State of New York : Department of Health

In the Matter of the Request of

PRIME DRUG CORP.
224-17A Union Turnpike
Oakland Gardens, NY 11364

Appellant

Audit # 17-3521
Provider ID# 03488777

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 a Determination under 18 NYCRR Parts 517 and 518 to recover $438,056.94 in Medicaid Overpayments.

Before:	James F. Horan, Administrative Law Judge
Held at:	New York State Department of Health 90 Church Street New York, NY 10007 July 5, 2019 and November 14, 2019 By Cisco WebEx Videoconference July 28, 2020
Parties:	Office of the Medicaid Inspector General (OMIG) Office of Counsel 217 Broadway, 8th Floor New York, NY 10007 BY: Mara Pandolfo, Esq. and Patrick Scully, Esq. Kalb & Rosenfeld, P.C. Attorneys for Prime Drug Corp. 283 Commack Road Commack, NY 11725 BY: John A. Meringolo, Esq.
Record Closed:	October 19, 2020

Title 18 NYCRR §519.4 entitles a Medicaid provider to a hearing to review the Department's determination to impose sanctions or require repayment (Recoupment). Medicaid Fee for Service does not reimburse all covered drugs for patients whose coverage is deemed as "emergency services only". The OMIG determined that in 243 instances pertaining to 42 patients, the Appellant Medicaid Pharmacy Provider filed claims for drugs which were not on the list of covered medications for Emergency Services Only and which lacked Department of Health (Department) approval. The Appellant submitted the claims by using exception/override codes, resulting in an overpayment of $438,056.94. The Appellant responded that: 1) the OMIG audit was beyond the Appellant's period of operation, 2) the Appellant relied on prescribing physicians to obtain requisite approval, 3) the billing system the Department created failed to reject the Appellant's claims, 4) the failure to reject the claims prejudiced the Appellant, 5) Recoupment would be inequitable because the Appellant dispensed the medications and 6) the lack of candor by the OMIG hearing witness and the OMIG failure to consider each of the Appellant's objections require dismissal. After a hearing on this matter, the ALJ upholds the Audit determination to recoup $438,056.94 from the Appellant, with a limitation on the interest with the Recoupment.

I. Background

After the OMIG issued the Notice of Final Agency Action seeking Recoupment, the Appellant requested the hearing, which took place at the Department's Metropolitan Regional Office in New York City and by WebEx Videoconference. The ALJ conducted the hearing in this matter pursuant to New York Social Services Law (SSL) Articles 1 and 5 (McKinney Supp.

2020), New York Public Health Law (PHL) Article 1 (McKinney Supp. 2020), New York State Administrative Procedure Act (SAPA) Articles 3-5 (McKinney 2016) and Title 18 NYCRR Parts 504, 517, 518 & 519.

The OMIG presented one hearing witness, OMIG Pharmacy Consultant Diane Baker. The Appellant presented two witnesses Pharmacist Yuri Davydov, the President and a shareholder in Prime Drug Corp., and [redacted] All witnesses testified under oath and subject to cross-examination. The OMIG offered 26 exhibits into evidence, of which the ALJ received 25 into the record:

1 Prime Drug Corp DAR 17-3521,
2 Revised DAR audit 17-3521,
3 Prime Drug Corp FAR 17-3521,
4 DOH Approval letters and background-patient [redacted],
5 DOH Approval letters and Background-patient [redacted],
6 NY Office of Professions online Verifications,
7 DOH Prime cease and desist letter and emails-May 5, 2016,
8 DOH phone logs regarding patients [redacted]. and [redacted].,
10 Prime Drug 17-3521 draft audit response,
11 Provider hearing request,
12 Sale agreement Prime Drug,
13 New York State Medicaid Update August 2007, v. 23, no 8,
14 New York State Medicaid Update July 2008, v. 24, no 8,
15 Medicaid eligibility verification system and dispensing validation System provider manual, January 2013 v. 4.10,
16 New York State Medicaid update April 2013, v. 29 no. 5,
17 New York State Medicaid Program Durable medical equipment manual Policy guidelines, April 2013, v. 2013-1,
18 New York State Medicaid update August 2014, v. 30 no. 8,
19 New York State Medicaid program Pharmacy manual policy guidelines November 2015, v. 2015-1,
20 New York State Medicaid update August 2016, v. 32 no. 8,
21 New York State Medicaid update December 2016, v. 32 no. 12,
22 NYS Medicaid program email basis,
23 Selected Regulations:
A. 18 NYCRR § 540.1,
B. 18 NYCRR § 518.3,
C. 18 NYCRR § 518.1,
D. 18 NYCRR § 540.7,
E. 18 NYCRR § 517.3,

