**STATE OF NEW YORK**
**DEPARTMENT OF HEALTH**

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| In the Matter of the Request of<br><br>**RITE AID OF NEW YORK, INC.,**<br>**Pharmacy Store # 10824,**<br>**formerly doing business as**<br>**ECKERD CORPORATION,**<br>**Pharmacy Store # 5021,**<br>Medicaid ID # 01819089<br><br>for a hearing pursuant to 18 NYCRR Part 519 to review a determination to recover Medicaid overpayments. | **Decision After Hearing**<br><br>Audit #08-1017 |

Before: Denise Lepicier
Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, New York 10007

Dates of Hearing: June 6th and 7th and July 17th of 2013, and April 23, 2014

Parties: New York State Office of the Medicaid Inspector General
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## 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, unacceptable practices, mistake or improper claiming in the Medicaid program, and to recover improperly expended Medicaid funds.

The OMIG determined to seek restitution of payments made by Medicaid to Eckerd Corporation, store #5021, now doing business as Rite Aid of New York, Inc., store #10824 (Appellant). (Ex. 2) 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. (Ex.9)[1]

## 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 for six years, 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).

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[1] Numbers in parentheses refer to transcript page numbers or exhibits. Transcript references will be cited as a "T." followed by the appropriate page number(s); exhibits will be cited by an "Ex." followed by the appropriate exhibit number(s) or letter(s).

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).

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). 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 contrary, to be an accurate determination of the total overpayments made.

DSS regulations generally pertinent to this hearing decision are at: 18 NYCRR § 360-7 (payment for services), 18 NYCRR § 505 (medical care, in particular § 505.3 regarding drugs), 18 NYCRR § 517 (provider audits), 18 NYCRR § 518 (recovery and withholding of payments or overpayments), and 18 NYCRR § 519 (provider hearings).

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 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).

## ISSUE

Is the OMIG's determination to recover Medicaid overpayments in the amount of $165,258.28 from the Appellant correct?

## FINDINGS OF FACT

1. At all times relevant hereto, Appellant Rite Aid store #10824, formerly operating as Eckerd store #5021, was enrolled as a pharmacy provider in the New York State Medicaid program. (Ex. 7, p.2)

2. The Appellant submitted claims to Medicaid for pharmacy services that were paid by Medicaid during the period January 1, 2004 through December 31, 2005 for patients who were eligible for coverage under the Medicaid program. This was the review period or audit period for the audit in this case. (T. 124; Ex. 7, p.2 )

3. The OMIG conducted a review of the Medicaid claim records submitted by the Appellant along with a review of the pharmacy's records. The purpose of the review was to determine whether the claims for payment were submitted in compliance with Medicaid program requirements. (Ex. 7, p. 2 ) The review was conducted on a random sample of 200 of the 119,657 claims paid by Medicaid in the audit period. (Ex. 7, p. 2)

4. The total amount the Appellant was paid for the 119,657 claims (the universe of paid claims) by Medicaid was $7,353,205.67. (T. 125-126; Ex. 3; Ex. 7, p. 2)

5. Of the 200 claims in the audit sample, the OMIG found that in 62 instances the ordering prescriber "conflicted" with the prescriber submitted on the Medicaid claim. In one additional case, Appellant did not produce a prescription or fiscal order to support the claim. (T. 133; Ex. 2, ex. II & III)

6. By draft audit report dated October 30, 2008, the OMIG notified the Appellant that the OMIG had identified overpayments in the amount of $192,193, when the overpayments identified in the audit were extrapolated over the entire universe of paid claims in the audit period. (Ex. 5, ex. 1)

7. Appellant submitted a response dated December 18, 2008 to the draft audit report. (Ex. 6)

8. After considering Appellant's arguments in its response, by final audit report dated April 23, 2009, the OMIG notified the Appellant that the OMIG had revised its findings in the draft audit report and had identified and determined to seek restitution of Medicaid overpayments, extrapolated over the entire universe of paid claims in the audit period, in the amount of $175,142. (T. 139-142, 152-153; Ex. 7, p. 4)

