STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Request of	:	
TEJET EXPRESS TRANSPORTATION, INC.	:	**Decision After Hearing**
Medicaid ID # 03111319	:	
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.	:	Audit #2012Z31-062D

Before: Denise Lepicier
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
800 No. Pearl Street
Albany, N.Y. 12204
By: Sharon Miller, Esq., and Ricja Rice, Esq.

Tejet Express Transportation, Inc.
2309 Avenue Z
Brooklyn, New York 11235-2805
By: Richard S. Harrow, Esq.
O'Connell & Aronowitz
54 State Street
Albany, New York 12207

Dates of Hearing: January 29, 2014
January 30, 2014

JURISDICTION

The Department of Health ("Department") acts as the single state agency to supervise the administration of the Medicaid 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 Tejet Express Transportation, Inc. ("Tejet" or "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)[1]

ISSUE

Was OMIG's determination to recover Medicaid overpayments in the amount of $382,983.57 from Appellant Tejet Express Transportation, Inc., correct?

FINDINGS OF FACT

1. At all times relevant hereto, Appellant was enrolled as a provider in the New York State Medicaid program. (Ex. 13, stipulation 1)

2. The Appellant submitted claims for transportation services provided by ambulette and was paid for these claims between January 1, 2008 and December 31, 2011. (Ex. 13, stipulation 1 & 2)

3. OMIG conducted an audit of payments made between June 1, 2011 and December 31, 2011 to verify Appellant's drivers' compliance with the Vehicle and Traffic Law. (Ex. 4, pp. 2, 4-5; Ex.2; T. 177-179)

4. Forty-three claims, totaling $2,112.38, were identified as overpayments because a driver was not qualified under Article 19-A of the Vehicle and Traffic Law. (T. 177-206; Ex. 2, ex. II; Ex. 4, ex. II; Ex. 5; Ex. 11)

5. OMIG conducted an audit of payments made between January 1, 2008 and December 31, 2011 to verify the accuracy of driver license numbers on claims. (Ex. 4, pp. 2, 6-7; Ex. 2)

6. Six thousand eight hundred and forty claims, totaling $364,311.99, were identified as overpayments because a driver license number of nine zeroes was entered on the claim. There is no valid New York State driver license number that consists of nine zeroes. (T. 206-219, 419; Ex. 2, ex. III; Ex. 4, ex. III)

7. By final audit report dated October 17, 2013, OMIG notified the Appellant that OMIG had determined to seek restitution of Medicaid overpayments and interest in the amount of $382,983.57. (Ex. 2, p. 8)

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).

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[1] References in parentheses refer to transcript page numbers or exhibits. Transcript references will be cited as "T." followed by the appropriate page number(s); exhibits will be cited by an "Ex." followed by the

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).

The DSS regulations generally pertinent to this hearing decision are at: 18 NYCRR § 360-7 (payment for services), 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 (authorization of medical care, in particular 18 NYCRR § 540.6 – "billing for medical assistance").

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appropriate exhibit number(s) or letter(s).

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. (Ex. 6, 7, 8 & 9) www.emedny.org. The Medicaid program also issues a monthly Medicaid Update with additional information, policy and instructions. (Ex. 5) 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

OMIG presented the audit file and summarized the case, as is required by 18 NYCRR § 519.17. OMIG presented documents (Exhibits 1-11 & 13) and the testimony of Timothy Perry-Coon, a medical assistance specialist in the Department of Health, and Sandra Noonan, a management specialist in OMIG. The Appellant called [redacted], a former Tejet office worker who worked for Appellant for essentially all of the audit period involved in this case, and [redacted], a programmer who created and installed the program Appellant used to submit its claims to Medicaid beginning in 2008.

Mr. Perry-Coon, who works in the Department of Health, Office of Health Insurance Programs transportation policy unit, provided useful background information about Medicaid transportation policy. (T. 95-98) Regulations state, in relevant part, that "Ambulette drivers must be qualified under Article 19-A of the Vehicle and Traffic Law." 18 NYCRR § 505.10 (e)(6)(ii). Mr. Perry-Coon explained the requirements an ambulette driver must meet to be qualified pursuant to Article 19-A of the Vehicle & Traffic Law. An ambulette driver must have a commercial driver license, pass a physical

exam, and pass a background check that includes a prior employment check, a driving history check and a criminal history check. (T. 102-106) Medicaid requires this qualification to help insure that ambulette drivers provide safe driving and assistance to the Medicaid beneficiaries they transport who are a vulnerable, medically-challenged population. (T. 124-126)

Ms. Sandra Noonan, an OMIG employee in the division of system utilization review, oversaw the audit. (T. 165, 169) She explained that based on information obtained from the Department of Motor Vehicles, OMIG identified two drivers for Tejet who were not qualified under Article 19-A of the Vehicle and Traffic Law. (T. 178- 206; Ex. 2, ex. II; Ex. 4, ex. II; Ex. 11) OMIG disallowed the claims involving these drivers.