F. 18 NYCRR § 504.3,
G. 42 C.F.R. § 440.255.

24 Email from Department of Health to OMIG dated February 13, 2018,
25 EmedNY,
26 Billing breakdown.

The ALJ declined to accept OMIG 9, a chart prepared by Ms. Baker that repeats information already in the record from other Exhibits. The Appellant offered 14 exhibits into evidence, which the ALJ received into the record:

1 Prehearing conference notice and disclosure, 2/14/18,
2 Final audit report, 11/21/17,
3 Audit report attachment A-1,
4 Provider's response to draft audit report,
5 Revised draft audit report, 9/25/17,
6 Draft audit report, 6/28/17,
7 Prehearing conference disclosure 5/30/19,
8 OMIG charge back amount v. Kinray purchase actual,
9 Certificate of business records,
10 DOH Foil response, 1/30/19,
11 DOH Foil response, 2/8/19,
12 Expert notice disclosure,
13 U.S. HHS submission clarification code meaning,
14 Asset sale agreement.

The record also contained the hearing transcript which a stenographer prepared (pages 1-359).

The ALJ declined to accept testimony from Ms. [redacted] as an expert on Medicaid billing, because the witness never worked in Medicaid billing. The introduction of the witness, *voir dire* and the ruling by the ALJ appear in the record at Transcript pages 305-350.

Following the hearing, each party submitted a Brief and a Reply to the other party's Brief. The hearing record closed when the ALJ received the parties' Reply Briefs on October 19, 2020.

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. 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.

Title 18 NYCRR § 519.18(a) limits the issues and documentation for consideration at hearing to issues directly relating to the NFAA. 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, except where the determination is based upon an alleged failure of the provider to comply with generally accepted business, accounting, professional or medical practices or standards of health care, the department must establish the existence of such practice standards. 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 a conclusion or fact; less than a 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. The substantial evidence standard demands only that a given inference is reasonable and plausible, not necessarily the most probable, Ridge Road Fire District v. Schiano, 16 N.Y.3d 494 (2011).

II. Findings of Fact

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

2. 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].

3. The Appellant operated a retail pharmacy that served as a Fee for Service Medicaid Provider in Oakland Gardens, New York [OMIG 3].

4. All claims at issue in this proceeding were submitted using the Appellant's Medicaid Provider Number [T. 55-58]

5. Yuriy Davydov and Yuriy Mosheyev each owned 50% of the shares in Prime Drug Corp., which opened the retail pharmacy on September 20, 2012 [T 239].

6. The Appellant sold Prime Drug Corp. on December 17, 2015 to Oakland Garden Pharmacy, whose sole shareholder is Yuriy Mosheyev [T 239-240].

7. Upon the sale, Oakland Gardens Pharmacy used the Appellant's Medicaid Provider Number to bill Medicaid pending Oakland's approval as a Medicaid Provider [T 270].

8. The Sale Agreement allowed Oakland to use the trade name Prime Drugs and to submit claims for reimbursement under the Appellant's Medicaid Agreement for a reasonable period of time after closing [Appellant 14].

9. As of January 25, 2016, Oakland registered with the State Education Department Office of the Professions as doing business as Prime Drugs [OMIG 6].