9. Just prior to the hearing and after the pre-hearing conference in this matter, at the behest of the OMIG attorney handling the case, the OMIG withdrew the disallowances for sample numbers 81, 101 and 124, and modified the amount disallowed downward with respect to sample numbers 9, 56, 82 and 140, resulting in an overpayment amount, extrapolated over the entire universe of paid claims in the audit period, of $165,258.28, which is the amount claimed by the OMIG as the overpayment in issue in this hearing.[2] (T. 142-143, 146-149, 751-753; Ex. 27 & 29)

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[2] The sample numbers were assigned to claims by the OMIG auditors.

10. In fifty-nine claims of the 200 paid claims in the audit sample, the ordering prescriber and the prescriber Appellant submitted on its claim to Medicaid were different ("conflicted"). (T. 151-152; Ex. 27, ex. II) Fifty-three claims named Buffalo General Hospital as the prescriber where neither the prescriber, nor the facility listed on the prescription, was Buffalo General Hospital (sample numbers 5, 8, 9, 14, 19, 25, 28, 29, 40, 48, 49, 55, 56, 57, 60, 63, 68, 69, 74, 75, 76, 77, 82, 83, 85, 89, 94, 97, 102, 110, 122, 126, 127, 128, 130, 134, 136, 140, 145, 150, 159, 164, 165, 168, 171, 180, 182, 186, 188, 189, 192, 193 & 198). Three claims named Millard Fillmore Hospital as the prescriber where neither the prescriber, nor the facility listed on the prescription was Millard Fillmore Hospital (sample numbers 45, 80 & 96). Two claims named a prescribing individual other than the individual who signed the prescription (sample numbers 36 & 173). One claim named the Erie County Medical Center as the prescriber where neither the prescriber, nor the facility listed on the prescription, was the Erie County Medical Center (sample number 46). (Ex. 28; see also, copies of prescriptions in Ex. 1, D-6)

11. On each of the claims where the ordering prescriber conflicted with the prescriber submitted by Appellant on the claim to Medicaid, the OMIG sought an overpayment equal to the dispensing fee for the drug (either $4.50 [generic] or $3.50 [name brand]) or, if the cost of the prescription was less than $3.50, the entire amount of the claim was disallowed. When only an amount equal to the dispensing fee was disallowed, it was termed a "partial disallowance." (T. 134-136) The total amount disallowed for these fifty-nine claims was $230.19. (Ex. 27)

12. For one claim of the 200 claims audited, no prescription or fiscal order was produced by Appellant (sample number 125) and the OMIG disallowed the entire amount of this claim or $46.04. (T. 145-146; 149-152; Ex. 7 & 27)

13. The total disallowance for the two hundred claims in the audit was $276.23, or $1.3811 per sample in the audit. (Ex. 27) This amount was extrapolated over the entire universe of paid claims in the audit period (119,657) for a total disallowance of $165,258.28. (Ex. 27)

14. The Appellant failed to challenge by argument or evidence the presumption of accuracy in the overpayment calculation, did not dispute the OMIG's determination that the ordering prescriber was inaccurately identified in 59 claims in the sample, and did not dispute that it failed to maintain and produce a prescription or fiscal order for sample 125.

## DISCUSSION

The OMIG presented documents (Exhibits 1-9 and 11-29) and the testimony of James Eckert, the OMIG auditor who supervised and helped compile the audit, and Sharon Conway, the Pharmacy Audit Manager and a licensed pharmacist. The Appellant called Bobby Kent, current manager of third party audit for Appellant, and Deborah Acanfora, who was an OMIG audit manager at the time of the audit in this matter, and was Deputy Medicaid Inspector General from August 2010 to August 2013.[3] Appellant also introduced documentary evidence (Exhibits A1-A16).

