STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Request of **FAST HELP AMBULETTE SERVICE, INC.** Medicaid Provider ID # 01299967 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 #11-4196

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
217 Broadway, 8th floor
New York, New York 10007
By: Tina M. Dolman, Esq.

Mr. Mark Bokman, Owner
Fast Help Ambulette Service, Inc.
1474 East 31st Street
Brooklyn, New York 11234
By: Steven Yuniver, Esq., and Mark Bratkovsky, Esq.
Law Offices of Mark Bratkovsky, P.C.
2652 Coney Island Avenue
Brooklyn, New York 11223

Dates of Hearing: September 29, 2016
November 3, 2016

Record closed: February 10, 2017

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.

Pursuant to Chapter 58 of the Laws of 2005, OMIG was permitted to employ county social service districts to conduct audits as agents of OMIG. The audit in this matter was conducted by the New York City Human Resources Administration under the oversight of OMIG. [1] (T. 91-94, 106, 349) [2]

Subsequent to the audit, OMIG determined to seek restitution of payments made by Medicaid to Fast Help Ambulette Service, Inc. ("Fast Help" or "Appellant"). (Ex. 2; Ex. 3) 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 OMIG's determination. (Ex. 13)

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).

[1] Hereinafter references to OMIG mean OMIG and/or the New York City Human Resources auditors (OMIG agents).

Medicaid program participation is a voluntary, contractual relationship between the provider of service and the State. SSL § 365(a); 18 NYCRR § 504.1; Schaubman v. Blum, 49 NY2d 375 (1980); Lang v. Berger, 427 F.Supp. 2d 204 (S.D.N.Y. 1977). A Medicaid provider agrees to comply with all program requirements as a prerequisite to payment and continued participation in the program. 18 NYCRR §§ 504, 515, 517, 518. The provider certifies at both the time of enrollment and when submitting claims that the provider will comply or has complied with all its contractual responsibilities. 18 NYCRR §§ 504.3, 540.7(a)(8).

Based on these contractual obligations, the Medicaid program employs a pay-first-and-audit-later system to insure compliance. This process helps ensure that providers are paid promptly. All claims are subject to post-payment audit to determine if claims are supported by documentation of complete and accurate information. 18 NYCRR §§ 504.3, 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).

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

[2] 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

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 of the Department's proof. 18 NYCRR § 519.18(g).

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 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 (authorization of medical care, in particular 18 NYCRR § 540.6 – "billing for medical assistance").

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. 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

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

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).

Regulations, provider manuals and Medicaid updates particularly relevant in this matter provide the following:

> --"All claims . . . submitted to Medicaid by nonemergency ambulette transportation providers . . . must contain the Driver's license number and the Vehicle License Plate Number." DOH Medicaid Update November 2005, Vol. 20, No. 12. See also, MMIS Transportation Manual Policy Guidelines, Version 2006-1 (effective Oct. 20, 2006); 18 NYCRR § 504.3.
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> -- "If a different driver and/or vehicle returns the Medicaid enrollee/s from the medical appointment, the license number of the driver and vehicle used for the origination of the trip should be reported on the claim." MMIS Transportation Manual Policy Guidelines, Version 2006-1 (effective Oct. 20, 2006).
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> --Ambulette transportation providers are required to record the name of the driver transporting the Medicaid recipient in contemporaneous records that Medicaid refers to as "trip tickets." 18 NYCRR § 505.10(e)(8); MMIS Transportation Manual Policy Guidelines, Version 2004-1, Section II.
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> --"Ambulette services must be authorized by the Department of Transportation." 18 NYCRR § 505.10(e)(6)(ii).
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> --"Ambulette drivers must be qualified under Article 19-A of the Vehicle and Traffic Law." 18 NYCRR § 505.10(e)(6)(ii). See also, Vehicle and Traffic Law § 509-d, *et seq.*; MMIS Transportation Manual Policy Guidelines, Version 2006-1 (effective Oct. 20, 2006).
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> --Billing codes for trips can vary in relation to how long (mileage) a trip may be. 18 NYCRR § 505.10(f)(5)(i).
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> --A transportation provider must use an accurate billing code to submit for a claim. 18 NYCRR § 504.3(f) & (h).
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> --A transportation provider must record the time of pick-up and drop-off for each trip after September 1, 2010. DOH Medicaid Update August 2010, Vol. 26, No. 10. See also, 18 NYCRR § 505.10(e)(8)(iv); MMIS Transportation Manual Policy Guidelines, Versions 2004-1 & 2009-3;

ISSUE

Is OMIG's determination to recover Medicaid overpayments in the amount of $1,102,553 from Appellant Fast Help Ambulette Service, Inc., correct?