10. The Department informed the Appellant on August 17, 2016, that the Appellant's participation in the Medicaid Program terminated on August 16, 2016, due to "Ownership Change" [OMIG 25].

11. The OMIG issued the Final Audit Report in Audit # 17-3521 (Audit) on November 21, 2017, which found overpayments to the Appellant amounting to $438,056.94 [OMIG 2].

12. The Audit determined that in 243 instances pertaining to 42 Medicaid patients whose status was deemed Emergency Services Only, the Appellant used exception/override codes to bill for drugs which were not on the list of covered

medications for Emergency Services Only and which were not approved as medical necessity by the Department [OMIG 2].

13. The Audit covered the period from April 1, 2013 through March 1, 2017 [OMIG 1].

14. The OMIG reviewed the 243 disallowed claims that were submitted from July 19, 2014 to April 29, 2016 [T 29-30].

15. Emergency Service Only status applies to Medicaid recipients who are Aliens granted lawful permanent resident status or lawful temporary resident status [T 61].

16. Federal Medicaid regulations limit Fee for Service coverage for services to Aliens [ON 42 CFR § 440.225].

17. The guidelines for drug coverage for Emergency Services Only Medicaid recipients appeared in the Department's Medicaid Update for April 2013 [T 65-66; OMIG 16].

18. The April 2013 Update states that Medicaid Fee for Service does not reimburse for all covered drugs for patients whose coverage is deemed Emergency Services Only [OMIG 16].

19. Coverage may be available for services necessary for an emergency medical condition [OMIG 16].

20. The list of drugs covered for Emergency Services Only is available at the DOH Website [OMIG 16].

21. For patients with limited coverage, a pharmacy may receive the denial response "Patient is not covered" for drugs that do not meet the definition of emergency medical condition [OMIG 16].

22. Providers can verify a patient has coverage for Emergency Services Only by performing an eligibility request using the eMedNY Tools Center [OMIG 16].

23. The eMedNY System is the claiming adjudication system that New York Medicaid uses for the transaction of Medicaid claims [T 34].

24. Exception/override requests require a letter of medical necessity, providing a rationale as to why the request meets the Federal definition of emergency medical condition [OMIG 16].

25. The Department's August 2014 Medicaid Update stated that, if an exception is made, both the physician and pharmacy will be contacted and will also receive

written documentation for their records noting the approved drug and time frame [OMIG 18].

26. That Update warned that pharmacies should not attempt to override the "not covered" response unless they have been contacted by the Department and have received approval letters [OMIG 18].

27. Medicaid providers must comply with all laws, rules, regulations, guidelines and updates of the Department as well as any applicable Federal laws and regulations [ON 18 NYCRR § 504.3(i)].

28. Medicaid Providers can opt to receive Medicaid Updates electronically and the Appellant was on the list at primeDrugs@hotmail.com to receive Medicaid updates electronically [T 70].

29. On May 5, 2016, DOH contacted Prime Drug about the pharmacy's "misuse" of exception/override codes when submitting drug claims for patients whose coverage is deemed Emergency Services Only [OMIG 7].

30. An exception/override code is also known as a submission clarification code (Code) [T 46].

31. The May 5th letter advised Prime Drug that "these claims must be reversed" [OMIG 7; T 102-103].

32. The Appellant reversed none of the claims [T 102-103].

33. The Appellant received an Approval Notice on May 26, 2016 in response to a letter of Medical Necessity approving coverage for a drug which was not on the list of reimbursable medicines for persons whose coverage is deemed as Emergency Services only [OMIG 4].

34. The May 26, 2016 letter warned the Appellant to keep the Notice on file, in the event of an audit, to support the usage of an override code for dispensing the medication [OMIG 4].

35. Of the 250 claims examined in the Audit, the Appellant received medical approval to proceed with 7 claims and received permission to use Code 03 for processing those claims [T 86].

