

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

In the Matter of the Request of

CHELSEA EXPRESS TRANSPORTATION, INC.
Provider ID # 03025234

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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: **Decision After Hearing**
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: Audit #11-5528
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Before: William J. Lynch
Administrative Law Judge

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

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Tina M. Dolman, Esq.
Patrick F. Scully, Esq.

Alex Khod, Manager
Chelsea Express Transportation, Inc.
108-36 Corona Avenue, 3rd Floor
Corona, New York 11368
By: Richard S. Harrow, Esq.
O'Connell & Aronowitz
54 State Street
Albany, New York 12207

Dates of Hearing: August 1 and 2, 2017

Briefs Submitted: March 4, 2019

JURISDICTION

The Department of Health (Department) acts as the single state agency to supervise the administration of the medical assistance program (Medicaid) in New York State pursuant to Public Health Law (PHL) § 201(1)(v) and Social Services Law (SSL) § 363-a. The Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority pursuant to PHL §§ 30, 31 and 32, to pursue administrative enforcement actions against any individual or entity that engages in fraud, abuse, or unacceptable practices in the Medicaid program, and to recover improperly expended Medicaid funds.

Chelsea Express Transportation, Inc. (Appellant) is enrolled as a Medicaid fee for service provider. The OMIG issued a determination seeking recoupment of payments made by Medicaid, and the Appellant requested a hearing pursuant to SSL § 22 and the former Department of Social Services (DSS) regulations at 18 NYCRR § 519.4. (Ex. 3, 5.) A hearing was held on August 1 and 2, 2017. After the hearing, Ms. Dolman, the OMIG attorney assigned to this matter at the time, advised me in an October 16, 2017 email as follows:

Shortly after receiving the transcript for Chelsea Express Transportation, I was notified by NYC HRA that a change might be made to this audit. I was not told what the change might be, but that if they made the change, it could reduce the amount owed by the provider. When I contacted our Division of Audit, it was confirmed that this was a possibility, but they could not offer me any more information. They also couldn't tell me how long it was going to take for them to decide whether the change would be made even though I mentioned that we had finished the hearing and were supposed to be setting up a schedule to submit briefs. Mr. Harrow and I feel that it would be best to hold off scheduling a submission date for briefs since we don't know what, if any, changes will be made. Please let me know if this would be acceptable.

Due to this information, the matter was held in abeyance until October 15, 2018, when I received an email from Mr. Scully, the newly assigned OMIG attorney, advising me that the parties had agreed upon November 12, 2018, as the date for submission of their

briefs. Due to an application made by the Appellant to reopen the hearing which was later denied, the submission date was then extended to March 4, 2019.

APPLICABLE LAW

DSS regulations generally pertinent to this hearing decision are: 18 NYCRR Part 505 (medical care) in particular 18 NYCRR § 505.10 (transportation for medical care and services), 18 NYCRR Part 517 (provider audits), 18 NYCRR Part 518 (recovery and withholding of payments or overpayments), 18 NYCRR Part 519 (provider hearings), and 18 NYCRR Part 540 (provider documentation).

The New York State Medicaid program issues Medicaid Management Information Systems (MMIS) provider manuals, which are available to all providers and include billing policies, procedures, codes and instructions. Medicaid also issues a monthly Medicaid Update with additional information, policy and instructions. www.emedny.org. By enrolling, providers agree to comply with these official directives. 18 NYCRR § 504.3(i).

In order to receive payment for services to Medicaid recipients, a provider must be lawfully authorized to provide the services on the date the services are rendered. A transportation service and its drivers must comply with all requirements of the New York State Department of Transportation and Department of Motor Vehicles, and the transportation service must ensure that all ambulette drivers are qualified under Article 19-A of the Vehicle Traffic Law. An ambulette service operating in New York City has the additional requirement of being licensed by the New York City Taxi and Limousine Commission. 18 NYCRR § 505.10(e)(6).

As a condition of their enrollment, Medicaid providers agree to submit claims on officially authorized claim forms in a manner specified by the Department and to ensure that the information

provided in relation to any claim is true, accurate and complete. Fee-for-service providers must prepare and maintain contemporaneous records demonstrating their right to receive payment, and their records are subject to audit for six years. 18 NYCRR §§ 504.3(a)&(h), 517.3(b), 540.7(a)(8). Payment to a provider of ambulette services will only be made for services documented in contemporaneous records in accordance with section 504.3. 18 NYCRR 505.10(e)(8).

