

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

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In the Matter of the Appeal of :
:
PERSISTENT CAR SERVICE CORP. :
:
Medicaid ID #02949833 :
:
for a hearing pursuant to Part 519 of Title 18 of the :
Official Compilation of Codes, Rules and Regulations :
of the State of New York (“NYCRR”) to review a :
determination to recover Medicaid overpayments. :
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Decision After Hearing

Audit #11-3805

Before: Dawn MacKillop-Soller
Administrative Law Judge

Held At: NYS Department of Health
150 Broadway
Suite 510
Menands, New York 12204

Date of Hearing: November 4, 2016
Record closed: February 10, 2017

Parties: NYS Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Ricja Rice-Ghyll, Esq.
Thomas Coles, Esq.

Persistent Car Service Corp.
38 North White Street
Poughkeepsie, New York 12601
By: Mr. Kevin Dyer

JURISDICTION

The Department of Health (“Department”) acts as the single state agency to supervise the administration of New York’s medical assistance program (“Medicaid”). PHL § 201(1)(v), Social Services Law (“SSL”) § 363-a. The New York State Office of the Medicaid Inspector General (“OMIG”), an independent office within the Department, has the authority to pursue civil and administrative enforcement actions against entities or individuals engaged in fraud, abuse, or unacceptable Medicaid practices and to recover the improperly paid funds. Public Health Law (“PHL”) §§ 30, 31, 32. The OMIG determined to recover Medicaid Program overpayments made to Persistent Car Service Corp. (“Appellant”.) The Appellant requested a hearing pursuant to SSL 22 and former Department of Social Services regulations at 18 NYCRR 519.4 to review the overpayment determination. (Exhibit 18.)

At the hearing, the Department submitted documents (Exhibits 1-18) and presented two witnesses: Joseph D’Agostino, OMIG management specialist (Transcript, p. 42), and Richard Nawrot, Empire Health Advisors consultant. (Transcript, p. 122.) The Appellant produced as witnesses [REDACTED], transportation provider in the New York State Medicaid Program (Transcript p. 208), and the Appellant’s owner, Richard Dyer. (Transcript, p. 222.) A transcript of the hearing was made. (Transcript, p. 1-259.) Each side submitted one post-hearing brief and the Department submitted a reply brief. The Appellant has the burden of showing that the OMIG’s determination was incorrect and that all payments received were allowable. 18 NYCRR 519.18(d)(1).

FINDINGS OF FACT

1. The Appellant, Persistent Car Service Corp., a taxi company licensed by the New York State Department of Transportation and located in Poughkeepsie, New York, is enrolled as a

transportation provider in the New York State Medicaid Program. The Appellant is owned and operated by Richard Dyer. (Transcript, p. 41-42.)

2. The OMIG completed a transportation audit through its private contractor, Empire Health Advisors (“EHA”), as part of a County Demonstration Project. The purpose of the audit was to determine whether the Appellant’s records were in compliance with Medicaid Program requirements. (Transcript, p. 44, 51.)

3. During the audit period of January 1, 2008 through December 31, 2010, the Appellant was paid \$783,980.29 for 16,198 claims for Medicaid transportation services to 937 Medicaid recipients. The audit consisted of a review of a randomly selected sample of 150 of those claims for 101 recipients, paid in the total amount of \$6,964.25. (Exhibit 3-A1; Transcript, p. 58.)

4. After a review of the EHA’s audit findings and documentation, the OMIG identified violations of Medicaid Program requirements as stated in the regulations, laws and the MMIS Provider Manual for Transportation in the submission of 133 claims. The OMIG’s violations for “No Documentation/Missing Documentation,” are grouped into five subcategories:

Missing the name of the drivers in violation of MMIS Provider Manual for Transportation Version 2006-1:

In 103 instances pertaining to 76 recipients, (Samples 2, 3, 5-8, 10-13, 16, 17, 20-22, 24-25, 27, 30-31, 33-34, 36-38, 40-41, 43-44, 46-49, 51-54, 56, 58, 61-63, 65, 68-71, 73-76, 79, 82-87, 89-91, 93, 96-109, 111-114, 116-117, 119, 122-125, 128, 130, 132-134, 136-140, 143, 145-149), contemporaneous documentation supporting the name of the driver was incomplete. This resulted in a sample overpayment of \$4,483.50;

