STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Request of **SUNRISE HANDICAP TRANSPORT CO.** Medicaid ID # 01865003 for a hearing pursuant to Part 519 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) to review a determination to recover Medicaid overpayments.	:	**Decision After Hearing** Audit #2012Z31-011T

Before: Kimberly A. O'Brien
Administrative Law Judge

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

Parties: New York State Office of the Medicaid Inspector General
217 Broadway, 8th floor
New York, New York 10007
By: Ricja Rice, Esq.

Sunrise Handicap Transport Co.
By: Timothy Perry Coon, Esq.
McGivney & Kluger, P.C.
80 Broad Street, 23rd Floor
New York, New York 10004

Dates of Hearing: June 4, 2014
March 12, 2015

Briefs: May 12, 2015

JURISDICTION

The Department of Health ("Department") acts as the single state agency to supervise the administration of the medical assistance program ("Medicaid") in New York State. Public Health Law ("PHL") § 201(1)(v), Social Services Law ("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.

OMIG determined to seek restitution of payments made by Medicaid to Sunrise Handicap Transport Co. ("Appellant") [Ex. 2]. The Appellant requested a hearing pursuant to SSL § 22 and the former Department of Social Services ("DSS") regulations at 18 NYCRR § 519.4 to review the determination [Ex. 1].

ISSUE

Was OMIG's determination to recover Medicaid overpayments in the amount of $27,609.11, inclusive of interest, from Appellant correct?

FINDINGS OF FACT

The items appearing in brackets following the findings of fact ["FOF"] indicate exhibits in evidence [Ex.] and testimony from the transcript [Tr.], which support the finding of fact. In instances in which the cited testimony or exhibit contradicts other testimony or exhibits from the hearing, the ALJ considered that other testimony or exhibit and rejected it.

1. At all times relevant hereto, Appellant was enrolled as a provider in the New York State Medicaid program [Ex. 2].

2. Appellant submitted claims and was paid for ambulette transportation it provided between January 1, 2008 and December 31, 2011 and the Medicaid program paid these claims [Ex.2].

3. OMIG conducted an audit of payments made between January 1, 2008 and December 31, 2011 [Ex. 2].

4. OMIG's audit was based solely upon a review of a remittance statement generated for the Medicaid Program by Computer Science Corporation ("CSC") [Tr. 222-223; Ex. 2, Ex. 4; Ex. 9].

5. By draft audit report dated October 24, 2012, OMIG notified Appellant that OMIG had determined to seek restitution in the amount of $27,609.11, which includes Medicaid overpayments in the amount of $25,064.71 and accrued interest in the amount of $2,464.40 [Ex. 2]

6. The draft audit report disallowed 285 claims because Appellant made "*transportation claims with incorrect driver's license information for the date of service*" [Ex. 2 at p.6 - *finding #3*].

7. Appellant submitted a draft audit response dated November 27, 2012 that included a spread sheet with a valid driver license number that corresponded with the driver on each of the disallowed claims [Ex. 3].

8. By final audit report dated November 5, 2013, OMIG notified the Appellant that OMIG had determined to seek restitution in the amount of $27,609.11, which includes Medicaid overpayments in the amount of $25,064.71 and accrued interest in the amount of $2,464.40 [Ex. 4].

9. The final audit report reflects that OMIG disallowed the same 285 claims because Appellant made "*transportation claims with incorrect driver's license information for the date of service.*" No other information contained in the disallowed claims was challenged [Ex. 4 at p.5 - *finding #3*; Tr. 42, 53].

APPLICABLE LAW

Medicaid fee-for-service providers are reimbursed by Medicaid on the basis of the information they submit in support of their claims. The information provided in relation to any claim must be true, accurate and complete. Providers must maintain records demonstrating the right to receive payment and all claims for payment are subject to audit for six years, 18 NYCRR §§ 504.3(a)&(h), 517.3(b), 540.7(a)(8).

If a Department audit reveals an overpayment, the Department may require repayment of the amount determined to have been overpaid, 18 NYCRR §§ 504.8(a)(1), 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). Interest may be collected upon any overpayments determined to have been made, 18 NYCRR § 518.4(a)

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, 18 NYCRR §§ 517.5(b) & 519.18(d)(1). An Appellant may not raise issues regarding . . . "any new matter not considered by the department

upon submission of objections to a draft audit or notice of proposed agency action" 18 NYCRR § 519.18(a).

DSS regulations generally pertinent to this hearing decision are at: 18 NYCRR § 505 (medical care, in particular 18 NYCRR § 505.10- "transportation for medical care and services"), 18 NYCRR § 517 (provider audits), 18 NYCRR § 518 (recovery and withholding of payments or overpayments), 18 NYCRR § 519 (provider hearings), and 18 NYCRR § 540 (provider documentation).

The New York State Medicaid program issues Medicaid Management Information Systems (MMIS) provider manuals, which are available to all providers and include, *inter alia*, billing policies, procedures, codes and instructions, and 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). Each provider claim submitted for ambulette transportation services must include a valid driver license number for the individual driving the vehicle [Ex. 4; Medicaid Update in November of 2004 (Vol. 19, No. 11); Transportation Policy Manual Guidelines Versions 2009-4 (effective September 1, 2009), 2010-1 (effective November 1, 2010), 2011-1 (effective January 1, 2011), 2011-2 (effective July 15, 2011)].

DISCUSSION

OMIG presented the audit file and summarized the case, 18 NYCRR § 519.17. OMIG presented documents (Exhibits 1-7, 9) as did Appellant (Exhibits A-D). OMIG presented the testimony of Sandra Noonan, Management Specialist- *Audit Supervisor*,

and Jean Hanson, Management Specialist. The Appellant called [redacted], Billing Manager, and [redacted], EDI Supervisor.

