

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

In the Matter of the Request of
RELIANCE AMBULETTE, INC.
Medicaid Provider ID # 01395248
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.

**Decision After
Hearing**

Audit #08-1781

Before: Denise Lepicier
Administrative Law Judge

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

Parties: New York State Office of the Medicaid Inspector General
217 Broadway, 8th floor
New York, New York 10007
By: Tina M. Dolman, Esq., and Ferlande Milord, Esq.

Mrs. Vasumathi Pai, Owner
Reliance Ambulette, Inc.
162-19 Depot Road
Flushing, New York 11358
By: Alan Sclar, Esq. and Thomas H. Herndon, Esq.
Sclar Adler, LLP
120 West 45th Street – Suite 605
New York, New York 10036

Dates of Hearing: November 12, 2015
November 13, 2015
February 1, 2016

Affidavits marked on: March 29, 2016, as ALJ Exhibits I & II¹

Final Briefs and Replies by: April 13, 2016

¹ The ALJ requested additional information on two issues (i.e., when a computer program “edit” was created to reject claims without an “ordering provider” identification, and what amounts were being sought for secondary and tertiary findings of claim disallowances) which information was provided in affidavits.

JURISDICTION

The Department of Health (“Department”) acts as the single state agency to supervise the administration of the Medicaid program (“Medicaid”) in New York State. Public Health Law (“PHL”) § 201(1)(v), Social Services Law (“SSL”) § 363-a. Pursuant to PHL §§ 30, 31 and 32, the Office of the Medicaid Inspector General (“OMIG”), an independent office within the Department, 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.

Pursuant to Chapter 58 of the Laws of 2005, OMIG was permitted to employ county social service districts to conduct audits as agents of OMIG. The audit in this matter was conducted by the New York City Human Resources Administration under the oversight of OMIG.² (T. 91-94, 106, 349)

Subsequent to the audit, OMIG determined to seek restitution of payments made by Medicaid to Reliance Ambulette, Inc. (“Reliance” or “Appellant”). (OMIG Ex. 1, Book 1, pp. A1-1to A1-24; OMIG Ex. 12)³ The Appellant requested a hearing pursuant to SSL § 22 and the former Department of Social Services (“DSS”) regulations at 18 NYCRR § 519.4 to review OMIG’s determination. (OMIG Ex. 7)

APPLICABLE LAW

Medicaid fee-for-service providers are reimbursed by Medicaid on the basis of the information they submit in support of their claims. The information provided in relation

² Hereinafter references to OMIG mean OMIG and/or the New York City Human Resources auditors (OMIG agents).

to any claim must be true, accurate and complete. Providers must maintain records demonstrating the right to receive payment, and all claims for payment are subject to audit for six years. 18 NYCRR §§ 504.3(a)&(h), 517.3(b), 540.7(a)(8).

Medicaid program participation is a voluntary, contractual relationship between the provider of service and the State. SSL § 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). A Medicaid provider agrees to comply with all program requirements as a prerequisite to payment and continued participation in the program. 18 NYCRR §§ 504, 515, 517, 518. The provider certifies at both the time of enrollment and when submitting claims that the provider will comply or has complied with all its contractual responsibilities. 18 NYCRR §§ 504.3, 540.7(a)(8).

Based on these contractual obligations, the Medicaid program employs a pay-first-and-audit-later system to insure compliance. This process helps ensure that providers are paid promptly. Over the years, as the program has evolved to an electronic claims submission process, the programmers who have created and periodically modify the electronic claims submission program have created some computerized “edits” in the program that may reject a claim in appropriate circumstances. The fact that Medicaid’s computer program may at some times automatically reject a claim does not relieve a provider of the obligation to submit a claim with the required complete, accurate information included. 18 NYCRR §§ 504.3, 540.7(a)(8).

If a Department audit reveals an overpayment, the Department may require repayment of the amount determined to have been overpaid. 18 NYCRR §§ 504.8(a)(1),

³ References in parentheses refer to transcript page numbers or exhibits. Transcript references will be cited as “T.” followed by the appropriate page number(s); exhibits will be cited by an “Ex.” followed by the

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). Interest may be collected upon any overpayments determined to have been made. 18 NYCRR § 518.4(a).

