STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **EMA'S AMBULETTE, INC.** Medicaid ID: 01928505	:	**Decision After Hearing**
from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments	:	**Audit Number: 11-5525**

Before: Natalie J. Bordeaux
Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, New York 10007

Hearing Dates: May 9, June 18, and August 20, 2019
The record closed on January 6, 2020

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Kathleen Dix, Esq.

Moshe Newhouse, President
Ema's Ambulette, Inc.
13 Ashe Street
Monsey, New York 10952
By: William J. McDonald, Esq.
The McDonald Law Firm
222 East Main Street
Suite 212
Smithtown, New York 11787

JURISDICTION

The Department of Health (Department) is the single state agency for the administration of the medical assistance (Medicaid) program in New York State. SSL § 363-a. The New York State Office of the Medicaid Inspector General (OMIG) is an independent office within the Department with the authority to pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the Medicaid Program. Such actions may include the recovery of improperly expended Medicaid Program funds. PHL §§ 30-32.

The OMIG determined to seek restitution of payments made under the Medicaid Program to Ema's Ambulette, Inc. (Appellant). The Appellant requested a hearing pursuant to Social Services Law § 22 and Department of Social Services (DSS) regulations at 18 NYCRR § 519.4 to review the OMIG's determination.

FINDINGS OF FACT

1. At all times relevant hereto, the Appellant was an ambulette services provider enrolled in the New York State Medicaid Program. (Exhibit 2.)

2. By letter dated September 20, 2011, the OMIG advised the Appellant that the New York City Human Resources Administration (HRA), acting as the OMIG's agent pursuant to a State and County Demonstration Project, would audit the Appellant's records pertaining to claims paid by the Medicaid Program. (Exhibit 1.)

3. On December 12, 2011, an entrance conference was held with HRA staff and Moshe Newhouse, the Appellant's President, during which Mr. Newhouse was provided a list of 150 randomly-selected ambulette services claims paid by the Medicaid Program during the

period January 1, 2008 through December 31, 2010 and advised that the auditors required supporting documentation. (Exhibit 2.)

4. During the period January 1, 2008 through December 31, 2010, the Appellant was paid $6,152,169 for 101,132 claims submitted to the Medicaid Program for ambulette services. (Exhibit 7.)

5. On May 24, 2016, an exit conference was held with Mr. Newhouse and two HRA auditors, during which the auditors discussed their findings. The auditors sent the Appellant an exit conference summary before the meeting to afford the Appellant an opportunity to review the findings and provide additional supporting documentation. (Exhibit 3.)

6. On October 5, 2016, the OMIG issued a draft audit report to the Appellant, which identified violations of Medicaid Program requirements and disallowed payments totaling $5,770. The draft audit report also advised the Appellant that the audit employed a statistical sampling methodology allowing for extrapolation of the sample findings to the universe of claims. By using the extrapolation, OMIG determined preliminarily that the Medicaid overpayment received by the Appellant was $3,135,674. (Exhibit 4.)

7. On December 16, 2016, the Appellant submitted its response to the draft audit report, contesting the disallowances and objecting to the extrapolation methodology employed by the OMIG in its determination to recover $3,135,674. (Exhibit 5.)

8. On December 29, 2016, the OMIG issued a final audit report in which the number of disallowances was reduced to 100 of the sampled claims and the extrapolated overpayment was correspondingly reduced to $2,503,088. (Exhibit 7.)

9. The OMIG's restitution claim was an extrapolation based upon a statistical sampling method whereby the value of the 100 disallowed claims in the audit sample was

projected to the total 101,132 claims paid by the Medicaid Program during the audit period. (Exhibit 7.)

10. The OMIG organized the 100 disallowances into the following categories:

1. Driver is Not Taxi and Limousine Commission Licensed (Samples 2, 3, 6, 7, 10, 17, 20-22, 27, 31, 34, 37-40, 42, 43, 45, 46, 48-50, 53-56, 58-61, 63, 65, 66, 69, 72, 73, 76, 80-82, 84-88, 90, 91, 93-99, 102, 104, 108, 109, 111-114, 117, 119, 122, 124, 125, 134, 135, 137, 139, 141, 148-150.)

2. Missing/Incomplete Documentation (Samples 4, 8, 9, 13, 29, 30, 33, 64, 74, 75, 77-79, 89, 92, 100, 106, 116, 120, 129, 133, 143, 145, 147.)

(Exhibit 7.)

