STATE OF NEW YORK: DEPARTMENT OF HEALTH

In the Matter of

SPEEDY MEDICAL TRANSPORT 1, LLC
Provider # 01436066,
Appellant,

DECISION
2017Z31-068K

from a determination by the NYS Office of the
Medicaid Inspector General (OMIG)
to recover Medicaid Program overpayments.

Before: Jean T. Carney
Administrative Law Judge

Held at: New York State Department of Health
By video conference

Hearing Dates: July 28, 2020, September 24, 2020, September 25, 2020
Record closed on January 4, 2021

Parties: Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Kathleen Dix, Esq.
kathleen.dix@omig.ny.gov

Speedy Medical Transport 1, LLC
219 S. Center Street
East Syracuse, New York 13057
By: Jeffrey P. Reisner, Esq.
Taddeo Shahan & Reisner, LLP
120 East Washington Street, Suite 400
Syracuse, New York 13202
jreisner@tsrllp.com

JURISDICTION

Pursuant to Public Health Law (PHL) § 201(1)(v) and Social Services Law (SSL) § 363-a, 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. 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 to recover improperly expended Medicaid funds.

The OMIG determined to seek restitution of payments made under the Medicaid program to Speedy Medical Transport 1, LLC (Appellant). The Appellant requested a hearing pursuant to 18 NYCRR § 519.4 to review that determination.

APPLICABLE LAW

Medicaid Program participation is a voluntary, contractual relationship between the provider of services and the state. (Social Services Law § 365[a]; 18 NYCRR § 504.1; *Schaubman v Blum*, 49 NY2d 375 [1980]; *Lang v Berger*, 427 F.Supp. 2d 204 [S.D.N.Y. 1977]). Medicaid providers agree to comply with all program requirements as a prerequisite to payment and continued participation in the program. (18 NYCRR §§ 504, 515, 517, and 518). Based on these contractual obligations, the Medicaid Program employs a pay-first-audit-later system to ensure compliance, and enable prompt payment to providers. (18 NYCRR SS 504.3 and 540.7[a][8]). Medicaid providers are required to prepare, maintain, and furnish to the Department on request, contemporaneous records demonstrating their right to receive payment from the Medicaid Program. All information regarding claims for payment is subject to audit for six years. (18 NYCRR § 504.3).

When the Department has determined that claims for medical services have been submitted for which payment should not have been made, it may require repayment of the amount determined to have been overpaid. (18 NYCRR §§ 504.8 and 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 Appellants bear the burden of proving by substantial evidence that the OMIG's determination is incorrect, and of proving any mitigating factors affecting the severity of any sanctions imposed. (18 NYCRR §§ 519.18[d] and [h]); New York State Administrative Act (SAPA) § 306[1]). Substantial evidence means such relevant proof as a reasonable mind may accept as adequate to support a 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 [1984]). 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).

HEARING RECORD

The OMIG presented documents (OMIG Exhibits 1-17); and the testimony of Emily Amiccuci, OMIG's Manager of the System Match and Recovery Unit, Christina Farrell, OMIG's Manager of Medicaid Analytics and Database Support Unit, and Rita Guido, Outreach Supervisor Manager at CSRA[1]. The Appellant presented documents (Appellant Exhibits A-L); and the testimony of Anthony L. Calarese, Owner, [redacted] Business Manager, [redacted], Biller, and [redacted], Owner of Medical Answering Services. A stenographic transcript of the proceedings was made.

ISSUES

[1] CSRA is the company that acts as the fiscal agent for the New York state Medicaid program. (T Guido).

Was OMIG's determination to recover Medicaid Program overpayments for transportation billed fee-for-service during an inpatient stay correct?

Was OMIG's determination to recover Medicaid Program overpayments for transportation claims for ambulette services with unqualified/disqualified driver's license for date of service correct?

Was OMIG's determination to recover Medicaid Program overpayments for transportation claims for ambulette services with incorrect/missing driver's license for date of service correct?

FACTS

Citations in parentheses refer to testimony (T) and exhibits (Exhibit) found persuasive in arriving at a particular finding. Conflicting evidence, if any, was rejected in favor of cited evidence.

1. The Appellant is an ambulette and transportation service operating in Central New York, and is enrolled as a provider in the New York State Medicaid Program to provide services as an ambulette, a taxi, and for day treatment transportation. (Exhibit 11; T Farrell at p. 119).

2. The OMIG conducted a desk audit of claims "billed fee-for-service during an inpatient stay, as well as transportation claims for ambulette services paid by Medicaid" for the period from January 1, 2012 to December 31, 2015. (Exhibits 1, 4, and 5).

3. The OMIG issued a Draft Audit Report on December 19, 2017, identifying $25,467.39 in Medicaid Program overpayments in four separate findings. (Exhibit 1).

4. On March 9, 2018, the Appellant submitted its response to the Draft Audit, and supplemented that response on April 25, 2018, including contemporaneous records maintained by the Appellant, confirming the drivers' names and license numbers for disallowed claims in Finding 3. (Exhibit 3).

5. The OMIG issued a Final Audit Report on June 12, 2019, seeking $17,017.83. Subsequently, the OMIG revised the Final Audit Report and currently seeks $16,801.50[2] including interest. The Appellant objects to three of the four findings in the final audit report. (Exhibits 4 and 5).

6. A System Match and Recovery Audit looks for duplicate claims; claims that do not comply with rules, regulations or policies; or claims that conflict with other systems, such as Department of Motor Vehicle records. This type of audit does not verify whether the service was actually provided or necessary. (T Amiccuci at p. 24-26; T Farrell at p. 82-83).

