

**STATE OF NEW YORK  
DEPARTMENT OF HEALTH**

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In the Matter of the Appeal of	:	
	:	
<b>Harry's Nurses Registry, Inc.</b>	:	<b>Decision After</b>
Medicaid ID #01233509	:	<b>Hearing</b>
	:	
from a determination by the NYS Office of the	:	
Medicaid Inspector General to recover Medicaid	:	
Program overpayments	:	#18-3900

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**Before:** John Harris Terepka  
Administrative Law Judge

**Held at:** New York State Department of Health  
By videoconference  
January 28, March 31, April 9, 23, 2021  
Record closed October 1, 2021

**Parties:** New York State Office of the Medicaid Inspector General  
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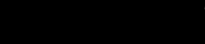
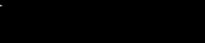
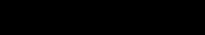
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### JURISDICTION

The New York State Office of the Medicaid Inspector General (OMIG), an independent office within the Department of Health (the Department), determined to seek restitution of payments made under the Medicaid Program to Harry's Nurses Registry, Inc. (the Appellant). The Appellant requested a hearing pursuant to Social Services Law 22 and the former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the determination. (Exhibit 9.)

A hearing was scheduled for April 21, 2020, but was rescheduled on the request of the Appellant and with the OMIG's consent to October 22, 2020, and then to January 28, 2021. (Exhibit 10.)

### HEARING RECORD

Witnesses for the OMIG:	Nancy Grandino, audit manager
OMIG exhibits:	1-20
Witnesses for the Appellant:	Harry Dorvilier, CEO
	 healthcare consultant
	 nursing supervisor
	 statistical consultant
	 , LPN
Appellant exhibits:	AA (with attachments A-Z), BB (with attachment BB-1), CC, DD, EE

A transcript of the proceedings was made. (Transcript pages 1-473.) After the OMIG submitted two and the Appellant three post hearing briefs the record closed on October 1, 2021.

### SUMMARY OF FACTS

1. Appellant Harry's Nurses Registry, Inc. is a private duty nursing and licensed home care services agency, enrolled as a provider in the New York State Medicaid Program.

2. By audit notification letter dated May 17, 2018, the OMIG initiated an audit of the Appellant's records for private duty nursing (PDN) services provided to

Medicaid recipients and paid by the Medicaid Program during the period January 1, 2013 through December 31, 2015. The purpose of the audit was to determine whether the Appellant's records demonstrated compliance with Medicaid Program requirements. (Exhibit 1.)

3. During the period January 1, 2013 through December 31, 2015, the Appellant was paid \$21,940,356.78 by the Medicaid Program for 73,761 claims for private duty nursing services to Medicaid recipients. The audit consisted of a review of a random sample of 100 of these claims, paid in the total amount of \$28,897.18.

4. After reviewing the Appellant's documentation in support of its claims for Medicaid reimbursement for the services in the sample, the OMIG identified violations of one or more Medicaid Program requirements in the submission of 70 of the 100 claims, and disallowed payments in the total amount of \$18,924.62.

5. The OMIG issued a draft audit report dated May 2, 2019, which identified proposed findings and afforded the Appellant an opportunity to present additional documentation and argument in objection to them. (Exhibit 6.)

6. The Appellant submitted a response to the draft audit report, along with 219 pages of additional documentation, on July 2, 2019. (Exhibit 7.)

7. By final audit report dated August 19, 2019, the OMIG notified the Appellant that after reviewing the Appellant's response, its audit findings remained the same except for a change in category for one disallowance that did not alter the overpayment determination. (Exhibit 8, Bates page 000311.)

8. The audit report organized the disallowed claims into eleven categories, based upon the reason for the disallowance:

1. Failure to complete required health assessment. Forty-four claims. (Samples 1, 2, 3, 4, 5, 8, 10, 11, 12, 14, 22, 23, 25, 28, 39, 42, 44, 46, 48, 51, 54, 55, 57, 59, 60, 61, 62, 63, 68, 74, 75, 76, 78, 79, 80, 90, 92, 93, 96, 97, 99, 100.)
2. Failure to complete annual performance evaluation. Twenty-eight claims. (Samples 2, 4, 7, 8, 9, 10, 15, 17, 19, 21, 24, 33, 38, 47, 50, 51, 57, 63, 64, 65, 66, 68, 77, 78, 85, 90, 91, 94.)
3. Missing certificate of immunization. Eighteen claims. (Samples 1, 2, 8, 10, 11, 12, 14, 25, 26, 42, 48, 57, 75, 78, 89, 98, 99, 100.)
4. Missing documentation of a PPD (Mantoux) skin test or follow-up. Eighteen claims. (Samples 1, 2, 8, 10, 11, 12, 14, 25, 26, 42, 44, 57, 59, 68, 78, 89, 99, 100.)
5. Missing or insufficient documentation of hours billed. Ten claims. (Samples 2, 7, 8, 14, 42, 70, 74, 78, 86, 92.)
6. Billed for services in excess of ordered hours. Six claims. (Samples 44, 63, 80, 81, 82, 87.)
7. Missing medical orders/plan of care. Five claims. (Samples 12, 26, 55, 97, 100.)
8. Failed to obtain authorized practitioner's signature within required time frame. Two claims. (Samples 69, 75.)
9. Billed for services performed by another provider/entity. One claim. (Sample 4.)
10. Medical orders/plan of care not signed by an authorized practitioner. One claim. (Sample 20.)
11. Excluded individual providing service. One claim. (Sample 22.)

Payments disallowed in more than one category were only disallowed once. The overpayments disallowed in the audit sample were in the total amount of \$18,924.62. (Exhibit 8, Bates page 000306.)

9. The final audit report advised the Appellant that the OMIG had determined to seek restitution of Medicaid Program overpayments in the amount of \$4,156,971. (Exhibit 8.)

10. The restitution claim includes an extrapolation utilizing a statistical sampling method in which the value of the disallowances found among the randomly selected sample of 100 claims was projected to the total of 73,761 claims paid by the Medicaid Program during the audit period. (Exhibits 8, 13, 14.) For the purposes of

extrapolation, the OMIG used only the overpayment findings in disallowance categories 5 through 11, in the total amount of \$5,617.69. The overpayment determination for disallowance categories 1 through 4 was limited to the sample findings, in the total amount of \$13,307. (Exhibit 8, Bates page 000306.)

### ISSUES

Was the OMIG's determination to recover Medicaid Program overpayments from Appellant Harry's Nurses Registry, Inc. correct? If so, what is the amount of the overpayment?

### APPLICABLE LAW

As is set forth in section 363 of the Social Services Law, the legislature established the Medicaid Program "to operate in a manner which will assure a uniform high standard of medical assistance throughout the state." The Department of Health acts as the single state agency to supervise the administration of the Medicaid Program in New York. SSL 363-a; Public Health Law 201(1)(v). Pursuant to PHL 30, 31 and 32, the OMIG, an independent office within the Department of Health, has the authority 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.

Medicaid providers are required, as a condition of their enrollment in the program, to prepare and to maintain contemporaneous records demonstrating their right to receive payment from the Medicaid Program and fully disclosing the nature and extent of the care, services and supplies they provide; and to furnish such records, upon request, to the Department. The information provided in relation to any claim must be true, accurate and complete. All information regarding claims for payment is subject to audit,

and providers are required to maintain records to support their claims for six years. Notification by the Department to the provider of the Department's intent to audit shall toll the six-year period for record retention and audit. 18 NYCRR 504.3(a)&(h), 504.8, 517.3(b)&(c), 540.7(a)(8).

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 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. The Appellant, however, 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).

