STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **David M. Poole** Provider #01799068 Appellant, from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.	**Decision After Hearing** #2017Z31-038W

Before: John Harris Terepka
Administrative Law Judge

Held at: New York State Department of Health
By videoconference
November 4, 5, 6, 2020; January 5, 2021
Record closed March 1, 2021

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JURISDICTION

The Department of Health acts as the single state agency to supervise the administration of the Medicaid Program in New York. 42 USC 1396a, Public Health Law (PHL) 201(1)(v), Social Services Law (SSL) 363-a. The Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority to pursue administrative enforcement actions to recover improperly expended Medicaid funds. PHL 30, 31 and 32.

The OMIG determined to seek restitution of payments made under the Medicaid Program to David M. Poole (the Appellant). 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.

HEARING RECORD

OMIG witnesses:	Emily Amiccuci, OMIG management specialist 3 Christina Farrell Trimarchi, manager, Medicaid analytics & database support unit Rita Guido, CSRA provider services outreach manager
OMIG exhibits:	1, 3-11
Appellant witnesses:	David M. Poole
Appellant exhibits:	A-1 (includes A-G), H-M, Q-R

The hearing was held by videoconference. A transcript of the hearing was made. (Transcript, pages 1-569.) Each side submitted one post-hearing brief.

SUMMARY OF FACTS

1. David M. Poole, d/b/a F&T Transportation, operates an ambulette and transportation service in central New York, and is enrolled as a provider in the New York State Medicaid Program. The Appellant was enrolled both as an ambulette service (0602) provider and as a taxi service (0603) provider. (Exhibit 8; Transcript, page 40.)

2. The OMIG reviewed the Appellant's Medicaid claims for transportation services paid from January 1, 2012 through December 31, 2015. The Appellant's Medicaid claims were submitted electronically through the Department's eMedNY web-based electronic claiming system. (Transcript, pages 215-16.)

3. The OMIG issued a draft audit report dated December 19, 2017, which preliminarily identified $211,977.99 in Medicaid overpayments, plus accrued interest of $35,291.80, for a total overpayment of $247,269.79. (Exhibit 1.) The draft audit report advised the Appellant of findings in four categories:

1. Transportation billed fee-for-service during an inpatient stay. (No disallowance.)

   The OMIG alleged that "in numerous instances" the Appellant billed for transportation services provided to a hospital inpatient. The audit report did not identify any overpayments in connection with these services.

2. Transportation claims for ambulette services with unqualified/disqualified driver [sic] license for date of service. (Draft audit report attachment II, 60 payments: Disallowance of $3,492.50.)

   The draft audit report disallowed 60 payments in the amount of $3,492.50 on the grounds that "the driver's license was disqualified on the date of service."

3. Transportation claims for ambulette services with incorrect/missing driver's license for date of service. (Draft audit report attachment III, 2,717 payments: Disallowance of $208,058.49.)

   The draft audit report disallowed 2,717 payments in the amount of $208,058.49 on the grounds that "the driver's license number listed on the claim was incorrect or missing."

4. Transportation claims with incorrect/missing vehicle license plate for date of service. (Draft audit report attachment IV, 5 payments: Disallowance of $427.)

   The draft audit report disallowed 5 payments for ambulette services in the total amount of $427 on the grounds that "the vehicle plate number listed on the claim was incorrect or missing."

Pursuant to 18 NYCRR 515.6, the draft audit report offered the Appellant an opportunity to submit arguments and documents in response to the proposed audit findings.

