STATE OF NEW YORK: OFFICE OF THE MEDICAID INSPECTOR GENERAL

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IN THE MATTER OF THE REQUEST

OF **DECISION**

Christian Ambulette, Inc. **AFTER**
Audit #07-4175
Provider #01426484 **HEARING**

Appellant

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.

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Before:	Larry G. Storch Administrative Law Judge
Held at:	NYS Department of Health New York, New York March 15, 2012 March 16, 2012 April 12, 2012 June 20, 2012 June 21, 2012 June 22, 2012 August 16, 2012 Record Closed October 9, 2012
Parties:	NYS Office of the Medicaid Inspector General By: Francis Ruddy, Esq. Senior Attorney OMIG 217 Broadway, 9th Floor New York, New York 10007
	Christian Ambulette, Inc. By: Ruskin, Moscou Faltischek, P.C. East Tower - 15th Floor 1425 RXR Plaza

Uniondale, New York 11556-1425

William J. McDonald, Esq.

JURISDICTION

Christian Ambulette, Inc. (‘‘the Appellant’’) requested this hearing pursuant to Section 519.4 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (‘‘18 NYCRR’’) to appeal from a determination of the Office of the Medicaid Inspector General (‘‘the OMIG’’) to recover alleged overpayment of reimbursement by the Medical Assistance for Needy Persons Program (‘‘the Medicaid Program’’).

FINDINGS OF FACT, ANALYSIS AND CONCLUSIONS

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Administrative Law Judge in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

The OMIG’s audit of ambulette services provided by Appellant during the period of January 1, 2004 through December 31, 2005 resulted in a claimed overpayment of $2,154,065.00, plus interest. The Appellant has the burden of showing that the

OMIG's determination was incorrect. 18 NYCRR §519.18(d)(1). For the reasons set forth below, I conclude that the Appellant has sustained its burden of proof.

To begin with, this matter followed an unusually circuitous route to hearing. The Audit commenced with a Notice of Audit dated August 3, 2007. Following the entrance conference, OMIG's auditors visited the Appellant's business approximately nine times, and collected additional samples. Appellant cooperated fully with the audit. Upon receiving the Draft Audit Report, dated October 7, 2009, Appellant learned for the first time that OMIG had considered certain documentation missing. The Draft Audit Report revealed that the auditors rejected the manner in which Appellant documented time on its invoices, driver's logs, dispatch sheets and authorization forms. OMIG failed to award any credit for documenting time when the Appellant listed a particular service shift at a dialysis center to document time of service (all of the claims at issue involve transportation of Medicaid recipients to and from kidney dialysis programs). The Draft Audit Report claimed that Appellant received overpayments totaling $2,923,565 (the meanpoint estimate following extrapolation of sample overpayments of $6,649) for 87,940 services billed during the Audit Period.

On November 11, 2009, the Appellant submitted a timely response to the Draft Audit Report. (Exhibit #22). On April 14, 2010, OMIG issued a final Audit Report which demanded payment of

$1,975,129, representing the lower confidence limit of the alleged overpayments identified. The meanpoint estimate in this Final Audit Report was $2,227,960. (Exhibit #5).

Appellant made a timely demand for a hearing. Thereafter, OMIG learned that it had erred in its statistical certification of the sampling methodology and withdrew the initial Notice of Hearing. In December, 2010, OMIG revised the Final Audit Report. This hearing was scheduled to commence on March 15, 2012.

Immediately prior to the hearing's first day of testimony, OMIG revised its findings (again), which are set forth in a March 16, 2012 Final Audit Report (hereinafter, ''the Final Report''). (Exhibit #27). This constituted the third ''Final'' Report issued regarding the subject audit. This report reduced the OMIG's demands to two findings: 1) Missing/incomplete documentation (''Finding 1'') and 2) Incorrect Rate Code Billed (''Finding 2'').