FINDINGS OF FACT

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

2. Appellant submitted claims for transportation services provided by ambulette in New York City to Medicaid recipients and was paid for these claims by Medicaid. (Ex. 1)

PRE-HEARING HISTORY

3. By letter dated June 14, 2011, OMIG notified the Appellant that OMIG intended to conduct an audit of the records that support Appellant's Medicaid claims for transportation/ambulette services. 18 NYCRR § 517.3(c). This letter explained that the New York City Human Resources Administration ("HRA") would conduct the audit as an agent of OMIG. (Ex. 1, p. B3-1)

4. On August 3, 2011, OMIG conducted an entrance conference with Mark Bokman, Appellant's owner, and Eric Bokman, Appellant's Manager, to explain the process. (Ex. 1, p. B2-1to B2-11; Ex.5; Ex. 6) 18 NYCRR § 517.3(f). Appellant was told that the scope of the audit was paid claims from January 1, 2008, to December 31, 2010, and that the audit sample would encompass claims for 150 services. The audit team collected some basic information about how Appellant operated at this entrance conference. (Ex. 1, p. B2-1 to 11; Ex. 6)

5. OMIG conducted the audit of 150 randomly selected claims paid in the period between January 1, 2008, and December 31, 2010. (Ex. 3) The number (the universe) of all paid claims in this period was 50,041 claims, and Appellant was paid $3,017,963.81 for these claims. (Ex. 3)

6. On June 14, 2013, an exit or "closing" conference was conducted pursuant to 18 NYCRR §517.5(a). The attendees included Mark Bokman, Eric Bokman, Stephen Solarsh, Fast Help's business advisor, and members of the OMIG audit team. (Ex. 1, p. B1-7; Ex. 8) A copy of the exit conference summary of findings had been provided to the Appellant by letter dated March 14, 2013. (Ex. 1, p. B1-8 to B1-39; Ex. 9)

7. At the exit conference, the summary of all the audit findings was discussed. (Ex. 1, p. B1-1; Ex. 8) Eric Bokman stated that he wished to provide additional information and requested time to do so. (Ex. 1, p. B1-1 to B1-5)

8. Appellant responded to the exit conference summary on or about June 28, 2013. The audit team considered the additional information provided and the findings were adjusted downward in Appellant's favor. The adjustments were made because some of the disallowed claims appeared to have resulted from typographical errors. (Ex. 1, p. A5-1 to A5-20, A6-1 to A6-370; B1-5; B1-21)

9. By letter dated November 12, 2013, a Draft Audit Report ("DAR") was sent to Appellant seeking an overpayment in the amount of $1,102,553. (Ex. 2)

10. By letters dated December 10, 2013, and January 31, 2014, Appellant provided a response to the DAR. (Ex. 11; Ex. 19) OMIG reviewed the additional

information submitted but made no changes to the audit findings. (T. 43; Ex. 1, p. A2-1 to A2-16; Ex. 3; Ex.11; Ex. 19)

11. By report dated June 12, 2014, OMIG issued a Final Audit Report ("FAR") seeking an overpayment amount of $1,102,553. (Ex. 3)

12. By letter dated June 17, 2014, Appellant requested a hearing. (Ex. 13)

13. By Notice of Hearing dated June 25, 2014, this matter was set for hearing on October 1, 2014. (Ex. 15) The hearing was adjourned a number of times and began on September 29, 2016.

FINDINGS REGARDING THE AUDIT

Missing/Inaccurate Information on Medicaid Claim - Inaccurate Vehicle Plate Number (Exhibit 3, sub-exhibit II)

14. Information from the 150 claims in the audit sample was compared to the supporting documentation provided by the Appellant, and additional information the Appellant supplied, as to which vehicle was used to provide the service for each claim. (T. 167-177, 187, 216-234)

15. OMIG demonstrated through a review of claim sample number 7 from the audit that Appellant failed to prove that the vehicle submitted on the claim for the first leg of the round trip was the vehicle used to provide the service. (T. 127- 147; Ex. 1, p. D6-71 to D6-82) The Appellant submitted the claim which indicated that the vehicle plate number was T404537C. (Ex. 1, p. D6-71) On the trip ticket the vehicle number was indicated as number 12. (Ex. 1, p. D6-72) The dispatch log for the day in question indicates that vehicle 12 was used to transport the patient on the first leg of the round trip. (Ex. 1, p. D6-73) A chart that the provider was asked to complete during the audit

process confirmed that vehicle 12 was used for sample claim number 7. (Ex. 1, p. D6-74) However, the NYS Department of Transportation inspection document indicates that the plate number for vehicle 12 was T425610C, and the registration for vehicle 12 has a plate number of T425610C. (Ex. 1, p. D6-78 to 79). Information provided by the Appellant in response to the DAR did nothing to resolve the discrepancy. (Ex. 1, p. A3-7 to A3-11)