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 of the Department's proof. 18 NYCRR § 519.18(g).

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 §§ 517.5(b), 519.18(d)(1). An Appellant may not raise issues regarding . . . "any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action." 18 NYCRR § 519.18(a).

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

NYCRR § 540 (authorization of medical care, in particular 18 NYCRR § 540.6 – “billing for medical assistance”).

The New York State Medicaid program issues Medicaid Management Information Systems (MMIS) provider manuals, which are available to all providers and include, *inter alia*, billing policies, procedures, codes and instructions. www.emedny.org. The Medicaid program also issues a monthly Medicaid Update with additional information, policy and instructions. www.emedny.org. Providers are obligated to comply with these official directives. 18 NYCRR § 504.3(i); Lock v. NYS Department of Social Services, 220 A.D.2d 825, 632 N.Y.S.2d 300 (3d Dept. 1995); PSSNY v. Pataki, 58 A.D.3d 924, 870 N.Y.S.2d 633 (3d Dept. 2009).

ISSUE

Is OMIG’s determination to recover Medicaid overpayments in the amount of \$2,659,293.15 from Appellant Reliance Ambulette, Inc., correct?

FINDINGS OF FACT

1. At all times relevant hereto, Appellant was enrolled as a provider in the New York State Medicaid program.

2. Appellant submitted claims for transportation services provided by ambulette in New York City to Medicaid recipients and was paid for these claims by Medicaid. (OMIG Ex. 1, pp. A1-1 to A1-24; OMIG Ex. 12)

PRE-HEARING HISTORY

3. By letter dated April 3, 2008, OMIG notified Mrs. Vasumathi Pai, an owner of Reliance Ambulette, Inc., that OMIG intended to conduct an audit of the records that support Appellant’s Medicaid billings. 18 NYCRR § 517.3(c). This letter

explained that the New York City Human Resources Administration (“HRA”) would conduct the audit as an agent of OMIG. (OMIG Ex. 1, Book 7, pp. B3-1 to B3-2; OMIG Ex. 5)

4. On April 15, 2008, an entrance conference was conducted with Mrs. Pai at Appellant’s business to explain the process and to answer preliminary questions. 18 NYCRR § 517.3(f). Mrs. Pai was told that the scope of the audit was from January 1, 2005, to December 31, 2006, and that the audit sample would encompass all claims for 100 Medicaid recipients, or about 12,000 transactions, in that period. Mrs. Pai was also told that required information would include the recipient’s name, the recipient’s Medicaid Client Identification number, the type of service provided, the origination and destination of each trip, the date and time of service, the name of the transporting driver, the driver daily log schedule, and payroll information. (OMIG Ex. 1, Book 7, pp. B2-1 to B2-8)

5. Sometime after the audit began, Mrs. Pai requested that the audit be limited to one year on the grounds that she found the audit for the 100 Medicaid cases (recipients) in 2005 and 2006 burdensome as many of these patients were dialysis patients who would use services multiple times in a week. She refused to agree however to a condition OMIG required which was that she would not contest the extrapolation methodology given the smaller number of cases audited. (T. 416-417, 466-467)

6. At some point in 2009 or early 2010, the audit was changed from an audit of all services for 100 Medicaid recipients to an audit of 200 claims/services (200 samples). (T. 253-254, 353-355; OMIG Ex. 1, Book 8, pp. B6-95 to B6-96) On May 10, 2010, Mrs. Pai was provided with the list of 200 claims and asked to provide

documentation in support of these claims. (OMIG Ex. 1, Book 6, p. A5-2365) When she requested additional time to respond, extensions of time to respond were granted. (T. 256) Copies of the documentation collected for the original 100 Medicaid recipients part of the audit were kept and were reviewed, as appropriate, when relevant to a service in the audit of 200 claims. (T. 255, 361)

7. OMIG conducted the audit of 200 randomly selected claims paid in the period between January 1, 2005, and December 31, 2006. (OMIG Ex. 12, ex. I) The number (the universe) of all paid claims in this period was 96,227 claims, and Appellant was paid \$5,029,980 for these claims. (OMIG Ex. 1, Book 1, pp. A1-2; OMIG Ex. 12, p. 2)