4. On April 6, 2018, the Appellant submitted documents and a written response to the draft audit report. (Exhibits A-1, A-G.) The response included contemporaneous trip logs which identified the driver and license number, vehicle and plate number for nearly every disallowed payment in disallowance categories 2, 3 and 4 as follows:

> Finding 2: For 54 disallowed payments, the response acknowledged, and the trip logs showed, that the driver whose license number was reported on the electronic claim submission was not the driver who performed the service. (Exhibits B, C.)
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> Finding 3: The trip logs identified driver's license numbers for most of the 2,717 payments for which a license number was not reported on the claim submission. In 124 instances the response failed to identify a driver's license number and acknowledged overpayments in the total amount of $8,927.18. (Exhibits B, D.)
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> Finding 4: The trip logs identified vehicle license plate numbers for the 5 payments that had failed to include them on the claim submissions. (Exhibits B, E.)

5. By final audit report dated June 18, 2019, the OMIG notified the Appellant that it had determined to seek restitution of $139,562.15 in Medicaid overpayments, plus accrued interest. (Exhibit 4.)

> Finding 2: The final audit report disallowed 54 payments for ambulette services in the amount of $3,050.50 on the grounds that "the driver's license was disqualified on the date of service." (Exhibit 4, attachment II.)
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> Finding 3: The final audit report disallowed 1,742 payments for ambulette services in the amount of $136,084.65 on the grounds that "the driver's license number listed on the claim was incorrect or missing." (Exhibit 4, attachment III.)

Finding 4: The final audit report disallowed 5 payments for ambulette services in the amount of $427 on the grounds that "the vehicle plate number listed on the claim was incorrect or missing." (Exhibit 4, Attachment IV.)

6. Pursuant to 18 NYCRR 518.4(b), the OMIG added accrued interest from the date of each overpayment in the total amount of $21,846.02. (Exhibit 4, Bates pages 937, 1025, 1026.) The total audit overpayment, with interest, is $161,408.17. (Exhibit 4, Bates page 929.)

7. The vehicle driver reported on claims for the 54 disallowed payments in Finding 2 was not the driver who performed the claimed service. (Exhibits B, C.)

8. The Appellant's claims did not list "incorrect" driver's license numbers for the 1,742 payments disallowed in Finding 3, or "incorrect" vehicle license plate numbers for the 5 payments disallowed in Finding 4. In all of these instances, driver's license and plate numbers were missing from the claim submissions. (Transcript, pages 76-77, 209, 272.) The electronic claims that the Appellant submitted did have a field for reporting license and plate numbers, but the Appellant left the field blank on the claim submissions and the Medicaid Program paid them anyway.

ISSUES

Was the OMIG determination to recover Medicaid Program overpayments correct? If so, what is the amount of the overpayment?

APPLICABLE LAW

Medicaid providers are required, as a condition of their enrollment in the program, to prepare, maintain and furnish to the Department upon request, contemporaneous records demonstrating their right to receive payment from the Medicaid Program and fully disclosing the nature and extent of the care, services and supplies they

provide. The information provided in relation to any claim must be true, accurate and complete. All information regarding claims for payment is subject to audit for six years. 18 NYCRR 504.3(a)&(h), 504.8, 505.10(e)(8), 517.3(b), 540.7(a)(8).

When the Department has determined that claims for medical services have been submitted for which payment should not have been made, it may require repayment of the amount determined to have been overpaid. 18 NYCRR 504.8, 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).

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 519.18(d). Computer generated documents prepared by the Department or its fiscal agent to show the nature and amount of payments made under the Medicaid 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. 18 NYCRR 519.18(f).

In order to receive payment for an ambulette service, the provider's driver must be qualified under Article 19-A of the Vehicle and Traffic Law. 18 NYCRR 505.10(e)(6)(ii). A Department Medicaid Update of November 2004 (Vol.19, No.11) provides:

Ambulette Transportation Providers
Additional Information Required for Billing
Transportation providers billing for ambulette services… are now required to:
Include the **driver license number** of the individual driving the vehicle on their claim.
Include the **license plate number** of the vehicle used to transport the Medicaid client on their claim.
Providers should diligently update their billing systems to comply with this requirement.

