STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **Niagara Pharmacy** Medicaid ID # [redacted] from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments	:	**Decision After Hearing** #09-3508

Before: John Harris Terepka
Administrative Law Judge

Held at: New York State Department of Health
584 Delaware Avenue
Buffalo, New York 14202
May 5, 6, 2011
Record closed July 8, 2011

Parties: New York State Office of the Medicaid Inspector General
584 Delaware Avenue
Buffalo, New York 14202
By: William L. Busler, Esq.

Jayson Bulmahn, owner
Niagara Pharmacy
455 Niagara Street
Buffalo, New York 14202
By: Gregory Stamm, Esq.
Stamm Law Firm
1127 Wherle Drive, Suite 100
Williamsville, New York 14221

JURISDICTION

The Department of Health (the Department) acts as the single state agency to supervise the administration of the Medicaid Program in New York State. PHL 201(1)(v), SSL 363-a. Pursuant to PHL 30, 31 and 32, the Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority to pursue administrative enforcement actions against any individual or entity that engages in fraud, abuse or unacceptable practices in the Medicaid Program, and to recover improperly expended Medicaid funds.

The OMIG determined to seek restitution of payments made under the Medicaid Program to Niagara Pharmacy (the Appellant). The Appellant requested a hearing pursuant to Social Services Law 22 and the former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the determination.

SUMMARY OF FACTS

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. At all times relevant hereto, Appellant Niagara Pharmacy was a pharmacy and was enrolled as a provider in the New York State Medicaid Program. Niagara Pharmacy, owned in part by Jayson Bulmahn, is located in Buffalo, New York.

2. The OMIG conducted a review of the Appellant's records in order to determine whether they demonstrated compliance with Medicaid Program requirements.

3. During the period January 1, 2005 through December 31, 2008, the Appellant was paid $20,375,619.24 by the Medicaid Program for 302,488 pharmacy

services to Medicaid recipients. The OMIG audit consisted of a review of a sample of 200 of these services, paid in the total amount of $15,465.65.

4. After reviewing the Appellant's documentation in support of its claims for Medicaid reimbursement for the 200 services in the sample, the OMIG identified violations of Medicaid Program requirements in the submission of 40 of the claims, and disallowed payments in the total amount of $207.50.

5. By final audit report dated July 13, 2010, the OMIG notified the Appellant that it had determined to seek restitution of Medicaid Program overpayments in the amount of $313,831. (OMIG Exhibit 3.)

6. The OMIG's restitution claim was an extrapolation using a statistical sampling method in which the value of the 40 disallowed claims found among the sample of 200 claims was projected to the total of 302,488 claims paid by the Medicaid Program during the audit period. (OMIG Exhibits 3, 5.)

7. The OMIG set forth grounds for disallowing the 40 claims in five categories:

> Ordering prescriber conflicts with claim prescriber. Twenty nine claims (samples 3, 5, 12, 15, 21, 22, 25, 26, 29, 37, 40, 56, 71, 93, 94, 99, 100, 112, 122, 126, 136, 167, 169, 171, 173, 184, 189, 190, 199), disallowances in the total amount of $109.86.
>
> Pharmacy billed in excess of prescribed quantity. Three claims (samples 150, 172, 177), disallowances in the total amount of $44.90.
>
> Missing supervising MD on prescription/fiscal order by Physician's Assistant. Six claims (samples 16, 42, 68, 108, 146, 198), disallowances in the total amount of $25.
>
> Prescription/fiscal order refilled without prescriber's authorization. One claim (sample 170) in the amount of $14.34.

Pharmacy billed for different item than ordered. One claim (sample 9) in the amount of $13.40.

8. In sample 9, as an alternative to the primary finding (pharmacy billed for different item than ordered) in the amount of $13.40, the OMIG made a secondary finding (ordering prescriber conflicts with claim prescriber) in the amount of $4.50. The OMIG withdrew secondary findings in samples 16, 170 and 190. (Transcript, page 128.)

9. At the hearing, the OMIG withdrew the disallowance in sample 172, in the amount of $1.88. (Transcript, page 51.)

ISSUES

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

APPLICABLE LAW

Medicaid providers are required, as a condition of their enrollment in the program, to prepare and maintain contemporaneous records demonstrating their right to receive payment from the Medicaid Program and fully disclosing the nature and extent of the care, services and supplies they provide. The information provided in relation to any claim must be true, accurate and complete. All information regarding claims for payment is subject to audit. 18 NYCRR 504.3(a)&(h), 517.3(b), 540.7(a)(8).