The audit process includes a draft audit report and final audit report. The draft audit report must advise the provider of the basis and legal authority for the proposed action, contain a clear statement of the action to be taken, and afford the provider an opportunity to respond to the proposed action. 18 NYCRR § 517.5(a)&(b). Before the Department issues a final audit report, it must consider the objections, any supporting documents and materials submitted, the draft audit report, and any additional material which may become available. 18 NYCRR § 517.6(a). The final audit report requiring the repayment of overpayments or restitution constitutes a final determination. 18 NYCRR § 519.3(b).

If an 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).

If the Department requires repayment, a provider is entitled to a hearing to review the Department's determination. 18 NYCRR § 519.4. At the hearing, a Department representative must present the audit file and summarize the case including a brief description of the facts, evidence and reasons for supporting the action. 18 NYCRR §§ 519.17(a) & 519.17(b)(3). The Appellant has the burden of showing that the Department's determination was incorrect and that

all claims submitted and denied were due and payable under the program. 18 NYCRR § 519.18(d). An Appellant may not raise issues regarding any new matter not considered by the Department upon submission of objections to a draft audit or notice of proposed agency action. 18 NYCRR § 519.18(a).

In the absence of expert testimony and evidence to the contrary, an extrapolation based upon an audit utilizing a statistical sampling method certified as valid will be presumed to be an accurate determination of the total overpayments made. An appellant may submit expert testimony and evidence to the contrary, or an accounting of all claims paid, in rebuttal to the Department's proof. 18 NYCRR § 519.18(g).

ISSUE

Was OMIG's determination to recover Medicaid payments to Appellant in the amount of \$636,926.00 correct?

FINDINGS OF FACT

1. At all times relevant hereto, Appellant was enrolled as a provider in the New York State Medicaid program. (Ex. 1.)
2. On September 20, 2011, OMIG notified Appellant that this audit would be conducted jointly by the Human Resources Administration for the City of New York (HRA) and OMIG as part of the County Demonstration Program. (Ex. 1A, p. B3-1.)
3. The purpose of the audit was to verify that Appellant's "drivers and vehicles were properly licensed, certified and or registered; prior authorizations were obtained; all billing and rate requirements were met; Medicaid reimbursable services were rendered for the dates billed;

appropriate procedure codes were billed for services rendered; vendor records contained the documentation required by the regulations; and the claims for payment were submitted in accordance with Department regulations and the Provider Manuals for Transportation.” (Ex. 3.)

4. On December 2, 2011, HRA held an Entrance Conference at Appellant’s place of business and advised Appellant that the audit would review a random sample selected by the OMIG of 150 services paid by Medicaid to Appellant for the period from January 1, 2008 through December 31, 2010. (Ex. 1A, p. B2-1.)

5. HRA commenced the audit on January 12 and 13, 2012. The Appellant provided the HRA auditors with documentation for the 150 samples including trip tickets, driver licenses, and 19-A certifications. The audit did not find that the Appellant was missing required contemporary documentation for the claims. (Ex. 1A, p. B2-1; T. 129, 188.)

6. On March 6, 2014, HRA held an Exit Conference with Appellant and provided a CD containing a limited number of data fields received from the OMIG related to Appellant’s claims. (Ex. 1A, p. B1-1; T. 163.)

7. On October 29, 2014, OMIG issued a draft audit report which indicated that Appellant had no information or zeros in the data fields for the ordering provider and the driver license in a number of the sample claims as received by Medicaid. (Ex. 3.)

8. Specifically, the draft report indicated that the ordering provider identification number was not properly placed in ordering provider field in 52 of the 150 samples; that the driver license field was empty in 30 of the 150 samples; and that the driver license field contained zeroes in 18 of the 150 samples. (Ex. 2; T. 157-176.)

9. Appellant’s drivers were properly licensed and certified, and all vehicles were properly licensed and inspected. Appellant had entered the driver on each of the claims, and the software

program being used at the time was designed to insert the driver license number which was already stored in the system. The software program failed to insert the numbers, which caused the driver license data field to be left blank or to fill with zeros when submitted. When the Appellant learned of this, he promptly found a new vendor and has used a new software program which eliminated all problems with subsequent claim submissions. (T. 232-239.)