16. OMIG demonstrated through a review of claim sample number 9 from the audit that Appellant failed to prove that the vehicle submitted on the claim for the first leg of the round trip was the vehicle used to provide the service. (T. 149-150; Ex. 1, p. D6-97 to D6-113) The Appellant submitted the claim which indicated that the vehicle plate number was T42510C. (Ex. 1, p. D6-97) On the trip ticket the vehicle number was indicated as number 9. (Ex. 1, p. D6-98) The dispatch log for the day in question indicates that vehicle 9 was used to transport the patient on the first leg of the round trip. (Ex. 1, p. D6-99) A chart that the provider was asked to complete during the audit process confirmed that vehicle 9 was used for sample claim number 9. (Ex. 1, p. D6-100) However, the NYS Department of Transportation inspection document indicates that the plate number for vehicle 9 was T4045373C and the registration for vehicle 9 has a plate number of T4045373C. (Ex. 1, p. D6-109-110 to 79). Information provided by the Appellant in response to the DAR did nothing to resolve the discrepancy. (Ex. 1, p. A3-13 to A3-17)

17. OMIG demonstrated through a review of claim sample number 11 from the audit that Appellant failed to prove that the vehicle submitted on the claim for the first leg of the round trip was the vehicle used to provide the service. (T. 150-153; Ex. 1, p. D6-135 to D6-153A) The Appellant submitted the claim which indicated that the vehicle

plate number was T4045373C. (Ex. 1, p. D6-135) On the trip ticket the vehicle number was indicated as number 7.[3] (Ex. 1, p. D6-136) The dispatch log for the day in question indicates that vehicle 7 was used to transport the patient on the first leg of the round trip. (Ex. 1, p. D6-137) A chart that the provider was asked to complete during the audit process confirmed that vehicle 7 was used for sample claim number 11. (Ex. 1, p. D6-138) However, the NYS Department of Transportation inspection document indicates that the plate number for vehicle 7 was T517256C and the registration for vehicle 7 has a plate number of T517256C. (Ex. 1, p. D6-149 to 150). Information provided by the Appellant in response to the DAR did nothing to resolve the discrepancy. (Ex. 1, p. A3-19 to A3-22)

18. OMIG demonstrated through a review of claim sample number 22 from the audit that Appellant failed to prove that the vehicle submitted on the claim for the first leg of the round trip was the vehicle used to provide the service. (T. 153-157; Ex. 1, p. D6-283 to D6-297) The Appellant submitted the claim which indicated that the vehicle plate number was T425349C. (Ex. 1, p. D6-283) On the trip ticket the vehicle number was indicated as number 9. (Ex. 1, p. D6-284) The dispatch log for the day in question indicates that vehicle 9 was used to transport the patient on the first leg of the round trip. (Ex. 1, p. D6-285) A chart that the provider was asked to complete during the audit process confirmed that vehicle 9 was used for sample claim number 22. (Ex. 1, p. D6-286) However, the NYS Department of Transportation inspection document indicates that the plate number for vehicle 9 was T404537C and the registration for vehicle 9 has a plate number of T404537C. (Ex. 1, p. D6-294 to 295). Information provided by the

[3] Testimony indicated that a "77" on the trip ticket really meant a "7" and a "55" meant a "5." (T. 140-141, 151)

Appellant in response to the DAR did nothing to resolve the discrepancy. (T. 154-155; Ex. 1, p. A3-34 to A3-37)

19. OMIG demonstrated through a review of claim sample number 47 from the audit that Appellant failed to prove that the vehicle submitted on the claim for the first leg of the round trip was the vehicle used to provide the service. (T. 155-156; Ex. 1, p. D6-634- to D6-650) The Appellant submitted the claim which indicated that the vehicle plate number was T404537C. (Ex. 1, p. D6-634) On the trip ticket the vehicle number was indicated as number 7. (Ex. 1, p. D6-635) The dispatch log for the day in question indicates that vehicle 7 was used to transport the patient on the first leg of the round trip. (Ex. 1, p. D6-636) A chart that the provider was asked to complete during the audit process confirmed that vehicle 7 was used for sample claim number 47. (Ex. 1, p. D6-637) However, the NYS Department of Transportation inspection document indicates that the plate number for vehicle 7 was T517256C and the registration for vehicle 7 has a plate number of T517256C. (Ex. 1, p. D6-647 to 648). Information provided by the Appellant in response to the DAR did nothing to resolve the discrepancy. (Ex. 1, p. A3-68 to A3-72)

20. OMIG demonstrated through a review of claim sample number 90 from the audit that Appellant failed to prove that the vehicle submitted on the claim for the first leg of the round trip was the vehicle used to provide the service. (T. 156-158; Ex. 1, p. D6-1252 to D6-1266) The Appellant submitted the claim which indicated that the vehicle plate number was T404537C. (Ex. 1, p. D6-1252) On the trip ticket the vehicle number was indicated as number 5. (Ex. 1, p. D6-1253) The dispatch log for the day in question indicates that vehicle 5 was used to transport the patient to the physician's office. (Ex. 1,

p. D6-1254) A chart that the provider was asked to complete during the audit process indicated that vehicle 12 was used for sample claim number 90. (Ex. 1, p. D6-1255) The NYS Department of Transportation inspection document indicates that the plate number for vehicle 5 was T425613C and the registration for vehicle 5 has a plate number of T425613C. (Ex. 1, p. D6-1263 to 1264). Information provided by the Appellant in response to the DAR did nothing to resolve the discrepancies. (Ex. 1, p. A3-110 to A3-113)

21. Samples numbered 7, 9, 11, 22, 47 and 90 were representative of the 36 samples OMIG identified which were disallowed for lack of an accurate vehicle plate number.