Finding 1 alleged that in 109 instances pertaining to 86 recipients, time of service documentation was missing, resulting in a sample overpayment of $4,769.00. (Exhibit #27, Sec. II). In addition, this finding alleged 2 instances pertaining to 2 recipients, no documentation was presented, resulting in a sample overpayment of $112.00. (Exhibit #27, Sec. III). Finding 2 alleged that in 3 instances pertaining to 3 recipients, the lowest rate by the most direct route was not charged, resulting in a sample overpayment of $18.00. (Exhibit #27, Sec. V).

As detailed in ‘‘the Final Audit Report’’, OMIG now seeks an award of $2,154,065.81, which represents the meanpoint estimate. Although this estimate has been lowered for a third time, the lower confidence limit remained $1,975,129.00. OMIG also seeks interest payments from Appellant. (T. 10).

OMIG presented several witnesses. Robert Fishstein, the Director of Audits for the Office of Medicaid Provider Fraud and Abuse Investigations, a part of New York City’s Human Resources Administration (‘‘HRA’’). Mr. Fishstein has been the Director of Audits since May, 2009, and he explained how OMIG evaluated the Appellant’s time of service documentation. (T. 76).

Kevin Ryan is OMIG’s Director of Business Intelligence. He testified concerning the running of the random sample generator program for this audit. He testified regarding the nature of the two different certifications which he authored - the November 17, 2010 certification (Exhibit #16), and the November 17, 2011 certification (Exhibit #20).

Karl Heiner, Ph.D., testified regarding the statistical sampling methodology employed in this audit. (T. 406 *et seq*.). Timothy Perry-Coon, is employed by the New York State Department of Health, Office of Health Insurance Programs, Bureau of Administration, Transportation Policy Unit. Mr. Perry-Coon testified regarding the Medicaid regulations, guidelines and updates concerning transportation issues which are relevant to this proceeding.

Appellant presented two witnesses. Michael P. Salve, Ph.D. testified regarding the statistical sampling methodology used by OMIG. [redacted] is the dispatcher for Christian Ambulette, and he testified regarding the documentation used by the provider to demonstrate time and date of service.

There are two principal issues to be decided on this appeal. First, are the disallowances cited by the OMIG for failure to record time of service supported by the controlling regulation.[1] If this is answered in the affirmative, the second issue to be determined is whether the sampling methodology used by the OMIG is a statistically valid method for extrapolating the sample findings.

Mr. Fishstein acknowledged that Appellant maintained voluminous contemporaneous documentation of service provided to Medicaid recipients, including invoices, dispatch sheets, driver's logs, clinic letters, service requests and/or authorization forms. Ultimately, the auditors ignored the bulk of this documentation and only accepted claims where the pickup time for each leg of a round trip was recorded. (Exhibit #27).

The applicable regulation pertaining to payment of claims for ambulette services is found in 18 NYCRR §505.10(e)(8). This regulation states that ''Payment to a provider of ambulette services will only be made for services documented in

1 Appellant conceded that it could not contest the findings regarding two samples (#36 and #174). Therefore, these two disallowances shall be upheld.

contemporaneous records in accordance with section 504.3 of this Title. Documentation must include: (i) the recipient's name and MA identification number; (ii) the origination of the trip; (iii) the destination of the trip; (iv) the date and time of service; and (v) the name of the driver transporting the recipient''.

[redacted] Appellant's dispatcher, testified that he used contemporaneously prepared dispatch sheets to document the services provided. The scheduling information contained therein was provided by the dialysis centers, to indicate the dialysis shifts that the recipients were to attend. (T. 613-614). However, the auditors rejected any claims that did not specifically list a pick up and drop off time. I can find no support in the regulations or other interpretative guidelines to support the auditor's position.

