The State of New York Department of Health

IN THE MATTER OF THE REQUEST OF

Sigma Transportation, Inc.,
Appellant

Decision
Audit Number
2017Z31-212V

Provider ID # 01463363

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 (18 NYCRR) to review the Determination of the Office of the Medicaid Inspector General to recover $16,002.82 in Medicaid Overpayments.

Before: James F. Horan, Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, NY 10007
March 20, 2019

Parties: Office of the Medicaid Inspector General
Office of Counsel
800 North Pearl Street
Albany, NY 12204
BY: Phillip Hoffman, Esq. & Harry Glick, Esq.

Sigma Transportation, Inc.
244 Hempstead Turnpike
Hempstead, NY 11552
BY: Mandip Singh, Owner, Pro Se

Summary and Jurisdiction

In this matter pursuant to Title 18 NYCRR §519.4, the Office of the Medicaid Inspector General (OMIG) seeks to recover overpayments totaling $16,002.82, including interest, from a Medicaid Transportation Provider - following an audit. The OMIG issued a Final Audit Report (Final) alleging that the Appellant received Medicaid overpayments by billing Medicaid for transporting recipients during in-patient hospital stays and by billing for transports by persons with unqualified or disqualified drivers' licenses [Hearing Exhibit 2]. After a hearing on the charges, the ALJ sustains the findings in the Final and affirms the order that the Appellant repay $16,002.82 in overpayments and interest.

Background

In response to the Final, the Appellant requested the hearing that took place on March 20, 2019 [Hearing Exhibit 4] at 90 Church Street in New York, NY. The ALJ conducted the hearing pursuant to New York Social Services Law (SSL) Articles 1 and 5 (McKinney Supp. 2019), New York Public Health Law (PHL) Article 1 (McKinney Supp. 2019), New York State Administrative Procedure Act (SAPA) Articles 3-5 (McKinney 2015) and Title 18 NYCRR Parts 504, 517 & 519.

At hearing, the OMIG offered nineteen exhibits, which the ALJ received into evidence:

Exhibit 1 Draft Audit Report (Draft) dated February 1, 2018 with Attachments;

Exhibit 2	Final dated August 21, 2018 with Attachments;
Exhibit 3	Delivery Information;
Exhibit 4	Hearing Request;
Exhibit 5	Notice of Hearing with Delivery Information;
Exhibit 6	Notice of Pre-Hearing Conference with Delivery Information;
Exhibit 7	Audit Worksheet;
Exhibit 8	Email Correspondence;
Exhibit 9	Provider Response, DMV Letter, Drivers' Licenses;
Exhibit 10	LogistiCare Records;
Exhibit 11	Attachment I (6/26/18) With Notes and eMedNY Roster;
Exhibit 12	Recipient Report;
Exhibit 13	Notice of Proposes Agency Action (10/14/15);
Exhibit 14	Stipulation (12/15/15);
Exhibit 15	Deleted Claim (Finding I);
Exhibit 16	Deleted Claims (Finding II);
Exhibit 17	19A Bus Driver Search Results;
Exhibit 18	Authorities Cited;
Exhibit 19	Additional Documents Submitted by Provider.

The OMIG presented two witnesses, Christine Farrell of the OMIG Bureau of Business Intelligence and Emily Amiccuci from the OMIG Division of System Utilization Review. [redacted] spoke for the Appellant, but did not testify, and the Appellant called no witnesses. The Appellant offered three documents into evidence. The ALJ received into evidence a Spread Sheet [Exhibit A] and copies of four prior Medicaid provider decisions by Health Department ALJs [Exhibit C]. The ALJ rejected a document the Appellant pre-marked as Exhibit B and described as a "Data Dump". The document appeared to be just random symbols and [redacted] admitted that he himself could not decipher it (Transcript page 129). The record from the hearing also included a transcript that a stenographic reporter prepared (pages 1-146).

Under SAPA § 306(2), all evidence, including records and documents in an agency's possession of which an agency wishes to avail itself, shall be offered and made a part of the record of a hearing. Under Title 18 NYCRR § 519.18(f), computer generated documents prepared by the Department or its fiscal agent to show the nature and amounts

of payments made under the 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. In addition to testimony and documents in evidence, and pursuant to SAPA § 306(4), an ALJ may take Official Notice of any matter for which Judicial Notice may be taken.