10. In a draft audit response dated March 11, 2015, Appellant submitted two disks which contained data from Appellant's electronic record of Medicaid claims showing the ordering provider was included with the claim submissions. Appellant also provided documentation of the driver license numbers with screen shots indicating that he had input the information into the system for the associated sample claims. (Ex. 1A, p. A2-62.)

11. In a second draft audit response dated March 20, 2015, Appellant submitted more electronic data and raised a claim that this audit should be dismissed because OMIG had conducted another audit for the same period (Audit # 2012Z31-063D), for the same reasons. Appellant also asserted that all the services were authorized and rendered by properly licensed and 19-A qualified drivers, and that requiring repayment was not warranted where there was no fraud and no indicia of a scheme to receive payment from Medicaid for an amount greater than the amount the provider was entitled to be paid for services provided to Medicaid recipients. Appellant objected to the recoupment of payments solely on the basis of an alleged technical error or omission which did not correspond to the quality of care provided or its necessity. (Ex. 1A, p. A2-40; Appellant C.)

12. In a third draft audit response dated April 10, 2015, Appellant submitted additional documentation and information contained in Appellant's software program related to the sample claims. (Ex. 1A, p. A2-1.)

13. The other audit of Appellant's claims for transportation services referenced in paragraph 11 above was initially for the period January 1, 2008 through December 31, 2011 and was part of a large system match project of a number of transportation providers (Audit # 2012Z31-063D). When OMIG realized that the dates of the two audits overlapped, OMIG reduced the system match audit to the one-year period from January 1, 2011 through December 31, 2011. (T. 29-31.)

14. Due to a clerical error, however, a Draft Report for the system match audit dated December 27, 2012 (Audit # 2012Z31-063D), stated that the audit covered the period from January 1, 2008 through December 31, 2011. Therefore, OMIG issued a Revised Draft Audit Report dated September 13, 2013 which corrected the error. (T. 32; OMIG Ex. 11A, 11B.)

15. The Final Audit Report dated September 29, 2015 contains the same findings as the Draft Audit Report. The total sample overpayment was \$6,086.40. The sample findings for missing/inaccurate information in the Ordering Provider data field, plus an extrapolation of the sample findings for the missing/inaccurate information in the Driver License data field to the universe of cases was \$636,926. (Ex. 3; T. 157.)

DISCUSSION

OMIG presented the audit file and summarized the case, as is required by 18 NYCRR § 519.17. OMIG presented documents (Exhibits 1-11B) and called four witnesses.

Sandra Noonan is a Management Specialist 3 and the unit manager of the system recovery unit at OMIG. Ms. Noonan testified about her involvement with the system match audit which was resolved with the Appellant by stipulation. She explained that OMIG initially pulled claims for four years, but then realized that the system match audit overlapped with this County

Demonstration Program audit which was already open. Therefore, the scope of the system match audit was reduced to a single year – 2011. She stated that the initial version of the Draft Audit Report for the system match audit unfortunately contained an error by incorrectly stating that the audit covered the period from January 1, 2008 through December 31, 2011, but that a revised draft was then issued which corrected that error. There is, consequently, no overlap between these two audits.

Theresa Smith is a Management Specialist 1 who has worked for OMIG on the County Demonstration Program transportation audits. Ms. Smith explained that counties can opt to join the program, and the counties then share in some of the recoveries. She was involved in this audit from the beginning and explained the findings. The auditors were looking to see whether the Appellant had properly filled in the information on the claim forms and whether the Appellant had maintained proper documentation of the services provided. She stated that this audit “is not related to whether there was a service actually performed.” (T. 81.) The OMIG does not dispute that the transportation services in this audit were in fact provided.

██████████ is employed by HRA and supervised the employees who conducted this audit. ██████████ testified that the Appellant provided the auditors with the trip tickets for each of 150 sample claims, and the auditors received documentation of the driver license and 19-A certification for the drivers indicated on the trip tickets. (T. 188.) He stated that the auditors determined that an overpayment had been made to Appellant for any claim which had been received by Medicaid with zeros or an empty data field for the driver license in spite of the auditors receiving valid documentation for the driver named on the trip ticket.