Missing the full printed name of the drivers in violation of Medicaid Update, Version 2010-1:

In 24 instances pertaining to 20 recipients, (Samples 9, 15, 18-19, 26, 28-29, 35, 55, 57, 64, 66-67, 78, 80-81, 88, 94, 121, 127, 131, 142, 144 and 150), contemporaneous documentation supporting the printed full name of the driver was incomplete. This resulted in a sample overpayment of \$679.50;

Missing the time of drop off in violation of Medicaid Update, Version 2010-1:

In three instances pertaining to three recipients, (Samples 39, 50 and 118), contemporaneous documentation to show the time of drop off was missing. This resulted in a sample overpayment of \$126.75;

Missing the vehicle license plate number in violation of Medicaid Update, Version 2010-1:

In one instance, (Sample 1), contemporaneous documentation to support the vehicle license plate number was missing. This resulted in a sample overpayment of \$20.00;

Missing the time of pickup in violation of Medicaid Update, Version 2010-1:

In two instances pertaining to two recipients (Samples 115 and 129), contemporaneous documentation to reflect the time of pickup was missing. This resulted in a sample overpayment of \$18.00.

5. By draft audit report dated April 21, 2015, in which the audit findings were detailed, the OMIG advised the Appellant that it had determined to seek restitution of Medicaid overpayments in the amount of \$575,325.00. (Exhibit 3-A4.)

6. In a June 15, 2015, response to the draft audit report, the Appellant, by its former attorney, David R. Ross, Esq. of O'Connell and Aronowitz, objected to the OMIG's "financial error rate of 76%" in 133 sample claims and to the statistical sampling methodology employed by the OMIG to determine the mean per unit point estimate. The Appellant also claimed that its records were "damaged, destroyed and/or rendered unreadable as the result of a flood on or about August 28, 2011," resulting in "a total loss of documentation."

7. The Appellant produced dispatch rosters from MAS to show the 133 Medicaid transportation trip assignments for each of the sample claims and trip sheets. (Exhibit 3-A3; Transcript, p. 67-68.) MAS is an independent brokerage corporation that provides transportation

management services in the form of assigned transports and is independent from both the OMIG and the Appellant. (Exhibit 14, Transcript, p. 120- 121.)

8. The OMIG's final audit report dated December 4, 2015, reaffirmed the findings and overpayment determination set forth in the draft audit report. (Exhibit 3-A1.)

9. The OMIG's restitution claim is an extrapolation based upon an audit utilizing a statistical sampling method certified as valid, in which the value of the 133 disallowed claims found among the random sample of 150 claims was projected to the total of 16,198 claims paid by Medicaid during the audit period. The OMIG's findings and the extrapolation are set forth in attachments to the draft and final audit reports. (Exhibits 3-A1, A4.)

10. On December 29, 2015, the Appellant requested an administrative hearing contesting the OMIG's final determination. (Exhibit 18.)

APPLICABLE LAW

1. Providers are subject to audit by the department and are required "to reimburse the department for overpayments discovered by audits in accordance with Parts 516 and 517." 18 NYCRR 504.8(1).

2. An overpayment is defined to include "any amount not authorized to be paid under the medical assistance 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).

3. When the Department has determined "that any person has submitted...claims for...services...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).

4. "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 or penalty to be imposed.” 18 NYCRR 519.18(g).

5. A Medicaid provider’s record-keeping obligations under the Medicaid Program are described in 18 NYCRR 504.3. Those obligations include:

- a. [to] prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the ...New York State Department of Health.

[¶] . . . [¶]

- g. to permit audits, by the persons and agencies denominated in subdivision (a) of this section, of all books and records or, in the discretion of the auditing agency, a sample thereof, relating to services furnished and payments received under the medical assistance program...including...case files and patient-specific data.
- h. that the information provided in relation to any claim for payment shall be true, accurate and complete; and
- i. to comply with the rules, regulations and official directives of the department. *See also* 18 NYCRR 517.3(b)(1), 540.7(a)(8).