8. A December 15, 2010, scheduled exit conference was adjourned at Appellant's request and eventually occurred on February 3, 2011. Mrs. Pai did not attend, but the attendees included the Appellant's attorneys and members of the OMIG Fraud and Abuse Investigation team. (OMIG Ex. 1, Book 7, pp. B1-36 to B1-43) A copy of the exit conference summary of findings had been provided to the Appellant by letter dated November 26, 2010. (OMIG Ex. 1, Book 7, pp. B1-1 to B1-35)

9. At the exit conference, the summary of all the audit findings was discussed. (T. 96-98, 363; OMIG Ex. 1, Book 7, pp. B1-36 to B1-43) The fact that Appellant's drivers did not have NYC Taxi and Limousine Commission ("TLC") licenses was discussed; Appellant's response was that prior to 2008 Appellant did not collect TLC license information for its drivers because Appellant was unaware it was required to have drivers who were TLC licensed.⁴ For all the other findings in the exit conference

⁴ Appellant did have copies of some of its drivers' TLC licenses in its files and did provide them during the audit. (T. 260, 431-432, 487-488, 494, 505-506, 513)

summary, the Appellant either provided additional information or asserted that additional information would be forthcoming. (OMIG Ex. 1, Book 7, p. B1-36 to B1-43)

10. Appellant responded in writing to the exit conference summary by letter dated February 18, 2011. (OMIG Ex. 1, Book 7, pp. A8-1 to A8-273)

11. Following the exit conference and the Appellant's written response, the audit findings were adjusted downward in Appellant's favor. (OMIG Ex. 1, Book 7, pp. A7-1 to A7-29)

12. By letter dated August 30, 2011, a Draft Audit Report ("DAR") was sent to Appellant seeking an overpayment amount of \$4,157,006. (OMIG Ex. 1, Book 7, pp. A6-1 to A6-42; OMIG Ex. 10)

13. By letter dated October 17, 2011, Appellant provided a response to the DAR. (OMIG Ex. 1, Book 2, pp. A5-1 to A5-2,375)

14. OMIG considered the information provided in Appellant's response to the DAR. (T. 97-98; OMIG Ex. 1, Book 2, pp. A4-1 to A4-20) OMIG also instituted a new audit protocol in May of 2013 which was applied to this audit. (T. 83-84, 92, 100, 103-104; Appellant's Ex. 1E) The audit findings were again adjusted downward.

15. By letter dated October 23, 2013, OMIG issued a Revised Draft Audit Report ("RDAR") seeking an overpayment amount of \$2,749,265. (OMIG Ex. 1, Book 2, pp. A3-1 to A3-22; OMIG Ex. 11)

16. By letter dated December 9, 2013, Appellant submitted a partial response to the RDAR. (OMIG Ex. 1, Book 1 & 2, pp. A2a-1 to A2a-159) By letter dated January 2, 2014, Appellant submitted a second letter of response to the RDAR. (OMIG Ex. 1, Book 1 & 2, pp. A2a 160 to A2a 858)

17. OMIG considered the additional information provided in Appellant's two responses to the RDAR, but made no changes to the audit findings. (T. 108; OMIG Ex. 1, Book 1, pp. A2-1 to A2-7)

18. By letter dated April 1, 2014, OMIG issued a Final Audit Report ("FAR") seeking an overpayment amount of \$2,749,265. (OMIG Ex. 1, Book 1, pp. A1-1 to A1-24; OMIG Ex. 12)

19. By letter dated April 11, 2014, Appellant requested a hearing. (OMIG Ex. 7)

20. By Notice of Hearing dated April 30, 2014, this matter was set for hearing on July 22, 2014. (OMIG Ex. 2) A prehearing conference between the parties was scheduled for June 30, 2014. (OMIG Ex. 2) The hearing was adjourned a number of times and began on November 12, 2015.