CSC is the organization that processes Medicaid provider claims. OMIG audited the CSC remittance statement which contains the Medicaid claims paid to Appellant for the period January 1, 2008 through December 31, 2011. The remittance statement includes the claims history information provided by Appellant at the time it submitted each of the claims [Tr. 207-208, 220, 226]. The Department of Motor Vehicles informed OMIG that there was no valid New York State driver's license number that contained letters of the alphabet [Tr. 202-03, 210]. Each claim was required to have an accurate driver license number in the driver license number field [Tr. 28, 105-06]. The CSC remittance statement showed that 285 of Appellant's Medicaid claims for ambulette transportation contained a driver license number with both numbers and letters. The Medicaid Program does not verify the validity of the information provided in the claim before it pays a claim, the claim system only verifies that there is information in the field, in this case a driver license number [Tr. 202, 209, 247].

OMIG issued a draft audit report notifying Appellant that it had disallowed each of these claims because they did not contain a valid driver license number. Appellant submitted a response to the draft audit which included among other things a spread sheet identifying each of the 285 disallowed claims with: recipient Id#, recipient first and last name, date of service, payment date, driver name, unit number, license plate number, and driver license number for each of the disallowed claims ("spread sheet") [Ex.3]. Ms. Noonan testified that "Providers are required to keep records for six years and support anything that they bill to a Medicaid claim" [Tr. 221]. The OMIG did not consider the

spread sheet in preparing the final audit report because it determined that the information contained in the spread sheet was prepared "in response to the draft audit" and it did not look as though it was "original records" created at the time the service was provided [Tr. 57].

Ms. Noonan conceded that it was not until the hearing that OMIG notified Appellant that it did not consider the draft audit submission because OMIG deemed the information contained in the spreadsheet was not "contemporaneous" with the claims. Ms. Noonan said Appellant bore the responsibility to submit contemporaneous information during the draft audit period [Tr. 146-149; Ex.7]. The final audit report affirmed OMIG's draft audit finding that 285 claims contained incorrect driver license information.

Appellant argued that the disallowed claims are valid because all the claims were paid, and but for the driver license number none of the other information provided on each of the claims was in dispute [Tr. 207; Ex. 4]. Appellant did not contest the fact that New York State driver license numbers contain only numbers and that the CSC remittance statement contained driver license numbers with both numerical and alphabetical characters. However, Appellant contended that it provided valid driver license numbers to the Medicaid program when it submitted the original claims information ("data dump") [Tr. 190-192].

OMIG's determination that Appellant submitted "*transportation claims with incorrect driver's license information for the date of service*" was based upon a review of the CSC remittance statement, not an audit review of Appellant's actual claims or an audit review of its books and records [Tr. 222-225; Ex.9, Ex. C]. Appellant asserted that

somehow when the CSC remittance statement was created some of the driver license numbers were merged with letters contained in vehicle license plate numbers ("data merge") [Tr.189, 262-264]. Appellant argued that the CSC remittance statement was "edited" and is not a reflection of Appellant's original submission because therein the driver license numbers contain only four characters not eight characters [Ex. 4 –*Exhibit III*, Ex. B]. If Appellant had submitted claims with only four characters in the driver license field, instead of the required eight characters, the system would have rejected each of the claims [Tr. 174, 209; Ex. B, Ex. C, Ex. D, Ex. 5, Ex. 9]. [redacted] testified that the information contained in the spread sheet was obtained from Appellant's records [Tr. 173, 181; Ex. 3, Ex. B, Ex. C]. [redacted] testified that the spreadsheet is essentially a contemporaneous record of the disallowed claims submissions [Tr. 251-269; Ex. 3 at p. 3; *See* Ex. B, Ex. C, Ex. D].

CONCLUSIONS

OMIG is authorized to audit Medicaid providers post payment and it determined to disallow 285 claims ("disallowed claims") where invalid driver license numbers appeared in the CSC remittance statement. Pursuant to 18 NYCRR § 517.6, "In preparing the final audit report, the department must consider the objections, any supporting documents and materials submitted therewith, the draft audit report, and any additional material which may become available." I find it troubling that during the draft audit period OMIG actively decided that the spreadsheet was not "contemporaneous" documentation and it would not consider it, but provided no notice to Appellant about its decision until the first day of hearing. At hearing, Ms. Noonan testified "It's the provider's responsibility to answer our questions and analyze and help us understand

their data" [Tr. 221]. However, OMIG's failure to notify Appellant of its decision during the draft audit period effectively deprived Appellant of the opportunity to "help OMIG understand their data." I also find it troubling that at hearing OMIG failed to provide a cogent explanation for what OMIG would accept as constituting "original" and or "contemporaneous" information in this case.

The draft audit response contains data from the records maintained by Appellant to support its Medicaid claims. Specifically, Appellant provided valid driver license numbers that correspond with the other information contained in the disallowed claims. OMIG did not question the accuracy of the data provided in the draft audit response. Appellant has met its burden showing that "the determination of the department was incorrect and that all claims submitted and denied were due and payable under the program" [18 NYCRR § 519.18(d)(1)].

DECISION

OMIG's determination to recover Medicaid overpayments in the amount of $27,609.11 is reversed. This decision is made by Kimberly A. O'Brien, who has been designated to make such decisions.

DATED:
August 28, 2015
Albany, New York

_____
Kimberly A. O'Brien
Administrative Law Judge