may lose its Medicaid billing privileges.

Contrary to what New York argues, however, the standards in Parts 587 and 588 are not solely standards a CDT program must meet to obtain and maintain the certification that allows it to bill Medicaid. Section 505.25(h)(1) of 18 NYCRR states:

> State reimbursement shall be available for expenditures made in accordance with the provisions of this section **and** when the following conditions are met[.]

18 NYCRR § 505.25(h)(1) (emphasis added). "[T]his section" refers to section 505.25, including section 505.25(d)(1), which, as noted above, requires that programs meet the standards in 14 NYCRR Parts 587 and 588. Thus, section 505.25(h)(1) incorporates section 505.25(d)(1) by reference, thereby making the standards to which section 505.25(d)(1) refers requirements for reimbursing individual claims for CDT services. Accordingly, section 505.25(h)(1) makes compliance with sections 587.16(e)(5), 587.16(f), 587.18(b)(7), and 588.7(d) requirements for reimbursement of individual claims for CDT services.[26]

New York's argument that the only requirements for reimbursing individual claims are in section 505.25(h)(1)(i)-(v) appears to be based on a misreading of section 505.25(h)(1). New York in effect ignores the language "made in accordance with the provisions of this section" and reads section 505.25(h)(1) as referring only to the "following conditions," i.e., those in subparagraphs (i)-(v). However, the use of the conjunction "and" clearly signals that the requirements for reimbursement include not only those conditions but also requirements imposed by other provisions of section 505.25.

We therefore conclude that the regulations in Parts 587 and 588 of NYCRR on which the deficiency findings for 14 sample claims were based constituted requirements for reimbursing individual claims.

Of these 14 sample claims, New York concedes that five claims, samples #1, 7, 10, 46, and 84, did not comply with section 587.18(b)(7); that three claims, samples #50, 57, 79, did not comply with section 587.16(g) ; and that one claim, sample #78, did not comply with section 588.7(d). NY Reply Br. at 16-17. We therefore uphold the disallowance with respect to these nine sample claims without further discussion.

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[26] There is also an independent basis for finding that section 588.7(d) of 14 NYCRR is a requirement for reimbursing individual claims for CDT services since section 588.7 is titled "Standards pertaining to reimbursement for continuing day treatment programs."

Below, we discuss the five sample claims remaining in dispute, consisting of two claims CMS found unallowable based on section 587.16(f) (progress notes not properly recorded)—samples #17 and 23; two claims CMS found unallowable based on section 588.7(d) (treatment plan not completed timely)—samples #62 and 82; and one claim CMS found unallowable based on section 588.16(e)(5) (treatment plan not complete)—sample #37.[27]

Sample #17

This claim was for services to S.M. on 8/27/07. The progress notes for the period 8/27/07-9/7/07 are signed by A.B., a licensed medical social worker. NY Ex. 18, at 13. CMS disallowed the claim "because the bi-weekly progress note was recorded by a clinical staff member who did not provide at least one service during the two week period." CMS Br. at 9. New York asserts that the progress notes themselves document that A.B., S.M.'s "primary worker," provided services to S.M. during that period. New York Reply Br. at 16. New York points to the following statement in the section of the progress report captioned "Outreach Efforts/Comments:"

> Client was out 8/28, 8/29, 8/31, 9/4-9/7 because she was waiting for repairs in her apartment. Outreach calls were made on those days. Client reports that she was told repair men would come but they kept delaying and would not show up to fix plumbing and finish painting.

According to New York, the "note indicates that conversations took place between the client and A.B., in which A.B. assessed the client's condition." *Id.* New York asserts that this note "proves that there was on-going clinical support services being provided by the caseworker to the client." *Id.* New York further asserts that "[t]hese services include crisis intervention, case management and verbal therapy." *Id.*[28]

New York's argument has no merit. The language on which New York relies merely shows that A.B., in her capacity as S.M.'s social worker, called S.M. on each of the days she did not attend the CDT program as scheduled and that S.M. reported that she was waiting for repairmen at her apartment. The note does not explain how this situation constituted a crisis, describe what A.B. said to S.M. when she called, or reflect the nature of any assessment made of S.M.'s condition. Thus, there is no basis for finding that A.B.

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[27] None of the sample claims remaining in dispute involve a deficiency finding based on section 587.18(b)(7).