Under SAPA § 306(1), the burden of proof in a hearing falls on the party which initiated the proceeding. Title 18 NYCRR § 519.18(d) provides that the Appellant bears the burden to show a determination of the Department was incorrect and that all claims submitted were due and payable. Title 18 NYCRR 519.18(h) and SAPA § 306(1) provide that a decision after hearing must be in accordance with substantial evidence. Substantial evidence means such relevant proof as a reasonable mind may accept as adequate to support conclusion or fact; less than preponderance of evidence, but more than mere surmise, conjecture or speculation and constituting a rational basis for decision, Stoker v. Tarantino, 101 A.D.2d 651, 475 N.Y.S.2d 562 (3rd Dept. 1984). Substantial evidence demands only that a given inference is reasonable and plausible, not necessarily the most probable, Ridge Road Fire Dept. v. Schiano, 16 N.Y.3d 494 (2011).

Findings of Fact

The ALJ made the following findings of fact (FF) after affording the parties an opportunity to be heard and after considering the evidence. The items in brackets that follow the findings represent documents in evidence [Ex], testimony from the record [T] and matters under Official Notice [ON] on which the ALJ relied in making the findings.

In instances in which conflicting evidence appears in the record, the ALJ considered and rejected that other evidence.

1 The New York State Department of Health (Department) is the single state agency responsible for administering the Medicaid Program in New York State [ON SSL § 363-a, PHL § 201.1(v)].

2 The OMIG is an independent office within the Department with the responsibility for investigating, detecting and preventing Medicaid fraud, waste and abuse and for recouping improper Medicaid payments [ON PHL § 30].

3 The OMIG conducted an audit on transportation claims the Appellant submitted for services from March 1, 2012 to December 31, 2015 [EX 2].

4 The Appellant billed Medicaid directly on numerous occasions for transportation of hospital in-patients [Ex 2].

5 Transportation costs for hospital in-patients are covered in the reimbursement rate to the in-patient hospital [Ex 18 Bates Stamp Page 302: DOH Medicaid Update October 2006 Vol 21, No. 10].

6 If the hospital sends a patient round trip to another facility for diagnostic or therapeutic services, the in-patient hospital is responsible to reimburse the transportation provider [Ex 18 Bates Stamp Page 302: DOH Medicaid Update October 2006 Vol 21, No. 10].

7 The Appellant should have billed the in-patient hospitals for the transportation costs rather than billing Medicaid directly [T 40].

8 The Appellant billed Medicaid inappropriately for these services resulting in a $1,643.34 Medicaid overpayment [Ex 2].

9 In order to receive payment for services provided to a Medicaid recipient, a Medicaid transportation provider must be lawfully authorized to provide such services [ON 18 NYCRR §505.10(e)(6)(ii)].

10 The provider's drivers must hold a special driver's license, on the date of service, issued pursuant to the standards at New York Vehicle and Traffic Law Article 19A [ON 18 NYCRR §505.10(e)(6)(ii)].

11 The eMedNY Transportation Manual Policy Guidelines require transportation providers billing for services to provide the driver's license number for the individual driving the vehicle and to provide the vehicle registration number for the vehicle that transports a Medicaid recipient [Ex 18 Bates Stamp Page 304-362: eMedNY Transportation Manual Policy Guidelines].

12 The Respondent submitted claims for numerous transportation services that contained driver's licenses disqualified on the date of service [Ex 2].

13 The Appellant billed Medicaid inappropriately for these services resulting in $12,056.14 in Medicaid overpayments [Ex 2].

Controlling Regulations and Statutes

Title 18 NYCRR § 518.1(c) defines overpayment as any amount not authorized to be paid under the Medicaid Program, whether paid as a result of improper claiming, unacceptable practices, fraud, abuse or mistake. Title 18 NYCRR § 504.3(h) states that a

provider agrees to provide true, accurate and complete information in relation to any claim. Title 18 NYCRR §504.3(i) provides that by enrolling, a provider agrees to comply with the rules, regulations and official directives of the Department. Title 18 NYCRR § 518.1(c) authorizes the OMIG to recover any overpayments that resulted from improper claiming or mistake. Title 18 NYCRR § 518.4 authorizes the OMIG to collect interest after determining an overpayment. Title 18 NYCRR § 519.4(a)(2) entitles a person to a hearing if an OMIG audit requires repayment or restitution of an overpayment.

Conclusions and Discussions

The Draft [Ex 1] identified the overpayment initially as $23,996.05, but the Final reduced that figure to $16,002.82 [Ex 2]. That figure represents $1,643.34 in overpayments in billings for transporting hospital inpatients, $12,056.14 in overpayments in billings for unqualified or disqualified license numbers and $2,303.34 in interest. The ALJ finds that the Appellant has failed to show that the OMIG Determination was incorrect and that all claims submitted were due and payable. Substantial evidence at the hearing showed that the Appellant submitted claims to Medicaid improperly for transportation services to hospital inpatients and submitted claims containing unqualified or disqualified driver's license numbers on dates of service.