6. The New York State Medicaid Program issues Provider Manuals and Medicaid Updates, which are available to all providers, and include Medicaid billing policies, guidelines, procedures, and instructions. (Transcript, p. 45.) Reimbursement to transportation providers will only occur “when acceptable records verifying a trip’s occurrence are complete and available to auditors upon request.” (Exhibits 10-11; *See*, www.eMedNY.org.)

7. For services provided from January 1, 2008 through September 1, 2010, the Appellant was required under the MMIS Provider Manual for Transportation effective on October 20, 2006,

to complete and maintain for each transportation service contemporaneous documentation to reflect the Medicaid recipient's name and Medicaid identification number, the trip origination and destination, the date and time and the name of the driver. MMIS Provider Manual for Transportation, Version 2006-1, Section II. A Medicaid Update effective on September 1, 2010 required the Appellant to include in its contemporaneous documentation the "full printed name" of the driver, the time of pickup and drop off and the vehicle license plate number for "both legs of the trip." Medicaid Update, August 2010, Vol. 26, No. 10.

ISSUE

Has the Appellant established that the OMIG's determination to recover overpayments in the amount of \$575,325.00 was not correct?

ANALYSIS AND CONCLUSIONS

Audit findings

At the hearing and pursuant to 18 NYCRR 519.19(a), the Department produced an OMIG "representative...to present the audit file and summarize the case." The OMIG's findings and the extrapolation are set forth in attachments to the final audit report. The OMIG determined that out of 150 claims, 133 were disallowed and not authorized to be paid as a result of the Appellant's improper record-keeping practices in violation of 18 NYCRR 504.3, 517.3, 540.7(a)(8) and the MMIS Provider Manual for Transportation. The OMIG reviewed the Appellant's response to the draft audit report and its findings remained unchanged in the final audit report dated December 4, 2015. (Exhibits 3-A1, A3.)

This process is set forth in 18 NYCRR 517.5 and 517.6 and provided the Appellant with notice of the audit and a chance to submit additional documents before a final determination was issued. (Exhibit 3-B7.) On May 25, 2011, the OMIG issued its audit notification letter identifying

the period when claims would be subject to audit. (Exhibit 3-B6.) The OMIG also provided the Appellant with additional opportunities to submit supplemental documentation, such as a driver's license to confirm the full name of a driver to complete trip details, but it chose not to. (Transcript, p. 164-165.) The Appellant voluntarily participates in the Medicaid Program, which has as a benefit expeditious payment for the services it bills with no questions asked. In the event of an audit, the Appellant should have been prepared to come forward with its contemporaneous documentation. Based on the Appellant's failure to come forward with contemporaneous documentation, it has not demonstrated its entitlement to payments.

Flood

The Appellant's reliance on a December of 2012 Medicaid Update – to argue that because its records were destroyed by a flood or “unforeseen incident” caused by Hurricane Irene in August of 2011, it should be exempt from the Medicaid Program record-keeping requirements – is unpersuasive. (Appellant's brief, p. 1.) This is apparent from its plain meaning. The Medicaid Update specifically provides that records proven “damaged by fire, flood or other disaster” will be “determined to meet the record-keeping requirements for Medicaid purposes” after a transportation provider properly reports “the loss of their records” to the Department. The Appellant admits to never reporting this alleged loss. As such, the record-keeping requirement as stated in the Medicaid Update was violated. (Exhibit 3-A3; *See* Medicaid Update, December 2012, Vol. 28, No. 14.)

Even if the Appellant had complied with the reporting requirement, the August 2011 flood does not excuse the Appellant's failure to produce documentation to support its claims at an entrance conference that took place in June 2011. At the time of the entrance conference on June 14, 2011, EHA consultant Richard Nawrot explained that the purpose was to “gather” all the documentation that the Appellant “had available.” (Transcript, p. 203.) The Appellant, in turn,

provided electronic files containing trip rosters and driver logs to support its claims, but conspicuously absent were trip details. (Exhibit 3-B9; Transcript, p. 82, 203, 236, 154, 157-160.) Mr. Dyer also represented at the hearing that he submitted all claim documentation “prior to the flood,” rendering the “unforeseen incident” exemption argument moot. (Transcript, p. 237.) The Appellant provided no explanation for its decision to wait until after the exit conference held on November 6, 2014, to assert this “unforeseen incident” exemption claim for the first time. (Transcript, p. 202.) Accordingly, the Appellant failed to produce evidence to excuse its failure to create and maintain complete documentation to verify its claims, as it was required to do under 18 NYCRR 504.3(a), 517.3(b) and 540.7(a)(8).