Claim submission requirements set forth in the MMIS Transportation Manual Policy Guidelines also include:

Reporting of Vehicle and Driver License Numbers
On claims for which an ambulette vehicle was **used**, providers are required to include **both**:

- the driver license number of the individual driving the vehicle; and
- the license plate number of the vehicle used to transport the enrollee.

Department regulations specify the certification that a provider must make in connection with every Medicaid claim. Each claim shall contain:

> A dated certification by the provider that the care, services and supplies itemized have in fact been furnished;… that such records as are necessary to disclose fully the extent of the care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment unless otherwise required by regulation, and information will be furnished regarding any payment claimed therefor as the local social services agency or the State Department of Social Services may request; and that the provider understands… that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided… 18 NYCRR 540.7(a)(8).

Any claim returned to a provider due to data insufficiency or claiming errors may be resubmitted by the provider upon proper completion of the claim in accordance with the claims processing requirements of the department within 60 days of the date of the notification to the provider advising the provider of such insufficiency or invalidity. 18 NYCRR 540.6(a)(2).

DISCUSSION

This audit, which the OMIG calls a "system match and recovery" audit (OMIG brief, page 7), was an in-house claims review as is authorized by 18 NYCRR 517.2(b). It was conducted by a review of the Appellant's Medicaid claim submissions against other information available to the OMIG, such as Department of Motor Vehicle (DMV) records. The OMIG made disallowances solely because of the omission of driver's license and vehicle plate numbers from the electronic claim submission forms, or on discrepancies between the information on the claim forms and DMV records about licensure of the drivers. Before issuing the draft audit report, the OMIG did not ask for or review any records prepared and maintained by the Appellant to support the claims.

In response to the draft audit report, and as authorized by 18 NYCRR 517.5, the Appellant submitted information and documentation objecting to the findings. (Exhibits A-1, A-G; Exhibit 3.) After reviewing the objections, the OMIG eliminated many of the disallowances from its final audit report. (Exhibit 4, Bates page 918.) In six instances draft audit report disallowances were eliminated from the final report because the OMIG accepted what appeared to be the inadvertent typographical error of one misprinted digit on a reported license number. (Exhibit C; Transcript, pages 63-64, 103-104.) The OMIG did not explain, however, why the final audit report also eliminated nearly 1,000 other disallowances that had been made in the draft audit report, including 76 Finding 3 disallowances that the response to the draft had conceded as overpayments. (*compare* Exhibit 1, attachment III; Exhibit 4, attachment III; Exhibit D; Appellant brief, attachment.)

The pertinent facts established by the substantial and credible evidence are very simple: In Finding 2, the Appellant identified the wrong driver on its claims for 54 services. In response to the draft audit report, it submitted corrected license numbers and contemporaneous trip logs identifying the drivers who actually performed the claimed services. In Findings 3 and 4, the Appellant did not enter any license or plate numbers on claims for over 1,700 services, leaving that field on the claim submission form blank. Although Medicaid policy directives required this information to appear on ambulette claims, the Medicaid Program paid the claims without questioning them. The Appellant's trip logs, produced when the OMIG first advised the Appellant that the original claims were incomplete, provide, in most instances, contemporaneous documentation of the missing license and plate numbers.

According to the OMIG, "the focus of this audit is the information on the submitted claims." (Transcript, page 14.) Emily Amiccuci supervised this audit for the OMIG and signed the final audit report. (Transcript, pages 37, 49, 78.) She testified:

> These driver's log showed that – they supported that a service was performed. This audit was not about whether a service was performed. This was about the claims and whether they were billed appropriately. This does not show me that the information on these driver's logs was entered on the claim…
>
> They would've needed to show me that the information that is on these driver's logs was submitted to Medicaid on the claim form. We are strictly looking at the information that was put on the claim. (Transcript, pages 55-56.)

This restriction of the audit to a "system match" approach results in the OMIG's position that the Appellant's records produced in support of its claims are irrelevant to the audit findings if they provide any information not included in the original claim submissions. (OMIG brief, pages 20, 26-27.) According to Ms. Amiccuci:

Q: So what could they possibly produce that would change that finding?