36. Of the 243 claims that the Audit disallowed, the Appellant submitted 225 and received a denial [T 114].

37. The Appellant then submitted those 225 claims again with Code 07 and the claims proceeded to payment [T 111-114].

38. The Appellant submitted 18 claims for which there was no denial because the Appellant submitted the claims using Code 07 [T 113].

39. The Appellant never received Department approval letters to submit any of the 243 claims using Code 07.

III. Conclusions

The credible evidence from this record showed that Medicaid received 243 claims, using the Appellant's Medicaid number, for medications for Emergency Services Only Medicaid recipients. None of the medications were on the approved list for Emergency Services Only recipients and the Department issued Medical Necessity approval letters for none of the 243 billings. Medicaid paid $438,056.94 on the claims and the Audit found this that entire amount constitutes an overpayment. Title 18 NYCRR 518.3 provides that OMIG may require repayment from the party who submitted an improper claim. The Audit sought recoupment for the entire $438,056.94, with interest.

The Appellant responded that: 1) the OMIG audit was beyond the Appellant's period of operation, 2) the Appellant relied on prescribing physicians to obtain requisite approval, 3) the billing system the Health Department created failed to reject the Appellant's claims, 4) the failure to reject the claims prejudiced the Appellant, 5) Recoupment would be inequitable because the Appellant dispensed the medications and 6) the lack of candor by the OMIG hearing witness and the OMIG failure to consider each of the Appellant's objections require dismissal. The Appellant also requested that the ALJ award no interest with the Recoupment due to delays during the hearing process that were largely due to factors outside the Appellant's control [T 355].

Period of Operation: The Appellant argued that the Appellant operated only until December 17, 2015 and should not be liable for any claims from its sale date. The Appellant contends that its existence ended on the sale date. The ALJ finds that the record reflects otherwise. On the sale date the retail pharmacy passed from operation by a corporation with Davydov/Mosheyev as 50% shareholders each to a corporation with Mosheyev as the 100% shareholder. The Department continued to receive claims using the Appellant's Medicaid number until April 2016. The sale agreement provided specifically that the Oakland Gardens could continue filing claims using the Appellant's Medicaid number for a reasonable time [Appellant 14]. The Appellant did not seek to terminate its Medicaid Provider Number until August 2016 [OMIG 25]. The ALJ finds that the Appellant bears responsibility for all claims made using its Medicaid Provider Number.

Reliance: The Appellant argued that it relied on the prescribing physicians to have obtained all requisite approvals. The ALJ concludes that the Appellant's assumption, that the prescribers obtained consents, indicates that the Appellant was aware that approvals were needed to obtain the medications and that the Appellant never verified with the prescribing physicians that they sought approvals, even after the Appellant received denials for 225 claims. Mr. Davydov testified that all the prescriptions behind these claims originated from a small number of oncologists at the Hope Pavilion Center in Elmhurst Hospital [T 250]. It should not have been difficult for the Appellant to verify its assumption with the providers when the Appellant began receiving the denials. The Appellant's Brief claimed that approvals were sought by the providers while the recipients were hospitalized. As the evidence showed, however, no one sought approval letters from the Department for filing in any of the 243 claims (FF 39). Further, the

Appellant's assumption is irrelevant, as the OMIG is not alleging a knowing misrepresentation by the Appellant to obtain overpayments.

Billing System: The Appellant argued further that the billing system the Department created failed to reject the Appellant's claims, so the Department of Health bears the responsibility for the overpayment. The ALJ finds that the evidence proved that the Department advised the Appellant on 225 of the claims that there was no coverage for the requested service. In addition, the Department advised Prime Drug by letter and phone call on May 5, 2016 that Prime Drug was misusing exception/overrides when submitting claims [OMIG 7]. The May 5th letter contained the direction to reverse the claims. There was no reversal on the claims. The ALJ finds that the Appellant bears sole responsibility for the overpayments. Title 18 NYCRR 518.1(c) states that overpayments include any amounts not authorized to be paid, including amounts paid by mistake.