AUDIT FINDINGS

21. OMIG conducted a review to verify Appellant's drivers' compliance with the New York City Taxi and Limousine Commission law. (OMIG Ex. 12, pp. 2- 4; OMIG Ex.11, pp. 2-4) Appellant needed to show that it had documentation proving the driver was TLC licensed at the time the service was provided. (T. 365-366, 419-420)

22. OMIG demonstrated through a review of claim sample number 34 from the audit that Appellant failed to prove that the driver for this sample was TLC licensed. At the time of the field audit, Appellant provided the dispatcher reports for sample number 34, which service was numbered 169 by Appellant and was provided on [REDACTED] 2006. The driver on the dispatcher report was indicated as [REDACTED] driving van number 85. (OMIG Ex. 1, Book 9, p. D6-477) The dispatcher report indicated [REDACTED]

drove both legs of the trip in van numbered 085. (OMIG Ex. 1, Book 9, p. D6-478) That [REDACTED] drove van 085 was confirmed by a written note provided by Appellant at the time of the field part of the audit. (OMIG Ex. 1, Book 9, p. D6-479) Appellant also provided [REDACTED] New York State commercial driver's license, but no TLC license was provided. (OMIG Ex. 1, Book 9, p. D6-481) In response to the draft audit, Appellant provided the TLC license of [REDACTED] with respect to proof of TLC licensure for the driver for audit sample number 34. (OMIG Ex. 1, Book 3, pp. A5-334 to A5-336) The TLC license of a different driver was not relevant to whether "[REDACTED]" was TLC licensed. (T. 263- 274)

23. OMIG demonstrated through a review of claim sample number 181 from the audit that Appellant failed to prove that the driver for the second leg of this sample was TLC licensed at the time the service was provided. At the time of the field audit, Appellant provided the dispatcher reports for sample number 181, which service was numbered 155 by Appellant and was provided on [REDACTED], 2005. The dispatcher documents indicate that "[REDACTED]" picked up the patient to drive him home in van numbered 55A. (OMIG Ex. 1, Book 13, pp. D6-2,579 to D6-2,580) "[REDACTED]" even wrote his name on the dispatcher report. At the time of the field audit, however, no licensure information was provided for this driver. (OMIG Ex. 1, Book 13, pp. D6-2577 to D6-2592) In response to the draft audit report, Appellant provided a copy of "[REDACTED]" [REDACTED] New York City TLC license, but the license's expiration date was September 14, 2008. (OMIG Ex. 1, Book 4, p. A5-996) Since TLC licenses are valid for two years, this license was not valid on the date of service in 2005. (T. 274-284)

24. Samples numbered 34 and 181 were representative of the responses OMIG received with respect to all the claims disallowed for lack of a TLC license. (T. 285)

25. One hundred twenty-five claims, totaling \$5,309, were identified as overpayments because no proof was provided that a driver was properly licensed by the New York City Taxi and Limousine Commission. Appellant needed to provide a copy of a TLC license for the driver valid at the time the service in issue was provided. These findings were extrapolated across the universe of paid claims in the audit period. (T. 108-109, 258-259, 285-289; OMIG Ex. 1, Book 1, p. A1-10; OMIG Ex. 12, ex. II; OMIG Ex. 11, ex. II)

26. OMIG conducted a review to verify the completeness of information provided on claims. (OMIG Ex. 12, pp. 4-5; OMIG Ex. 11, pp. 4-5) OMIG obtained copies of the information submitted by Appellant in support of its claims. When a disallowance is taken because required information is missing from a submitted claim, there is really nothing a provider can submit to prove the information was submitted because OMIG has a copy of what was submitted. (T. 117, 231-232)

27. OMIG demonstrated through a review of claim sample number 14 from the audit that Appellant failed to prove that required information was provided at the time of the claim submission. Sample claim number 14 was a service provided on October 6, 2006. (OMIG Ex. 1, Book 1, p. A1-17) OMIG had identified sample number 14 because Appellant had failed to provide the ordering provider identification number on the claim that was submitted. (T. 294-301, 393-394; OMIG Ex. 1, Book 9, pp. D6-207 to D6-218) Appellant identified this claim as number 51 in its dispatcher reports. None of the

documentation submitted during the field audit or in the response to the DAR remedied the absence of the ordering provider's identification number. (T. 294-303; OMIG Ex. 1, Book 9, pp. D6-207 to D6-218; OMIG Ex. 1, Book 2, p. A2a-659)

