State of New York : Department of Health

In the Matter of the Request of

Mahmoud Alam, R.Ph.
Essex Street Corp.
Medicaid ID #: [redacted]
Appellant,

Decision After Hearing

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 Department to recover $3,304.29 in Medicaid overpayments

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Before: James F. Horan, Administrative Law Judge

Held at: New York State Department of Health
Metropolitan Area Regional Office
90 Church Street
New York, NY 10007
March 23, 2011

Parties: Office of the Medicaid Inspector General
Office of Counsel
217 Broadway, 8th Floor
New York, NY 10007
BY: Ferlande Milord, Esq.

Essex Street Corp.
436 Rockaway Avenue
Brooklyn, NY 11212
BY: Jawaid Minhas, R. Ph.
Supervising Pharmacist

Summary and Jurisdiction

Essex Street Corp. (Appellant) requested a hearing pursuant to Title 18 NYCRR §519.4 to appeal a determination by the Office of the Medicaid Inspector General (OMIG) seeking repayment from the Appellant for overpayments totaling $3,304.29. The OMIG moved to obtain repayment following an audit pursuant to Title 18 §§ 504.3(e), 504.3(h), 504.3(i) & 518.1(c) on the grounds that the Appellant filled prescriptions by mistake or for medically unnecessary services for Medicaid recipients who were deceased at the time the Appellant filled the prescriptions. The Appellant argued that it filled the prescriptions in good faith because the Appellant received no notice from the Medicaid Program that the recipients had died. After a hearing in this matter and after reviewing the evidence and argument that the parties provided, the ALJ determines that the OMIG acted correctly in moving to recover overpayments.

Proceedings and Evidence

The ALJ conducted the hearing in this matter pursuant to New York Social Services Law Articles 1 and 5 (McKinney Supp. 2011), New York Public Health Law (PHL) Article 1 (McKinney Supp. 2011), New York Administrative Procedure Act (SAPA) Articles 3-5 (McKinney 2011) and Title 18 NYCRR Parts 504, 518 & 519. The OMIG presented one witness at the hearing: OMIG Associate Medical Facilities Auditor Sandra Noonan [Hearing Transcript pages 21-85]. The OMIG introduced eleven documents into evidence that the ALJ received into the record:

1 Collection Letter,
2 Response,
3 Draft Audit Report,
4 Second Response,
5 Final Audit Report,
6 Revised Audit Report,
7 Notice of Hearing,
8 Information relating to Recipient MZ,
9 Information relating to Recipient LR,
10 Information relating to Recipient NF,
11 Information relating to Recipient AF.

The Appellant conceded that Exhibits 2 and 4 were responses to the Audit Reports, which the Appellant provided [Hearing Transcript page 15]. The Appellant submitted one document that the ALJ received into the record:

A Prescription Information.

The record also contained the hearing transcript, pages 1-90.

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), appeal dismissed 63 N.Y.2d 649.

Findings of Fact

The ALJ made the following findings of fact 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 Appellant Pharmacy is a participating pharmacy provider under the Medicaid Program, Provider ID # [redacted] [Ex 1].

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

3. 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].

4. The OMIG conducted an audit concerning the Appellant's billings to the Medicaid Program over the period October 1, 2001 through December 31, 2006 and determined that the Appellant billed the Program for pharmacy services that the Appellant provided to recipients after the recipients died [Ex 1; T 23].

5. The Appellant filled a prescription for medication for Recipient on March 6, 2005 for which the Appellant billed Medicaid $74.47 [Ex A, Ex 1].

6. Recipient died on February 20, 2005 [Ex A, Ex 8].

7. The Appellant filled prescriptions for medication for Recipient on February 11 and March 2, 2005 for which the Appellant billed Medicaid $688.56 [Ex A, Ex 1].

8. Recipient died on January 28, 2005 [Ex A, Ex 9; T 42, 46].

9. The Appellant filled prescriptions for medication for Recipient on September 25 and 26, 2004 for which the Appellant billed Medicaid $2,325.00 [Ex A, Ex 1].

10. Recipient died on August 21, 2004 [Ex A, Ex 10; T 47].

11. The Appellant filled prescriptions for medication for Recipient on October 6, 2004 for which the Appellant billed Medicaid $216.26 [Ex A, Ex 1].

12. Recipient died on September 26, 2004 [Ex A, Ex 11; T 56-57].

Issue

Did the Appellant receive $3,304.29 in overpayments from the Medicaid Program and is the OMIG entitled to recover that sum from the Appellant?