[28] New York also states that A.B. "co-led several of the client's groups." NY Reply Br. at 16. However, New York does not allege that A.B. co-led any groups that the recipient attended during the period covered by the progress notes.

provided either crisis intervention or verbal therapy services. Moreover, New York does not explain how merely calling S.M. to find out why she was not at the CDT program rises to the level of a case management service. We therefore **uphold** CMS's finding that this claim is unallowable.

Sample #23

This claim was made for services to G.E. on 1/10/08. CMS disallowed the claim "because the bi-weekly progress note was recorded by a clinical staff member who did not provide at least one service during the two week period." CMS Br. at 10. Progress notes for the period 12/18/07-1/18/08 are signed by V.M. *See* OIG audit workpapers. New York does not dispute that V.M. signed these progress notes and provided no services to G.E. during the relevant period. However, New York asserts that G.E. "was seen by her treating psychiatrist on the date of service for medication management" and that the treating psychiatrist "recorded his observations in a progress note[.]" NY Reply Br. at 17. New York argues that this progress note met the regulatory requirement because the progress note was signed by a clinical staff member who provided a service—medication management—to G.E. on the DOS. *Id.*

The progress note on which New York relies is referred to in the provider's summary of the supporting documentation provided to the OIG[29] but is not included in either New York's Exhibit 19, which New York submitted to the Board in support of this claim, or in the OIG audit worksheets. Thus, although New York's argument may in theory have merit, it is not supported by source documentation. We therefore **uphold** CMS's finding that this claim is unallowable.

Sample #62

This claim was made for services to M.S. on 4/30/08. CMS disallowed the claim "because the Initial Treatment Plan was not completed prior to the 12th visit after admission[.]"[30] CMS Br. at 14. M.S. was admitted to the CDT program on 3/20/08 and had a treatment plan dated 4/18/08. NY Ex. 20, at 1. The OIG found, and New York does not dispute, that M.S. had already had 18 "visits" to the CDT program by 4/18/08. OIG Provider Worksheet at 8. Thus, although the 4/18/08 treatment plan was dated less than 30 days after admission, it was not timely.[31]

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[29] The summary states: "Progress note dated 1/15/08 written by [L.E.] MD indicates client was seen for medication management on that date." NY Ex. 19, 1st page (unnumbered).

[30] CMS also identified two other grounds for disallowing this claims (based on the OIG's findings): (1) the treatment plan did not include discharge planning and (2) the recipient did not sign the treatment plan. CMS Response at 14; *see also* OIG Provider Worksheet at 8. We need not address these grounds since we find that the treatment plan was not completed timely.

[31] As previously noted, section 588.7(d) of 14 NYCRR requires that the treatment plan be completed within 30 days of admission or prior to the 12th visit after admission, whichever occurs earlier.

New York argues that it nevertheless met the requirements of the regulation because all of the basic components of a treatment plan were in place by M.S.'s fourth visit to the CDT program on 3/25/08. NY Reply Br. at 17-18. According to New York, the case record documents that, by that date, M.S. "and the staff agreed on a plan of group therapy and a primary counselor and a psychiatrist were assigned to the client" and that M.S.'s "stated goal of getting ready to go back to work" was "incorporated" in this plan. *Id*. at 18.

New York's argument has no merit. New York's Exhibit 20, which New York submitted to the Board in support of this claim, includes a document pertaining to M.S., captioned "Behavioral Health Services Adult Assessment & Psychosocial," which was signed by a licensed medical social worker on 3/20/08 and by the director of the CDT facility on 3/25/08. NY Ex. 20, at 2, 13. This assessment shows a diagnosis of "Schizophrenia, disorganized type" that appears to be based on a "Behavioral Health Services Psychiatric Evaluation" performed by a psychiatrist on 3/17/08. *Id*. at 12 and 14-22. The assessment also lists "Neurological Evaluation," "MED management," and "family psychoeducation group" as "Concrete Service Needs." *Id*. at 13. However, the assessment does not indicate that anyone had been assigned to M.S.'s treatment team or include any reference to M.S.'s treatment goals. In addition, New York does not allege that the assessment includes other elements of a treatment plan required by section 587.16(e) of 14 NYCRR. We therefore **uphold** CMS's finding that this claim is unallowable.