28. Five claims, totaling \$274, were identified as overpayments because the ordering provider identification field on the claim was missing the ordering provider identification information. These findings were extrapolated across the universe of paid claims in the audit period. (OMIG Ex. 1, Book 1, p. A1-10; OMIG Ex. 12, ex. III; OMIG Ex. 11, ex. III)

29. Five claims, totaling \$60, were identified as overpayments because an inaccurate procedure code was provided on the claim. (T. 396) Appellant conceded that an inaccurate procedure code was provided for these claims and did not contest these findings. These findings were not extrapolated across the universe of all paid claims in the audit period. (T. 118-120, 276, 305-308, 534-536; OMIG Ex. 1, Book 1, p. A1-5; OMIG Ex. 12, ex. IV; OMIG Ex. 11, ex. IV)

30. OMIG demonstrated through a review of claim sample number 191 from the audit that Appellant failed to prove that required information was provided at the time of the claim submission in that the wrong driver's license number was provided on a submitted claim. (T. 309-316, 396-397) Sample claim number 191 was a service provided on [REDACTED] 2006. Claiming rules specified that Appellant needed to provide the driver's license number of the driver for the first leg of the trip. (OMIG Ex. 1, Book 1, p. A2a-306; OMIG Ex. 14, New York State Medicaid Program Transportation Manual Policy Guidelines, Version 2004-1, p. 14) Appellant identified this service as number 135 in its dispatcher reports for [REDACTED] 2006. The first leg of the trip was

driven by “ [REDACTED] as indicated on the dispatcher reports provided during the field audit. (OMIG Ex. 1, Book 13, p. D6-2720) The second leg of the trip was driven by “ [REDACTED] (OMIG Ex. 1, Book 13, p. D6-2721) Appellant provided a driver’s license number on the claim submitted as [REDACTED] (OMIG Ex. 1, Book 13, p. D6-2,719) This is the license number of [REDACTED]. (OMIG Ex. 1, Book 13, p. D6-2,728) Appellant agreed that [REDACTED] drove the first leg of the trip and that [REDACTED] drove the second leg of the trip. (OMIG Ex. 1, Book 1, p. A2a-173) Appellant provided an inaccurate driver’s license number on the submitted claim.

31. Sample claim number 191, totaling \$50, was identified as an overpayment because an inaccurate driver license number was provided on the claim. (T. 121-124, 309-316; OMIG Ex. 12, ex. V; OMIG Ex. 11, ex. V) This finding was extrapolated across the universe of all paid claims in the audit period. (T. 316)

32. OMIG conducted a review to verify the completeness of documentation justifying claims. (OMIG Ex. 12, p. 5; OMIG Ex. 11, p. 5)

33. OMIG demonstrated through a review of claim sample number 25 from the audit that Appellant failed to prove that documentation of the driver’s name for this claim was complete. (T. 397-398) Appellant identified this service as number 145 in its dispatcher reports for [REDACTED] 2006. (OMIG Ex. 1, Book 1, p. A1-20; OMIG Ex.1, Book 9, pp. D6-345 to D6-347) At the time of the field audit, dispatcher reports were produced which documented a return trip for this recipient in van number 57, but the report does not indicate the name of the driver. (OMIG Ex. 1, Book 9, p. D6-347) In response to the DAR, Appellant produced a dispatcher report identical to the page provided during the field audit, except that the van number had been rewritten and a driver name (“ [REDACTED]

██████ had been added. (OMIG Ex. 1, Book 2, p. A2a-705) Given these changes, none of the documentation submitted in response to the DAR for this claim could be accepted as contemporaneous documentation of the provision of the service. (T. 318-320; OMIG Ex. 1, Book 2, pp. A2a-702 to A2a-706)

34. Only part (one leg) of sample claim number 25, totaling \$31, was identified as an overpayment because contemporaneous documentation identifying the driver name was incomplete/missing. (T. 124-126; OMIG Ex. 12, ex. VI; OMIG Ex. 11, ex. VI) This finding was extrapolated across the universe of all paid claims in the audit period. (T. 320)