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[3] The OMIG initially had Ms. Acanfora on its witness list but determined not to call her as a witness. Ms. Acanfora was then the subject of a request by Appellant to this ALJ to subpoena her to testify, which the OMIG opposed. This ALJ refused to subpoena the witness because Appellant's counsel could not state what Ms. Acanfora would testify to and these hearings are not discovery proceedings. Appellant then issued a subpoena and sought to compel the witness' presence through an Order to Show Cause returnable in Supreme Court. The OMIG then reversed its position and stated that they would produce the witness for purposes of expediency only in this case. (T. 564-566)

It is important to note that this is not a case in which the OMIG is seeking to sanction this provider pursuant to 18 NYCRR Part 515, This is a provider audit pursuant to 18 NYCRR Part 517, in which the OMIG has determined that the Appellant "has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made." The overpayments in this matter are not charged as "unacceptable practices." The OMIG does not seek to impose any penalty or other sanction and, for all but one of the errors, the OMIG seeks to recover no more than an amount equal to the dispensing fee for the prescription. The restitution claim in this case is neither a penalty, nor a punishment. The restitution claim simply seeks repayment of payments that should not have been made.

The OMIG presented the audit file and summarized the case, as is required by 18 NYCRR § 519.17. Mr. Eckert, the audit supervisor, explained the audit process and how the audit was conducted. (T. 117- 149; Ex. 1, 2, 3, 4, 5, 6, 7 & 27) The OMIG compared the claim information it received from the Appellant to the information on the prescription copies it retrieved from the Appellant at the time of the field audit. (T. 171-174; Ex. 1, D-6; Ex. 28)

Mr. Eckert explained a few examples of claims disallowed because the ordering prescriber conflicted with the prescriber identified on the Medicaid claim. Sample # 5 was a prescription written by Zahrain Hall of the Jericho Road Family Practice. Dr. Hall's license number is 226083-1. (T.155-156; Ex. 1, p. D-6-1 and 2) During the period of this audit, Medicaid required that the pharmacy provide the license number or the Medicaid Management Information System number for the prescriber when a pharmacy submitted a claim for payment. (T. 150-151) See, MMIS Provider Manual for

Pharmacy (reissued 4/2004), p. 3-21, section 14 [revised 1/92]. Mr. Eckert demonstrated from the information provided to Medicaid for this prescription with the same patient name, date of service and prescription number that, despite having the actual prescriber's license number, the Appellant submitted the claim for payment with Buffalo General Hospital as the prescriber. (T. 156-159; Ex. 1, p. D-3-5) He repeated a similar demonstration with sample 8 (T. 163-164; cf. Ex. 1, p. D-6-3 & D-3-2); sample 9 (T. 165-168; cf. Ex. 1, p. D-6-5 & D-3-4); sample 36 (T. 186-187; cf. Ex. 1, p. D-6-11 & D-3-2); and sample 173 (T. 189-190; cf. Ex. 1, p. D-6-90 & D-3-1). Finally, Mr. Eckert identified sample 125 as a claim for which no prescription or fiscal order was produced. (T. 187, 190-192)

Mr. Eckert explained that the auditors used the audit protocol (effective January 2, 2009) that was in effect at the time of the final audit report (dated April 23, 2009) to determine whether to disallow a claim and how much of a disallowance would be taken. (T. 159-168, 320-321; Ex. 24) The audit protocol applied in this audit effective January 2, 2009 states, in relevant part, with respect to "16. Ordering Prescriber Conflicts with Claim Prescriber:"

> **OMIG Audit Criteria:** A partial disallowance equivalent to the dispensing fee, as found in the Reference Section of these protocols, is disallowed and projected for the following scenarios:
>
> - A facility ID number is used on the claim when the prescriber's license number/name/provider ID number is listed on the prescription.
> - A facility's name is on the prescription and a different facility's ID number is listed on the claim.
> - A prescriber's license number/name/provider ID/NPI number is shown on the prescription and a different prescriber's license number/name/provider ID/NPI number (not in the same practice group) is listed on the claim.