22. Thirty-six claims, totaling $2,203.20, were identified as overpayments because Appellant provided insufficient documentation that the vehicle plate number submitted on the claim was the vehicle used to provide the service. These findings were extrapolated across the universe of paid claims in the audit period. (T. 130-131; Ex. 3, sub-exhibit II).

Missing/Inaccurate Information on Medicaid Claim – Inaccurate Driver License Number (Exhibit 3, sub-exhibit III)

23. Information from the 150 claims in the audit sample was compared to the supporting documentation provided by the Appellant, and additional information the Appellant supplied, as to which driver was used to provide the service.

24. OMIG demonstrated through a review of claim sample number 33 from the audit that Appellant failed to prove that the driver's license number submitted on the claim for the first leg of the round trip was the driver license number of the driver used to

provide the service. (T. 357-364; Ex. 1, p. D6-428 to D6-443) The Appellant submitted the claim which indicated that the driver's license number was [redacted] (Ex. 1, p. D6-428) On the trip ticket the driver was indicated as number 12. (Ex. 1, p. D6-429) The dispatch log for the day in question indicates that the vehicle/driver was number 12. (Ex. 1, p. D6-430) A chart that the provider was asked to complete during the audit process confirmed that driver 12 was [redacted]. (Ex. 1, p. D6-431) However, [redacted] driver's license number was [redacted] (Ex. 1, p. D6-432). Information provided by the Appellant in response to the audit did nothing to resolve the discrepancy. (Ex. 1, p. A3-189 to A3-195)

25. Sample number 33 was representative of the 11 samples OMIG identified which were disallowed for lack of an accurate driver's license number. (T. 361-362, 387)

26. Eleven claims, totaling $674.40, were identified as overpayments because Appellant provided insufficient documentation that the driver's license number submitted on the claim was for the driver who provided the service. These findings were extrapolated across the universe of paid claims in the audit period. (T. 356-362; Ex. 3, sub-exhibit II)

Missing/Inaccurate Information on Medicaid Claim – Inaccurate Procedure Code (Exhibit 3, sub-exhibit IV)

27. At hearing, Appellant conceded and did not challenge the findings regarding inaccurate procedure codes. (T. 392; Ex. 3, sub-exhibit IV; Appellant's brief submitted 2/10/17, p.8)

28. Four claims, totaling $50.40, were identified as overpayments because Appellant provided an inaccurate procedure code on the claim. These findings were not extrapolated across the universe of paid claims in the audit period. (T. 392; Ex. 3)

Driver Not NYS DMV 19-A Certified (Exhibit 3, sub-exhibit V)

29. OMIG compared Appellant's DMV roster of drivers ("19-A carrier history report") and the 19-A qualification dates for each driver with the dates the drivers transported Medicaid patients for Appellant. OMIG obtained a 19-A carrier history report for Appellant from the DMV which indicated when a driver was certified to drive for Appellant, when, if applicable, he was dropped from Appellant's roster and when, if applicable, he was added to the roster again. (T. 394-395, 404) OMIG also reviewed additional information provided by Appellant which appeared to come from the DMV.

30. OMIG demonstrated through a review of claim sample number 12 from the audit that Appellant failed to prove that the driver for the second leg of a round trip was 19-A certified, as is required, on the date of service. Appellant's dispatch log indicates that driver number 9 drove the patient on [redacted] 2009. (Ex. 1, p. D6-156) The chart which the Appellant filled in during the audit process similarly indicated that [redacted] was driver number 9 and drove the patient in issue on [redacted] 2009. (Ex. 1, p. D6-157) However, the carrier history report for this driver indicates that he was not certified to work for Appellant until [redacted], 2011. (T. 395-397; Ex. 1, p. D6-164)

31. During the audit and in response to the DAR, Appellant provided a document which purported to be a DMV document and to show that [redacted] was 19-A certified on [redacted], 2009, to work for Appellant. (Ex. 1, p. D6-165 & A3-276)

OMIG requested clarification from the DMV concerning this document. DMV reported to OMIG that it has no record of this document and that it has no idea how the document came to be, however, the DMV indicated that the carrier history report it provided was accurate with respect to the date of this driver's 19-A certification for the Appellant. (T. 396-398)

32. OMIG demonstrated through a review of claim sample number 24 from the audit that Appellant failed to prove that the driver for the second leg of a round trip was 19-A certified, as is required, on the date of service. Appellant's dispatch log is illegible for the second leg of the trip with this patient on [redacted] 2010. The chart that the Appellant filled in during the audit process indicates that [redacted] was driver number 9 and drove the patient in issue on [redacted] 2010. (Ex. 1, p. D6-314-315) The carrier history report for this driver indicates that he was not certified to work for Appellant until [redacted], 2011. (T. 398-400; Ex. 1, p. D6-321)