35. OMIG demonstrated through a review of claim sample number 8 from the audit that Appellant failed to prove that documentation of the service for this claim was complete. (T. 398-399) Appellant identified this service as number 23 in its dispatcher reports for ██████ 2005. (OMIG Ex. 1, Book 1, p. A1-21; OMIG Ex. 1, Book 9, pp. D6-112 to D6-114) Since this claim was for seventy-five dollars, and a round trip (2 legs) for this procedure code (NY100) would be fifty dollars, the service claimed on this day was for three trips (3 legs). (T. 321-323) At the time of the field audit, a dispatcher report for the first leg indicated that “██████ was the driver in van number 51. The dispatcher report for a second leg indicated that “██████ was the driver in van number 7. No documentation was provided for a third leg for this claim. (OMIG Ex. 1, Book 9, pp. D6-113 to D6-127) In response to the DAR, Appellant provided a third dispatcher report which indicated that Appellant identified the service for this recipient on ██████ 2005, as number 18, and the van number was identified as 17. However, no driver was identified and no trip ticket was produced for this service. (OMIG Ex. 1,

Book 2, p. A2a-710) This information could not be accepted as contemporaneous documentation of the service for this claim. (T. 321-326)

36. One part (one leg) of sample claim number 8, totaling \$25, was identified as an overpayment because contemporaneous documentation of a transportation service was missing. (T. 126-129; OMIG Ex. 12, ex. VII; OMIG Ex. 11, ex. VII) This finding was extrapolated across the universe of all paid claims in the audit period. (T. 325-326)

37. OMIG conducted a review to verify Appellant's drivers' compliance with the Vehicle and Traffic Law, Article 19A. (OMIG Ex. 12, p. 6; OMIG Ex. 11, p. 6) The provider needed to provide documentation from the Department of Motor Vehicles to prove the driver was 19A certified at the time the service was provided. (T. 365)

38. OMIG demonstrated through a review of claim sample number 63 from the audit that Appellant failed to prove that the driver for one leg of the service for this claim was certified pursuant to Article 19A of the Vehicle and Traffic Law as required. Appellant identified this service as number 45 in its dispatcher reports for ██████████ 2005. The drivers for this sample claim were "██████████ in van 51 and ██████████ in van 37. (T. 382-388, 390-391) At the time of the field audit, Appellant provided documentation that "██████████" was added to Appellant's roster of 19A drivers on ██████████ 2003, but subsequently lost 19A certification and was dropped from Appellant's roster on ██████████ 2005. Nothing was provided to prove that "██████████" was 19A certified on the date of service. (OMIG Ex. 1, Book 1, p. A1-22; OMIG Ex. 1, Book 10, pp. D6-908 to D6-924; OMIG Ex. 1, Book 8, p. p. B6-10 [worked 12/3/2003 to 1/3/2005]) In response to the DAR, Appellant provided a chart indicating "██████████," instead of "██████████"

██████████ drove for this leg of service, and provided a dispatcher report apparently indicating that “██████████” drove van 37 on ██████████ 2005. (OMIG Ex. 1, Book 2, p.A2a-714) However, the response information was inconsistent with the handwritten list of drivers and vans provided by Appellant for the date of service. “██████████” does not even appear on this list. (OMIG Ex. 1, Book 10, p. D6-911) Further, Appellant’s chart indicates that “██████████” was not 19A certified until 2008, so even if he had driven on ██████████ 2005, he would not have been 19A certified at the time of service. (T. 326-333; OMIG Ex. 1, Book 2, p. A2a-714; OMIG Ex. 1, Book 8, p. B6-10 [hired 9/26/08])

39. One part of claim number 63, totaling \$25, was identified as an overpayment because Appellant did not verify that a driver was certified under Article 19A of the Vehicle and Traffic Law. (T. 129-131; OMIG Ex. 12, ex. VIII; OMIG Ex. 11, ex. VIII) This finding was extrapolated across the universe of all paid claims in the audit period. (T. 333)