> When a prescription is signed by a physician's assistant, the physician's assistant or the supervising physician's license number/name/provider ID/ NPI number will be accepted by audit on the claim.
>
> When the claim is for a restricted recipient, the actual prescriber's or the referring provider's provider ID/license/NPI number will be accepted by OMIG on the claim.
>
> Claims submitted for prescriptions written by interns and residents will be accepted by audit if claimed with the appropriate facility ID number or supervising physician's license number/provider ID/NPI number.
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> ***
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> If the service has no dispensing fee, the amount paid no greater than $3.50 will be disallowed and projected.[4]

(Ex. 24, p. 6-7) This protocol requires the projection or extrapolation of any disallowance over the entire universe of claims. Thus, whenever a finding was made by the auditors that met one of the factual bullet points in the protocol, a partial disallowance equal to the dispensing fee was taken (or if there were no dispensing fee, an amount no greater than $3.50) and was extrapolated.[5]

Sharon Conway, the OMIG Pharmacy Audit Manager, was not involved in this particular audit, but testified about general policies relating to pharmacy audits. (T. 396-397) She confirmed Mr. Eckert's testimony that it was the pharmacy protocol in effect at the time of the preparation and issuance of the final audit report that was applied to the audit. (T. 321-322, 325, 399-401, 465) The OMIG would not apply a different protocol after the final audit report issued. (T. 407-408) Ms. Conway testified that the same

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[4] Appellant's counsel took the position that the slash marks in this protocol represented "and" as opposed to "either/or." This ALJ rejects that position and reads the slash marks as meaning "either/or." (T. 178-183)

[5] The protocol similarly requires projection and extrapolation for the finding of a missing fiscal order, the only other finding in this audit, but a disallowance for the full amount of the order is required for this finding. (Ex. 24, p. 2)

policy has always been in effect in the OMIG with respect to what protocol would be applied. (T. 457)[6]

Ms. Conway also confirmed the instruction in the Provider Manual for Pharmacy that when a pharmacist did not have a prescriber's license or Medicaid Management Information System number on a prescription, the pharmacist needed to call the prescriber's office to obtain the appropriate number. (T. 485; see also, J. Eckert, T. 368) MMIS Provider Manual for Pharmacy (reissued 4/2004), pp. 3-21 & 3-23[last revised 1/92]. She also testified that at some point in time the OMIG made it impossible for a pharmacy claim to be paid if it were submitted with a facility number. (T. 477-481, 487) See also, Medicaid Update, Vol. 24, no. 1 (Jan. 2008).

Mr. Bobby Kent admitted he had nothing to do with the audit in issue in this matter. (T.74-75) The purpose of his testimony was apparently to show that none of the providers who actually wrote the prescriptions in issue was excluded from the Medicaid program and that, if the Appellant had used the correct provider's number on the claims it submitted, the claims still would have been paid. His evidence failed to establish the status of these providers during the audit period. More importantly, his testimony was irrelevant because none of the audit findings questioned the Medicaid status of any of the providers. (T. 69-86; Ex. A-1)

This audit found two areas of overpayment. One was that in one instance the pharmacy failed to produce a prescription or fiscal order to support a Medicaid claim.

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[6] Appellant repeatedly insisted that the OMIG pre-hearing decision not to pursue certain findings at hearing and the reduction of the overpayment amount with respect to other claims was a "revision" of the final audit report mandating that a 2012 audit protocol be applied. As this ALJ views it, this exercise of discretion in the litigation stage of this case had little to do with the decision to apply the protocol in effect at the creation of the final audit report. The final audit report is created as one of a series of steps mandated by regulation during the formal audit process and it is the last of those steps. 18 NYCRR Part 517

This finding was not challenged by the Appellant and was not the focus of the Appellant's case at hearing. (T.149-150) The other finding was that in 59 instances the Appellant failed to provide accurate information about the prescriber on the claim it made to Medicaid for payment. The Appellant's case focused on various reasons why these "conflict" findings should not be taken, or not extrapolated over the entire universe of claims.