Regulations of the former DSS most pertinent to this hearing decision are at 18 NYCRR Parts 505 (medical care, in particular section 505.23 regarding home health services), 517 (provider audits), 518 (recovery and withholding of payments or

overpayments) and 519 (provider hearings). Also pertinent are regulations of the Department of Health at 10 NYCRR Parts 763 (certified home health agencies); 765 (approval and licensure of home care services agencies); and 766 (licensed home care services agencies – minimum standards).

The Appellant has failed to explain how SSL 145-b or 363-e have any relevance to this proceeding to recover Medicaid overpayments pursuant to PHL 20&32, SSL 363-a and 18 NYCRR Parts 517&518. (Appellant brief, pages 7-13, 25-26; reply brief, page 2; Transcript, pages 115-118.) Throughout its briefs, the Appellant attempted to characterize the overpayment in this case to be a “penalty” or “fine.” (Appellant brief, page 25; reply brief, page 2; “sur reply,” page 1.) The OMIG correctly maintains (OMIG reply brief, pages 1-2) that an overpayment identified in an 18 NYCRR Part 517 audit is not a penalty or a fine, it is simply an overpayment that may be recovered pursuant to 18 NYCRR Part 518. Monetary Penalties and Provider Sanctions are addressed by regulations at 18 NYCRR Parts 515 and 516 and are not relevant to this audit.

### **DISCUSSION**

The Appellant is a licensed home care services agency and a provider of private duty nursing services in New York State, with seven to nine million dollars in yearly billings. It billed well over twenty million dollars to the Medicaid Program during the three-year audit period under review. Owner and CEO Harry Dorvilier has operated the Appellant since 1991, and during the time under audit had approximately eight full time employees and one hundred nurses providing services, mostly to Medicaid recipients. (Transcript, pages 147-54.)

The Medicaid claims reviewed in this audit were for private duty nursing (PDN) services to Medicaid recipients. (Exhibit 8, Bates page 000287.) The Appellant employed the nurses who visited patients in their homes to provide nursing care authorized under a plan of care ordered by a physician for each patient and preapproved by the Medicaid Program. The nursing services were billed to Medicaid by the hour and the nursing visits by the visit.

The Appellant's contention that this audit was not timely conducted is without merit. (Transcript, page 18.) Notification of intent to audit payments made in the calendar years 2013 through 2015 was provided by letter dated May 17, 2018, which was within the six-year period permitted under 18 NYCRR 517.3. (Exhibit 1.) The limitation period for audit and record retention was tolled at that point. The Appellant's further contention that a withhold of payments pursuant to 18 NYCRR 518.7 was improperly implemented is also without merit. (Appellant brief, pages 26-28.) The Appellant failed to demonstrate that the OMIG has not complied with 18 NYCRR 518.7 or 518.8 regarding withholding of payments, issuance of draft and final audit reports, and recovery of overpayments pending a hearing. (Transcript, pages 19-22.) The hearing was timely scheduled and all adjournments of the originally scheduled hearing date were granted upon the request of the Appellant, not the OMIG. (Transcript, pages 23-24.)

The issues addressed in the audit included verification that the Appellant's staff providing the services were properly assessed, supervised and immunized; that all services were documented as having been provided in compliance with Medicaid requirements; that authorization of medical need for the services was timely and appropriately documented; and that the services were properly billable to the Medicaid



Program. Where disallowances were made, the OMIG determined that the services were not documented to have been provided in accordance with applicable Medicaid requirements. The audit report set forth eleven categories under which 70 of the 100 sampled claims were disallowed. As some claims were disallowed under more than one category, the report detailed a total of 134 disallowances among those 70 claims. Only one overpayment was assessed against each of the 70 claims.

The Appellant's contentions that audit concerns and findings were not adequately disclosed or explained to him are without merit. (Appellant brief, pages 32-34; reply brief, page 5.) The Appellant was afforded ample opportunity to request information from the Department during the audit, and to submit any information it wanted the auditors to consider. (Transcript, pages 387-88.) Mr. Dorvilier's protestation "most of the time when the auditors got here and the communication with them, we never really have a communication to even comprehend the report or even go over the report itself" is not credible. (Transcript, pages 156, 371.) Among other things, it is noted that he walked out of the audit closing conference before it was completed. (Transcript, pages 158, 197, 371-72; Exhibit 5, Bates page 000039.) Throughout the audit and thereafter, the Appellant was provided with voluminous information and opportunities to discuss it with OMIG audit staff. In the Appellant's brief this became the basis of a complaint that the OMIG provided too much information to understand. (Appellant brief, page 33.)

The OMIG's audit procedures included a review of the Appellant's lengthy written response to a draft audit report. (Department Exhibit 7.) These documents were exchanged between the parties in accordance with audit procedures set forth at 18 NYCRR 517.5 and 517.6(a). The final audit report then set forth the OMIG's

conclusions and reasons for each of several categories of disallowance and listed every disallowed claim. (Department Exhibit 8.) The final audit report complies with the obligation to "clearly advise the provider... of the nature and amount of the audit findings, the basis for the action and the legal authority therefore." 18 NYCRR 517.6(b). Mr. [REDACTED] opinion that the audit report "does not contain sufficient detail to allow an outside reviewer to completely understand the basis for the disallowances taken" (Appellant Exhibit AA, [REDACTED] report, page 6; Transcript, page 207) is unpersuasive. There is nothing complicated or difficult to understand about the eleven disallowance categories it set forth. (*see* factfinding 8, *supra*.)

The Appellant suggests that the failure of the Department's claims processing data unit, eMedNY, to provide subpoenaed prior approval documentation in connection with six claims disallowed under category 5 (missing or insufficient documentation of hours billed - samples 7, 8, 74), and category 6 (billed for services in excess of ordered hours - samples 44, 63, 87), is grounds for reversal of those disallowances. (Exhibit AA, [REDACTED] report, pages 11, 12, 16, 17, 20, 25; Transcript, pages 164-65; Appellant brief, pages 39-42, 48-49, 52, 57.) The subpoena was issued on March 12, 2021, long after this audit closed and after this hearing was already underway. (Exhibit AA, attachment C, page 31.)

The Appellant has not explained how documentation submitted to the Medicaid Program in order to obtain prior approval to bill hours of service, or eMedNY's records of a prior approval request, might constitute documentation that those hours were in fact later properly provided and billed. The OMIG accepted and relied on the documentation provided by the Appellant itself to show prior approval for these services (Exhibit 16,

*passim*), and no disallowance in this audit involves a dispute about the number of hours for which the Appellant obtained prior approval.

For example, regarding sample 63 the Appellant's witness, Mr. [REDACTED] stated in his "Expert Report": "Based on OMIG's failure to provide the information required by HNR's subpoena, this disallowance should be reversed." (Exhibit AA, page 18.) At the hearing Mr. [REDACTED] then testified:

Q. Would you explain what you might be able to expect from the pre-approval people that would provide information that would clarify whether, indeed, there was double billing for the additional 12 hours in question?

A. Well, I'm not sure – I don't know exactly what is in the prior authorization files, so I can't comment. (Transcript, page 314.)

Mr. [REDACTED] went on to speculate how "different things could have happened," such as the existence of a prior authorization of which the Appellant is unaware, or a "keypunch error" or "technical error." (Transcript, pages 312-15.) He was unable to explain why it might be significant whether "edits" or "controls" preventing claims for more than authorized hours were in effect or not at the time of this claim, acknowledging "[t]hat requires some technical expertise that is beyond me." (Transcript, pages 315-18.)