Appellant introduced into evidence the June, 2003 Medicaid Update (Exhibit J) and an excerpt from the Version 2004 Transportation Manual Policy Guidelines (Exhibit I). Both of these documents address the requirements for reimbursement of ambulette services, and merely restate the language of 18 NYCRR §505.10 regarding the need to document the date and time of service. They do not set forth any specific requirements for how the information should be recorded, either in terms of hour and minute, or recording for each leg of a trip, or the type of form which must be used.

Nevertheless, the OMIG claims that these documents clearly

require that the Appellant needed to record a time of pick up and drop off for each leg of a trip by hour and minute. Respectfully, I disagree.

When pressed, Mr. Fishstein admitted that the regulations did not prohibit Appellant's timekeeping practice. (T. 328). However, he maintained that the shift of service had no relevance when determining time of service. (T. 329). Mr. Fishstein went so far as to claim that the need to write down the hour and minute was an ''inferred'' requirement. (T. 327). Simply put, there is no such thing as an inferred requirement. The state must clearly delineate the actions a regulated entity must take in order to be in compliance. Ambulette operators are not mind readers. They can only comply with those requirements which are published and available for review.

No evidence was presented that prior to the issuance of the draft audit report, Appellant or any other ambulette service had been held to the timekeeping requirements outlined by the auditors' report. The testimony of Mr. Perry-Coon was even more damning to the OMIG's position.

Mr. Perry-Coon admitted that ''Questions had been raised in the previous couple of years that what we had ***assumed*** was common sense - what we ***assumed*** would be reasonable and rational... we always ***assumed*** that was understood''. (T. 593). (Emphasis supplied). Clearly, it was **not** obvious to the ambulette industry that the OMIG had decided on a more restrictive

interpretation of the timekeeping requirements. In August, 2010 the OMIG issued a new Medicaid Update which for the first time, set out the necessity of recording the origination of the trip and time of pickup, as well as the destination of the trip and time of drop off for each leg of a trip. (Exhibit K). In addition, for the first time, the dispatch sheet was not allowed to serve as the only documentation of a trip. By implication, it would have sufficed for trips occurring before issuance of the August 2010 update. Most tellingly, the requirement for recording the time of drop off was effective September 1, 2010, nearly five years after the audit period at issue.

The testimony of the OMIG's own witnesses amply demonstrated that there was a lack of specificity in understanding the term ''time of service''. Mr. Perry-Coon defined time of service as the total time between when the enrollee was picked up and dropped off at the destination point. (T. 590). Mr. Fishstein defined time of service for the audit as time of pickup. (T. 302). Clearly, the term ''time of service'' is not as clear and unambiguous as the OMIG has asserted.[2]

The record-keeping requirements published by the OMIG in the August, 2010 Medicaid Update are a reasonable means of documenting provision of services for any time period after their

2 The time standard imposed by the Audit Report is further hampered by the fact that the billing codes audited, NY100 and NY102 are not dependent in any way upon the duration or time of service provided. They are distance-based codes based upon distance traveled for a round trip. They represent billing for travel of less than five miles or greater than 5 miles round trip. (T. 356).

publication. However, to essentially apply those requirements retroactively to services provided six years earlier would represent a gross overreach. Accordingly, I conclude that the OMIG determination to disallow the claims lacking documentation of time of pick up (with the exception of two claims which Appellant conceded have no supporting documentation) must be reversed.

Having decided that the disallowances are reversed, I do not need to reach the question of the validity of the OMIG's sampling methodology. The remaining two disallowed claims present too small of a sample for any meaningful analysis.

DECISION: The OMIG's determination to recover alleged overpayments in the amount $2,154,065.00, plus interest as set forth in Audit #07-4175 is reversed.

The disallowances for payments made regarding Sample#36 ($50.00) and Sample #174 ($6.00) are upheld.

This decision is made by Larry G. Storch, who has been designated by the Commissioner of Health of the New York State Department of Health to make such decisions.

Dated: Menands, New York
, 2013

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LARRY G. STORCH
ADMINISTRATIVE LAW JUDGE