11. Before the first scheduled hearing date, the OMIG revised its findings with respect to Disallowance Category #1 (Driver is Not Taxi and Limousine Commission Licensed) and withdrew the disallowances for all but Samples 3, 7, 20, 27, 31, 37, 39, 43, 48, 49, 54, 58, 60, 61, 72, 73, 84, 96, 98, 102, 108, 112, 114, 117, 119, 122, 134, and 135. The OMIG also withdrew the disallowance for Sample #143 from the findings pertaining to Disallowance Category #2 (Missing/Incomplete Documentation), leaving disallowances for Samples 4, 8, 9, 13, 29, 30, 33, 64, 74, 75, 77-79, 89, 92, 100, 106, 116, 120, 129, 133, 145, and 147. (Exhibits 8 and 10.)

12. Due to the OMIG's revisions to findings in both disallowance categories, the OMIG adjusted its claimed restitution amount downward to $1,179,603.65. (Exhibit 9.)

ISSUES

Was the OMIG's determination to recover Medicaid Program overpayments from the Appellant correct? If so, what is the amount of the overpayment?

APPLICABLE LAW

By enrolling in the Medicaid Program, Medicaid providers agree to prepare contemporaneous records demonstrating the right to receive payment under the Medicaid

Program and to furnish such records and information, upon request, to the Department. The information submitted in relation to any claim for payment must be true, accurate and complete. Medicaid providers also agree to comply with the rules, regulations, and official directives of the Department. 18 NYCRR §§ 504.3(a), (g)-(i), § 540.7(a)(8).

All information regarding claims for payment is subject to audit. Records must be maintained for six years from the date of service or from the date of billing to the Medicaid Program, whichever is later. Notification by the OMIG to a provider of its intent to audit shall toll the six-year period for record retention and audit. 18 NYCRR § 504.3(a), §§ 517.3 (b)-(c).

When it is determined that a provider has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, the OMIG may require repayment of the amount determined to have been overpaid. 18 NYCRR § 504.8(a)(1) and § 518.1(b). An overpayment includes any amount not authorized to be paid under the Medicaid Program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake. 18 NYCRR § 518.1(c).

A Medicaid provider is entitled to a hearing to review the OMIG's final determination to require repayment of an overpayment or restitution. 18 NYCRR § 519.4. The Appellant has the burden of showing by substantial evidence that the OMIG's determination was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR § 519.18(d)(1); SAPA § 306(1).

DISCUSSION

At the hearing, the OMIG presented the audit file and summarized the case, as required by 18 NYCRR § 519.17. The OMIG presented documents (Exhibits 1 - 23) and the following witnesses: (1) Patricia Smith, Management Specialist I at the OMIG, who oversees county

demonstration projects involving Medicaid transportation providers and assists in reviewing documentation (T 32-80); and (2) Gregory Maynard, HRA Director of Audit, who participated in this audit as the supervising management auditor. (T 90-218.)

The Appellant presented three exhibits (Exhibits A-C). Moshe Newhouse, President of Ema's Ambulette, Inc. from 1999-2012, was its sole witness. (T 228-52.) Each party submitted a post-hearing brief.

The Audit Findings

Disallowance Category 1: Driver is not Taxi and Limousine Commission (TLC) Licensed

The OMIG identified 28 disallowances in this category with a total sample overpayment of $986.40 for ambulette services paid for by the Medicaid Program. (Exhibit 10.)

Ambulette services operating in New York City must be licensed by the Taxi and Limousine Commission (TLC). 18 NYCRR § 505.10(e)(6)(ii). Every eMedNY (MMIS) Transportation Provider Manual since at least 2004 has explained that Medicaid reimbursement is only available to lawfully authorized ambulette providers for ambulette transportation furnished to recipients whenever necessary to obtain medical care. (Exhibits 4 and 7.)

For purposes of TLC rules, ambulettes are paratransit vehicles. 35 RCNY § 4-01[1]. A paratransit vehicle, also known as a wheelchair accessible van, is equipped with a hydraulic lift or ramp(s) designed for the purpose of transporting persons who use wheelchairs or containing any other physical devices designed to permit access to and the transportation of a person with a disability. 35 RCNY § 4-01.[2] Such vehicles are used to transport individuals with mobility impairments who require the use of mobility aids and who cannot, board, ride or disembark from

[1] The provision, as cited, was in effect during the audit period.
[2] This definition and the corresponding citation were in effect during the audit period. It is found in current TLC rules at 35 RCNY §56-03(g).

such a vehicle without the use of a wheelchair lift or other boarding assistance device. 35 RCNY § 4-01.[3]

A driver shall not operate a paratransit vehicle for hire within the City of New York, unless it is properly licensed by the TLC. 35 RCNY § 4-06(b)&(c).[4] An owner shall not allow a paratransit vehicle to be dispatched and a base owner shall only dispatch a driver with a current paratransit driver's license. 35 RCNY § 4-09(b).[5] During the audit period, MMIS Transportation Provider Manuals reminded transportation providers that compliance with TLC regulations was required. (Exhibits 4 and 7.)