Discussion and Conclusions

Title 18 NYCRR § 518.1(c) defines overpayment as any amount not authorized to be paid under the medical assistance program, whether paid as a result of improper claiming, unacceptable practices, fraud, abuse or mistake. Under Title 18 NYCRR §504.3(e), by enrolling in the Medicaid Program, a provider agrees to submit claims for payment only for services actually furnished and which are medically necessary or otherwise authorized. 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. The DOH Medicaid Update for November 2003, Vol . 18, No. 11 and the DOH Medicaid Update for January 2004, Vol. 19, No. 1 both prohibit automatic prescription refills or orders for prescription drugs.

The closing statement by the OMIG hearing counsel stated that there was no factual dispute between the parties [T 85]. Although the parties agreed on many factual issues, the Appellant did challenge whether the OMIG introduced sufficient evidence to prove the deaths of Recipients ███, ███ and ███, because there was no confirmation from

the Office of Vital Records concerning the deaths. The Appellant also questioned why it took three years to determine that the four recipients at issue had died. Further, the Appellant pointed out that the OMIG audit letters were addressed to Mahmoud Alam, a pharmacist at the Appellant pharmacy, but not an owner or a supervising pharmacist at the Appellant pharmacy. The parties did agree that the Appellant filled the prescriptions and received payment for the filling the prescriptions at issue and that the Electronic Medicaid Eligibility Verification System (EMEVS) listed the Recipients as eligible at the time the Appellant filled the prescriptions and billed Medicaid. The OMIG did not contest the Appellant's assertion that the pharmacy filled the prescriptions in good faith. The main conflict between the parties involved whether prescribing and billing in good faith constitutes a defense to this action to recoup an overpayment. The Appellant asked what it can differently to avoid a hearing to recoup an overpayment in the future.

The ALJ concludes that the Appellant received legally sufficient notice concerning the issues in the hearing and the Appellant received the opportunity to present a defense to the action to recoup payment. In questioning the OMIG witness, Ms. Noonan, the Appellant's Representative asked why the correspondence from OMIG was addressed to Alam Mahmood, R. Ph., a manager and part-time pharmacist at the Appellant, but not an owner or supervisor. The Appellant asked Ms. Noonan if OMIG had a list of owners or officers of the Appellant. Ms Noonan answered that the OMIG addressed correspondence to Mr. Mahmood after the initial collection notice [Ex 1] because Mr. Mahmood submitted written answers to the collection notice and later correspondence [Exs. 2 and 4]. The ALJ then asked if the Appellant was taking the position that Mr. Mahmood was not authorized to speak for the Appellant and the

Appellant's Representative indicated that Mr. Mahmood was not so authorized [T 61]. The ALJ treated that statement as a challenge by the Appellant to notice about the issues in the hearing. The ALJ rejected that contention by the Appellant. The ALJ noted that the OMIG introduced into evidence Exhibits 2 and 4, which the OMIG described as replies by the Appellant to collection letters from OMIG. Mr. Mahmood signed those letters. At the time the OMIG introduced those Exhibits, the ALJ asked the Appellant's Representative whether Exhibits 2 and 4 were from the Appellant and the Representative indicated that the Exhibits were from the Appellant [T 14-15]. The ALJ also notes that Exhibits 2 and 4 presented the argument that the Appellant filled the prescriptions at issue in good faith, because EMEVS indicated that the Recipients named on the prescriptions remained Medicaid eligible. The Appellant continued to raise that same good faith defense at the hearing.

The ALJ concludes that the OMIG presented substantial evidence to prove that Recipients ██, ██ and ██ had died by the times the Appellant filled the prescriptions at issue for those recipients. Exhibit 9 indicated that Recipient ██ was a patient at Mary Immaculate Hospital from January 23, 2005 to January 28, 2005. Exhibit 10 indicated that Recipient ██ was a patient at Brookdale Hospital Medical Center (Brookdale) from August 20, 2004 to August 21, 2004. Exhibit 11 indicated that Recipient ██ was a patient at Brookdale from September 25, 2004 to September 26, 2004. All three Exhibits contained the discharge codes "20" and "42" under the title "Status". Ms. Noonan testified that the discharge codes "20" and "42" meant that the Recipients died [T 42, 47]. The Appellant introduced no evidence to contradict Ms. Noonan's testimony concerning the meaning of the codes. The Appellant did argue that a prescription was issued for

Patient ███ for Tylenol # 3 on September 25, 2004, four weeks after August 21, 2004, the date on which Exhibit 10 indicated that Recipient ███ died. The Appellant argued that the prescription for September 25th must mean that the prescribing physician saw the Recipient alive on September 25th. The Appellant presented nothing from the prescribing physician, however, such as testimony or a written statement, to indicate that the prescribing physician saw the Recipient alive on the 25th. The ALJ notes that there was no indication of any further hospital stay for Recipient ███ after August 21, 2004. The ALJ finds the testimony by Ms. Noonan more convincing evidence on the issue than the existence of the prescription for September 25th.