33. During the audit and in response to the DAR, Appellant provided a document which purported to be a DMV document and to show that [redacted] was 19-A certified to work for Appellant on [redacted], 2008. (Ex. 1, p. D6-322 & A3-279) OMIG requested clarification from the DMV concerning this document. DMV reported to OMIG that it has no record of this document and that it has no idea how the document came to be, however, the DMV indicated that the carrier history report it provided was accurate with respect to the date of this driver's 19-A certification for the Appellant. (T. 399-400)

34. OMIG demonstrated through a review of claim sample number 82 from the audit that Appellant failed to prove that the driver for the second leg of a round trip

was 19-A certified, as is required, on the date of service. Appellant's dispatch log indicates that driver number 9 drove this patient on the second leg of the round trip on [redacted] 2009. The chart which the Appellant filled in during the audit process indicates that [redacted] was driver number 9 and drove the patient in issue on [redacted] 2009. (Ex. 1, p. D6-1146-1148) The carrier history report for this driver indicates that he was certified to work for Appellant on [redacted] 2008, and was terminated on [redacted] 2008. (T. 400-; Ex. 1, p. D6-1152)

35. During the audit and in response to the DAR, Appellant provided a DMV document dated August 16, 2008, which indicated that [redacted] was 19-A certified to work for Appellant on [redacted] 2008. (Ex. 1, p. A3-286, D6-1155) However, in response to the DAR, Appellant provided another Add/Drop acknowledgement report purportedly from the DMV that included no date of hire and appeared to have had other information deleted. (Ex. 1, p. A3-286) OMIG requested clarification from the DMV concerning this document. DMV reported to OMIG that it has no record of the document that appeared to be missing information and that it has no idea how the document came to be, however, the carrier history report it provided was accurate with respect to the date of this driver's 19-A certification for the Appellant. (T. 400-401)

36. Sample claim numbers 12, 24 and 82 were representative of the 12 samples OMIG identified which were disallowed for lack of 19-A certification of the driver to work for Appellant at the time of service. (Ex. 3, sub-exhibit IV)

37. Twelve claims, totaling $367.20, were identified as overpayments because Appellant used drivers who were not 19-A certified to drive for Appellant at the time of the service provided. These findings were extrapolated across the universe of

paid claims in the audit period. (T. 401-402, 404; Ex. 3, sub-exhibit IV)

Missing/Incomplete Documentation - Missing Time of Service (Exhibit 3, sub-exhibit VI)

38. In conducting a review of whether a pick-up and drop-off time was recorded for each trip, OMIG reviewed Appellant's trip tickets for each trip after September 1, 2010, when this requirement was made explicit. (T. 444-447)

39. OMIG demonstrated through a review of claim sample number 99 from the audit that Appellant failed to provide a drop-off time for the trip to the patient's appointment and a pick-up time for the trip from the patient's appointment. (T. 445; Ex. 3, sub-exhibit VI; Ex. 1, p. D6-1384, A3-313, A3-314)

40. One claim, totaling $60.00, was identified as an overpayment because Appellant did not record the pick-up and drop-off time for each leg of the trip. This finding was extrapolated across the universe of paid claims in the audit period. (T. 447)

DISCUSSION

OMIG presented the audit file and summarized the case, as is required by 18 NYCRR § 519.17. OMIG presented documents (OMIG Ex. 1 through 3, 5, and 7 through 24), the testimony of Tricia Smith, who reviews and supervises the county transportation audits statewide for Medicaid, and Ping Tran, who is a "Management Auditor" for HRA. (T. 32-36; 117-118) The Appellant presented the testimony of Eric Bokman, the owner's [redacted] and the Manager of Appellant.

Regulations governing the duties of providers in the Medicaid program state that by enrolling the provider agrees: "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to

keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department . . . ." 18 NYCRR § 504.3(a). OMIG conducted a review to verify that Appellant provided accurate information on the Medicaid claims submitted and maintained records which demonstrated Appellant's right to receive payment. (T. 166-167)

Missing/Inaccurate Information on Medicaid Claim - Inaccurate Vehicle Plate Number (Exhibit 3, sub-exhibit II)

New York State Medicaid Program Transportation Manuals state that "[transportation providers billing for ambulette services . . . are required to . . . [i]nclude the license plate number of the vehicle used to transport the Medicaid client on their claim. If a different driver and/or vehicle returns the recipient from the medical appointment the license number of the driver and vehicle used for the origination of the trip should be reported on the claim." MMIS Transportation Manual Policy Guidelines, Version 2006-1. Appellant needed to provide an accurate vehicle license plate number on the claim for each service provided. (T. 48; Ex. 3, sub-exhibit II) Appellant also had to maintain records indicating the vehicle license plate number for each trip.