The Appellant argued that Medicaid claiming allowed the use of facility numbers as the prescriber on claims for payment. (T. 95-197) This, however, is not entirely accurate. As far back as January of 1992, the Medicaid Management Information System Provider Manual for Pharmacy gave this direction, in relevant part, on the input of the prescriber information on Medicaid claims for payment:

> 14. ID/LICENSE NUMBER(ORDERING/PRESCRIBING PROVIDER)
> Prescriptions from Private Practitioners
> Enter the MMIS ID Number of the prescriber. If the prescriber is not enrolled in MMIS, enter his/her State License number.
>
> Prescriptions from Facilities
> For orders originating in a hospital, clinic, or other health care facility, the facility's MMIS ID Number may be entered only when the prescriber's MMIS ID or State License number is unavailable.
>
> When a prescription is written by an unlicensed intern or resident, the supervising physician's MMIS ID number should be entered. If the supervising physician is not enrolled in MMIS, his/her State License number may be entered. When these numbers are unavailable, enter the facility's MMIS ID Number.
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> Prescriptions from Physician's Assistants

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(Provider Audits). It makes sense that the OMIG would apply the audit protocol in effect at the time of the final audit report to an audit at its completion of the formal audit process.

> When prescriptions have been written by a physician's assistant, the supervising physician's MMIS ID Number should be entered. If the supervisor is not enrolled in MMIS, enter his/her State License number. If these numbers are unavailable and the prescription originated in a facility, enter the facility's MMIS ID Number.
>
> Prescriptions from Nurse Practitioners
> Nurse practitioners certified to write prescriptions have a seven character license number which includes the letter "F" followed by six numeric digits. Enter the seven character license number of the nurse practitioner.
>
> Certified nurse practitioner licenses which contain six numeric digits only (not preceded by the letter F) can write for fiscal orders only. Enter the six digit numeric license number of the nurse practitioner.
>
> **Note**: If the MMIS ID or State License number is not on the prescription, it is the pharmacist's responsibility to obtain it.

MMIS Provider Manual for Pharmacy (reissued 4/2004), pp. 3-21 & 3-23[last revised 1/92].

The samples which Appellant challenged on this ground in its response to the draft audit report and that were still included in the final audit report were sample numbers 49, 55, 56, 57, 60, 74, 82, 89 and 127. In all of these samples a facility number, other than the facility listed on the prescription, was used on the claim to Medicaid. Sample number 74 was written and ordered by Heather Wheat, M.D., who wrote the prescription at the Erie County Medical Center. (Ex. 1, pp. D-6-36 to 37) Appellant submitted the claim for payment with Buffalo General Hospital as the prescriber. (Ex. 28) All of the other samples were ordered by Nadezhda Polataiko, M.D., who wrote the prescriptions on her pad with the facility name listed as Riverside/Black Rock Family Care Center. (Ex. 1, pp. D-6-20 to 29, 47 to 48, 33 to 34, 68 to 69) Appellant submitted

these eight claims for payment with Buffalo General Hospital as the prescriber. (Ex. 28) None of these facts was challenged in any manner by Appellant.

Appellant seems to be taking the position that any facility number could be used to submit claims. What is clear from the language from the MMIS Manual for Pharmacy quoted above is that in those limited circumstances when it was permissible to use a facility number, the pharmacy could only use "the facility's MMIS Number," not just any facility number. Moreover, in the Medicaid Update, March 2004, Vol. 19, No.3, pharmacists were given this instruction, in relevant part:

> **Pharmacists: A facility MMIS number can only be used to process pharmacy claims under the Medicaid program as a last resort.** Use of a large number of facility IDs by a pharmacy will result in closer scrutiny and review of the pharmacy's claims. If the prescriber's license number or MMIS number has not been provided, pharmacists should attempt to contact the prescriber to obtain their license number or MMIS number and to verify the prescriber's identity.

Even if Appellant's pharmacists were unaware of the MMIS manual for pharmacy, then this notice in March of 2004 should have alerted them to proper procedure. Instead, the Appellant's pharmacists continued to submit inaccurate claims even after this update was issued. (Ex. 1, pp. D-6, e.g. Sample 5, pp. D-6-1 & D-6-2) In addition, Appellant proffered no proof that its pharmacists ever tried to contact the prescribers in issue to obtain the prescriber's license or MMIS number.