In any event, the Appellant's contention that it is excused from its recordkeeping responsibilities by the failure of a third party to produce records, long after an audit has closed, is rejected. It is the basic responsibility of all Medicaid providers to maintain and produce for audit documentation demonstrating entitlement to payment. Physician orders and plans of care are obtained by the provider, not the Medicaid Program. Whatever the Medicaid Program received in connection with requests for prior approval came from the Appellant itself. As Mr. Dorvilier explained, when these documents are collected by the

provider and submitted to eMedNY “You have to keep a copy for you and a copy for [eMedNY].” (Transcript, pages 166-70.) He testified: “We retain a copy of the prior approval. We retrain [sic] the copy of the nursing assessment. We obtain a copy of the psychosocial, but eMedNY has a copy and we have a copy ourselves for the office.” He then acknowledged “I could not tell you from 2013 what happened to those prior approval or the nursing assessment or those doctor’s order” and talked about the “large volume of paper” involved. (Transcript, pages 172-74.)

It is noted that the Department did respond to the Appellant’s March 12, 2021 subpoena, by letter dated May 7, 2021. A search by the Department and its contractors determined that they are no longer in possession of any documents from 2013-14 that would be responsive to the subpoena. (Exhibit CC.) This predictable outcome simply underscores why the burden of maintaining and producing documents to justify its billings is on the Medicaid provider.

This is a review of the Appellant’s compliance with its obligation to prepare, maintain and produce for audit documentation demonstrating entitlement to the payments it received. It is not a continuation of an audit that ended in 2019 with the issuance of a final audit report. The burden is on the provider, not third parties or the Medicaid Program, to prepare, maintain and produce that documentation for audit. 18 NYCRR 505.3(a), 519.18(d). The Appellant failed to meet this burden in connection with the disallowances in categories 5 and 6. The two disallowances in category 8 (samples 69 and 75), for which prior approval information was also subpoenaed, are reversed in this decision (see *infra*), not because of any issue relating to the subpoena, but entirely on the basis of documentation the Appellant did maintain and produce for audit.

The audit findings.I. Sample disallowances not extrapolated. (Disallowance categories 1-4.)

The Appellant offered neither argument nor evidence to show its entitlement to payment in the first four categories of disallowance that were not extrapolated:

Category 1. Failure to complete required health assessment. Forty-four claims. (Samples 1, 2, 3, 4, 5, 8, 10, 11, 12, 14, 22, 23, 25, 28, 39, 42, 44, 46, 48, 51, 54, 55, 57, 59, 60, 61, 62, 63, 68, 74, 75, 76, 78, 79, 80, 90, 92, 93, 96, 97, 99, 100.)

Providers are required to document annual health status assessments for all personnel who have direct patient contact. 10 NYCRR 766.11(d)(5). The Appellant failed to produce the required assessments. (Transcript, pages 45-47.)

Category 2. Failure to complete annual performance evaluation. Twenty-eight claims. (Samples 2, 4, 7, 8, 9, 10, 15, 17, 19, 21, 24, 33, 38, 47, 50, 51, 57, 63, 64, 65, 66, 68, 77, 78, 85, 90, 91, 94.)

Providers are required to document an annual assessment of the performance and effectiveness of all personnel, including at least one in-home visit to observe performance, if applicable. 10 NYCRR 766.11(k). The auditors were willing to accept an annual assessment that was dated within one year before the service date. The Appellant failed to produce the required assessments. (Transcript, pages 47-48.)

Category 3. Missing certificate of immunization. Eighteen claims. (Samples 1, 2, 8, 10, 11, 12, 14, 25, 26, 42, 48, 57, 75, 78, 89, 98, 99, 100.)

Providers are required to document immunization of personnel with direct patient contact. 10 NYCRR 766.11(d)(1),(2)&(3). The Appellant failed to produce the required documentation of immunization for personnel providing claimed services. (Transcript, pages 49-50.)

Category 4. Missing documentation of a PPD (Mantoux) skin test or follow-up. Eighteen claims. (Samples 1, 2, 8, 10, 11, 12, 14, 25, 26, 42, 44, 57, 59, 68, 78, 89, 99, 100.)

Providers are required to document annual tuberculosis testing of personnel with direct patient contact. 10 NYCRR 766.11(d)(4). The auditors were willing to accept any testing that was dated within one year before the service date. The Appellant failed to produce documentation of tuberculosis testing for personnel providing these services. (Transcript, pages 50-51.)

All 108 of these disallowances are affirmed.

II. Extrapolated sample disallowances. (Disallowance categories 5-11.)

The Appellant limited its challenge at this hearing to the disallowance of twenty-six claims in the seven categories of disallowance that were extrapolated.

Category 5. Missing or insufficient documentation of hours billed. Ten claims. (Samples 2, 7, 8, 14, 42, 70, 74, 78, 86, 92.)

No payment will be made under the Medicaid Program for home health services unless the claim for payment is supported by documentation that each service is documented in the clinical record. 10 NYCRR 766.2(a)(2). The required documentation must include a signed and dated progress note following each visit. 10 NYCRR 766.6(a)(5). The audit report, citing these specific regulations, disallowed hours of service that the Appellant failed to document. (Transcript, pages 52-58.)

For sample 7 the date of service was [REDACTED] 2015, for which 9 hours were billed. The audit allowed the 8-hour shift from 7am to 3pm, documented by a nursing note that day. (Exhibit 16, Bates page 009303.) The Appellant claims the other hour is accounted for by the end of the previous day's shift, [REDACTED] from 5pm to 1am. (Exhibit 16, Bates page 009306.) Two progress notes for [REDACTED] were produced during the audit, showing one nurse documenting two 8 hour shifts on [REDACTED]. The first note documented a shift from 7am to 3pm, and the second, by the same nurse, a second shift from 5pm-1am. (Exhibit 16, Bates pages 009305&6.) The claims detail report shows that the Appellant billed and was paid for 16 hours on [REDACTED] (Exhibit 16, Bates page 009275.) The Appellant had already claimed and been paid the extra hour on [REDACTED] and was not entitled to be paid for it again on the [REDACTED] claim.

For sample 2 the date of service was [REDACTED], 2013. At the hearing the Appellant offered a photocopy of a progress note for that date. (Exhibit AA, attachment A.) The photocopy of the handwritten note is illegible, except that the date of service has obviously been overwritten to make the appropriate date clear. For sample 14, sample 42, sample 70, sample 78, sample 86, and sample 92, the Appellant also offered at the hearing, photocopies of progress notes purporting to document the dates in question. (Exhibit AA, attachments F, J, O, R, V, X.)

This documentation was not produced until December 2020, long after the May 2, 2019 draft audit report advised the Appellant to produce any documentation it wanted considered in support of these claims, and long after the July 30, 2020 prehearing conference at which exhibits were required to be exchanged. (Exhibit 6, Bates page 000055; Exhibits 11, 12.) The Appellant offered no explanation to justify or reasonably excuse its failure to maintain and produce the documents for audit and for this hearing as and when required under the regulations. This material was not timely produced and may not be introduced as evidence documenting entitlement to payment. 18 NYCRR 517.5(b)&(c), 519.14(a)&(b), 519.18(a).

The Appellant's argument that documentation produced for the first time in December 2020 is not "new matter" is unpersuasive. (Appellant brief, page 37.) In the context of this audit of documentation to support Medicaid claims, "new matter" is precisely what a previously unproduced progress note is.

There is also good reason to reject these belated documents on their merits. They were not submitted to the OMIG until December 28, 2020, shortly before this hearing commenced. (Transcript, page 340.) This was nineteen months after the draft audit report advised the Appellant it had one month to produce any additional documents it relied on for its claims, and fourteen months after the hearing had been requested. (Exhibit 6, Bates page 55; Exhibit 9.) It was Mr. Dorvilier who provided them to Mr. [REDACTED] for inclusion in the review and report he presented at the hearing. (Transcript, pages 344, 374; Exhibit AA.)