The disallowed samples in this category pertained to claims for ambulette transportation services within New York City under codes NY100 (one-way trip inside common medical marketing area) and NY102 (one-way outside common medical marketing area).[6] (Exhibits 2, 3, and 15.) The Appellant provided the auditors with photocopies of licenses issued by the New York State Department of Motor Vehicles (DMV) for the drivers who transported the Medicaid recipients in the claims sampled but did not submit evidence of valid TLC licensure for all of them. A TLC license is a physical document distinct from a DMV driver's license which contains the driver's photo, TLC-issued license number and license expiration date. (T 118-20, 161-71.)

In response to the draft audit report, the Appellant submitted a list of TLC license numbers which purportedly pertained to some of the disallowed samples. The OMIG ultimately

[3] This citation was in effect during the period audited. This information is contained in current TLC rules at 35 RCNY § 56-03(f)&(g).
[4] The cited provision was in effect during the audit period. In current TLC rules, the information can be found at 35 RCNY § 56-11(a)&(b).
[5] This provision was in effect during the audit period. The exact wording is not used in current TLC rules.
[6] The June 2006 Medicaid Update instructed providers to submit claims using code NY102 when transporting a Medicaid recipient more than 5 miles from the recipient's home, a distance which in these samples remained within New York City.

removed many disallowances from this category after reviewing the Appellant's supplemental information, leaving 28 disallowances in this category which the Appellant disputes. (Exhibit 10.)

In samples with drivers possessing proper TLC licensure on the date of service (other than Sample 134 discussed below), the disallowances were removed. When the driver's TLC licensure was not valid on the date of service, the disallowance remained. The Appellant did not provide valid TLC licensure information to the auditors for the other drivers in the disallowed claims.

At the hearing, the Appellant presented verification from the TLC of the licensing status of some of the drivers who rendered services for which corresponding payment was disallowed by the OMIG. (Exhibit A.) The Appellant did not show that the drivers of the vehicles used for Samples 3, 7, 20, 27, 31, 37, 39, 43, 48, 49, 54, 60, 61, 72, 73, 84, 96, 98, 102, 108, 112, 114, 117, 119, 122, and 135 had valid TLC licenses on the date of service. (Exhibits 2 and 15.) These disallowances are upheld.

The OMIG also determined to disallow one-half of the roundtrip billed in Sample 58. This claim involved two drivers, only one of which the Appellant was able to establish had valid TLC licensure on the date of service. (Exhibit 15, pp. 953-63.) The Appellant failed to meet its burden of proving that the disallowed ambulette service was provided by a properly-licensed driver in ambulette vehicle. For that reason, the disallowance for Sample 58 is also upheld.

As an alternative objection to the findings, Mr. Newhouse testified that not all vehicles utilized for ambulette services rendered in the disallowed claims were ambulettes or paratransit vehicles. Instead, several of the vehicles used were buses and were not wheelchair accessible.

Mr. Newhouse contended that the drivers of the vehicles that were not ambulettes did not require licensure by the TLC. (T 238.)

The Appellant's position in this matter is paradoxical: it argues that TLC licensure was not required because it did not use wheelchair-accessible or paratransit vehicles, while simultaneously asserting that it provided ambulette services for which it is entitled to reimbursement from the Medicaid Program. (T 245-51; Appellant Brief pp. 6-8.) An ambulette service transports the invalid, infirm or disabled **by ambulette** to or from facilities which provide medical care. 18 NYCRR § 505.10(b)(4). An ambulette is defined as a special-purpose vehicle, designed and equipped to provide nonemergency transport, that has **wheelchair-carrying capacity, stretcher-carrying capacity, or the ability to carry disabled individuals**. 18 NYCRR § 505.10(b)(3).