MAS

The Appellant’s attempt to justify its incomplete documentation as “understandable” – because Medical Answering Services, LLC (“MAS”) never provided training on the Medicaid Program documentation requirements and MAS waited until June of 2011 to include driver and vehicle information on its dispatch roster – is equally unavailing. (Exhibit 3-A3.) These requirements are found in the MMIS Provider Manual for Transportation, a handbook that the evidence established is given to all providers as part of the enrollment process. This manual contains guidelines that have been found by the courts to constitute the “official directives of the department” and the Appellant was obligated to follow it. Lock v. NYS Dept. of Social Services, 220 AD2d 825, 827 (3rd Dept. 1995); 18 NYCRR 504.3(i). The requirements are also published online at www.eMedNY.org, a website that the Appellant admits to regularly accessing for billing purposes. (Exhibit 9; Transcript, p. 76-77, 85, 239, 251.) The Appellant had access to these resources. As such, it should have known that it was responsible to maintain its own records. It also should have known that MAS is an independent broker whose only role is to assign trips, not

to educate the Appellant on its reporting obligations.

Medicaid Program overpayments

The audit findings for the 150 claims in the sample were extrapolated to the universe of 16,198 claims that the Department's computer billing and payment records show were paid by the Medicaid Program during the audit period. (Exhibit 3-A3.) Such 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 certifications from statistician Karl W. Heiner and OMIG Deputy Inspector General, Kevin Ryan (Exhibits 13 and 14), confirming the validity of the statistical sampling method. The Appellant failed to submit adequate documentation in support of the individual claims and merely objected to the statistical sampling and extrapolation by raising questions about the methodology relied upon by the OMIG in its overpayment calculation. 18 NYCRR 519.18(g); *See, Matter of Mercy Hospital of Watertown v. NYS Dept. of Social Services*, 79 NY2d 197, 216 (1992). It did so without presenting any expert testimony or evidence challenging the extrapolation or an actual accounting of all claims paid in rebuttal to the Department's proof. 18 NYCRR 519.18(g). Accordingly, the Appellant's attempt to undermine the Department's methods for calculating the overpayments is without merit.

Conclusion

It is undisputed that the Appellant provided the "medically necessary" (Appellant's brief, p. 1) transportation services underlying the claims. However, as a participant in the Medicaid Program, in submitting its bills for payment, the Appellant was also required to maintain the contemporaneous trip details to document and verify those services. 18 NYCRR 504.3(a) and (i),

517.3(b); MMIS manuals 2006-1 through 2010-1. The Appellant relies on a federal audit to criticize the OMIG for an overly technical interpretation of its Medicaid Program documentation regulations. (Exhibit 3-A3; *See*, U.S. Dept. of Health and Human Services Office of the Inspector General of Medicaid claims, Report Number A-02-08-01006.) However, the Appellant’s own characterization of its Medicaid clients as “the neediest” and “most vulnerable” patients emphasizes the importance in providers complying with the Medicaid Program documentation requirements. In order to protect these patients and the public funds that pay for the “sixty-three billion dollar” Medicaid Program, as Mr. D’Agostino pointed out, “accountability” on the part of all providers is required. (Appellant’s brief, p. 3; Transcript, p. 83.) The OMIG is hardly “insistent on a level of perfection” that is “unattainable,” as suggested by the Appellant, in its requirement that providers account for the payments they receive. (Exhibit 3-A3.)

The Appellant has failed to meet its burden of proving entitlement to payment for the claims disallowed by the OMIG.

DECISION:

The OMIG’s determination to recover Medicaid Program overpayments from Persistent Car Service Corp. is affirmed. The overpayment is in the total amount of \$575,325.00.

This decision is made by Dawn MacKillop-Soller, who has been designated by the Commissioner of the New York State Department of Health to make such decisions.

Dated: _____, 2017
Albany, New York

Dawn MacKillop-Soller
Administrative Law Judge