A: The only thing would be as they could prove that they did put that information in there…

Q: Well, you have the claim… and you know it's not in there, right?... So there isn't anything that they could give you that could change your finding?

A: Correct. (Transcript, page 58.)

A "system match" review is an entirely appropriate and useful tool for the OMIG in reviewing Medicaid claims to detect possible or actual problems. Missing information, or a failure of a claim to match DMV or other records, is good reason to presumptively disallow it on audit. But as the Appellant points out, "The claim itself is not a contemporaneous record." (Transcript, page 31.) The OMIG has used missing information, which the Department also overlooked in processing the claims, to sort out claims for disallowance with no willingness to afford the Appellant an opportunity to demonstrate, by producing contemporaneous documentation, its entitlement to payment.

There is little to choose between the parties on this issue, the Appellant maintaining that it does not matter what is on a claim submission, the OMIG that all that matters is what is on the claim submission. This leaves the documentation, and the burden of proof, as the only bases on which to resolve the findings.

For most of the disallowances in this audit, the Appellant complied with the regulation applicable to claims for transportation services, which specifies that payment will only made for services documented in contemporaneous records. 18 NYCRR 505.10(e)(8). The Appellant also complied with the 18 NYCRR 540.7(a)(8) certification it was required to submit with every claim by producing for audit "such records as are necessary to disclose fully the extent of the care, services and supplies provided." That

certification submitted with each claim does not include, because the regulation does not require it to include, any representation conditioning payment upon error free claims submissions. The OMIG's attempt to construe the requirement to keep "all information regarding claims for payments" to be a "separate and broader requirement" to produce error free claims submissions on audit distorts the language of the regulation and is not persuasive. (OMIG brief, page 26.)

The OMIG is effectively taking the position that a provider can never be paid if it makes an error on an initial claim submission. Medicaid regulations entitle providers to correct and resubmit claiming errors when advised by the Department of them. 18 NYCRR 540.6(a)(2). In this case, it is unreasonable to deny the Appellant an opportunity to correct these claims: Because they were paid, it had no reason to be aware that there were omissions or errors to be corrected.

The audit findings.

Finding 1: Transportation billed fee-for-service during an inpatient stay. No disallowance.

The draft and final audit reports alleged that "in numerous instances" the Appellant billed for transportation services provided to a hospital inpatient. Transportation providers are expected to look to the hospital, not the Medicaid Program, for payment in such circumstances. 18 NYCRR 505.10(e)(9)(ii). The audit reports did not disallow any payments for these services, however, and this audit finding is not in dispute in this hearing.

Finding 2: Transportation claims for ambulette services with unqualified/disqualified driver [sic] license for date of service. (Audit report attachment II, 54 payments: Disallowance of $3,050.50.)

OMIG auditors determined from DMV records that the driver's license numbers reported on the claims for these 54 payments were for drivers not qualified under Article 19-A of the Vehicle & Traffic Law on the date of service, as required by 18 NYCRR 505.10(e)(6)(ii). To be eligible for Medicaid payment, the service must have been provided by a driver who was "connected" with the billing provider and on its Article 19-A roster on file with the DMV at the time of service.

The drivers identified in the Appellant's Medicaid claims as having performed the 54 services disallowed in the final audit report were [redacted], 48 services; and [redacted] 6 services. (Exhibit 4, Attachment II.) DMV records show that these drivers were at one time on the Appellant's Article 19-A roster but had been disconnected from the roster before the dates of the disallowed services. [redacted] was disconnected on [redacted] 2014, Devries on [redacted] 2013. (Exhibit 11; Exhibit J.) These 54 services for which they were reported to be the drivers were performed after their disconnection. (Exhibit 4, Bates pages 935-937.)