When the Department has determined that claims for medical services have been submitted for which payment should not have been made, it may require repayment of the amount determined to have been overpaid. 18 NYCRR 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 person is entitled to a hearing to have the Department's determination reviewed if the Department requires repayment of an overpayment. 18 NYCRR 519.4. At the hearing, the Appellant has the burden of showing that the determination of the Department was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. Where its determination is based upon an alleged failure to comply with generally accepted professional or medical practices or standards of health care, however, the Department has the burden of establishing the existence of such practices or standards. 18 NYCRR 519.18(d).

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. The Appellant, however, may submit expert testimony and evidence to the contrary, or an accounting of all claims paid in rebuttal to the Department's proof. 18 NYCRR 519.18(g).

Regulations of the former DSS most pertinent to this hearing decision are at 18 NYCRR Parts 505 (medical care, in particular section 505.3 regarding drugs), 517 (provider audits), 518 (recovery and withholding of payments or overpayments) and 519 (provider hearings).

The New York State Medicaid Program issues Medicaid Management Information Systems (MMIS) provider manuals, which are available to all providers and include, among other things, billing policies, procedures, codes and instructions. www.emedny.org. The Medicaid Program also issues a monthly Medicaid Update with additional information, policy and instructions. www.emedny.org. Providers are obligated to comply with these official directives. 18 NYCRR 504.3(i); Lock v. NYS

Department of Social Services, 220 A.D.2d 825, 632 N.Y.S.2d 300 (3d Dept. 1995); PSSNY v. Pataki, 58 A.D.3d 924, 870 N.Y.S.2d 633 (3d Dept. 2009).

DISCUSSION

The OMIG presented the audit file and summarized the case, as is required by 18 NYCRR 519.17. The OMIG presented documents (Exhibits 1-13), one post hearing brief and two witnesses: Sharon Conway, a registered pharmacist, is a pharmacy supervisor with the OMIG. (Transcript, page 37.) Anne Markwardt, a registered nurse, is the OMIG management specialist who conducted this audit for the OMIG. (Transcript, pages 90-92.)

The Appellant presented documents (Exhibits A-I, L, M), one post hearing brief and two witnesses: Jason Bulmahn, a pharmacist, is a part owner of Niagara Pharmacy. (Transcript, page 164.) Mark P. Zaporowski, Ph.D is a professor of economics and finance who reviewed, at the Appellant's request, the sampling and estimation procedure used in this audit. (Transcript, pages 234, 237; Appellant Exhibits D, L.)

The audit findings

The OMIG's final audit report set forth its reasons for each disallowance and listed every disallowed claim. (OMIG Exhibit 3.) The final audit report incorporated the OMIG's conclusions after review of the Appellant's response to a draft audit report. (OMIG Exhibit 2.) These documents were exchanged between the parties in accordance with audit procedures set forth at 18 NYCRR 517.5 and 517.6(a).

The reasons for which the 39 claims remaining at issue were disallowed were organized into five categories:

Ordering prescriber conflicts with claim prescriber. Twenty nine claims (samples 3, 5, 12, 15, 21, 22, 25, 26, 29, 37, 40, 56, 71, 93, 94, 99, 100, 112, 122, 126, 136, 167, 169, 171, 173, 184, 189, 190, 199), disallowances in the total amount of $109.86.

In 29 instances, the OMIG determined that the prescription the Appellant produced to support its Medicaid claim was not written by the provider the Appellant identified on the Medicaid claim. Mr. Buhlman conceded that this finding was accurate. (Transcript, page 218.) In these instances the OMIG elected to limit its disallowance to the service fee portion of the claim (in the amount of $3.50 or $4.50) rather than the entire amount paid by Medicaid to the Appellant. In the 2 instances (samples 93, 100) in which the Medicaid payment was under $3.50, the entire payment was disallowed. (Transcript, pages 118-19.)

All information submitted with a Medicaid claim must be true, accurate and complete. 18 NYCRR 504.3(h). Billing providers certify with each claim that no material fact has been omitted from the claim. 18 NYCRR 540.7(a)(8). A claim for a service ordered by one provider, submitted with the representation it was ordered by some other provider, is a significant violation of these Medicaid requirements. Accurate reporting is not only material to the individual claim, it is essential to the Department's ability to oversee and administer the Medicaid Program as a whole. (Transcript, pages 96, 98-99; OMIG brief, page 7.)

The sample 171 prescription was written by Donna J. Conway, whose name and license number appear on the prescription. The Appellant's Medicaid claim identified Kim Marie Bowen, who is not identified on the prescription by name, number or in any other manner, as the ordering provider. (OMIG Exhibit 8, page 14; OMIG Exhibit 11.) The OMIG's disallowance of payment is affirmed.

The remaining 28 claims disallowed in this category were submitted under an MMIS provider number identifying a hospital – either Buffalo General Hospital, Erie County Medical Center, or Women's & Childrens Hospital - as the ordering provider. (OMIG Exhibit 8.) The MMIS provider manual specifies:

> For orders originating in a hospital, clinic or other health care facility, the facility's MMIS ID Number may be entered only when the prescriber's MMIS ID or State License number is unavailable. MMIS Manual (Pharmacy) April 2004 (Rev. 1/92), page 3-21.