OMIG requested information during the audit identifying which vehicle was used for the origination of each service in the sample. Appellant provided "trip tickets" on which a number was written in the "Driver Signature" field. (Ex. 1, p. D6-72) However, when this information was compared to the copies of registrations provided by Appellant, with the numbers of the vehicles recorded in the upper right hand corner by the

Appellant, the vehicle plate number on the registration did not always match the number provided on the claim for the particular vehicle number. (Ex. 1, p. D6-82)

Appellant's principle argument at hearing with respect to the finding that an inaccurate vehicle plate number was provided on 36 of the claims was first asserted in a December 10, 2013, letter from Appellant's attorney that stated:

> The way that this company's computer program was set up was that every time they acquired a new vehicle or a new driver was hired the computer assigned the next chronological number. Thus the vehicle number on the claim and the driver number on the claim is the internal number assigned to that vehicle and the internal number assigned to that driver. Thus our client can assert definitively which car was used and which driver made the trip for each service in the sample.
>
> The driver, however, on the trip ticket would write the number emblazoned on the car and the number emblazoned on the car would also be the number which would appear on the DMV inspection reports. . . . There is also a possibility that a driver may have written the number of the radio assigned to them on the trip ticket rather than the car number . . . [T]here was no conflict . . . and our client can definitively identify the vehicle on the claim by its internally assigned car number. (Ex. 11)

In a second letter in response to the draft audit report dated January 31, 2014, the attorney again asserted the above and added: "There is also a possibility that initials or signature written by the driver were interpreted by the auditors to be a number on the trip ticket." Appellant's attorney at that time asserted that "I do not believe that there is any way to resolve this other than for a new sample to be generated and the audit re-done." She asserted this belief despite reiterating that "our client can definitively identify the vehicle on the claim by its internally assigned car number." (Ex. 19)

This "explanation" essentially amounts to an admission that the Appellant did not create and maintain accurate records to support its claims. Furthermore, in spite of the assertion that Appellant could accurately identify the vehicle on each of the disallowed

claims, Appellant offered no information to evidence this. (T. 50-51) Appellant was given the opportunity to complete a chart prior to the issuance of the DAR to assist the auditors in identifying the vehicle which should be attached to the claims, and Appellant confirmed the information supplied on the trip tickets. (T. 128-129, 158-159)

Eric Bokman's testimony for the first time at hearing that the auditor told him what to fill in on the chart was not credible and was not timely. (T. 284-285, 308-309, 285-289) An Appellant may not raise issues at hearing regarding . . . "any new matter not considered by the department upon submission of objections to a draft audit . . . ." 18 NYCRR § 519.18(a). *See*, Rego Park Nursing Home v. Perales, 206 A.D.2d 781, 615 N.Y.S.2d 773 (3rd Dept. 1994)(failed to raise issues in response); In Re Westmount Health Facility v. Bane, 195 A.D.2d 129, 606 N.Y.S.2d 832 (3rd Dept. 1994)(failed to give sufficient notice of grounds for objections and, therefore, failed to preserve objections for hearing). 18 NYCRR § 517.5 provides in relevant part that:

> (b) . . . . the issues to be addressed at an administrative hearing will be limited to those matters contained in any objection to the proposed action.
>
> (c) . . . . Any objections must include a statement detailing the specific items of the draft report to which the provider objects and provide any additional material or documentation which the provider wishes to be considered in support of the objections.

Department auditors can only consider arguments and documentation presented to them before the final audit determination is prepared. This hearing is limited to a review of information provided prior to or in response to the DAR. 18 NYCRR 519.18(a). If Mr. Bokman had been told what information to enter into the chart, he would have raised this issue in response to the "closing" conference or DAR. Appellant did not do so and, therefore, this testimony is not credited. OMIG properly relied on information provided

by the Appellant and Appellant's documentation does not justify the license plate reported on Appellant's claims for service in thirty-six instances.[4]

Appellant raised another new argument at hearing that similarly is not credited. Eric Bokman testified at hearing that Appellant used billing software called "Thoroughbred" to submit claims. (T. 243-244, 254-256, 258-267) He testified that the driver's name and vehicle number that were submitted on the claims was provided to him by the dispatcher as the service was being completed. In other words, the dispatcher would tell Mr. Bokman directly what vehicle and driver transported the patient as it occurred and the license number and plate number would be immediately input by him into the billing system.[5] (T. 294) This is essentially an admission that no contemporaneous record supporting the claim with respect to the vehicle used or the driver name was kept.[6] Essentially, Appellant's position was that the information it put

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[4] Indeed, in 114 of the claims in the sample, the information supplied by the Appellant did support the claim. If, as Appellant asserts, the numbers on the trip tickets and in the dispatch logs cannot be trusted, then the entire 150 claims should have been disallowed and extrapolated. (T. 49-50, 189, 191-192, 198)

[5] Mr. Bokman stated that he had memorized the appropriate vehicle plate and driver's license numbers for five to six drivers and five to six vehicles! (T. 331-333)

[6] When asked what the meaning was of the number in the driver's name field on the trip ticket, Mr. Bokman stated:

Q: Please turn to D6-72. Down at the line where it says, "driver's signature," is that a driver's signature?
A. No.
Q. Could you tell me what that is?
A. It's a number.
Q. What number would that be?
A. Twelve.
Q. Is that how your driver [signs] his name?
A. No.
Q. Then I ask you to turn to A38-8. Under the field that says, "Driver One." Have you a "12" there?
A. Correct.
Q. I think you testified that is for your driver of the last name [redacted]
A. Let me double check his license. That's correct.
Q. But there is a 12 next to the vehicle number too, is there not?
A. Correct.
Q. But that number 12 has nothing to do with the vehicle number?
A. Correct. It may.
Q. It may, under what circumstances?
A. It depends who is dispatching that day.
Q. How would you know whether it's referring to the driver number or a vehicle number?
A. Okay. So when we picked up M.G., my dispatcher tells me what driver is transporting her and in what vehicle. The numbers (on the trip tickets) for me never play a role. I do not need to know that. It doesn't do anything for our business.

into its claiming software was its record of what was done. (T. 275-281, 324-325) Medicaid regulations state in relevant part:

> By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . .

18 NYCRR § 504.3. If the information input into the claiming software was deemed to be an underlying contemporaneous record of the information supporting the claim, then audits would never find errors, because the claim submitted would always match the claim Medicaid has on file. (T. 326-329) There is no reason to consider this argument further, however, because it was not an argument raised at the time of the response to the DAR.[7] Nor was this argument raised when this category of claim was discussed earlier, in person, at the exit conference. (Ex. 8) The failure to mention this argument at any time prior to hearing, not only prevents the consideration of this argument on appeal, but also greatly diminishes any credibility to be attached to it.

Missing/Inaccurate Information on Medicaid Claim – Inaccurate Driver License Number (Exhibit 3, sub-exhibit III)

Appellant was required to provide an accurate driver's license number on the claim for each service provided. (T. 355-356; Ex. 3, sub-exhibit III) With respect to the disallowances under the category of inaccurate driver's license number, Appellant relied on the argument that he raised in the prior category, i.e. that his claim submission system

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Moreover, Medicaid MMIS Transportation Manual Policy Guidelines, Version 2004-1, states that the driver's name must be on the trip ticket. Had OMIG not accepted that the number represented the driver and vehicle, all 150 of the audit samples would have been excluded and extrapolated.

[7] The fact that Appellant submitted a screenshot of what he submitted to Medicaid on the claim without any argument does not mean this argument was raised at the time of the DAR.

was the underlying record of what was submitted on the claim.[8] (T. 387-388) Again, this was not an argument raised in response to the draft audit report and is, therefore, not an issue that may be considered on this appeal. More importantly, the claim submitted cannot meet Appellant's obligation "to maintain contemporaneous records demonstrating its right to receive payment." The claim submission software demonstrates nothing except what was submitted.

Finally, at no point during the "closing" conference or in response to the draft audit report, did Appellant give any indication of how the auditors could ascertain who the driver was for the services in question, despite, once again, the assertion of Appellant's lawyer that "our client can definitively determine which driver it was on each claim from the internally assigned driver number." (T. 52-53; Ex. 11; Ex. 19) Indeed, at times, Eric Bokman, Appellant's manager, seemed confused about how things worked, or seemed to pose theories in hopes that one might be accepted. He testified that the computer assigned number for a driver could never change; then he testified that the number could differ; then he testified that he could never change the number, but that he could change the license number associated with the number. (T. 264-266, 310, 340-341) The equivocation in his testimony made his testimony on all issues less credible.

Missing/Inaccurate Information on Medicaid Claim – Inaccurate Procedure Code (Exhibit 3, sub-exhibit IV)

Appellant did not challenge and conceded the findings that Appellant had employed an inaccurate procedure code with respect to four claims. (T. 392; Appellant's

[8] In 139 of the 150 claims in the sample, Appellant's trip tickets and dispatch log information supported the driver license number that Appellant submitted on its claims. (T. 356-359)

brief submitted 2/10/17, p. 8)

Driver Not NYS DMV 19-A Certified (Exhibit 3, sub-exhibit V)

The DMV requires that drivers must be certified pursuant to Article 19-A of the Vehicle and Traffic Law ("VTL") for the particular provider for whom the driver is working. (T. 394) It is unavailing that a driver might be 19-A certified for another company. (T. 404-416) VTL, Article 19-A, § 509-d details what a motor carrier "shall" - or must - do before employing a driver. This section requires the motor carrier to qualify its drivers pursuant to Article 19-A. This section does not permit a motor carrier to employ a driver it has not qualified. The motor carrier has additional responsibilities once it has qualified a driver and a carrier cannot comply with these requirements if a driver is not on its roster of employees.

The DMV is also required to inform the provider of changes in a driver's status, e.g., because of a revocation or suspension of license or of a conviction. The article clearly contemplates a continual updating and exchange of information between the carrier and the DMV. It is essential that a carrier's roster of drivers remains up-to-date and that only drivers 19-A qualified on the provider's current roster drive for the provider. VTL §§ 509-d, 509-e, 509-f, 509-g, 509-i, & 509-m.