After the Appellant presented these documents at this hearing, OMIG recalled its witness, audit supervisor Nancy Grandino, who was promptly able to demonstrate that the photocopies of progress notes produced by the Appellant in December 2020 and purporting to document the services disallowed in sample 2, sample 14, and sample 42, were progress notes the Appellant had previously produced in support of other service dates. (Transcript, pages 382-86.) Handwritten progress notes had been photocopied and then altered to change the dates in order to present them as progress notes in support of more than one service date. (*Compare:* Appellant Exhibit AA, attachment A and Exhibit 16, Bates page 008618; Appellant Exhibit AA, attachment F and Exhibit 16, Bates page 010178; Appellant Exhibit AA, attachment J and Exhibit 16, Bates page 011193.)

The Appellant's response to Ms. Grandino's demonstration that the records produced in December 2020 are altered and photocopied progress notes from other dates only rendered more plausible the Appellant's own culpability for the fabrication of patient records. The only consistency in it is a failure to deny the obvious: that nursing notes were photocopied and redated.

On the one hand, the Appellant seems to have been aware that it had a record fabrication problem. Its nursing supervisor [REDACTED] circulated a memo to the Appellant's nurses in 2014, which stated:

I am requesting that all Skilled Nurses refrain from photo copying Progress Notes or re-writing them at any time. I have noticed some nurses performing these illegal acts and must stop this practice immediately. (Exhibit DD.)

But Ms. [REDACTED] then testified at the hearing that she does not believe the nurses falsified the progress notes in this case. (Transcript, page 408.) That leaves as the most plausible conclusion that it was the Appellant that did it at some point after being audited. The Appellant did not attempt at the hearing to deny the obvious fabrication. Instead, in its post hearing briefs, it inexplicably objected to the consideration of evidence of falsified documentation in support of sampled claims on the grounds that it somehow "violates DOH's sampling methodology." (Appellant brief, pages 38, 43, 47; reply brief, page 6.)

The Appellant's protestation of "surprise" at Ms. Grandino's testimony in rebuttal is itself surprising. (Appellant brief, pages 37-38.) A reason for her testimony on this issue did not arise until the Appellant, on April 9, 2021, on the third day of this hearing and well after the OMIG had completed its direct case on January 28, offered the falsified documents in support of Mr. [REDACTED] report. (Transcript, page 337.)

These actions of presenting signed progress notes with falsified dates constitute both fraud and abuse in the Medicaid Program. 18 NYCRR 515.1(b)(1)&(7). They also constitute the unacceptable practice of false statements:

False statements. (i) Making, or causing to be made any false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a medical assistance payment, or for use in determining the right to payment. (ii) Inducing or seeking the making of any false, fictitious or fraudulent statement or a misrepresentation of material fact. 18 NYCRR 515.2(b)(2).

In these three instances, the apparent fraud, abuse, and unacceptable practice in the Medicaid Program may not have been committed until late December 2020 when the Appellant presented the falsified progress notes to the OMIG with the explicit representation that they documented entitlement to payment for three claims. As this event occurred well after this audit was completed and closed and the final audit report was issued, the fabrication of patient care records was not alleged in it and is not under review in this administrative proceeding. It is for the OMIG to determine whether to pursue additional action pursuant to 18 NYCRR Part 515 or referral to the New York State Medicaid Fraud Control Unit (MFCU).

For sample 8 and sample 74, the Appellant offered neither argument nor evidence to refute the disallowances. The Appellant has failed to explain how its subpoena for prior approval records from eMedNY could shed any light on its failure to document that a prior approved service was later actually provided and documented on the date in question.

All ten disallowances in this category are affirmed.

Category 6. Billed for services in excess of ordered hours. Six claims. (Samples 44, 63, 80, 81, 82, 87.)

Nursing services provided in the patient's home must be in accordance with a physician's written order and plan of treatment, which must be documented. 10 NYCRR 85.33(f); 10 NYCRR 766.3&766.4; 18 NYCRR 505.8(f). In these instances, the OMIG determined that the Appellant billed for more hours of home health care than were authorized by the ordering physician and treatment plan. The OMIG disallowed payment for hours billed in excess of the hours authorized. (Transcript, pages 62-69.)

Sample 63. The service date was [REDACTED] 2013. The prior authorization was for 12 hours per day, 7 days per week. (Exhibit 16, Bates page 012269-70.) The Appellant billed 96 hours for the week [REDACTED] (Exhibit 16, Bates page 012212.) This billing included two 12-hour shifts on [REDACTED], 2013. (Exhibit 16, Bates page 102211.) The Appellant was not authorized to provide more than 12 hours on [REDACTED].

The Appellant concedes that the Medicaid Program payment records show it billed and was paid for two 12-hour shifts on [REDACTED]. The authorized and preapproved care was 12 hours per day. The Appellant offered no evidence to support Mr. [REDACTED] speculation that "different things could have happened. It could be that it is just, you know, a keypunch error" causing the Medicaid payment records to be inaccurate. (Transcript, pages 312-13.) The Department's Medicaid Program payment records are



entitled to a presumption of accuracy that the Appellant offered no evidence to refute. 18 NYCRR 519.18(f).

The claim reference information for the sampled and disallowed claim matches the second claim, paid on [REDACTED] 2013, not the first, paid on [REDACTED], 2013. (Exhibit 13, Bates page 001693; Exhibit 16, Bates page 012211.) Mr. [REDACTED] agreed "the claim selected was the unsupported claim." (Transcript, pages 333, 349.) The Appellant had already been paid for 12 hours on this date and is not entitled to the second payment it received. The disallowance is affirmed.

Samples 44, 80, 81, 82, 87. The remaining five disallowances in this category rely upon effectively switching the sampling unit from the claim to the week of claims.

There is no reason why this random sample of audited claims could not have, by chance, included two claims for the same patient in the same week. In such a case, the method employed here could disallow twice as many hours as were actually billed over the authorized hours for the week. For example, if the randomly selected audit sample had happened to include two claims in the week [REDACTED] for the patient in sample 44, the audit disallowance methodology applied here would result in disallowing 4 hours when the billing was for only 2 more hours than were authorized for the week.

The sampled claims should be independent, and in such a case they are not. The OMIG's explanation for the audit disallowance does not account for or address this issue, nor did the OMIG attempt to address it at the hearing or in its briefs.

For sample 44, the Appellant billed 12 hours on [REDACTED], 2014, of which the OMIG disallowed 2 hours because 56 hours was approved for the week and the Appellant billed 58 hours during the week [REDACTED]. (Exhibit 16, Bates pages 011227.) The prior authorization was for 56 hours per week effective [REDACTED], 2014. (Exhibit 16, Bates page 011257-58.)

The unit for sampling and extrapolation was the claim for the day, not the week. On [REDACTED], 12 hours of the 56 hours per week authorized effective [REDACTED] were still available. (Transcript, page 308.) This disallowance is reversed.

For sample 80 the service date was [REDACTED] 2015. The Appellant billed 67 hours for the week [REDACTED], 2015. (Exhibit 16, Bates page 013597.) Its timesheet for the week [REDACTED] showed 60 hours. (Exhibit 16, Bates page 013622.) The prior authorization was for 60 hours per week, effective [REDACTED] 2015. (Exhibit 16, Bates pages 013666-67.) The unit for sampling and extrapolation was the claim for the day, not the week. By both the Appellant's timesheet and the OMIG's own reckoning, which used the payment week reflected in its claims detail report, 10 hours of the authorized care for the week were still available on [REDACTED]. This disallowance is reversed.

For sample 81 the date of service was [REDACTED] 2015. The Appellant billed 116 hours for the week [REDACTED], 2015. (Exhibit 16, Bates page 013675.) The prior authorization was for 112 hours per week effective [REDACTED] 2015. (Exhibit 16, Bates pages 013787-88.) The OMIG concluded that the Appellant billed for 4 hours on [REDACTED] when its 112 hours had been used for the week.