MMIS manual billing guidelines applicable to these prescriptions also state:

> The facility's Medicaid ID number may be entered [on the Medicaid claim] **only** when the prescriber's or the supervising physician's Medicaid ID or License number is unavailable.
>
> **…**
>
> **If the Medicaid ID or State License number of an authorized prescriber is not on the prescription, it is the pharmacist's responsibility to obtain it.** MMIS Manual Pharmacy Billing Guidelines Version, 2005-1 (04/01/05), page 19 of 53.

In 19 of these 28 instances (samples 3, 5, 12, 15, 21, 25, 37, 40, 71, 93, 94, 112, 122, 136, 169, 173, 189, 190, 199), the prescriber's name and license number appeared on the prescription. In the other 9 instances (samples 22, 26, 29, 56, 99, 100, 126, 167, 184) the prescriber's name appeared on the prescription. Samples 29, 112, 136 and 167, furthermore, were orders taken by telephone calls, during which correct claiming information could also have been verified. (OMIG Exhibit 11.)

Even if a prescription originates at a hospital or other health care facility, the facility's number should be used for Medicaid billing only when the prescriber's number is "unavailable." The prescribers' license or MMIS numbers in these instances were clearly not "unavailable." In 19 instances, the pharmacist began with that information: it was right on the prescription. In the other 9 instances there still can be no question of any

inability to identify the ordering prescriber. In every instance, the Appellant had the prescriber's name right on the prescription. There is no evidence the Appellant took any steps to obtain the associated number if it did not already have it. The Appellant simply ignored the information on the prescriptions and instead identified hospitals on the Medicaid claims. The Appellant had no good reason and no excuse for failing to identify the actual prescribers on these claims.

Mr. Bulmahn acknowledged that the Appellant did, until 2007, use as a "default" the MMIS numbers of hospitals in order to submit claims to the Medicaid Program. (Transcript, page 203.) The Appellant did this basically as a matter of convenience, or at best, as the Appellant's brief expressed it, "habit rather than necessity." (Appellant brief, page 6.) The pharmacist simply decided not to use the correct information because a hospital MMIS number was the more expedient way to ensure the claim would be approved and paid by Medicaid.

Mr. Bulmahn claimed that sometimes the prescriber's license number just "would not go through the system" and so a facility number was used as a "last resort." (Transcript, page 204.) The "last resort" to which Mr. Bulmahn refers, however, obviously concerns a last resort for filling an order and getting paid without any difficulty and not, as intended by MMIS billing requirement and as upheld in PSSNY v. Pataki, *supra*, as a last resort when unable to identify the actual prescriber on a claim. (Transcript, page 79.)

The Appellant points out that the Department eventually instituted changes in its electronic claiming system that now allow it to immediately reject pharmacy claims submitted under the number of a health care facility. (Transcript, pages 77, 145;

Appellant brief, page 6.) This improvement in the Department's initial claim screening system is irrelevant to provider billing obligations that were already in place.

Mr. Buhlman was admittedly aware of those billing obligations as far back as the year 2000 but considered them "no big deal" because the Department was not requiring repayment. It was not until around 2005 or 2006, when another of his pharmacies was audited, that he "got on it." (Transcript, page 170.) He said "we saw they were going to charge us money if we didn't have it right, and then we obviously started getting it right." (Transcript, page 171.) His excuse for ignoring the requirement, then, is that he assumed he could get away with it. This is not a compelling defense. During the entire audit period Medicaid billing requirements clearly obligated pharmacies to identify the actual prescriber on claims, and the Appellant was clearly aware of this obligation.

All 29 disallowances in this category are affirmed. The alternative finding under this category in sample 9 is also affirmed: The prescription was written by Dianne Loomis, whose name and license number were on the prescription, but the Medicaid claim identified Buffalo General Hospital. (OMIG Exhibit 8, page 7; OMIG Exhibit 10.)

> Pharmacy billed in excess of prescribed quantity. Two claims (samples 150, 177), disallowances in the total amount of $43.02.

Sample 150 was a fiscal order for 100 Chux disposable underpads. (OMIG Exhibit 9; Transcript, page 41.) These non-prescription medical supplies come in sealed bags of 30, with four bags in each box. (Transcript, page 48.) The OMIG does not dispute the Appellant's contention that it was not appropriate to break open a bag in order to dispense precisely 100 items. The Appellant dispensed and billed for 120 items, or one box. (OMIG Exhibit 8, page 23.) The OMIG contends it should have either obtained a corrected fiscal order, or dispensed three bags and billed for 90 items. (Transcript, page

47.) The OMIG disallowed the payment difference between 90 and 120 items. (Transcript, page 49.)