40. At hearing, OMIG announced that it would not seek reimbursement for the samples numbered 47, 98, 154 and for one-half of samples 168 and 188 in the final audit report, lowering the overpayment recovery sought to \$2,659,293.15. (T. 57, 336; OMIG brief dated 4/1/16, p. 9)

41. On this appeal, Appellant has not contested the manner or methodology by which the sample of claims was identified for this audit, nor the method of extrapolation employed by OMIG to determine the amount of the overpayment sought. (T. 6-9; OMIG Ex. 3; OMIG Ex. 4; OMIG Ex. 8)

DISCUSSION

OMIG presented the audit file and summarized the case, as is required by 18 NYCRR § 519.17. OMIG presented documents (OMIG Ex. 1 through 15), the testimony of Joseph D'Agostino, who supervises a team of auditors in OMIG, and Ping Tran, who is a "Management Auditor" for HRA. (T. 349-350) The Appellant presented documents (Appellant's Ex. 1A, 1B, 1D and 1E) and the testimony of Vinayak Damle, Appellant's computer consultant, and Vasumathi Pai and Mohan Pai, Appellant's owners. This appeal is limited to issues raised by Appellant in its responses to the DAR and the RDAR. 18 NYCRR §519.18(a).

Appellant has made two notice arguments. One argument is that Appellant did not have notice at the time it submitted its claims in 2005 and 2006 that its drivers needed to be licensed by the New York City Taxi and Limousine Commission ("TLC"). Appellant asserts as one of its objections to this class of disallowances that OMIG is attempting to retroactively apply law and guidance that was published after the 2005 and 2006 claims were submitted. Appellant is correct to object to the retroactive application of any law or guidance; only information available prior to a claim's submission is relevant to the propriety of the claim. Information which became available after a claim's submission will not be considered with respect to the propriety of any claim. In the Matter of Christian Ambulette, Inc., Audit # 07-4175, decision (10/09/2013).

However, Appellant also seems to be arguing that the legal analysis of this part of its notice argument is limited to the citations in the audit reports and this is to conflate a notice argument based on the sufficiency of the notice in the audit reports with the question of whether there was sufficient notice of the licensure requirement at the time

the claims were submitted. The proper analysis of the argument regarding whether Appellant had sufficient notice of the requirement that driver's be TLC licensed is to review the authority available at the time the claims were submitted. It is not an analysis of the notice provided in the audit reports which, self-evidently, did not exist at the time the claims were submitted. The question is what the law, regulation and guidance was at the time the claims were submitted. (T. 115)

In 2005 and 2006, the following regulation was in effect at 18 NYCRR §505.10(e):

(6) In order to receive payment for services provided to an MA recipient, a vendor must be lawfully authorized to provide transportation services on the date the services are rendered. A vendor of transportation services is lawfully authorized to provide such services if it meets the following standards:

(ii) Ambulette services must be authorized by the Department of Transportation. Ambulette drivers must be qualified under Article 19-A of the Vehicle and Traffic Law. Ambulette services and their drivers must comply with all requirements of the Department of Transportation and the Department of Motor Vehicles or have a statement in writing from the appropriate department or departments verifying that the ambulette services or their drivers are exempt from such requirements. In addition, ambulette services operating in New York City must be licensed by the New York City Taxi and Limousine Commission.

Appellant argues that this regulation says nothing about drivers and the TLC, and that this regulation applies only to the corporate entity, and further asserts that the corporate entity (the "base") was TLC licensed.⁵ (T. 479, 487-489) OMIG argues that "Ambulette services" is defined in the regulation as "an individual, partnership, association, corporation, or any other legal entity which transports the invalid, infirm or

disabled by ambulette to or from facilities which provide medical care,” and that this means drivers must be TLC licensed. (T. 113-114) 18 NYCRR § 505.10(b)(4). This ALJ agrees that this definition means that any person who, or any association or legal entity which, provides ambulette services in New York City must be licensed by the TLC.