Appellant also argues that "regulations expressly permit the use of a facility number in lieu of a prescriber's license number or Medicaid MMIS number," citing 18 NYCRR §§ 505.3(b)(2) and 512.2(a)(4). (T. 643) However, § 505.3(b)(2) is a section requiring that there be a written order and that an order (prescription) for drugs must

include, among other things, "the practitioner's MMIS provider identification number, the practitioner's license number or the certification number of the facility in which the drugs were ordered." This section describes what information is required on the prescription itself, not what information is permitted for the claiming process. Section 512.2 is part of "Part 512. Drug Utilization Review." 18 NYCRR § 512.1(a) states: "Scope. This Part sets forth the requirements and procedures for the department's medical assistance (MA) prospective drug utilization review program." Thus, again, the information required is not for the claiming process; it is for a separate program and the information is entered into the Electronic Medicaid Eligibility Verification System (EMEVS), the system to verify an individual's eligibility for medical assistance. 18 NYCRR §§ 512.1(c)(2) and 512.2.

None of these arguments addressed the fact that the Appellant had the correct prescriber information on the prescription.

Appellant also raised two due process arguments on this appeal. First, Appellant argued that it was "arbitrary and capricious" for the OMIG not to apply an audit protocol with an effective date of May 4, 2012 to the audit in this case with a final audit report date of April 23, 2009, instead of the audit protocol that was applied, which was in effect at the time of the final audit report, and was effective January 20, 2009. (Ex. 24; Ex. 25) It was alleged that the audit is not complete until the hearing is over. The reason for Appellant's argument was that under the 2009 protocol an amount equal to the dispensing fee, or less, for each finding was projected over the universe of claims in the audit period, and under the 2012 audit protocol the conflict finding would result in an "actual disallowance (not projected)." (cf. Ex. 24, p.6 & Ex. 25, p. 13) The 2012 protocol would

result in a smaller overpayment amount in this case, and Appellant believes that it should have the benefit of the newer protocol. (T. 663, 722)

The second of the due process arguments was that both Durable Medical Equipment providers and Certified Home Health Agencies face the same conflict finding with respect to the ordering prescriber conflicting with the claim prescriber, but that these findings are not projected in the protocols governing those provider audits. (T. 736) This, it is alleged, is "arbitrary and capricious" on the part of the OMIG and therefore a due process violation.

It must first be noted that neither of these due process arguments was raised in response to the draft audit. (Ex. 6) The regulation governing hearing procedure in this hearing specifically states that "[a]n appellant may not raise issues regarding . . . any new matter not considered by the department upon submission of objections to a draft audit . . ." 18 NYCRR § 519.18(a). The reason for such a rule, at least in part, is that this proceeding is a review of what was found during the audit process, a process with many procedural safeguards of its own.[7] (T. 687, 695-696) 18 NYCRR Part 517. Thus, these due process arguments are not properly before this hearing officer.

Secondly, the Fourteenth Amendment to the United States Constitution, section 1, states that no State shall "deprive any person of life, liberty, or property, without due process of law." The New York State Constitution, Article 1, section 6, states that "[n]o person shall be deprived of life, liberty or property without due process of law." Neither of these constitutional provisions has been violated because Appellant has not established

[7] Appellant did raise a due process argument in its response to the draft audit with respect to the sampling methodology, but the specific due process arguments raised herein were not mentioned at the time of the response. Appellant did not contest the sampling methodology at hearing. (T. 764-765)

any property right of which it is being deprived. As was stated in Deas v. Levitt, 73 N.Y. 2d 525,531, 541 N.Y.S. 2d 958, 962 (N.Y. 1989):

> Analysis of petitioner's due process claim begins with the identification of the particular property interest affected, if any, and once identified, the determination of what process is due him (citations omitted). The Constitution does not create property interests (citations omitted). Rather, "they are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law – rules or understandings that secure certain benefits and that support claims of entitlement to those benefits" (citations omitted).