The OMIG disallowance is based on MMIS Manual policy guidelines regarding fiscal orders for non-prescription drugs and medical supplies, which frequently come in prepackaged quantities. These guidelines provide:

> If the ordering practitioner does not request a quantity that corresponds to the pre-packaged unit, the pharmacist may supply the drug in the pre-packaged quantity that most closely approximates the amount ordered. MMIS Provider Manual (Pharmacy), Version 2010-2, December 15, 2010, page 4 of 45.

In the OMIG's view, the nearest pre-packaged quantity in this instance was 90.

The Appellant persuasively argues that attempting to follow these guidelines presented it with a choice between opening a box and dispensing just three bags (90 items) from it, or dispensing a full box (120 items). (Transcript, page 177.) The Appellant's decision to dispense a full box in this instance is a reasonable interpretation of the guidelines. This disallowance is reversed.

The prescription in sample 177 was clearly written for 12 pills. (OMIG Exhibit 9.) The Appellant billed for 120 pills. (OMIG Exhibit 8, page 7.) MMIS Provider Manual (Pharmacy) policy guidelines specify that prescription drugs must be dispensed in the amount prescribed. The OMIG disallowed payment for the 108 pills not ordered on the prescription. (Transcript, pages 53-55.)

The Appellant points out, and it is not in dispute, that this patient had for quite some time been presenting a monthly prescription for 120 pills of this medication. (Transcript, page 68; OMIG Exhibit 2, workpapers A-4-11 through 53.) According to the Appellant, the prescription was obviously intended to be written for 120 pills, but was written in error for 12. This conclusion is not at all obvious, but even if it is accurate it

does not excuse the Appellant for simply going ahead and dispensing 120 pills, if that is what it did. It also does not excuse the Appellant for billing the Medicaid Program for 120 pills, which it clearly did.

As Ms. Conway pointed out, there could well have been some reason why the prescription was written for only 12 and not 120 pills on this occasion. (Transcript, page 70.) The proper procedure in this case was to either dispense and bill for only the 12 pills ordered, or to contact the prescriber, obtain clarification and correction of the prescription, and document that contact. (Transcript, pages 55-56.) The Appellant did none of these things. Mr. Bulmahn himself assumed, because there was no documentation of any contact, that the pharmacist did not call the prescriber and simply dispensed and billed for the usual 120 pills without checking. (Transcript, pages 179, 181-82, 201.)

Noticing and taking appropriate steps when an apparent or suspected error in a prescription occurs is an important responsibility for any pharmacist. It is, furthermore, a misdemeanor under the Education Law to dispense a greater amount of a medication than is ordered on the prescription. Ed.L 6816(1)(a). It was the pharmacist's professional responsibility to look into the matter, not simply ignore what was written, assume a clerical error had been made, and just fill the "usual" order. It was also incumbent upon the pharmacist to document that the matter had been looked into and with what result. None of that occurred in this case. The Appellant failed to comply either with its professional obligations as a pharmacy or with Medicaid claiming requirements. If Mr. Bulmahn is correct in his assumption that his pharmacist did not call the ordering

prescriber, his dispensing pharmacist may also have committed a misdemeanor under the Education Law. (Transcript, page 201.)

The Appellant points out that this one disallowance, because of its relatively high dollar value in the audit sample, had an especially significant effect on the extrapolated overpayment claim. (Appellant brief, page 3.) Although it is irrelevant to the validity of the audit methodology, it is noted that this disallowance also appears to be the most egregious violation of the Appellant's responsibility both as a pharmacy and as a Medicaid Provider. The disallowance is affirmed.

The disallowance in sample 150, in the amount of $4.60, is reversed. The disallowance in sample 177, in the amount of $38.42, is affirmed.

> Missing supervising MD on prescription/fiscal order by Physician's Assistant. Six claims (samples 16, 42, 68, 108, 146, 198), disallowances in the total amount of $25.

These prescriptions were written by physician's assistants. (OMIG Exhibit 12.) Medicaid Program requirements for prescriptions written by physician's assistants include the following:

> Prescriptions/orders from a physician's assistant must be written on the blank of the supervising physician and shall include the name, address and telephone number of the physician…
>
> …
>
> The registered physician's assistant must also include on the prescription/order form the physician's license number and all other information required of the physician except the physician's signature. MMIS Provider Manual (Pharmacy) Pharmacy Guidelines 2.2.1 (Rev. 1/92) pages 2-39, 2-40.

Pursuant to Department of Health regulations:

> (1) A registered physician's assistant may write prescriptions for a patient who is under the care of the physician responsible for the supervision of the registered physician's assistant. The prescription shall be written on the form of the supervising physician and shall include the name, address and telephone number of the physician.

...