Vehicles that are not paratransit or wheelchair accessible are not ambulettes pursuant to 18 NYCRR § 505.10(b)(3). Although the Appellant established that the driver in Sample 134 possessed valid TLC licensure on the date of service, the submitted DOT Bus Safety Inspection Program documentation indicates that the vehicle driven possessed no available wheelchair space and was therefore not paratransit. (Exhibits 5 and 15.) A condition of receiving payment from the Medicaid Program is that services claimed were actually rendered. 18 NYCRR § 504.3(e). Since the Appellant did not provide ambulette transport, it is not entitled to reimbursement from the Medicaid Program for ambulette services. This disallowance is upheld.

In electing to bill the Medicaid Program for ambulette services in lieu of livery services (regular passenger transport which yields a lower reimbursement rate), the Appellant's receipt of payment was subject to conditions over and above the mere provision of transportation. These conditions included that the services be provided by "ambulette," and that they be provided by a

properly-licensed driver. 18 NYCRR § 505.10(b)(4)&(e). The Appellant has failed to establish that it complied with the rules, regulations, and official directives of the Department when claiming payment for ambulette services from the Medicaid Program. 18 NYCRR § 504.3(i). The disallowances made for Samples 3, 7, 20, 27, 31, 37, 39, 43, 48, 49, 54, 58, 60, 61, 72, 73, 84, 96, 98, 102, 108, 112, 114, 117, 119, 122, 134, and 135 are upheld.

Disallowance Category 2: Missing/Incomplete Documentation

The OMIG determined to disallow the second leg of billed round-trip ambulette services in 23 instances totaling $733.20 because the Appellant was unable to provide documentation regarding the second leg or portion of the trip. (Exhibit 8.)

Payment to a provider of ambulette services will only be made for services documented in contemporaneous records in accordance with 18 NYCRR § 504.3. Documentation must include: (i) the recipient's name and Medicaid identification number; (ii) the origination of the trip; (iii) the destination of the trip; (iv) the date and time of service; and (v) the name of the driver transporting the recipient. 18 NYCRR § 505.10(e)(8). These record keeping requirements have also been included in the MMIS Transportation Manual Policy Guidelines since at least 2004. (Exhibit 7.)

Effective May 5, 2009, the eMedNY Transportation Provider Manual advised providers:

> As there is no assumption of a round trip, a trip is considered to be one way. Therefore, trip records, as described above, are required for each trip performed in a day. Failure to maintain adequate trip documentation may result in payment disallowance. (Exhibit 7.)

An August 2010 Department of Health Medicaid Update also advised transportation providers of these documentation obligations:

> Transportation providers will only be reimbursed when acceptable records verifying a trip's occurrence are complete and available to auditors upon request…

> Ambulette, Taxi, Livery, and Group Ride Providers: For each leg of the trip, trip verification should be completed at the time of the trip and must include, at a minimum:
>
> - The Medicaid beneficiary's name and Medicaid identification number;
> - The date of the transport;
> - Both the origination of the trip and time of pickup;
> - Both the destination of the trip and time of drop off;
> - The vehicle license plate number; and
> - The full printed name of the driver providing the transportation.
>
> …Providers are urged to maintain a record with all information listed above in case of a Medicaid audit. If any of the information above is lacking, illegible, or false, a claim will be denied…

(Exhibit 19.)

The disallowed claims were for round-trip ambulette services in which the Appellant failed to document the second leg of the trip. The OMIG disallowed one-half of the total Medicaid payment received for each claimed round-trip service. (T 123-61.)

The Appellant incorrectly argues that the auditors applied this documentation requirement to services rendered "from 2008 through 2010." (Appellant Brief, p. 11.) All dates of service for which portions of round-trip claims were disallowed in this category occurred after May 5, 2009, the effective date upon which providers were advised that documentation for each leg of a trip was required. (Exhibit 7.)

The Appellant's claim that documentation for the first leg of the trip was sufficient to justify payment for the roundtrip amount billed is not supported by applicable policy and billing guidelines. (T 239; Appellant's Brief, p. 11.) Providers were given timely and clear notification of the requirements before they were implemented, and the OMIG auditors ensured that no disallowances were made before the effective date of notification. The OMIG's determination to disallow one-half of the total amount claimed in Samples 4, 8, 9, 13, 29, 30, 33, 64, 74, 75, 77-79, 89, 92, 100, 106, 116, 120, 129, 133, 145 and 147 is upheld.

The Overpayment Amount

The Appellant argued that it should receive "some credit" because five years elapsed between the commencement of the audit and the OMIG's issuance of the draft audit report. The Appellant ceased its operations in 2012, after the commencement of the audit. The Appellant's counsel contended that the Appellant was "lucky" to be able to retrieve any of the documentation requested during the audit. (T 26.)