See also, Petix v. Connelie, 47 N.Y. 2d 457, 418 N.Y.S. 2d 385 (N.Y. 1979); Gorey v. Board of Education of City of Buffalo, et al., 239 A.D. 2d 902, 659 N.Y.S. 2d 680 (App. Div. 4th Dept. 1997). Cf., St. Joseph Hospital of Cheektowaga v. Novello, 43 A.D.3d 139, 840 N.Y.S. 2d 263 (App. Div. 4th Dept. 2007) (closing of hospital where State must contain rising Medicaid costs), 10 N.Y. 3d 702 [leave to appeal denied] (N.Y. 2008), N.Y. 3d 988 [appeal dismissed *sua sponte* as no constitutional question involved] (N.Y. 2007).

The OMIG is not seeking to sanction the Appellant herein. No fines are being sought. The OMIG does not seek to exclude the Appellant from the Medicaid program. Rather, the OMIG is seeking repayment for claims that should not have been paid because the claim information submitted was not "true, accurate and complete" and the claims did not comply with Medicaid rules, regulations and other guidance with respect to how a claim should be submitted. Indeed, the OMIG is not even seeking repayment of the entirety of the claims paid. The OMIG seeks only a partial disallowance, the repayment of an amount equal to the dispensing fee, or less if the total claim was less

than $3.50. Appellant has not established that it is being deprived of any property right to which it is entitled.

Ms. Deborah Acanfora was called by Appellant to testify about why the new audit protocol (May 4, 2012) was not applied to older audits and why different providers were subject to different treatments under the audit protocols (i.e., Durable Medical Equipment [DME] providers and Certified Home Health Agency [CHHA] providers as compared to Pharmacy providers). Ms. Acanfora testified that the conflict finding in pharmacy for ordering and prescribing provider was particularly important because the OMIG needed the information to analyze physician prescribing practices in the Medicaid program. (T. 627-629) Regarding the difference in protocols for pharmacy and durable medical equipment providers, she testified that the prescriber was a less significant part of the process in the durable medical equipment field. (T. 632) With respect to the applicable protocol for this audit, Ms. Acanfora confirmed what had already been stated when the OMIG presented its case. The audit protocol in effect at the time of the final audit report was applied to that audit. (T. 683, 693-694, 718-719) She also testified that this had been the policy for a very long time. Her testimony supported the Department's case.

In summary, the Appellant's submission of claims that inaccurately identified the ordering prescriber is a clear violation of Medicaid billing requirements. These claims should not have been submitted as they were. The payments made are overpayments that the Department may recover.

Inaccurate claiming is not a trivial or insignificant matter. The provider's obligation to report accurate information on claims is essential to the Department's ability to oversee and administer the Medicaid program, a multi-billion dollar publicly funded

program. The Appellant's frequent reporting of inaccurate information in this case has no excuse. In this case the pharmacist was in possession of accurate information identifying the prescriber. It was on the prescriptions. The pharmacist ignored that information and identified a different prescriber on the claim, usually a hospital. Appellant offered no reasonable explanation for ignoring the accurate information, relying instead on meritless arguments that it was allowed to do so under regulations and billing procedures that clearly forbid such conduct.

It was the Appellant's obligation to comply with all Medicaid rules and regulations. 18 NYCRR § 504.3. Among these regulations was an obligation to report accurately. 18 NYCRR §§ 504.3(h). It was the Appellant's inaccurate claim reporting that led to the overpayments in this case. 18 NYCRR §§ 504.3(g), 517.3(b). It is Appellant's burden to prove that the audit is in error. 18 NYCRR § 518.1(c) The Appellant has failed to carry its burden of proof.

**DECISION:**

The OMIG's determination to recover Medicaid overpayments in the amount of $165,258.28 is affirmed. This decision is made by Denise Lepicier, who has been designated to make such decisions.

DATED:
October 3, 2014
New York, New York

[redacted]

Denise Lepicier
Administrative Law Judge