The Appellant's weekly timekeeping records ran from Saturday to Friday. (Transcript, page 299.) Its weekly timecard began on Saturday, [REDACTED] and documented 112 hours for the week [REDACTED] 2015. (Exhibit 16, Bates page 013677.) In this instance, if the week runs from Sunday [REDACTED] to [REDACTED] the Appellant

billed 4 unauthorized hours on [REDACTED]. If it runs from Saturday [REDACTED] to [REDACTED] as is documented on the Appellant's timecard, 4 authorized hours were available on [REDACTED].

It is obvious that no disallowance for exceeding a weekly authorization could be made if the provider is simply able to retroactively designate the day on which a week's authorization is to begin, or if the OMIG is prohibited from even considering the issue whether the billing on one day exceeded the authorization for a week. Claims for unauthorized hours, however, is an entirely appropriate issue for a billing audit such as this.

As Mr. [REDACTED] pointed out: "a place like Harry's doesn't have much choice except to put together a standard week." (Transcript, pages 303-307.) Choosing a week starting from the commencement of the original authorization would require keeping track of every individual patient's authorization dates, sometimes extending back several months and through several changes. He argued "I don't think it is practical for pretty much anybody who has paper record to try to chase that particular concept." (Transcript, pages 354-55.) Under these circumstances, it was reasonable for the Appellant to establish a seven-day period to be used in keeping track of authorized hours, provided the period was consistently applied.

The evidence shows that the Appellant did consistently use a Saturday to Sunday week for keeping track of hours. That practice was reasonable and is not biased in favor of either the Appellant or the OMIG on a subsequent audit such as this. Mr. [REDACTED] agreed "I didn't find any bias for it." (Transcript, page 354.) It will be applied here, and in sample 80, in order to establish a consistent methodology for determining sample overpayments in this audit. The four disallowed hours were authorized and available on [REDACTED]. The disallowance is reversed.

For sample 82 the service date was [REDACTED], 2014. The Appellant billed 130 hours for week [REDACTED], 2014. (Exhibit 16, Bates page 013792.) The prior authorization was for 126 hours weekly effective [REDACTED], 2014. (Exhibit 16, Bates pages 013873-74.) The Appellant's timecard for the week [REDACTED] 19 records fewer than 126 hours. (Exhibit 16, Bates page 013794.) The unit for sampling and extrapolation was the claim paid for one day, not claims paid for the week. By both the Appellant's timesheet and the OMIG's own reckoning, on [REDACTED] the four hours disallowed in this audit were still authorized. The disallowance is reversed.

For sample 87 the service date was [REDACTED], 2014. The Appellant billed 57 hours for the week [REDACTED], 2014. (Exhibit 16, Bates page 014193.) The prior authorization was for 56 hours per week. (Exhibit 16, Bates page 014280.) The unit for sampling and extrapolation was claim for the day, not the week. By both the Appellant's timesheet and the OMIG's own reckoning, on [REDACTED] the one hour disallowed in this audit was still authorized. This disallowance is reversed.

The disallowance of sample 63 is affirmed. The disallowances in this category of samples 44, 80, 81, 82 and 87 are reversed. Sample 44 is also disallowed in categories 1&4. Samples 80 and 82 are also disallowed in category 1. The overpayments in those categories remain as overpayments for the audit sample. Samples 81 and 87 are reversed in their entirety. The total sample overpayment is reduced by \$153.99, and the overpayment for extrapolation by \$555.19.

Category 7. Missing medical orders/plan of care. Five claims. (Samples 12, 26, 55, 97, 100.)

Home health services must be provided in accordance with Department of Health regulations at 10 NYCRR Chapter V. 18 NYCRR 505.23(b). These regulations require a written plan of care for all services provided. 10 NYCRR 763.6. In these instances, the Appellant failed to produce a written plan of care covering the services for which it billed the Medicaid Program. The OMIG disallowed all services billed for the dates of service that were not documented with a written care plan. (Transcript, pages 69-72.)

It is not disputed that the Medicaid Program preauthorized the hours of care billed. For these and indeed every disallowance it challenges in this audit, the Appellant offers the bootstrapping argument that "pre-approval by DOH/EMEDNY creates a presumption that Appellant's submissions for all of the 26 projected samples were complete and fully compliant." (Appellant brief, page 30.)

This argument, as applied to the five disallowances in this category, is that prior authorization from eMedNY constitutes the required documentation because, according to Mr. [REDACTED] "medical orders/plan of care, which are usually the same thing have to exist to get a prior authorization." (Transcript, pages 73-76; 175, 297; Appellant brief, pages 13-14.) The burden of maintaining and producing documentation for audit, however, remains on the Appellant. A plan of care is documentation obtained by the provider. A prior authorization issued by the Department is not the documented plan of care, which remains the Appellant's obligation to prepare and maintain to support its claims.

OMIG audit supervisor Grandino testified that the OMIG does customarily make an attempt to access the Department's eMedNY records to see if a copy of the plan of care can be found there, but those attempts are not always successful. (Transcript, pages 103-104.) In this case, the Appellant also subpoenaed eMedNY records and learned that they were no longer maintained by eMedNY. (Appellant brief, page 30; Exhibit CC.)

The Appellant is not entitled to rely upon other entities to maintain or obtain documentation the Appellant was required to prepare, maintain and produce for audit. 18 NYCRR 504.3(a). Mr. Dorvilier acknowledged he was unable to locate this documentation which, if it is what he relies on to demonstrate his entitlement to payment, he was required to produce for audit. (Transcript, pages 361-63.) The Appellant cannot shift its responsibility to prepare, maintain and produce documentation by arguing, in effect, that it provided it to someone else who then failed to maintain it.

For these five sample disallowances, the Appellant offered, at the hearing, plans of care covering the dates of service. (Exhibit AA, attachments E, I, L, Y, Z.) As in disallowance category 5, this material was not timely produced for audit or for this hearing. For the reasons discussed in connection with category 5, it is not accepted as either timely produced or credible evidence demonstrating entitlement to payment. 18 NYCRR 517.5(b)&(c), 519.14(a)&(b), 519.18(a).

All five disallowances are affirmed.

Category 8. Failed to obtain authorized practitioner's signature within required time frame. Two claims. (Samples 69, 75.)

In order to be payable under the Medicaid Program, home health nursing services must be ordered by a physician. 18 NYCRR 505.8(f). The order authorizing the services must be authenticated within one year. 10 NYCRR 766.4.

In these instances, the OMIG determined that the Appellant billed for services for which the physician's order was not signed within the required one-year time frame. The Appellant did produce care plans with physician signatures on them, but the date lines next to the signatures were blank.

For sample 69 the date of service was [REDACTED] 2014. The signed physician's order bore dates showing a fax transmission from the Appellant on [REDACTED], 2013, with a return fax transmission from the physician on [REDACTED] 2014 at the top. (Exhibit 16, Bates page 012727; Transcript, pages 77-79.) For sample 75 the date of service was [REDACTED] 2014. The signed physician's order bore dates showing a fax transmission from the Appellant on [REDACTED], 2014, with a return fax transmission from the physician on [REDACTED], 2014 at the top. (Exhibit 16, Bates page 012982; Transcript, pages 79-83.)

The OMIG did not accept the dates on fax lines at the top of the care plans as sufficient to establish the orders were authenticated within the required time period. (Transcript, page 79.) 10 NYCRR 766.4(d)(1) does not require the care plan to be "signed and dated." It requires that it be "authenticated by an authorized practitioner within 12 months." These care plans were signed, and the fax dates on them are substantial evidence to establish that the signatures authenticating them were affixed within the required one-year period. (Transcript, pages 321-22.)