Sample #82

This claim was made for services to D.J. on 7/6/07. CMS disallowed the claim "because the Initial Treatment Plan was not completed prior to the 12th visit or within 30 days of admission." CMS Br. at 16. D.J.'s treatment plan is dated 4/24/07, more than 30 days after her admission to the CDT program on 3/8/07. NY Ex. 21, at 5; OIG Provider Worksheet at 8. New York points out that after D.J. was admitted to the CDT program, "she was hospitalized for 15 days on an inpatient psychiatric unit." NY Reply Br. at 18. The record shows that D.J. went to the hospital on 3/16/07 and returned home on 4/2/07. NY Ex. 21, at 1-2. New York argues:

> [A]lthough the treatment plan was completed 47 days after her admission to the CDT program, this does not account for the time she was unable to attend the program. The treatment plan was formulated only 21 days after she returned to the program on her sixteenth visit. The note and treatment plan indicate that the patient was resistant to treatment, had poor insight and had a difficult time articulating her goals….Given this client's mental status at the time she came back to the CDT, 21 days after she was discharged from a psychiatric in-patient unit and the 12th visit would barely have been sufficient time to adequately assess the patient and engage her in a productive discussion of her treatment goals.

NY Reply Br. at 18-19.

New York's argument has no merit. Even if D.J.'s admission date were considered to be April 3— the date of her first visit to the CDT program following her return from the hospital, that does not change the fact that the treatment plan was not completed prior to the 12th visit after admission as the regulation requires. New York argues in effect that it could not comply with this requirement due to D.J.'s mental status upon her return from the hospital. However, New York does not point to any authority in its state law for waiving this requirement in extenuating circumstances. We therefore **uphold** CMS's finding that this claim is unallowable.

Sample #37

This claim was made for services to D.S. on 11/12/07. CMS disallowed the claim "because the applicable treatment plan does not include a plan for additional services to support the beneficiary outside the program or the criteria for discharge planning." CMS Br. at 12. Section 587.16(e)(5) of 14 NYCRR requires that the treatment plan include "criteria for discharge planning." New York asserts that D.S.'s 11/7/07 treatment plan met this requirement for the following reasons:

> [T]here is a section in the treatment plan that is clearly identified as "Discharge Criteria/Areas of Need: Recommendations for Discharge." There are two sections checked off on this sheet which indicate criteria that has to be met before the client is discharged: "consistent abstinence from mood altering illicit drugs or alcohol and mood behavior" and "thought stabilized sufficiently to independently carryout [*sic*] basic self-care." Additionally, a review of chart indicates the justification for client's need for a structured group home, medication, AA meetings and her need for rehabilitation…The client's goals are presented in an organized fashion and are linked to the treatment and discharge plan….

NY Reply Br. at 19.

Contrary to what New York suggests, however, the section identified as "Discharge Criteria/Areas of Need: Recommendations for Discharge" is not on its face part of D.S.'s treatment plan. Instead, it appears in a document titled "Core Evaluation" dated 11/7/07. NY Ex. 22, 5th page (unnumbered). Not only is this document clearly identified as an evaluation, but it is signed only by G.H., a licensed medical social worker, and not by a treating physician, as required for treatment plans by section 587.16(e)(1) of 14 NYCRR. *Id*. at 5th-6th pages. New York does not explain why this document should be considered part of the treatment plan. We therefore **uphold** CMS's finding that this claim is unallowable.

For the foregoing reasons, we conclude that none of the 14 sample claims discussed above are allowable.

III. New York's other arguments have no merit.

As New York points out, the disallowance at issue here is "based entirely upon State regulations[.]" NY Br. at 6. New York asserts that in determining that it failed to comply with those regulations, the OIG and ultimately CMS applied their own interpretation of those regulations. According to New York, CMS's interpretation "contradicts long standing industry practice with respect to documenting the provision of CDT services that was widely accepted not only by the State regulatory agency, but also by New York State's Medicaid regulatory enforcement body," the Office of the Medicaid Inspector General (OMIG). NY Br. at 14-15; NY Supp. Br. at 3, 17. New York argues that CMS should have deferred to the interpretation reflected by this practice since "[i]t is well settled that the construction given statutes and regulations by the agency responsible for their administration, if not irrational or unreasonable, should be upheld." NY Br. at 14; NY Supp. Br. at 16 (both citing cases). New York also argues that CMS's interpretation is invalid because "CMS is applying a previously undisclosed, retroactive standard that creates an extreme hardship for the CDT providers and the State." NY Br. at 15; NY Supp. Br. at 18.

As evidence of its interpretation, New York relies primarily on two reviews conducted by OMIG of a total of 95 claims from two of the CDT providers who were subject to the OIG audit for services provided during three of the four years covered by the OIG audit. NY Br. at 7; NY Supp. Br. at 9. New York states:

> Although OMIG cited the providers for some technical violations, for all 95 of these claims, OMIG concluded that there was sufficient documentation to conclude that a Medicaid eligible service had been provided. This contrasts sharply with the conclusions drawn by the OIG auditors which disallowed every claim sampled for these two providers for a lack of such documentation, accounting for over 25% of the total OIG recommended audit recovery amount[.]