Appellant's argument that a driver is certified for a two year period, and may drive while certified, is unavailing. Under the VTL, carriers, in this case ambulette service providers, are required to qualify each driver working for them pursuant to Article 19-A. A driver may be Article 19-A qualified to work for five carriers, but a sixth carrier my not employ that driver until that driver is qualified by the DMV to work for the sixth carrier. Also, a driver may lose his certification at any time because of a suspension or

revocation of a license, or because of a conviction. Appellant will not get notification of such actions unless the driver is on the Appellant's DMV roster of active employees. Appellant's reasoning that a driver is certified for a two year period and, therefore, may drive all through that period would defeat the intent of the statute to provide only safe, qualified drivers. (T. 237-242)

Missing/Incomplete Documentation - Missing Time of Service (Exhibit 3, sub-exhibit VI)

One claim in the sample of paid claims was identified as missing drop-off and pick-up times. Appellant's argument appears to be that all that was required to be recorded for this round trip was the time the patient was picked up for the first leg of the trip and the time the patient was dropped off for the second leg of the trip, as evidenced by the two trip tickets submitted in response to the DAR where one time was entered and circled on each of the two trip tickets. (Ex. 1, p. A3-313 to A3-314) This is not accurate.

MMIS Transportation Manual Policy Guidelines, Version 2004-1, states:

> Payment to a provider of ambultette services will only be made for services documented in contemporaneous records, typically referred to as "trip tickets." Documentation shall include the following:
>
> > Recipient's name and Medicaid identification number;
> >
> > Origination of the trip;
> >
> > Destination of the trip;
> >
> > Date and time of service; and,
> >
> > Name of the driver transporting the recipient.

MMIS Transportation Manual Policy Guidelines, Version 2009-3, p. 7, states:

> As there is no assumption of a round trip, a trip is considered to be one way. Therefore trip record documentation required in the MMIS Manuals prior, are required for each trip performed in a day.

The DOH Medicaid Update of August 2010 (effective 9/1/2010) made absolutely explicit that "time of pickup and time of drop-off are required."

In checking Appellant's compliance with this requirement, OMIG found one sample after September 1, 2010, where the Appellant did not record the time of drop-off for the first leg of the round trip and the time of pick-up for the second leg of the round trip. Curiously, the Appellant did recognize the trips as separate and recorded the trips on two separate trip tickets which reflected separate drivers for each leg. (Ex. 1, p. D6-1384 to D6-1386)

Appellant argued at hearing that this finding should not be extrapolated, but offered only argument on this issue. Because this issue was raised for the first time at hearing, and not in response to the DAR, it is not properly raised on this appeal. 18 NYCRR § 519.18. Further, if Appellant had raised a challenge to the statistical sampling methodology or the extrapolation in Appellant's response to the DAR, Appellant would have to introduce the evidence of an expert to explain why the sampling method or extrapolation was in error or introduce an accounting of all claims paid to demonstrate the alleged error. Appellant did not do so. Otherwise, a statistical sampling method certified as valid, as here, is presumed to be valid. (Ex. 17; Ex. 18) 18 NYCRR § 519.18.

OMIG identified one claim in the sample after September 1, 2010, where the time of drop-off and pick-up was not properly recorded on the trip tickets. OMIG did not charge the Appellant with any such errors prior to September 1, 2010. In the absence of

any evidence to the contrary, the disallowance was properly extrapolated over the universe of paid claims in the audit period.

CONCLUSION

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.[9]

The total dollar amount of the overpayments was $3,355.20. Of that $50.40 of the overpayments was not to be extrapolated. The total amount of the overpayments to be extrapolated was $3,304.80.

There were 150 claims in the audit sample. The overpayments to be extrapolated divided by the number of claims in the audit sample gives an overpayment of $22.032 per claim in the sample. The number of claims in the audit period was 50,041. When the number of claims in the audit period is multiplied by (extrapolated over) the sample overpayment ($22.032), the result is $1,102,503. OMIG added $50 to this amount for the dollar disallowance that was not extrapolated. The total overpayment is, therefore, $1,102,553. (Ex. 3, sub-exhibit I)

[9] OMIG made multiple findings (secondary and tertiary) with respect to many of the claims in this audit. (T. 459-462; Ex. 3, sub-exhibit VII) Secondary and tertiary findings were made because, if the primary reason for a claim disallowance was proven invalid at hearing, OMIG would then claim a disallowance for the second reason. Only one disallowance can be taken for a specific claim, but if a primary reason for a disallowance was refuted, then a secondary reason for disallowance could be considered to disallow the claim and, if a secondary reason for a disallowance was refuted, a third reason could be considered. Since

DECISION:

OMIG's determination to recover Medicaid overpayments in the amount of $1,102,553 is affirmed. This decision is made by Denise Lepicier, who has been designated to make such decisions.

DATED:
May 25, 2017
New York, New York

_____
Denise Lepicier
Administrative Law Judge

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this decision upholds the primary findings made, this decision does not consider the secondary and tertiary reasons for disallowance.