The disallowances of samples 69 and 75 in this category are reversed. Sample 69 was disallowed in the amount of \$307.97. Sample 75, disallowed in the amount of \$492.75, was also disallowed in categories 1 and 3. (Exhibit 8, Bates page 000309.) The overpayment in Sample 75 remains as an overpayment for the audit sample. The total sample overpayment is reduced by \$307.97, and the overpayment for extrapolation by \$800.72.

Category 9. Billed for services performed by another provider/entity. One claim. (Sample 4.)

The Medicaid Program will pay for home health services only when the services are medically necessary and provided in the patient's home. 18 NYCRR 505.23(a). The recipient in this instance was receiving hospital emergency room care on the date and at the time for which 8 hours of home care nursing services were billed by the Appellant.

The patient, age [REDACTED] was admitted and treated at [REDACTED] Hospital on [REDACTED] 2014, the same date for which 8 hours of nursing care in the home was billed. The Appellant's home care service nurse's progress note for [REDACTED] records that the nurse "left [REDACTED] with [REDACTED] in a good condition" at 3:30 pm. (Exhibit 16, Bates page 008954.) The Department's eMedNY record of institutional claims, however, documents the patient was admitted at [REDACTED] Hospital at 2:58 pm on [REDACTED] (Exhibit 17.)

The auditors rejected the entire progress note, concluding it was invalid to establish that any home care services were provided to this patient on the service date. (Transcript, pages 84-88, 119.) This conclusion is reasonable, and the Appellant offered no evidence, other than the demonstrably unreliable progress note itself, to refute it.

Mr. [REDACTED] suggested that "the real issue here is, you know, which information is more reliable." (Transcript, pages 216, 275.) The substantial evidence establishes that it is the hospitalization record. The credibility of the Appellant's progress notes having been severely undermined by their demonstrated fabrication in connection with other disallowances, this progress note, which is directly contradicted by a hospital admission record, is also not credited.

It is further noted that after raising the question whether the OMIG's evidence of the time of hospitalization on [REDACTED] was accurate (Exhibit AA, page 10), the Appellant offered no indication it had attempted to verify the information with the hospital. This comes as no surprise: on rebuttal, the OMIG produced extensive documentation obtained directly from the hospital, which left no doubt that this patient began receiving several hours of emergency room treatment 32 minutes before the Appellant's home care nurse, according to the Appellant's documentation, "left [REDACTED] with [REDACTED] in a good condition." (Exhibit 16, Bates page 008954.)

An affidavit of the nurse in question attached to Mr. [REDACTED] report has no persuasive value, being simply a statement prepared for her 7 years after the fact, filled with additional details and speculation about what might explain this matter, that is completely inconsistent with the evidence. (Exhibit AA, attachment B, affidavit of [REDACTED] Transcript, pages 448-49, 450-51.) When she was called to testify about it, the nurse was understandably unable to remember anything, saying "I can't recall anything after seven years ago." (Transcript, page 458.)

The disallowance is affirmed.

Category 10. Medical orders/plan of care not signed by an authorized practitioner. One claim. (Sample 20.)

Nursing services must be ordered by a physician. 18 NYCRR 505.8(f); 10 NYCRR 766.4. In sample 20 the plan of care covering the claim for service on [REDACTED] 2013 was not signed by a physician or anyone else. (Exhibit 16, Bates page 010386-87; Transcript, pages 92-93.) The Appellant failed to produce a signed physician order for the claimed service. At the hearing, the Appellant offered another care plan for the same period, this one signed. (Exhibit AA, attachment G.) As previously discussed in this decision, this material was not timely produced for audit and may not be considered in support of the claim. 18 NYCRR 517.5(b)&(c), 519.14(a)&(b), 519.18(a).

The disallowance is affirmed.

Category 11. Excluded individual providing service. One claim. (Sample 22.)

The Medicaid Program does not pay for health care services provided by persons who have been excluded from the Medicaid Program. 18 NYCRR 504.1, 515.5. The date of service for this claim was [REDACTED], 2013. (Exhibit 8, Bates page 000307.) The nurse who provided the home care had been excluded from the Medicaid Program

many years earlier. (Exhibit 16, Bates pages 010475, 010477, 010527; Transcript, pages 94-99.)

The Appellant suggests, without any evidence, that the OMIG is wrong and that this nurse was not excluded from the Medicaid program in 2013. The Appellant offered no affirmative evidence of this nurse's status with the Medicaid Program in [REDACTED] 2013. Its evidence presented at this hearing consisted of a copy of an online search of the nurse's licensure status with the Department of Education, which is irrelevant to the disallowance because professional licensure and Medicaid provider status are not the same thing. The Appellant also submitted a copy of results from a search of OMIG Medicaid exclusion records that misspelled the name of the nurse in question. (Exhibit AA, attachment H; Transcript, pages 293-96, 366.) The OMIG's evidence, in the form of Department records documenting this nurse's exclusion from the Medicaid Program on [REDACTED], 2002 for conviction of a crime, is credited. (Exhibit 16, Bates page 010477.)

The Appellant's protest that it did not know the nurse was excluded from the Medicaid Program does not entitle it to payment. 18 NYCRR 518.1(c). As the Appellant's own witness, Mr. [REDACTED] also pointed out, a provider has "many options" to research whether a person is excluded. (Exhibit 19.)

The disallowance is affirmed.

### III. Medicaid Program overpayments.

The 100-claim audit sample was randomly selected from an audit frame of all claims that the Department's billing and payment records show were paid by the Medicaid Program to the Appellant during the three-year audit period. Computer generated documents prepared by the Department or its fiscal agent to show the nature and amount of payments made under the Medicaid Program will be presumed, in the absence of direct evidence to the contrary, to constitute an accurate itemization of the payments made to a provider. 18 NYCRR 519.19(f). The Appellant did not challenge or offer any evidence to rebut this presumption.

The amount disallowed for each claim in the audit sample is set forth in the exhibits attached to the final audit report. The category 8 disallowance in sample 69 (\$307.97) and the category 6 disallowances in samples 81 (\$123.19) and 87 (\$30.80), in the total amount of \$461.96, are reversed herein. The category 8 disallowance in sample 75 (\$492.75), and the category 6 disallowances in sample 44 (\$61.60), sample 80

(\$215.60), and sample 82 (\$123.20), in the total amount of are \$893.15, are reversed only for the purposes of extrapolation and so the disallowances remain. The overpayment in the sample is reduced to \$18,462.66.

The claims disallowed in this audit, as affirmed in this hearing decision, were not authorized to be paid under the Medicaid Program because they were not supported by documentation demonstrating compliance with Medicaid Program requirements. The OMIG is entitled to recover the overpayments made.

IV. The statistical sampling and extrapolation.

For disallowance categories 1 through 4 the overpayment determination was limited to the sample findings. (Exhibit 8, Bates page 000306.) For disallowance categories 5 through 11, the OMIG extrapolated the overpayment in the sample findings to the 73,761 claims paid by the Medicaid Program during the audit period.

The audit exit conference summary provided to the Appellant in connection with the March 27, 2017 exit conference provided a detailed explanation of the sampling and extrapolation methodology applied in this audit. (Exhibit 4, pages 000031-33.) The draft audit report (Exhibit 6) and the final audit report (Exhibit 8) also explained and set forth the manner in which the extrapolation was made. These documents identified the disallowed claims, the audit frame to which they were extrapolated, and the method of estimation.

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. 18 NYCRR 519.18(g). The OMIG submitted the required certification in the form of affidavits from

Dr. Karl W. Heiner, the statistical consultant who designed the sampling and estimation methodology and the computer program that implemented it, and Theresa A. Gulum, the OMIG employee who implemented the methodology to establish the audit frame and select the random sample. (Exhibits 13, 14.)