Medicaid providers are required to retain records for a minimum of six years, a period that is tolled once a provider is advised of the OMIG's intent to audit such records. 18 NYCRR § 504.3(a), §§ 517.3 (b)-(c). The Appellant was advised of the OMIG's intent to audit its records for the period of January 1, 2008 through December 31, 2010 in September 2011, well within the mandatory six-year record-retention period, and less than one year after the end of the period being audited. At that point, the Appellant was duly advised to maintain all records for the relevant period. (Exhibit 1.) The Appellant was then given a list of the specific 150 claims comprising the audit sample in December 2011, before its business closed. (Exhibit 2.) The Appellant's decision to stop its operations in 2012 is irrelevant. The Appellant received Medicaid payments for claims submitted during the audit period and was therefore required to prepare and maintain all documentation necessary to establish its right to payment. 18 NYCRR § 504.3(a).

The Appellant blames its difficulties in finding required paperwork on the OMIG's "unconscionable delay in issuing" the draft audit report. (Appellant Brief, p.3.) The four and a half-year period between the commencement and completion of the audit afforded the Appellant considerable time and opportunity to submit documentation to support the accuracy of its claims. The Appellant availed itself of this opportunity and requested extended time to respond, which

the OMIG granted. After consideration of the Appellant's supplemental information, the OMIG significantly reduced the number of disallowances in the first category. However, for the samples ultimately disallowed and upheld in this decision, the Appellant did not provide the documentation necessary to justify its entitlement to payment from the Medicaid Program for the billed ambulette services. The OMIG is authorized to recover amounts paid for the unsubstantiated claims pursuant to 18 NYCRR § 518.3.

Extrapolation

An extrapolation based upon an audit utilizing a statistical sampling method certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made. However, the Appellant may submit expert testimony challenging the extrapolation or an actual accounting of all claims paid in rebuttal to the Department's proof. 18 NYCRR § 519.18(g).

At the hearing, the OMIG presented a September 27, 2017 certification by Dr. Karl W. Heiner, statistical consultant to the OMIG who designed and monitored sampling procedures for statistical audits carried out by the New York State Medicaid Program. Dr. Heiner certified that the OMIG correctly generated random numbers in selecting a sample of 150 claims from the Appellant's total claims universe for the audit period. In addition, he explained that the OMIG's use of a mean point estimate is a "commonly accepted statistical projection technique." The OMIG also presented an October 26, 2017 certification by OMIG employee Kevin Ryan. Mr. Ryan, who is responsible for managing the production of statistical sampling materials used in OMIG audits, described the procedure for identifying a random audit sample, and included a summary of all claims paid by the New York State Medicaid Program to the Appellant during the audit period. (Exhibit 17.)

The Appellant advised the OMIG of its disagreement with the OMIG's use of statistical sampling extrapolation in its response to the draft audit report (Exhibit 5) and in its opening statement (T 29-31). Its post-hearing brief again advises that the draft audit report contested the OMIG's methodology. (Appellant Brief, p. 2.) However, as the OMIG correctly notes, the Appellant offered neither expert testimony nor an actual accounting of all claims paid to rebut the presumption of accuracy established by the certifications. 18 NYCRR § 519.18(g). (OMIG Brief, p. 6.) The Appellant failed to meet its burden of proof with respect to the remaining disallowances or the OMIG's computation of the Appellant's overpayment using extrapolation by statistical sampling.

The OMIG's determination is affirmed in its entirety.

DECISION AND ORDER

1. With respect to Disallowance Category 1 (Driver is not Taxi and Limousine Commission Licensed), the OMIG's determination to recover Medicaid Program overpayments from the Appellant for Samples 3, 7, 20, 27, 31, 37, 39, 43, 48, 49, 54, 58, 60, 61, 72, 73, 84, 96, 98, 102, 108, 112, 114, 117, 119, 122, 134, and 135 is affirmed.

2. With respect to Disallowance Category 2 (Missing/Incomplete Documentation), the OMIG's determination to recover Medicaid Program overpayments from the Appellant for one-half of the total amount billed for Samples 4, 8, 9, 13, 29, 30, 33, 64, 74, 75, 77, 78, 79, 89, 92, 100, 106, 116, 120, 129, 133, 145 and 147 is affirmed.

3. The overpayment in the audit sample is $1,749.60.

4. The OMIG is entitled to recover restitution in the amount of $1,179,603.65.

Dated: January 29, 2020
Menands, New York

/Natalie J. Bordeaux/
Natalie J. Bordeaux
Administrative Law Judge