NY Br. at 7; NY Supp. Br. at 9-10. New York explains the difference in the results as follows:

> OIG used an arbitrarily strict audit protocol, unsupported by either statute or regulation, and recommended disallowances unless there was a separate group attendance sheet to demonstrate client participation on the specific date of service to support a Medicaid claim. OMIG, on the other hand, reviewed all available documentation to support the Medicaid claims, including: sign-in/sign-out sheets, client schedules with day and time specification, progress notes, treatment plans, and group notes.

NY Br. at 7; NY Supp. Br. at 10. New York also states that it "engaged a consultant expert in the area of inspections and chart reviews in behavioral health care, Behavioral and Organizational Consulting Associations (BOCA)," to review each of the claims identified by the OIG. NY Br. at 5. According to New York, "[i]n the majority of cases where OIG determined that services were not …documented, BOCA determined that there was ample documentation in the charts to refute OIG's findings." *Id.*

New York's arguments do not provide a valid basis for reversing the disallowance. The Board has long held that a state's interpretation of its own regulations is generally entitled to deference. In *New York Department of Social Services,* DAB No. 1112, the Board stated in pertinent part: "New York correctly pointed out that an administering agency's interpretation of its own regulations deserves deference. Ohio Dept. of Human Services, DAB No. 725 (1986). We agree that HCFA should defer to the state's interpretation of it[s] own regulation where there is a reasonable basis in the language for that interpretation." DAB No. 1112, at 12-13, n.14. However, as explained in section II of our Analysis, we conclude based on the plain language of New York's regulations that Parts 587 and 588 of 14 NYCRR impose requirements that must be met for an individual claim to be reimbursable. New York's contrary interpretation is not entitled to deference since there is no reasonable basis in the regulatory language for that interpretation. We further conclude, for the reasons below, that New York has not shown that it had an interpretation of section 505.25(h)(1)(ii) of 18 NYCRR (discussed in section I of our Analysis) inconsistent with that applied here that is entitled to deference.

Contrary to what New York suggests, the results of the OMIG reviews are not evidence of an interpretation of section 505.25(h)(1)(ii). New York did not provide a review report or other evidence of the OMIG reviews, much less detailed information about the individual claims and documentation that OMIG reviewed. Thus, New York's assertion that OMIG found all of the claims it reviewed allowable based on a review of all available documentation tells us nothing about how OMIG interpreted section 505.25(h)(1)(ii). In addition, although BOCA reviewed the same claims at issue here, New York does not allege that that BOCA's review was based a prior interpretation provided to it by New York. Thus, even if the results of BOCA's review reflect a different interpretation of the applicable requirements than the OIG's and CMS's, it is BOCA's own interpretation and is not entitled to any deference.

Furthermore, it is not clear from the OIG Report that, as New York asserts, the OIG "recommended disallowances unless there was a separate group attendance sheet to demonstrate client participation on the specific date of service." The report explains why the weekly schedules and progress notes for the questioned claims did not identify one or more CDT services delivered on the DOS. It does not say that such documents could

under no circumstances identify such services or that the only acceptable documentation would be a group attendance sheet. Nor is there any indication in the record that CMS took this position. Thus, the disallowance may not even reflect the interpretation of section 505.25(h)(1)(ii) to which New York objects.

Indeed, New York has not shown that any question of interpretation is raised here. New York does not dispute that section 505.25(h)(1)(ii) requires documentation that specifically identifies at least one CDT service delivered on the DOS. Whether this requirement is met is a question of fact that can be resolved only by examining the documentation provided for a particular claim. As shown in our analysis above, we have considered all the relevant documents (even those in the OIG workpapers but not submitted to us by New York) and resolved that factual question individually for each sample claim.

The principle of deference on which New York relies simply does not apply in this situation.

Conclusion

For the foregoing reasons, we reverse the disallowance with respect to nine sample claims (samples #6, 13, 20, 34, 35, 44, 61, 87, and 100) and uphold the disallowance with respect to the remaining 39 sample claims. CMS should determine the amount attributable to the nine sample claims and reduce the disallowance accordingly.

/s/
Leslie A. Sussan

/s/
Susan S. Yim

/s/
Stephen M. Godek
Presiding Board Member