In response to the Appellant's question as to why it took the OMIG three years to determine that the Recipients had died, Ms. Noonan testified that it not necessarily take that long to determine that the Recipients died [T 35]. Ms. Noonan indicated that OMIG has six years to audit Medicaid claims and that the audit in this case spanned the years 2001 to 2006. Ms. Noonan indicated that the timing of the 2007 repayment demand reflected when the audit occurred rather than the death and that a claim may already be six years old when the OMIG audits the claim.

The ALJ accepts the Appellant's explanation that the Appellant filled the prescriptions in this case in good faith, but the ALJ concludes that the OMIG may recoup $ 3,304.29 in Medicaid overpayments from the Appellant because the prescriptions were not medically necessary and the prescriptions did not go to the intended recipients. Recipients ███, ███, ███ and ███ were dead on the dates the Appellant filled the prescriptions. Ms. Noonan testified that eligibility information in EMEVS and payment on claims are not final eligibility determinations [T 36]. Medicaid claims require

satisfaction of all sorts of tests and the audit makes the final determination on whether a claim meets all the tests. If Medicaid waited to pay until after an audit, pharmacies and other providers would be unable to stay in business [T 60, 66]. Medicaid pays and then audits, in much the same way that the United States Internal Revenue Service may issue a tax refund, but later audit a tax return [T 60].

In two previous Medicaid hearing cases concerning recouping overpayments from provider pharmacies, the pharmacies raised acting in good faith as a defense to a demand to recoup overpayments. In both cases the defense failed. In *Peter Della Mura and Circle Pharmacy, Inc., FH# 1999000K, 1995,*[1] the former Department of Social Services sought to recoup overpayments for fraudulent prescriptions and to disqualify a pharmacy from the Medicaid Program for filling the prescriptions. In that case, physicians whose names appeared on prescriptions denied writing the prescriptions. In *Saifal Kibria and Bathgate Prescription Center, Inc., 1999,* the Department of Health sought to recoup payments and exclude from Medicaid a pharmacy that filled fraudulent prescriptions. In *Kibria* as in *Della Mura,* physicians named on the prescriptions denied writing the prescriptions. In both cases following hearing, the ALJs who conducted the hearings found the prescriptions fraudulent, but also found that the pharmacies acted in good faith in filling the prescriptions because the pharmacies had no way of knowing about the fraud. The ALJs accepted acting in good faith as a defense to the request to exclude the pharmacies from the Medicaid Program and the ALJs refused to exclude the pharmacies. The ALJs rejected acting in good faith, however, as a defense to recouping the overpayments. In both cases, the ALJs ruled that recouping the overpayment was correct because payment

[1] Copies of both prior cases are available on request from the Bureau of Adjudication.

on the prescriptions should never have been made[2]. In the Appellant's case, Medicaid should never have made payments on prescriptions for deceased recipients.

The Appellant asked repeatedly at hearing what the Appellant had done wrong and what the Appellant could do to avoid being in this situation in the future. This ALJ notes first that the OMIG made no accusation about wrongdoing against the Appellant. There was no request in this hearing to exclude the Appellant from Medicaid as there were in the *Kibria* and *Della Mura* cases and there were no professional disciplinary actions against the pharmacists involved. The OMIG sought repayment only. The Appellant filled the prescriptions at issue because the Appellant allows persons other than those named on a prescription, such as spouses or family members, to pick up prescriptions. If the Appellant stops allowing others to pick up prescriptions, it would avoid a situation such as this, but that change would also cause inconvenience for a great number of people who must count on help from others in picking up prescriptions. If the Appellant continues to allow people to pick up other people's prescriptions, the possibility will remain that the Appellant could fill other prescriptions for unnecessary services. Ms. Noonan testified that, in this case, if the Appellant provided information to the OMIG immediately after receiving the Audit Report, concerning the people who picked up the prescriptions at issue, the OMIG could have pursued such people for repayment rather than the Appellant [T 72]. The collection letters from the OMIG to the Appellant advised the Appellant to submit to the OMIG documentation supporting the Appellant's position within 30 days from receiving the OMIG draft audit report [Ex 3]. The Appellant failed to provide any information in a timely manner and instead

[2] Department of Social Services ALJ Reginald Brantley made the ruling in the *Della Mura* case and Department of Health ALJ Ralph Erbaio made the ruling in the *Kibria* case.

submitted documentation at the pre-hearing conference in the weeks just before the hearing [T 69, 79-83]. By that time the Audit Report in this matter was final.

Decision

The ALJ finds correct the decision by the OMIG to recover $3,304.29 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.

April 29, 2011
Troy, NY

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James F. Horan
Administrative Law Judge