Approval: In addition, the Appellant argued that it was prejudiced because the Department approved the claims and denied the Appellant the opportunity to resubmit the claims. The ALJ finds that the Appellant never sought or received approval letters for the 243 claims at issue in the Audit. The Department denied 225 claims initially for lack of coverage. Those denials alerted the Appellant to problems with the claims, but the Appellant used Code 07 without approval to resubmit the claims.

Medications Dispensed: The Appellant contends Recoupment is inequitable and unjust in this case because the Appellant paid for and dispensed the medications for all the claims. The ALJ notes that there is no accusation that the Appellant billed for services which were never provided. The Audit is not seeking the Appellant's exclusion from the Medicaid Program or referring the Appellant for a criminal investigation. It is quite clear under 18 NYCRR § 518.3

that repayment is the remedy for the party who submits an improper claim and there was ample notice from the 225 denials that there were problems with these claims.

Appellant's Objections: The Appellant argues that Ms. Baker lacked candor in her testimony and the OMIG failed to consider all the arguments the Appellant raised in its Response to the OMIG Draft Audit Report. For these reasons, the Appellant requested the dismissal of the Recoupment claim. The Appellant provided no authority from law, regulation, court ruling or prior ruling by an ALJ in a Recoupment case to support the request.

A fact finder considers witness credibility in assessing testimony and deciding what weight to provide that testimony. There was little in the way of factual disputes in this case. The Appellant claimed that it did not submit an override code, but rather used a submission clarification code [T 250]. Ms. Baker testified that the terms are used interchangeably [T 46]. The crux of the Appellant's argument regarding Ms. Baker is that she lacked candor in testifying about whether the OMIG considered all the arguments in the Appellant's Response to the Draft Audit Report. The ALJ finds Ms. Baker was direct and credible in addressing the Response. She testified that she and her supervisor considered the Response, but that the only thing she would have accepted to overturn a disallowance was proof of a medical necessity approval letter from the Department [T 46].

The Appellant argues further that the ALJ should dismiss the Recoupment claim because the Medicaid Auditors did not consider the Appellant's equitable arguments before issuing the Final Audit Report. The ALJ rejects the request. The Appellant has had the opportunity at this hearing to raise all its defenses and the OMIG addressed them during the hearing and in the post hearing submissions. The ALJ has also considered all the Appellant's defenses and found then without merit.

Interest: The Audit found that the Recoupment should include interest. The Appellant opposed any interest due to delays in the hearing process that were outside the Appellant's control. The ALJ granted an adjournment in this proceeding because the Appellant sought information from the Department through a Freedom of Information Law (FOIL) request. It took over one year for the Department to provide that documentation. Some of that documentation became exhibits which the ALJ eventually received into evidence at the hearing. The hearing was delayed again when the initial OMIG counsel announced at the second hearing day that she would be leaving her job at OMIG the following week for a new position. There was a delay for replacement of counsel and then the hearing was delayed further by the shutdown from the COVID Pandemic. The ALJ ruled on the record on July 20, 2020 that there would be no interest awarded for the previous two years due to these delays [T 355]. The ALJ affirms the imposition of interest for the period from the Final Audit forward, pursuant to 18 NYCRR § 518.4, with the exception of the two years from July 20, 2018 to July 20, 2020.

IV. Decision

After reviewing the evidence from the hearing and the parties' post-hearing briefs, the ALJ:

1. Affirms the Audit finding that the Appellant filed improper claims.
2. Affirms the Audit determination to recoup the overpayment of $ 438,056.94 from the Appellant.
3. Affirms the Determination to impose interest pursuant to 18 NYCRR § 518.4, with the exception of the period from July 28, 2018 to July 28, 2020.

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 sanctions.

Dated: November 4, 2021
Menands, New York

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James F. Horan
Administrative Law Judge

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