The Appellant does not dispute this evidence. The Appellant claims entitlement to these payments not because the drivers reported on the claims were qualified, but because other Article 19-A qualified drivers actually performed the services. According to Mr. Poole the Appellant "inadvertently" entered license numbers for drivers who had not performed the services, instead of the actual drivers. (Transcript, pages 385-86, 389, 495; Appellant brief, pages 15, 18.)

It is noted that this "system match" audit only identified these claims by chance. If the Appellant had reported the license numbers of 19-A qualified drivers on these claims, they would presumably have passed this audit with no problem even if the

reported driver had nothing to do with the provision of the services. This suggests that there are very likely many more instances among the thousands of services reviewed in this audit in which the Appellant submitted Medicaid claims that misrepresented the driver who performed the service. Such a practice presents obvious opportunities for fraudulent and abusive Medicaid billing, but that is not a concern that this "system match" audit could address.

In response to the draft audit report, the Appellant submitted trip logs documenting the actual drivers and their license numbers. (Exhibits B, C.) For the 54 remaining disallowed payments, these contemporaneous records documented that the services were actually provided by the following drivers:

[redacted]ott:	16 services
[redacted]:	17 services
D. Poole:	14 services
[redacted]:	6 services
(unidentified):	1 service

The Appellant claimed "every one of these drivers was Nineteen A – Nineteen A certified." (Transcript, pages 23-24, 413; Exhibit A-1, Bates page 5.) The Appellant met its burden of proving only one, [redacted] was Article 19-A qualified and connected with the Appellant on the dates the services in question were provided. [redacted] was on the Appellant's Article 19-A roster from [redacted] 2011 until [redacted], 2014. (Exhibit 11; Exhibit J, Bates page 760; Transcript, page 504.) The 17 services for which the Appellant's trip logs documented her as the actual driver were provided before her disconnection date.

For the unidentified driver, the service date was [redacted] 2013. (Exhibit 3, Bates page 934.) The driver reported on the Medicaid claim was [redacted] who was

discontinued [redacted], 2013. (Exhibit 11; Transcript, page 504.) The Appellant conceded the disallowance of $28.21 for this service. (Exhibit C, Bates page 533; Transcript, page 101.) The Appellant failed to document that the other three drivers, [redacted] Poole and [redacted] were qualified on its Article 19-A roster on the dates of the 36 services attributed to them.

Pointing out that these drivers appear on trip logs for services on other dates that were not disallowed in this audit does not meet the Appellant's burden of maintaining and producing for audit contemporaneous documentation that they were Article 19-A qualified for the services in question on the dates in question. (Transcript, pages 105, 397-400, 404-405, 511-12; Appellant brief, page 19.) The Appellant's complaint that it is now difficult to obtain documentation from the DMV or former employees (Exhibit R; Appellant brief, page 18) does not excuse its failure to prepare and maintain documentation of its entitlement to payment for claims it submitted, and to produce that documentation for audit. (Transcript, page 458-59, 462-63.) This is a problem it created for itself when it submitted inaccurate claims.

The Appellant claims:

> *Despite there being no mention in the Final Audit Report challenging the 19-A certification of Poole's drivers listed in the contemporaneous records*, at the hearing, OMIG counsel challenged, for the first time, the 19-A certification of some of the drivers. (Appellant brief, page 18.)

These assertions – made for the first time in the Appellant's post-hearing brief - are not accurate. Both the draft and final audit reports referenced and cited the Article 19-A requirements as a basis for these disallowances. (Exhibit 1, Bates page 8; Exhibit 4, Bates page 925.) The Appellant's own April 6, 2018 response to the draft audit report clearly demonstrates that it was well aware of this criticism, stating:

> The Agency contends that its drivers were properly qualified under the Vehicle and Traffic Law Article 19-A, and that none of its d[r]ivers for the trips listed on Attachment II were unqualified or disqualified, as of the date of service. (Exhibit A-1, Bates page 5.)