Theresa Golum is a Management Specialist 1 employed by OMIG. She stated that Medicaid claims are processed by a company named CSRA which was formed by the merger of

Computer Sciences Corp., and SRA International. She further stated that the central depository of all claims processed by New York Medicaid is another company, Currier, McCabe & Associates Consulting Services (CMA). She explained that she wrote code to extract all data fields for the sample claims, and she was unable to locate anything that looked like a driver license. (T. 213.)

On cross-examination, Ms. Golum explained that the Medicaid program puts edits in place which will deny, pend, or pay and report a claim if a data field is not properly filled; however, she did not know whether an edit was in place for the driver license field during the period of this audit. If an improperly completed claim was submitted while an edit was in place, the provider would receive a remittance statement providing notification of the problem, and a provider could resubmit a corrected claim within two years of the date of service. (T. 223.)

Three findings were made against the Appellant. The first finding was that the ordering provider ID was not in the appropriate field of the electronic claim. Ms. Smith testified that because the ordering provider was identified elsewhere in the claim form, OMIG did not extrapolate this disallowance. (T. 85.) The second finding was that the driver license number was missing from the claim. Ms. Smith testified that there was nothing that Appellant could have provided to the auditors to remove this finding because the claim as received by Medicaid was missing the driver license number. (T. 89.) The third finding was that the driver's license number was inaccurate because it contained all zeros. Ms. Smith testified that no driver license is issued with all zeros, and there was nothing Appellant could have provided to the auditors to remove this finding. (T. 100, 128.) Ms. Smith acknowledged that the audit did not find that the Appellant's contemporaneous documentation such as trip tickets and other required documentation for the claims was missing or inaccurate. (T. 129.)

Alex Khod has been the owner of Chelsea Express Transportation for ten years and has done the Medicaid billing for the services provided. He testified that the company currently has eight vehicles and employs eight drivers who transport individuals who need transportation to medical facilities. Mr. Khod testified that he provided the auditors with space to work and gave them all requested documentation including the trip tickets and driver license information. He stated that all his drivers were properly licensed and certified and that all vehicles were properly licensed and inspected. (T. 232.) He asserted that he had entered the driver on each of the claims, and the software program was designed to insert the driver license number which was already stored in the system. (T. 239.) Mr. Khod's understanding was that a glitch in the software program caused the problem, so he found a new vendor and has used a new software program which has eliminated all problems with his claim submissions. (T. 237.) He testified that he had no notice that the Medicaid Program had not received the driver license number on some claims until December 2012, after this audit was commenced and after the time period in which he was entitled to correct the claims had expired.

Appellant made an application to have this audit dismissed because OMIG had previously conducted the system match audit related to the same time period for the same reasons and entered into a settlement with Appellant. However, OMIG has demonstrated that it discovered the overlapping period in the two audits and limited the system match audit to a one-year period which was not included in this audit. There was an error which was carried over into the initial draft report, but that the error was corrected in a revised draft audit report which eliminated any overlap between the two audits. Therefore, Appellant's application is denied.

Appellant contended that it was improper to deny payment to a provider absent any allegation that the services were not provided, were not necessary, or were not provided consistent

with professional standards. Appellant claimed that the Department made a similar argument in defense of findings made by the United States Department of Health and Human Services Office of the Inspector General (OIG) regarding Medicaid overpayments made by the Department to providers (citing to the Department's submission in response to OIG Report No. A-02-08-01006). Appellant urged that this argument is no less valid when raised by providers in response to an audit by the OMIG.

Appellant further contended that mistakes in transportation claims for services should not be deemed to be overpayments. In response, the OMIG alleged that Appellant's improper claiming was the basis for deeming these payments to have been overpayments because 18 NYCRR § 518.1(c) states that an overpayment includes any amount not authorized to be paid under the Medicaid program as the result of improper claiming. The question presented here is whether claiming errors which are omissions, but not misrepresentations, submitted electronically to the Medicaid program are overpayments requiring repayment when the evidence procured by the auditors establishes that the Appellant has prepared, maintained and produced contemporaneous documentation establishing that necessary services were provided, and as such there is no evidence that Appellant received any excessive or unearned payments from the Medicaid Program.

