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| TO: | New York State Council for Community Behavioral HealthcareAttn: Lauri Cole, Executive DirectorNYS Coalition for Children’s Behavioral HealthAttn: Andrea Smyth, Executive DirectorNYASAPAttn: John Coppola, Executive DirectorThe Coalition for Behavioral HealthAttn: Amy Dorin, President & CEOCOMPAAttn: Allegra Schorr, President |  |  |
| FROM: | Robert A. Hussar, Esq. |
| DATE: | May 24, 2021 |
| RE: | OMIG OPRA Audit IssuesRR File No.: 898049.1 |

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OMIG OPRA AUDIT ISSUES

***Please be advised that the information below are general thoughts and DOES NOT CONSTITUTE LEGAL ADVICE. Providers are encouraged to consult with their own legal counsel.***

Potential defenses that providers may want to consider including in their response to OMIG’s Draft Audit Report. (when submitting their complete response – not the spreadsheet requested by OMIG and further discussed below):

* For years and even to this date, the state (through multiple state oversight agencies including NYSDOH, OMH, OASAS) has issued inconsistent and ambiguous guidance on OPRA;
* Several sources of guidance to providers indicated that claims that did not list an appropriately OPRA enrolled provider would be rejected.
* Claims were not rejected and providers were never informed that claims were inaccurate or incomplete and were therefore deprived of an opportunity to address any inaccuracies or deficiencies;
* Providers would have been in a much better place to correct any claim specific deficiencies and systemic issues, had providers been notified of rejections in real-time.
* The process for providers to locate records and identify whether an appropriate OPRA enrolled referring provider could be added to the claim would be overly burdensome given the time that has passed and the voluminous number of claims.
* The process to adjust claims in the eMedNY system, if it even feasible, would be extremely resource intensive and either costly or a drain on scare agency
* Perhaps most problematic is that the eMedNY system has auto-populated fields. In other words, that claims data submitted by providers was altered by the system. As a result, providers are unable to verify the accuracy of the information upon which the claims were adjudicated.
* We are led to believe that eMedNY system issues still exist today that preclude the inclusion of some provider’s data on the claim form.

In terms of responding to the Pilot Draft Reports, providers are not fully protected if they simply respond by providing information in the requested spreadsheet as requested by OMIG. OMIG has committed to not issue Final Audit Reports, that does not preserve arguments providers can raise at an administrative law hearing after the final is issued. The relevant regulation provides:

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

Therefore, I highly recommend that all probe audit providers seek an additional extension in order to preserve their right to raise additional arguments depending on the outcome of our negotiations with OMIG.

With that said, in the meantime, I suggest we still comply with the OMIG’s request to provide information in the spreadsheet. My current thinking (based on what we are informally hearing from OMH /OASAS) is that providers take advantage of the less onerous interpretation of “referring provider” and complete the spreadsheet using the name and NPI of the Medical/Clinic Director (even if a provider is unable to locate a document evidencing their signature on a treatment plan). **In order to avoid any future allegation of fraud or deceit, I would add language to the spreadsheet indicating that when identifying the “referring provider”, the agency utilized the name and NPI of either the provider signing the treatment plan and/or the provider serving in the role of Medical/Clinic Director or Supervisor.**