At no point did the OMIG, affirmatively or by omission, concede that the drivers identified in the response to the draft audit report were Article 19-A qualified.

Ms. Amiccuci was initially evasive on whether the auditors checked to see if the new drivers reported for these claims were Article 19-A qualified on the date of service. When pressed on the question, she resorted to saying it did not matter. (Transcript, pages 67-68.) She eventually admitted the auditors did not check, but the OMIG was not willing to concede they did not check. (Transcript, pages 115, 409.) Even if the auditors did check, it is plain that the OMIG sees no point in their doing so: [redacted] was, according to the OMIG's own evidence (Exhibit 11), on the Appellant's Article 19-A roster for the 17 services she is alleged in the response to the draft to have driven, yet the OMIG continues to stand by these disallowances.

At the hearing, the OMIG asserted for the first time that these payments were disallowed not just because the driver was not Article 19-A qualified; but also because the driver who performed the trip was not the driver identified on the claim. (Transcript, page 402.) Article 19-A qualification, however, was the only stated grounds for the disallowance in either the draft or final audit report. The OMIG did not respond to or address the evidence that the driver on the claim did not perform the service.

It is understandable that the draft audit report did not identify the second reason, because the OMIG only became aware of it on receipt of the response to the draft. This does not explain why, after receiving the Appellant's response to the draft advising and documenting that it was a different driver, the OMIG did not amend the findings to

advise the Appellant of the second reason. (Transcript, page 412.) Upon receiving the trip log information the OMIG did not make any meaningful use of it, instead reissuing the very same audit finding of "Unqualified/Disqualified Driver [sic] License" stating that "the driver's license was disqualified on the date of service," with no mention of the Appellant's admission that the driver it reported on the claim was not the driver who performed the service. At the hearing, Ms. Amiccuci dismissed this issue on the grounds "that is not a valid dispute." (Transcript, page 65.)

The Appellant submitted false claims by reporting on claim submissions, drivers who had not performed the services and who were not 19-A qualified. False statements and misrepresentations of material fact in claiming a Medicaid payment are an unacceptable practice in the Medicaid Program. 18 NYCRR 515.2(b)(2). The OMIG, however, did not allege this as a reason for disallowances, and even repeatedly pointed out that the disallowances are not based on unacceptable practices. (OMIG brief, pages 25, 28.)

The sole accusation in the final audit report is that the drivers were not qualified. The OMIG's own evidence shows this was not true for the 17 services provided by [redacted] (Exhibit 11.) The Appellant failed to document that the other drivers identified in the response to the draft audit report were qualified. The burden of proving they were qualified is on the Appellant, and it was not met.

The disallowances for 17 services for which [redacted] was the documented driver are reversed in the amount of $858.50, with interest in the amount of $118.50, for a total of $976.80, because the Appellant refuted the grounds for disallowance stated in the final audit report. The remaining 37 services are affirmed on the grounds stated in the final

audit report, because the Appellant failed to meet its burden of proving that the drivers it reported on these claims were Article 19-A qualified.

Finding 3: Transportation claims for ambulette services with incorrect/missing driver's license for date of service. (Audit report attachment III, 1,742 payments: Disallowance of $136,084.65.)

Finding 4: Transportation claims with incorrect/missing vehicle license plate for date of service. (Audit report attachment IV, 5 payments: Disallowance of $427.)

Findings 3 and 4 were made for essentially the same reason. According to the OMIG, the original claims for the payments disallowed in Finding 3 were all left blank in the field for designating a license number for a driver. (Transcript, pages 209, 272.) These claims apparently all also failed to include a vehicle license plate number but the OMIG did not make an adverse finding for this reason and so this omission is not at issue in this hearing. (Exhibit 4, Bates pages 938-1025; Transcript, pages 210-13.) The Finding 4 disallowances are for those five instances in which a driver's license number was provided but the vehicle license plate number was not. (Transcript, pages 76-77.)