(4) The registered physician's assistant shall sign all prescriptions by printing the name of the supervising physician, printing his/her own name and additionally signing his/her own name followed by the letters R.P.A. and his/her State Education Department registration number. 10 NYCRR 94.2(e).

The OMIG disallowed payment on the grounds that a supervising physician was not identified on these prescriptions. The disallowances were limited to the amount of the service fee in each instance.

Conduct contrary to the official rules and regulations of the Departments of Social Services, Health or Education, or contrary to Medicaid claiming instructions or procedures, is an unacceptable practice in the Medicaid Program. 18 NYCRR 515.2(a)(1),(2)&(3). Medicaid Program overpayments include amounts paid as the result of improper claiming or unacceptable practices. 18 NYCRR 518.1(c).

Mr. Bulmahn pointed out that three of these prescriptions (samples 42, 68, 146) were written on official New York State prescription forms. He said the Appellant made the "improper assumption" that they were in order because they were on the official forms. (Transcript, pages 174-75.) This is hardly a justification for submitting Medicaid claims that violated Medicaid requirements.

All six of these disallowances are affirmed.

Prescription/fiscal order refilled without prescriber's authorization. One claim (sample 170) in the amount of $14.34.

Drugs may be obtained only upon the written order of a practitioner. 18 NYCRR 505.3(b). A prescription may not be refilled more times than allowed on the prescription. Ed.L 6810(2). The Appellant billed the Medicaid Program for a third refill of this prescription when the order did not authorize any refills. (OMIG Exhibit 8, page 23;

OMIG Exhibit 13.) The Appellant conceded that it was not entitled to payment on this claim. (Transcript, pages 187-88; Appellant brief, page 7.) The disallowance is affirmed.

Pharmacy billed for different item than ordered. One claim (sample 9) in the amount of $13.40.

The prescription in sample 9 was for clotrimazole, and the Appellant apparently did dispense this medication. (OMIG Exhibit 10; Transcript, pages 185-86.) The Appellant billed the Medicaid Program, however, for a different medication, miconazole. (OMIG Exhibit 8, page 7.) The Appellant argues that the item billed was a similar medication and was the same price as the item actually ordered and apparently dispensed. It remains the case that the Appellant submitted a claim for a medication that was neither ordered nor dispensed. Medicaid overpayments include amounts paid as the result of mistake. 18 NYCRR 518.1(c). The disallowance is affirmed.

Medicaid Program overpayments

The amount disallowed for each claim in the audit sample was set forth in the exhibits attached to the final audit report. (OMIG Exhibit 3.) The total disallowance in the sample was $207.50. At this hearing, the disallowance in sample 172, in the amount of $1.88, was withdrawn by the OMIG. The disallowance in sample 150, in the amount of $4.60, is reversed in this decision. The total overpayment in the sample is $201.02. The payments disallowed in this audit, as affirmed in this hearing decision, were not authorized to be made under the Medicaid Program because they were not supported by documentation demonstrating compliance with Medicaid Program requirements. The OMIG is entitled to recover the overpayments. 18 NYCRR 518.1.

The findings in the 200 claim audit sample were selected from the “universe” of claims that the Department’s billing and payment records show were paid by the

Medicaid Program to the Appellant during the four year audit period. Computer generated documents prepared by the Department or its fiscal agent to show the nature and amount of payments made under the Medicaid Program will be presumed, in the absence of direct evidence to the contrary, to constitute an accurate itemization of the payments made to a provider. 18 NYCRR 519.19(f). The Appellant did not challenge this presumption.

The draft audit report (OMIG Exhibit 1) and the final audit report (OMIG Exhibit 3) each set forth the manner in which the extrapolation was made. Each report identified the disallowed claims, the universe to which they were extrapolated, and the method of estimation. 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. 18 NYCRR 519.18(g).

The OMIG submitted the required certification in the form of affidavits from Dr. Karl W. Heiner, the statistical consultant who designed the sampling and estimation procedure and the computer program that implemented it, and Kevin Ryan, the OMIG employee who used the procedure to select the audit sample. (OMIG Exhibits 4, 5.)

The Appellant did not challenge the validity of the random sample. Nor did the Appellant challenge the validity of the estimation methodology as described and implemented in the OMIG's certifications. The Appellant's witness on statistical issues, Dr. Zaporowski, conceded with regard to the estimation procedure described by Dr. Heiner and used in this audit that "the general methodology I think is ok." (Transcript,

pages 254, 263.) Asked for his conclusion after evaluating the audit and extrapolation in this case, Dr. Zaporowski said:

> -- well, again, if some of these items turn out to be okay and are allowed, then, you know, that's going to significantly impact the amount or just wipe out the amount that Niagara Pharmacy would owe the state. (Transcript, page 261.)

This conclusion in no way calls any of the OMIG's estimation methodology into question. To the contrary, it is completely supportive of that methodology.