7. All the claims in the audit subject to this proceeding were submitted electronically through the Electronic Provider Assisted Claim Entry System (ePACES), a web based application developed by the Department and managed by a fiscal agent retained by New York State to maintain the Medicaid management information system (eMEDNY). (Exhibit B; T Amiccuci at p. 68; T Farrell at p. 86).

8. All the data in claims submitted through ePACES are maintained in the Medicaid data warehouse. Data that meets specific criteria for a system match audit is extracted from the Medicaid data warehouse and forms the basis for that audit's findings. (T Farrell at p. 84-86).

9. Finding 1 determined that Medicaid was improperly billed for transportation services provided to hospital inpatients. The draft audit sought $192.56 in overpayments. The Appellant conceded to all but one claim in this finding, and submitted contemporaneous documents to support its position. In response to the Appellant's submissions, that amount was adjusted in the final audit to $148.26 in overpayments, including interest. (Exhibits 2, 3, and 4).

[2] The OMIG represented that they were seeking $16,835.60 in overpayments. However, when the total amounts from Findings 1 and 3 in the final audit report, and the listed amounts for Finding 2 in the revised final audit report are added together, the total comes to $16,801.60.

10. Finding 2 determined that claims were submitted for transportation provided by unqualified/disqualified drivers. The draft audit sought $2,017.13 in overpayments. Contemporaneous documentation regarding drivers' qualifications was provided, resulting in a downward adjustment in the final audit to $578.40, which was then revised further in the revised final audit to $362.07. (Exhibits 2, 3, 4, and 5).

11. Finding 3 determined that "numerous" claims were submitted with either incorrect or missing driver's license numbers. The draft audit report sought $23,257.70 in overpayments, including interest. The Appellant submitted contemporaneous documentation showing the drivers' names and license numbers for each claim flagged in the draft audit report. After reviewing the Appellant's response to this finding, that amount was adjusted to $16,291.17 in the final audit. (Exhibits 2,3, and 4).

12. At the time of the audit, driver license numbers were required on every claim submitted by ambulettes for payment to Medicaid; but not for taxi or day treatment transportation. If the driver license number was not given on a claim, the program would assume the service was provided by one of the categories that did not require that information. (T Farrell at p. 121, T Guido at volume II[3] p. 23).

13. Prior authorization codes were given to the Appellant by Medical Ambulance Services, LLC (MAS) for ambulette services. Those codes were entered into ePACES as part of their claim forms. MAS did not give out adult daycare prior authorization codes. (T Freeman at pp. 243 and 263).

14. The ePACES reference guide in effect at the time of the audit states that when a claim is complete, the validation process is triggered. "When errors exist, a table will be displayed on the confirmation page, indicating the error and its location on the claim." (Exhibit 17; T Freeman at p. 257).

[3] The transcript from the second day of testimony, September 24, 2020, did not continue the pagination from the first day, instead it started at page one. Therefore, the testimony from September 24, 2020 is cited as volume II and page number.

DISCUSSION

While the parties stipulated that the hearing concerned the Appellant's objections to Findings 1, 2, and 3; the record contains little evidence regarding Findings 1 and 2. The Appellant failed to show that the OMIG erred in its determinations related to these findings. However, the Appellant did show that the OMIG erred in its determination related to Finding 3.

Finding #1

The Appellant conceded the remaining claims in this finding. The OMIG's determination to recoup overpayments in the amount of $148.26 is sustained.

Finding #2

The Appellant failed to submit evidence refuting the claims in this finding. The OMIG's determination to recoup overpayments of $362.07 is sustained.

Finding #3

The Appellant reasonably relied on ePACES' representations that errors would be caught during the validation process if a claim was not properly completed. The ePACES online form identifies required fields with an asterisk and will not allow a provider to continue submitting the form if the provider has started to enter information in that field. One of those required fields is the driver license number for any ambulette service. Further, the Appellant was given prior authorization codes clearly denoting the type of service being provided as an ambulette; not day treatment. Additionally, the rate for day treatment services is lower than the rate for ambulette services and the Appellant was paid at the ambulette rate, not the day treatment rate for these claims.

However, the OMIG asserts that if the provider leaves the driver license number field blank, ePACES will not flag the error, and allow the provider to submit the claim on the assumption that the service provided is either a taxi or day treatment transportation.

This assertion is refuted by the evidence that the prior authorization codes and payments clearly demonstrate that these claims were ambulette transportation, not day treatment. The OMIG further contends that ePACES checks the claim for completion, not accuracy. (T Guido at Volume II, p. 60). The evidence does not support his contention. The ePACES reference guide clearly states that errors in the claim would be caught during the validation process, and the provider would be able to correct those errors prior to submitting the claim. The reference guide ePACES provided to the Appellant, and upon which providers rely, describes a validation process that checks for accuracy. This process failed, and the Appellant should not be penalized for relying on the OMIG's program not performing as described.

The OMIG does not allege that transportation services were not provided. The only basis for seeking recoupment under this finding is that "numerous" electronic claims, once retrieved from the data warehouse, did not include driver license numbers. The Appellant's obligation is to maintain and produce documentation substantiating its entitlement to payment on the disallowed claims. Here, the Appellant produced documentation substantiating its entitlement to payment on the disallowed claims. The OMIG's determination to recoup overpayments in the amount of $16,291.17 under this finding is overturned.

DECISION

OMIG's determination to recoup overpayments for Finding 1 in the amount of $148.26 is affirmed.

OMIG's determination to recoup overpayments for Finding 2 in the amount of $362.07 is affirmed.

OMIG's determination to recoup overpayments in the amount of $16,291.17 for Finding 3 is overturned.

This Decision is made 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.

DATED: January 6, 2022
Albany, New York

____

JEAN T. CARNEY
Administrative Law Judge