The Appellant initially took the position it did enter license numbers on these claims and that the Department somehow "lost" them. (Exhibit A-1, Bates pages 13-15.) The OMIG's witnesses explained how the data in its electronic claiming system was accurately reflected in the claims information relied on for this audit. (Transcript, pages 215-18, 229-31, 310-14, 317-20; OMIG brief, pages 16-17.) The Appellant offered no persuasive reason to reject this evidence, and conceded it was unable to present any evidence to rebut the presumption of accuracy in the Department's payment records or to meet its 18 NYCRR 519.18(d)&(f) burden of proof. (Transcript, page 26; Appellant brief, pages 16-17.)

Providers are obligated to comply with Department policies and procedures regarding the submission of claims. 18 NYCRR 504.3(f)&(i). There is no regulation requiring license numbers on claim submissions for ambulette services, but Medicaid provider policy and claiming instructions require ambulette claims to include this information. Medicaid Update November 2004, vol.19 no.11; MMIS Transportation Manual Policy Guidelines, Section II, Ambulette Services. (Transcript, page 17.) The OMIG was correct in provisionally disallowing these payments in the draft audit report because no license numbers were reported on the claims.

In response to the draft audit report the Appellant did provide and document the license number of the driver and vehicle used for most of these services. (Exhibit B.) The Appellant was unable to document driver's license numbers for 124 payments totaling $8,927.18. The final audit report disallowed 48 of those payments totaling $2,982.93. (Exhibit D; Appellant brief, attachment.) Those 48 disallowed and conceded overpayments are affirmed. The remaining payments disallowed in Findings 3 and 4, however, were supported by contemporaneous documentation of the driver's license and plate numbers.

The OMIG's position is that it does not matter that the Appellant produced and documented license and plate numbers because those numbers were not entered onto the claim submissions. (Transcript, pages 56, 58, 77; OMIG brief, page 20.) The Medicaid Program, however, also ignored the claiming requirements by paying claims for ambulette services that were submitted without license and plate numbers. The Department could have identified and rejected these claims when they were originally submitted. 18 NYCRR 504.8(c). There was evidence that it had the ability to do so, by

means of an "edit" in its claim processing system that can reject claims that do not include a driver's license number in the correct format. The OMIG acknowledges that this "edit" would automatically reject such claims when the provider was an ambulette (0602) provider only. However, for reasons it did not explain, this edit apparently did not always apply for providers such as the Appellant who were enrolled to bill for both ambulette (0602) and taxi (0603) services. (Transcript, pages 87, 127-29, 239-40, 262-64, 269-70, 296; OMIG brief, pages 22-23.) These claims were submitted for ambulette, not taxi services, but the Department paid them without advising the Appellant at the time that there was anything wrong with them.

The Appellant's suggestion that the OMIG created a "trap" for providers by an inconsistent use of edits in its electronic claims processing system is rejected. (Appellant brief, pages 12-15.) The existence or functioning of "edits" is irrelevant to the Appellant's obligation to demonstrate its entitlement to payment. The Medicaid Program is not required to have them in place, or if it does, to use them consistently, nor is the Medicaid Program obligated to advise providers which edits are in place. The OMIG is entitled to use them as a screening or investigative tool as it deems appropriate. Providers are not entitled to rely on edits to protect them from their own claiming errors and omissions, nor are they entitled to be advised of them so that they can devise their claims to circumvent them.

But neither is an "edit," or a "data match" finding, a substitute for a proper audit if it ignores issues that can be addressed by the provider's contemporaneous documentation of entitlement to payment. The absence of a required license number is clearly an error that would have justified rejection of these claims. Had the Department denied them, the

Appellant would have known there was a problem and could have corrected and resubmitted them. (Transcript, pages 527-28, 533-36.) The Appellant had no reason to be aware of or correct the errors before the audit was conducted, because the Medicaid Program paid the claims.