The Appellant did, however, offer other sorts of objections and complaints about the OMIG's overpayment determination. The Appellant characterized these as objections to the "application" of the methodology in this case. (Transcript, pages 272-73.)

Failure to give credit for underpayments. The Appellant pointed out that the OMIG's auditor noticed a claim in the audit sample (sample 138) that was apparently paid for less than should have been paid for the item ordered. (Transcript, pages 149-50; OMIG Exhibit 8, page 14.) The Appellant argues that the overpayment in the audit sample should be reduced to reflect an underpayment in the sample. This argument is rejected.

The OMIG is responsible for detecting Medicaid fraud and abuse and identifying and recovering Medicaid Program overpayments. PHL 30, 31, 32. It is not charged with auditing to detect and correct underpayments to providers. Providers are entitled and able to review their own Medicaid claims for accuracy, have their own avenues of redress for underpayments, and have the responsibility to pursue them.

Dr. Zaporowski claimed that a failure to audit and give credit for underpayments "invalidates any inferences about the population it has attempted to make" (Appellant Exhibit L, page 10), and "invalidates the entire procedure statistically." (Transcript, page

255.) His objection, however, is based upon his own apparent view of the purpose of the audit. The audit was conducted pursuant to the OMIG's statutory responsibility to identify and recover Medicaid Program overpayments. PHL 30, 32. Correction of underpayments is not included as a part of that responsibility. Underpayments are a provider's right and responsibility to pursue if it so desires and the OMIG is under no obligation to search them out. This audit is not required to in some global sense review and square all matters that might arise between the Medicaid Program and this provider.

Opportunity to correct billings. The Appellant also complained that it was not invited by the OMIG to correct its billings under hospital "default" numbers, as were, apparently, several pharmacies as mentioned in the discussion in PSSNY v. Pataki, *supra*. (Transcript, pages 23-24; Appellant brief, page 6.) This contention is irrelevant to any issue in this proceeding. Providers have the right and the opportunity to correct billings on their own initiative in accordance with Medicaid Program policy and procedures. The OMIG has no obligation to specifically invite them to do so.

This complaint, along with the Appellant's claim it "would have gladly resubmitted" (Appellant brief, page 6), rings especially hollow in this case, as Mr. Bulmahn admitted that one of his other pharmacies was among those invited to correct their billings. (Transcript, page 171.) Mr. Bulhman, then, was well aware of the "default" billing issue and the need to correct his claims, but apparently did not take that as any reason to review and resubmit the claims made by this pharmacy.

Error rate in the sample. The Appellant alleged, and the OMIG conceded, that if disallowances found in an audit sample amount to less than one percent, in dollar amount, of the total payment in the sample, the OMIG often terminates an audit without seeking

any restitution. (Transcript, pages 225-26.) This is an audit policy that is well within the OMIG's discretion and there is no reason nor is it appropriate to review it in this decision.

It is noted, in any event, that the dollar amount of the sample findings in the final audit report, as a percentage of the dollar amount in the sample, is 1.34 percent. The dollar amount of the findings upheld in this hearing decision as a percentage of the dollar amount in the sample is 1.29 percent. The OMIG has not deviated from the alleged policy in this audit.

The use of a four year audit period. The Appellant objects that the OMIG chose a four year audit period in this case, alleging that the OMIG "usually" audits a two year period. This objection is without merit. The OMIG is authorized to audit fee-for-service Medicaid payments for up to six years from the date the services were furnished or billed. 18 NYCRR 517.3(b). A determination to review payments over a one, two, four year, or indeed any particular time within those limits is a matter entirely within the OMIG's discretion.

The distribution of disallowances in the sample. The Appellant complains that virtually all of the disallowed payments in the audit sample were made in the first two years of the four year audit period. The Appellant attributes the absence of findings in the second two years to the success of its efforts to improve its claiming and recordkeeping practices. In particular, the Appellant reviewed and corrected its billing records to eliminate its admitted practice of using hospital MMIS numbers in its Medicaid claims as "default" numbers in place of the actual prescribers' numbers.

(Transcript, pages 170-73.) This claiming violation accounted for 29 of the 39 disallowances upheld in this hearing decision, and over half of the restitution claim.

There is little reason to question the Appellant's explanation for the uneven distribution by date in the audit disallowances. The Appellant's assertion that it is improper to apply these audit findings over the four year audit period, however, is rejected. The Appellant has failed to explain how an uneven distribution of findings within the audit period invalidates the OMIG's overpayment claim. While the overpayment is undoubtedly attributable almost entirely to claiming errors made during the first two years of the audit period, this circumstance does not compromise the validity or accuracy of the findings for the four year audit period.