Mr. Khod credibly testified that all drivers were properly licensed and certified and that he provided the auditors with contemporaneous documentation including trip tickets, driver licenses, and 19A certifications at the time of the audit. The OMIG's witnesses conceded that all required documentation was provided to the auditors, and the audit made no secondary finding that Appellant lacked any of this contemporary documentation.

The Appellant was not aware that the claims as received by the Medicaid Program did not contain the driver license numbers. The OMIG's witness acknowledged that Medicaid has the

ability to set up edits in the program which will deny or pend a claim which lacks required information, but here all claims were paid so Appellant would not have received notice that the claims were incomplete. Mr. Khod credibly testified that he was responsible for billing and had entered all the driver license information into the software program on his computer, and that he only became aware that the information had not been transmitted to Medicaid after the audit. Therefore, by ignoring the missing information and simply paying the claims, the Medicaid program deprived the Appellant of the opportunity to correct the claims, which Appellant clearly could have done with the information produced during the audit.

The only finding against Appellant is that the electronic claims of some of the samples as received by Medicaid had zeroes or were blank in fields that should have contained the ordering provider or the driver license number. The OMIG decided that Appellant's ability to produce contemporary documentation showing that the claims were for necessary services provided by properly licensed and certified drivers in properly registered vehicles had no impact on the amount of recovery sought. (T. 137-138.) However, while an error on a claim may be grounds for rejection of that claim with leave to correct it, an error on a claim is not necessarily a failure in the documentation a provider is required to maintain and produce in support of that claim. The OMIG is confusing the effect of these two different deficiencies by taking the unreasonable position that an inadvertent, innocent error on a claim's submission means the claim can never be paid no matter how completely the documentation produced on audit justifies the claim.

The OMIG points to prior decisions such as In the Matter of the Request of M.J. Trans. Corp., (Audit No. 2012Z31-093T) which found that OMIG had acted appropriately and within its statutory authority in seeking approximately \$26,000 in repayment for submitting claims which contained zeros because of a data entry mistake. On the other hand, Appellant points to the decision

In the Matter of Statewide Ambulette Service, Inc. (Audit No. 13-F-2317) which found that “it is unreasonable to demand complete restitution for services that the Appellants were able to document were provided and billed in the appropriate amount.” Having reviewed these prior decisions, I consider this case similar to Statewide Ambulette, in which documentation in support of the claims was produced, and that this case is unlike M.J. Trans. Corp., and other prior administrative decisions upholding the OMIG's determination of an overpayment. The Appellant here has established not only that he believed he had included the information with the claim and had no notice that it was not included, but also that the auditors who conducted an on-site review were provided with contemporary documentation supporting the Appellant's assertion that the necessary transportation services claimed were properly provided to Medicaid recipients (T. 188.).

The Department has a legitimate interest in ensuring that providers submit properly completed claims for the services that are provided to Medicaid recipients, and the Appellant agreed to provide true, accurate and complete information in relation to its claims in the manner specified by the Department as a condition of enrollment pursuant to the regulations. However, the regulations also allow a provider to correct claims and justify them on audit with contemporaneous documentation. Although the use of edits to deny and pend claims was not specifically raised in response to the draft audit report, Appellant successfully preserved the issue of a lack of notice depriving providers of their just compensation. The Department deprived Appellant of the opportunity to correct its claims by ignoring the missing information in the electronic data fields and simply paying the claims.

On audit in this case, the Appellant provided the auditors with contemporary documentation for the 150 samples verifying that Appellant's drivers and vehicles were properly

licensed, certified and or registered; that prior authorizations were obtained; that Medicaid reimbursable services were rendered for the dates billed; and that he entered the required information in the software program on his computer for the claims. No motive was suggested for Appellant to have submitted claims without the driver license number which was on the contemporary documentation produced by the Appellant for audit and viewed by the auditors. The Appellant's claim submissions were incomplete, but Appellant has met its burden of proving that the information provided for audit in relation to those claim submissions was true, accurate and complete, as was demonstrated by the contemporaneous records prepared, maintained and produced for audit that demonstrate its right to payment.

DECISION

The Department's determination to recover overpayments is reversed. This decision is made by William J. Lynch, who has been designated to make such decisions.

DATED: May 24, 2019
Albany, New York

William J. Lynch
Administrative Law Judge