The Appellant's argument that a Department regulation that specifically authorizes extrapolation in order to establish the accuracy of an overpayment amount is somehow not a regulation that authorizes extrapolation to prove the amount of an overpayment because it is titled "Hearing Procedure," is not accompanied by any persuasive explanation and is not convincing. The Appellant does not cite a single reported decision or any other authority that supports this view, which also confuses 18 NYCRR Part 518 overpayments with 18 NYCRR Part 516 and SSL 145-b monetary penalties. (Appellant brief, pages 59-60.)

The Appellant suggests, contrary to its own statistical witness, [REDACTED] (Transcript, pages 420, 438-39), that the extrapolation in this audit relies on "junk science" (Appellant brief, page 61), but there is an abundance of reported case law to the contrary. The OMIG's statistical sampling and estimation methodology has consistently been upheld in New York State Medicaid Program administrative hearings and by the New York courts, including the New York Court of Appeals. Mercy Hospital v. NYS DSS, 79 N.Y.2d 197, 581 N.Y.S.2d 628 (1992); Enrico v. Bane, 213 A.D.2d 784, 623 N.Y.S.2d 25 (3<sup>rd</sup> Dept. 1995); Clin Path, Inc. v. NYS DSS, 193 A.D.2d 1034, 598



N.Y.S.2d 583 (3<sup>rd</sup> Dept. 1993).<sup>1</sup> The Appellant failed to overcome the presumption of accuracy in the extrapolated overpayment.

Mr. [REDACTED] the Appellant's witness, testified that he had difficulty understanding the claims detail information for the 73,761 claims in the audit universe, complaining he had some difficulty verifying such matters as that the 100 sample items were actually among the 73,761 claims in the universe. The information provided in the certification, which included a claim reference number, date of service, and amount paid for each claim, is readily verifiable by a comparison of the sample and universe lists attached to Ms. Gulum's certification. (Exhibit 13.) It is also reconcilable with the claims detail reports provided in connection with each claim in the audit sample. (Exhibit 16.) There is no evidence that the Appellant asked the OMIG for any additional information or further clarification on it before Mr. [REDACTED] complained about it in his March 31, 2021 report and then at the hearing. The Appellant's suggestion that it ever had any reason to

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<sup>1</sup> Additional reported decisions affirming the 18 NYCRR 519.18(g) extrapolation methodology used in this audit include: West Midtown Management Group, Inc. v. State of N.Y., 31 N.Y.3d 533, 81 N.Y.S.3d 343 (2018); Sarfo v. Glass, 243 A.D.2d 824, 663 N.Y.S.2d 894 (3<sup>rd</sup> Dept. 1997); Tsakonas v. Dowling, 227 A.D.2d 729, 642 N.Y.S.2d 342 (3<sup>rd</sup> Dept. 1996); Lala v. Dowling, 226 A.D.2d 933, 640 N.Y.S.2d 933 (3<sup>rd</sup> Dept. 1996); Piasecki v. DSS, 225 A.D.2d 310, 639 N.Y.S.2d 319 (1<sup>st</sup> Dept. 1996); Polanco v. DSS, 212 A.D.2d 443, 622 N.Y.S.2d 932 (1<sup>st</sup> Dept. 1995); Kuchment v. DSS, 222 A.D.2d 806, 634 N.Y.S.2d 849 (3<sup>rd</sup> Dept. 1995); Enaw v. Dowling, 220 A.D.2d 942, 632 N.Y.S.2d 715 (3<sup>rd</sup> Dept. 1995); Lock v. DSS, 220 A.D.2d 825, 632 N.Y.S.2d 300 (3<sup>rd</sup> Dept. 1995); Ghosal v. Bane, 204 A.D.2d 215, 612 N.Y.S.2d 399 (1<sup>st</sup> Dept. 1994), *lv. denied* 84 N.Y.2d 805, 618 N.Y.S.2d 6; Ogunkoya v. DSS, 204 A.D.2d 122, 612 N.Y.S.2d 7 (1<sup>st</sup> Dept. 1994); Newman v. Dowling, 210 A.D.2d 552, 619 N.Y.S.2d 794 (3<sup>rd</sup> Dept. 1994); State v. Khan, 206 A.D.2d 732, 615 N.Y.S.2d 771 (3<sup>rd</sup> Dept. 1994); Roggeman v. Bane, 206 A.D.2d 622, 614 N.Y.S.2d 593 (3<sup>rd</sup> Dept. 1994), *lv. denied* 84 N.Y.2d 809, 621 N.Y.S.2d 518; Adrien v. Kaladjian, 199 A.D.2d 57, 605 N.Y.S.2d 33 (1<sup>st</sup> Dept. 1993); Lalani v. Bane, 199 A.D.2d 80, 605 N.Y.S.2d 48 (1<sup>st</sup> Dept. 1993); Metzies Shoe Brooklyn NY Corp. v. DSS, 151 A.D.2d 675, 542 N.Y.S.2d 731 (2<sup>nd</sup> Dept. 1989).

be confused about which 100 Medicaid claims were under review in this audit is not credible.

The OMIG attached to its certification (Exhibit 13) a list of all claims in the universe of claims audited (Bates pages 000326-001691); a list of the 100 claims selected from that universe to make up the sample (Bates pages 001692-001693); and a report explaining the manner and method by which the sample was selected, the numerical order in which the random numbers for the sample were selected by the sampling program, and the statistical tests performed on the selected numbers (Bates page 001694). Mr. [REDACTED] did not like the way the documents were labeled, objecting that these three documents, clearly described in and annexed to the OMIG's certification, were "not anywhere labelled as such." He apparently became confused by the lack of headings on the pages in order to guide him. (Transcript, pages 209-10.) However, having himself issued "probably in excess of 5,000 audit reports" in his 20 years as audit manager for the New York State Medicaid Program (Transcript, pages 203-204), he conceded that eventually "I think I figured out how I could do it now, but I did not have time to actually do it," and confirmed the information in the OMIG's very straightforward certifications. (Transcript, pages 210-12, 310.) Even his written report states that he "determined after some time that the sample methodology used was likely to be consistent with the certification provided in Exhibit 13." (Exhibit AA, [REDACTED] report, page 8.) This is hardly a compelling refutation of the OMIG's audit methodology, certification or claims data.

Immediately before complaining about "no guidance and sparse information," Mr. [REDACTED] report also complained both that "the information provided by OMIG cannot be readily understood by a Provider and does not contain sufficient detail to allow an outside

reviewer to completely understand the basis for the disallowances taken” and that “the OMIG reports contain significant detail that is difficult to comprehend for a provider of health care services.” (Exhibit AA, [REDACTED] affidavit, pages 6-7.) That “significant detail” is entirely about the 73,761 Medicaid claims that the Appellant was plainly able to comprehend well enough to submit to the Medicaid Program for payment. The sample list that the Appellant finds so confusing is just the same information, only 700 times shorter. In an audit of this many claims, there is obviously a large amount of detailed information, but there is nothing confusing about the documents supporting the OMIG certification.

The Appellant’s second witness on statistical sampling and extrapolation, [REDACTED] did not even claim that the sample size or extrapolation methodology approved by Dr. Heiner in this case was statistically invalid. Instead, she offered the uncontroversial opinion that increasing the sample size or using stratified sampling might improve the reliability and accuracy of the extrapolation by narrowing the confidence interval. (Transcript, pages 424-27.) She also acknowledged, however, that narrowing the confidence interval would not affect the point estimate, which is the figure relied on by the OMIG. (Transcript, page 436.)