It requires but little thought to understand that the audit methodology is unaffected by any particular distribution of disallowed claims by date within an audit period, and that it is inherent in the estimation methodology that it adjusts for any alteration in the audit period itself. To illustrate the matter at its simplest: If all of the errors were in the first two years, and only those two years were audited instead of four, an approximate halving in the number of services in the universe would be balanced by a corresponding doubling of the overpayments per sampled service, yielding roughly the same extrapolated overpayment. If only the second two years were then audited, no overpayment would be identified. Auditing all four years at one time does not change the total overpayment identified for those four years. The audit methodology accurately adjusts and accounts for alterations in an audit period regardless of the distribution of the findings within that period.

It is noted that the Appellant did not even ask its own professional witness on statistical issues, Dr. Zaporowski, to endorse its objections about this issue in his testimony. While Dr. Zaporwsky called the use of a four year period "questionable" in his written report, and suggested that the population should have been stratified into two segments, he did not assert it invalidated anything. (Appellant Exhibit L, pages 10-11.)

The Appellant suggests it is not receiving appropriate credit for improving its claiming practices in the second two years of this audit period. The OMIG is entitled to recover overpayments attributable to billing improprieties in 2005 and 2006 regardless of any findings for 2007 and 2008. Furthermore, appropriate credit is importantly reflected in the audit findings: If the Appellant had not corrected its practice of routinely using "default" hospital MMIS numbers and instead continued the practice on into 2007 and 2008, the overpayment identified in this audit would have been much greater.

The point estimate. The OMIG's overpayment claim is based upon the mean per unit point estimate, or "mid point" estimate derived from the sample findings. As is set forth in Dr. Heiner's certification, this mid point estimate is unbiased, which means that it does not tend to either overestimate or underestimate the overpayment claim in favor of either the Appellant or the OMIG. (OMIG Exhibit 5.) The Appellant has failed to meet its burden of proving that the overpayment claim based upon it was either invalid or inaccurate.

The Appellant did not actually dispute the mid point or suggest or offer any evidence to establish that the mid point is inaccurate or invalid. Dr. Zaporowski's written report did not disagree with or criticize any significant aspect of the extrapolation methodology or procedure. His report consisted of little more than an elaborately

presented series of completely uncontroversial calculations designed to illustrate the impact of various specific audit sample findings. (Appellant Exhibit L.) These recalculations did not take issue with the methodology, they adopted and employed it.

The low point estimate. The Appellant's arguments against the extrapolation were almost entirely about the "low point" estimate, which is based upon a separately calculated "confidence interval."

The low point estimate is not under review in this proceeding. The OMIG does not assert or defend it as an appropriate measure of the overpayment. The OMIG does not propose it for any purpose nor does it defend it for any purpose. The overpayment determination under review herein concerns the mid point estimate, which the OMIG has asserted and defends as the statistically valid overpayment figure. However, as the Appellant apparently perceives its case to be importantly about issues raised by the low point estimate, some observations about the low point estimate will be made.

The low point estimate is in some respects an arbitrary figure because it is dependent upon the confidence level chosen. The Appellant's witness on statistical issues, Dr. Zaporowski, noted that Dr. Heiner, and the OMIG, made use of a 90 percent confidence level in calculating the confidence intervals in this audit. Dr. Zaporowski opined that a 95 percent confidence level would be a better standard. (Transcript, page 240.) The OMIG is not compelled to use that or indeed any confidence level in determining a statistically valid estimation. Confidence intervals are nowhere specified or even mentioned in the Medicaid rules and regulations applicable to this audit, and have no bearing on the overpayment claim at issue in this hearing.

The Appellant complained that the spread between the mid point estimate and the low point estimate was far wider in other OMIG pharmacy provider audits than in this one. The Appellant apparently believes that there must be, somehow, something improper or incorrect about the OMIG's estimation procedures if the variances between mid and low point estimates can be so different in different audits. The evidence shows nothing of the kind.

The reasons for a varying spread between mid and low point estimates depending upon the "standard of deviation" in each case were developed in this hearing by the Appellant's own witness, Dr. Zaporowski. (Transcript, pages 242-44, 269-70.) The estimation methodology for the calculation of low – and high – point estimates takes into account the degree of uniformity and consistency in the sample findings for each audit. In simple terms, this means that a relatively greater number of smaller or similar findings in an audit sample will yield a more precise estimate than a few findings in greater or more varying amounts.

The validity of the statistical methodology used in this audit is not shown to be compromised by virtue of the fact that in other audits the standard of deviation was higher and the confidence interval wider. A more or less precise estimate, in the sense conveyed by the standard of deviation, will not affect the mid point. It will only widen or narrow the interval between the high and low point as a result of the sample findings being more or less uniform and consistent.