Because this was a "system match" audit, the first opportunity the Appellant had to submit its documentation in support of its claims was in the response to the draft audit report. In compliance with its 18 NYCRR 540.7 certification and with the specific regulation applicable to transportation claims, 18 NYCRR 505.10(e), contemporaneous documentation of driver and vehicle license numbers was maintained and was produced in that response when the claims were first questioned.

In taking the position in this audit that an error or omission on a claim submission form cannot be corrected under these circumstances, the OMIG is confusing documentation in support of a claim, which is what Department regulations at 18 NYCRR 504.3(a), 505.10(e) and 540.7(a)(8) required this provider to create and maintain, with the claim submission itself. To the extent that the Appellant did maintain and was able to produce for audit appropriate contemporaneous documentation demonstrating its entitlement to payment as required by 18 NYCRR 504.3(a), 505.10(e) and 540.7(a)(8), the OMIG's disallowances are not reasonable and are not upheld.

Previous Department administrative hearing decisions have addressed the OMIG's use of in-house "system match" audits to disallow paid claims solely because of errors on the claim submissions and refusing to consider the provider's contemporaneous documentation - if a provider can and does produce it - to demonstrate entitlement to payment. These decisions are all consistent with the analysis herein: LIN-WIL

Transportation, Inc. (#10-1469, July 16, 2013); M.J. Trans. Corp. (#2012Z31-093T, January 27, 2015); Sunrise Handicap Transport Co. (#2012Z31-011T, August 28, 2015); Statewide Ambulette Service, Inc. (#13-F-2317, October 28, 2015); Allcare Transportation, Inc. (#2017Z31-199W, March 5, 2019); Chelsea Express Transportation, Inc. (#11-5528, May 24, 2019); Kiddin' Around Town, Inc. (#2017Z31-106V, November 19, 2020).

These decisions do not hold that the Department cannot properly deny a claim because of errors on the claim submission. 18 NYCRR 504.8(c). However, on an audit performed long after a claim was paid and long after the 18 NYCRR 540.6 time limits for correction have passed, it is unreasonable to demand restitution where no attempt to take advantage of the Medicaid Program is apparent and the provider demonstrates on audit that it is able to fully comply with the requirement to prepare, maintain and produce contemporaneous documentation demonstrating its entitlement to payment.

The Medicaid Program involves thousands of providers, millions of claims, and billions of dollars in public expenditures. It entirely appropriate to demand strict compliance with documentation requirements from providers who choose to enroll in and bill the program. Proving a service was provided does not excuse a failure to prepare and maintain the required contemporaneous documentation of the service. Disallowances are not reversed in this decision because the services were in fact provided and billed "in good faith" or because the Medicaid Program documentation requirements are unreasonably burdensome. The pertinent issue is not that there was "no harm to the Medicaid Program or its recipients" or that these were "inadvertent" or "technical" errors. (Exhibit A-1, page 11; Appellant brief, pages 2, 20.) The disallowances are reversed

because the Appellant met its burden of timely producing contemporaneous documentation to justify the claims upon being made aware of the need to do so.

DECISION: The OMIG's determination to recover Medicaid Program overpayments is affirmed, with the following reductions in the overpayment amounts:

1. Of the 54 payments disallowed in Finding 2, 17 disallowances in the amount of $858.50, with interest in the amount of $118.50, are reversed in the total amount of $976.80.

2. The 1,742 disallowances in Finding 3 are reversed, with the exception of 48 payments in the total amount, with interest, of $2,982.93, as is detailed in Exhibit D. Disallowances in the total amount, with interest, of $154,464.25 are reversed.

3. The 5 disallowances in Finding 4, in the amount of $427, with interest in the amount of $64.97, are reversed in the total amount of $491.97.

The overpayment in the final audit report, in the total amount of $161,408.17 inclusive of interest, is reduced to $5,475.15 inclusive of interest.

This decision is made by John Harris Terepka, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Rochester, New York
March 8, 2021

John Harris Terepka
Administrative Law Judge