“Less reliable” than a more extensive audit is not the equivalent of “statistically invalid.” Ms. [REDACTED] opinion that “any time you increase your sample size means the closer you get to your universe size you are always going to have a better predictor of your parameter, your population value” (Transcript, pages 432-33) is completely uncontroversial. Her opinion that “stratified sampling is useful when there are extreme values within the population” (Exhibit BB, page 2) is also uncontroversial.

It is further noted that Ms. [REDACTED] offered her opinions in this case without actually looking at the relevant data. She talked about "what if I were consulting for Harry's Nurses, what I would do" (Transcript, page 431) without actually doing it:

Well, in my opinion, without analyzing the data. I am a data person, so I would analyze the data, but in my opinion what would likely happen would be that you have your spread reduced, which would, therefore, reduce your margin of error. (Transcript, page 430.)

Ms. [REDACTED] opined that "extreme values are likely since the sample universe population was over 73,000," but she did not demonstrate this or even explain why it might be likely, and because she admittedly did not analyze the data could not possibly know whether it was the case in this audit. She also suggested there might be "significant variability in either the universe of samples or the 100 samples selected" (Exhibit BB, page 2) because some of the disallowance categories are "likely to occur at a lower frequency" than others. She failed to explain her basis for making this assumption or why it matters. It is also difficult to understand her raising the point at all when she illustrated it by stating:

For example, an alleged falsified credential (sample 22) or an alleged falsified time card (sample 4) are likely to occur at a lower frequency than an alleged missing date on a signed plan of treatment (sample 69). (Exhibit BB, page 2.)

This assertion hardly raises a question about the OMIG's methodology in this case. To the contrary, to the extent it has any validity it confirms that frequency of occurrence in different types of claims is just what the sampling methodology reflects: Twice as many disallowances were made in sample category 8 as in categories 9 or 11. Ms. [REDACTED] admission that her opinion was given "without analyzing the data" was admirably candid and entirely credible.

Ms. [REDACTED] did not refute the presumption of accuracy in the OMIG's extrapolation by expressing concerns about accuracy and then saying "that is my concern without knowing the data and having looked at all the data." (Transcript, page 422.)

- Q. I didn't see anything in your report that indicated that what we do or Dr. Heiner suggested we do was incorrect; is that true?
- A. That is true.
- Q. Statistically it was a correct formulation?
- A. There is a difference between correct and accurate and reliable though.
- Q. Right, I get that. So by not stratifying you believe that our low and our high area are not as reliable as they could be?
- A. That is my opinion.
- Q. But what about the mean point estimate; is that reliable?
- A. I would assume. I don't exactly know. (Transcript, pages 438-39.)

Ms. [REDACTED] professional opinion consisted of no more than the assertion that the margin of error might have been reduced by increasing the sample size or stratifying. This falls far short of expert opinion refuting the validity of the statistical sampling and extrapolation methodology certified by Dr. Heiner.

#### V. Conclusion

The overpayment must be recalculated in accordance with the methodology set forth in Exhibits 8 and 14 to reflect the reversal of samples 44, 80, 81, 82 and 87 in disallowance category 6, and samples 69 and 75 in disallowance category 8. The overpayment for extrapolation is \$4,262.58. The extrapolated overpayment ( $\$4,262.58/100 \times 73,761$ ) is \$3,144,121.63. The overpayments not extrapolated total \$14,200.08. The total overpayment is \$3,158,321.71. A restitution claim in that amount is authorized under 18 NYCRR 518.1 and 518.3.

The Appellant complains that the OMIG's restitution claim is unreasonable and "a disproportionately large and punitive penalty." (Appellant brief, page 4.) This audit revealed a massive failure to comply with conditions of Medicaid reimbursement: 67 of

100 paid claims reviewed in the audit have been determined to be recoverable overpayments. The 128 reasons justifying the disallowance of these 67 claims included overpayments resulting from pervasive recordkeeping inadequacies; billing for care that was not provided; and billing for care that was not ordered. In 21 percent of the claims reviewed (categories 3&4), the Appellant billed for care provided by staff who were not documented to be immunized and tested for serious communicable diseases; and the Appellant also billed for care provided by a nurse who had been excluded from the Medicaid Program under 18 NYCRR 515.7(c) for conviction of a crime relating to the furnishing of or billing for medical care.

The record is devoid of evidence to support the Appellant's assertions that "the DOH audit program unfairly and unlawfully discriminates against minority businesses based on race" or its accusations that "the audit in this case is tainted by systemic racism." (Appellant brief, pages 16-24; Exhibit EE.)

In addition to accusing the OMIG of "institutional racism" (Exhibit EE, paragraph 11), Mr. Dorvilier testified:

Q. Do you feel like you benefit from a program, that would, maybe, provide some guidance and training to your company as to what OMIG, and eMedNY, Department of Health expectations are regarding your programs and how to comply with what their requirements are in terms of maintaining proper records?

A. ... But, you know, we have been doing that for quite a while. We assume the responsibility to do it well...

Q. Let me ask that question a different way. Do you think that – has there been any outreach or any attempt by the Department of Health to train you and your personnel as what their expectations and requirements are on the compliance issues?

A. Absolutely not, no such thing.

...

Q. I guess, are you aware that there is compliance – provider compliance program authorized by the regulations and in the Social Services Law?

A. Yes.

Q. But to date, you have not been a beneficiary of that program, correct?

A. No. (Transcript, pages 178-82.)

In rebuttal to Mr. Dorvilier's testimony and complaints that the Appellant had received "absolutely not, no" guidance and support in his Medicaid Program compliance obligations, the OMIG produced documentation showing that on March 30, 2015, nine months before this audit period ended, the Appellant certified to the OMIG that it had implemented plans of correction, trained affected individuals, and resolved all insufficiencies identified in an assessment done by the OMIG. (Exhibit 18; Transcript, pages 115-18, 178.) The sample reviewed in this audit included 17 claims for services provided after March 30, 2015, the date the Appellant certified correction and training to resolve compliance issues. (Samples 7, 9, 15, 16, 17, 27, 30, 36, 47, 53, 64, 71, 80, 81, 94, 95, 98.) This audit disallowed 10 of those 17 claims. (Samples 2, 7, 9, 15, 17, 64, 80, 81, 94, 98.) (Exhibit 8, attachment C.)

The OMIG was authorized to extrapolate all of the audit sample findings. Had it done so the overpayment would exceed \$13.9 million. The OMIG's final audit report extrapolated only 26 of the 70 sample overpayments and sought to recover \$4.1 million of the nearly \$22 million the Appellant received from the Medicaid Program during the three-year audit period. That overpayment has been reduced to \$3.1 million in this decision. The overpayment determination is appropriate and well within the scope of the OMIG's PHL 30 mandate to detect and combat Medicaid fraud and abuse and maximize the recoupment of improper Medicaid payments.

**DECISION:** The OMIG's determination to recover Medicaid Program overpayments is affirmed.

The disallowances of samples 44, 80, 18, 82 and 87 in disallowance category 6, and samples 69 and 75 in disallowance category 8, are reversed. All other disallowances are affirmed.

The overpayment for the audit sample is in the total amount of \$18,462.66.

The OMIG's determination to extrapolate the overpayments in audit sample categories 5 through 11 to all paid claims in the audit period is affirmed.

The sample overpayment for extrapolation (disallowance categories 5 through 11) is \$4,262.58. The extrapolated portion of the overpayment is \$3,144,121.63.

The sample overpayment not extrapolated (disallowance categories 1-4) is \$14,200.08.

The total overpayment is \$3,158,321.71.

This decision is made by John Harris Terepka, who has been designated to make such decisions.

DATED: Rochester, New York  
October 4, 2021

  
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John Harris Terepka  
Bureau of Adjudication