Mr. Bulmahn objected it is unfair that he should have been able to settle an audit of another of his pharmacies in which the standard of deviation was high for a low point figure of a few thousand dollars, but not settle this one, where the standard of deviation is

relatively low and consequently the low point much closer to the mid point, for a similarly low amount. (Transcript, page 191.) His contention ignores the significance of the standard of deviation. As his own witness, Dr. Zaporowski agreed, a relatively large number of similar disallowances in amount – as happened in this audit – can cause the low point to be closer to the mid point. (Transcript, page 262.)

Mr. Bulmahn's claim "if I would have made more mistakes, I would have to pay them less money" is simply not supported by the facts or the sampling methodology. Mr. Bulmahn testified that according to his calculations one large disallowance in this audit would have reduced the low point so far as to enable him to settle the audit for little or nothing. (Transcript, pages 193-94.) Dr. Zaporowski later agreed with this claim that one more large error in the sample "would lessen the amount of what he owed." (Transcript, page 242.) The claim is not accurate because it confuses the low point and the mid point estimates. A large additional disallowance would greatly increase the mid point estimate, which is the basis for the overpayment figure he would have confronted and would have been at issue in this hearing. Mr. Buhlman's suggestion that he might deliberately fail to justify a large dollar amount item on audit, on the assumption he could then take advantage of settling at the low end of a resultingly wider confidence range, is irresponsible and foolhardy. (Transcript, page 222.)

Ironically, Mr. Bulmahn is complaining, at bottom, that the findings in this audit, as expressed by the confidence interval, are statistically more precise than the findings in the other pharmacy audits he found more to his liking. This is hardly a persuasive reason to reject the OMIG's overpayment determination in this case.

The Appellant offered into evidence copies of final audit reports in eight other audits in an effort to support its claims about the low point. The OMIG's objection to these exhibits was sustained on the grounds of relevance. Under review in this hearing are the findings in this audit, not the findings in other audits of other Medicaid Providers.

The Appellant's failure to acknowledge the significance of the standard of deviation is further reason to reject these proposed exhibits on the grounds that, as offered, they were misleading with regard to the very purpose for which they were offered.

The Appellant's proposed exhibits included seven audit reports in which the relative widths of the confidence intervals varied considerably. According to the Appellant, they constituted evidence of inconsistency in the OMIG's audit methodology. However, the schedules showing the number and amounts of the specific disallowances in the samples in each of these other audits had been removed from the proposed exhibits. By omitting the schedules of disallowances the exhibits suppressed the very information that would enable the standard of deviation to be calculated and the varying confidence intervals thereby understood.

Consequently, these reports were not probative of any significant issue and were, in fact, misleading in the form presented. They purported to show some inconsistency in OMIG audit confidence intervals by simply ignoring the standard of deviation upon which confidence intervals are based.

The eighth audit report offered into evidence did include the amounts of the specific disallowances, but those additional details add nothing to what was already conceded by the Appellant's own witness, Dr. Zaporowski: fewer findings in the sample,

with a far greater variance in the amounts of each finding, lead to a higher standard of deviation, hence a wider spread between the low, mid and high point estimates. (Transcript, pages 242, 262.)

It is noted that the OMIG apparently does offer the low point estimate as a settlement option for providers in lieu of proceeding with a hearing. This is no secret: the OMIG's final audit reports, such as the one in this case, routinely offer to settle audits in this manner, at the same time advising providers that the OMIG will seek and defend the mid point estimate at a hearing.

The OMIG's use of the low point represents an intelligible and principled basis for a settlement offer by taking into account the size of the confidence interval in each particular audit, in an attempt to propose a settlement figure that both parties can be confident is, at a minimum, the amount owed. That is a matter that is entirely within the OMIG's discretion and is not a matter for review in this proceeding.

Conclusion

The overpayment in the sample, as adjusted in this hearing decision, is in the total amount of $201.02. The draft audit report (OMIG Exhibit 1) and the final audit report (OMIG Exhibit 3) each set forth the manner in which the extrapolation from the sample overpayment was made. The calculation is quite simple and straightforward: The overpayment in the sample is divided by the number of claims in the sample to provide an average overpayment per sampled claim. The overpayment per sampled claim is projected to the universe by multiplying it by the number of claims in the universe.

Application of the estimation procedure set forth in the audit report and in Dr. Heiner's certification yields an overpayment (rounded to the nearest dollar) in the total

amount of $304,031. A restitution claim in that amount is authorized pursuant to 18 NYCRR 518.1 and 518.3.

DECISION: The OMIG's determination to recover Medicaid Program overpayments is correct and is affirmed.

The disallowance in sample 172 is withdrawn, and the disallowance in sample 150 is reversed. The overpayment in the audit sample is $201.02.

The OMIG is entitled to recover restitution in the total amount of $304,031.

This decision is made by John Harris Terepka, who has been designated to make such decisions

DATED: Rochester, New York
July 20, 2011

_____/s/_____
John Harris Terepka
Bureau of Adjudication