Regarding the disallowance of the inpatient transportation claims, the Appellant argued that a provider never knows which patient is hospitalized and that the provider is not responsible to know if a patient is returning to a hospital or going home [T 122]. The ALJ finds that answer unconvincing. A transportation provider will know that they are

doing a possible hospital inpatient transport because the provider is picking up or dropping off a recipient at a building with a word or words such as "hospital" or "medical center" on the sign in front of the building. The provider knows at that point that the transport involves an inpatient and that the hospital or medical center may be the entity to bill, rather than Medicaid.

In answer to the disallowance for the unqualified/disqualified drivers, the Appellant argued that there are glitches in the system for transportation providers to report drivers' license information to Medicaid. The Appellant offered into evidence [Ex C] four decisions by Health Department ALJs in Medicaid transportation provider cases: Imi Transportation, Audit #11-1011 (Kimberly O'Brien ALJ); Statewide Ambulette Service, Inc., Audit #13-F-2317 (John Harris Terepka ALJ); Sunrise Handicap Transportation Co., Audit #2012Z31-011T (Kimberly O'Brien ALJ) and Christian Ambulette, Inc., Audit # 07-4175 (Larry G. Storch, ALJ). The Appellant argued that these four decisions support his claim that there are problems in the reporting system.

This ALJ reviewed the four decisions in evidence and found that only one, Imi Transportation, dealt with claim disallowances for unqualified/disqualified drivers' license numbers on the date of service. In that case, OMIG disallowed two transportation claims because the provider lacked 19-A documentation for the driver on the dates of service. Judge Kimberly O'Brien upheld the disallowances because the provider failed to provide proper documentation. This ALJ concludes that in none of the four prior decisions did the ALJ rule that the reporting system was inherently untrustworthy or unreliable. The Appellant has failed to show the OMIG was incorrect is disallowing the claims that contained unqualified/disqualified drivers' license information.

The Appellant argued that it was a small provider and that it should be offered an opportunity to correct any errors. The ALJ notes that the Appellant did receive an opportunity to correct errors when it filed a response to the Draft. Following the Appellant's response, the Final reduced the overpayment finding from $23,996.05 to $16,002.82. The reductions applied to both the billings for inpatient transportation and for disqualified/unqualified drivers' licenses.

The Appellant argued further that it is a small provider and suggested that the OMIG should seek to recover against the hospitals for payment for the transportation services to the hospital inpatients. The ALJ finds that suggestion inappropriate because there was no showing that any hospital received the inappropriate Medicaid payments for these transportation services. Seeking recovery from the hospitals would also leave the Appellant with the overpayments from the improper billings to Medicaid. The ALJ finds that the Appellant, who submitted the claims and received the inappropriate Medicaid payments, bears responsibility for repayment.

The Appellant also argued that there was no intent to commit fraud. The ALJ notes that there was no accusation in this case that the Appellant committed fraud. Further, the OMIG seeks only to recoup overpayments rather than to exclude the Appellant from the Medicaid Program or refer the Appellant for criminal prosecution, as would be the case if the case involved fraud allegations.

Finally, although the Appellant made reference to a stipulation agreement that supposedly relieved the Appellant of liability [T 122], the Appellant offered no stipulation agreement into evidence. The OMIG produced a stipulation that the Appellant entered into with the OMIG concerning Audit # 13-F-2610 [Ex 14]. The stipulation at

Exhibit 14 involved an audit for the period February 22, 2012 to July 2, 2013, concerning the Appellant's compliance with rules of the New York City Taxi and Limousine Commission [TLC Stipulation]. In the TLC Stipulation, the Appellant agreed to return $8,041.54 in overpayments. The OMIG counsel conceded at hearing that one overpayment claim at issue in the current hearing also related to the audit that resulted in the TLC Stipulation [T 119]. Counsel indicated the claim common to the two cases was removed from the overpayment amount in the Final. The ALJ finds that the TLC Stipulation relieved the Appellant from liability on the one common claim only.

Decision

The ALJ affirms the OMIG Determination to recover $16,002.82 including interest in Medicaid overpayments from the Appellant.

Administrative Law Judge James F. Horan renders this decision pursuant to the designation by the Commissioner of Health of the State of New York to render final decisions in hearings involving Medicaid provider audits.

Dated: July 3, 2019
Menands, New York

James F. Horan
Administrative Law Judge

To:

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