Ms. Noonan also explained that OMIG audited its own claim history from Tejet for the period from January 1, 2008, to December 31, 2011, checking to make sure that a valid driver license number was input on all claims. (T. 206-212) Medicaid Transportation Policy Manual Guidelines and a Medicaid Update confirm that transportation providers billing for ambulette services were required to include the driver license number of the individual driving the vehicle on their claims. (Ex. 5, 6, 7, 8 & 9). 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).

The Department of Motor Vehicles informed OMIG that there was no valid driver license number that contained all zeroes, but Tejet had sent in 6,840 Medicaid claims for transportation where the driver license field on the claim was all zeroes. (Ex. 4, pp. 2, 6-7 and ex. III; T. 206-219, 419; Ex. 2, ex. III; Ex. 4, ex. III)

Appellant argued that for many of the disallowed claims the driver did not drive both legs of the round trip. This issue arises because Medicaid requires providers to report only the first driver license number on a round trip claim. (T. 226-250) The Appellant never provided any proof in its response to the draft audit that any other driver drove the second leg of a round trip. (T. 228) Even if the Appellant had provided such proof, OMIG may properly disallow a claim when a disqualified driver has been used for any leg of the trip. (T. 230) Medicaid insists on qualified drivers as a safety issue. (T. 124, 230) Using unqualified drivers at any time is a clear violation of the Medicaid transportation program.

Appellant also argued that all the services claimed were actually provided, implying that because the services were provided there was no harm. (T. 232-233) This audit was not about whether the services were provided. It was about whether properly qualified licensed drivers provided the services. (T. 232-233) Appellant further argued that it had a software problem and that because of this problem zeroes were entered in the driver license field. The programmer Appellant employed, who installed and serviced the program that Appellant used to submit claims to Medicaid, admitted that, if a driver license number had not been entered into her program for a particular driver, the program would reflect all zeroes as the nine digit driver license number. (T. 458-459, 469, 472-473) This does not excuse the Appellant's improper claiming. It is the provider's responsibility to provide true, accurate and complete information in its claims. (T. 234-236, 249-251) 18 NYCRR § 504.3(h).

At hearing, Appellant's counsel repeatedly suggested that OMIG should have done more to determine whether qualified drivers drove the ambulettes on the claims that

were submitted with zeroes as a driver license number. (T. 86-92, 379-380, 412-413, 420-424) This is not OMIG's obligation. Medicaid employs a pay and audit system to meet its dual responsibilities to care for Medicaid beneficiaries and to pay only for valid claims. (T. 125-128, 133-134, 144, 394) It was the Appellant's obligation to comply with all Medicaid rules and regulations. 18 NYCRR § 504.3. Among these rules and regulations, Medicaid Transportation Policy Manual Guidelines and a Medicaid Update all confirm that transportation providers billing for ambulette services were required to include the driver license number of the individual driving the vehicle on their claims. (Ex. 5, 6, 7, 8 & 9). 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). It was Appellant's obligation to report accurately. 18 NYCRR §§ 504.3(h). Also among the regulations is an express provision that all payments are subject to audit. 18 NYCRR §§ 504.3(g), 517.3(b). It was the Appellant's inaccurate claim reporting that led to the overpayments.

In a post-hearing submission Appellant raised, for the first time, the argument that it had not been given notice of an intent to audit as referred to in 18 NYCRR § 517.3(c). The audit in this matter was not an on-site audit of Appellant's business records where a notice of intent to audit might be issued. It was an audit of the claims history that OMIG had in its possession**.**

In conclusion, it is Appellant's burden to prove 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). The Appellant has failed to carry its burden of proof.

DECISION:

OMIG's determination to recover Medicaid overpayments in the amount of $382,983.57 is affirmed. This decision is made by Denise Lepicier, who has been designated to make such decisions.

DATED:
June 9, 2014
New York, New York

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Denise Lepicier
Administrative Law Judge