Furthermore, the very first paragraph of Section I of the New York State Medicaid Program Transportation Manual Policy Guidelines, Version 2004-1, p. 4, states: “To participate in the Medicaid program, a provider must meet all applicable State, County and Municipal requirements for legal operation.” The fifth paragraph states: “Only lawfully authorized ambulette services may receive reimbursement for the provision of ambulette transportation.” (p.4) The first paragraph of Section II of this manual reiterates that: “Medicaid reimbursement is available to lawfully authorized transportation providers” (p. 5) This guidance remained in effect throughout the period of the audit. (Cf. Versions 2006-1 and 2006-2)

New York City Taxi and Limousine Commission regulations, during the relevant time period, stated that “[a] driver shall not operate a paratransit vehicle for hire within the City of New York, unless it is properly licensed by the Taxi and Limousine Commission” and “[a] driver of a New York City paratransit vehicle for hire must be duly licensed by the Commission.” 35 Rules of the City of New York (RCNY) § 4-06(b) & (c).⁶ The rules of New York City required that drivers of ambulettes be TLC licensed and a paratransit vehicle owner’s responsibility is to “only dispatch a paratransit driver

⁵ A “base” is defined as “a central facility approved by the Commission which manages, organizes and/or dispatches a licensed vehicle or vehicles.” 35 RNYC § 4-01.

⁶ A “paratransit vehicle” is “a wheelchair accessible van. For the purposes of these rules, this term shall include all ambulettes (whether wheelchair accessible or not).” 35 RCNY § 4-01.

with a current paratransit driver's license.” (OMIG Ex. 14) 35 RCNY § 4-09(b). Appellant was not entitled to ignore these rules. Indeed, to accept the Appellant's argument that only the base (company) needed to be licensed would be to accept the premise that a licensed ambulette company can ignore the very rules governing its operation under its TLC license, an absurd result.⁷

The second part of Appellant's notice objection is the general objection that Appellant could not determine what it did wrong. This objection was raised only in Appellant's response to the RDAR, in its last submission prior to hearing. Appellant asserts that “the explanations [OMIG] provided for many of the disallowances are too general to be of any real value in assessing the claims of deficiency. In many instances, we are forced to speculate. This is a violation of due process.” (OMIG Ex. 1, Book 1 & 2, pp. A2a 160 to A2a 858; OMIG Ex. 11) Initially, it should be noted that 18 NYCRR § 519.5 provides, in relevant part, with respect to notice that:

(a) The department must issue a written notice of a final determination to the person if it intends to . . . require repayment of an overpayment

* * * *

(c) The notice must clearly state the determination made, the basis and specific reasons for the determination

While this regulation is directed to the final determination only, Appellant seems to be arguing that at no point in the audit process could it determine what it did wrong. For this reason, the entire process will be reviewed.

⁷ E.g., 35 RCNY § 4-05(g) states, in relevant part: “A paratransit base may dispatch only Commission licensed paratransit vehicles.” And as discussed above, a paratransit vehicle may only be driven by a TLC licensed paratransit driver. To accept Appellant's argument would be to permit Appellant to operate in violation of its own TLC base license.

The process began with a letter dated April 3, 2008, apprising Appellant that OMIG intended to conduct an audit. (OMIG Ex. 1, Book 7, pp. B3-1 to B3-2; OMIG Ex. 5) An entrance conference was then conducted on April 15, 2008, and Appellant was informed of the scope and the timeframe for the audit. Appellant was also informed of the information the auditors would need to conduct the audit, i.e., the recipient's name, the recipient's Medicaid Client Identification number, the type of service provided, the origination and destination of each trip, the date and time of service, the name of the transporting driver, the driver daily log schedule, and payroll information. (OMIG Ex. 1, Book 7, pp. B2-1 to B2-8)

Because the audit was of the actual services provided to 100 patients in the audit period and because Appellant had many repeat services for each of these patients, the audit involved a substantial number of claims. At some point in time, Appellant expressed its frustration with the scope of the audit and the auditors recognized that they had collected less than half of the documents they needed from Appellant. In early 2010 a decision was made to switch the audit to a "sample" audit of 200 claims. (T. 253-255)

Following completion of the sample audit, an exit conference was scheduled by letter dated November 26, 2010, and Appellant was provided with a summary of what would be discussed at the exit conference including information concerning the proposed disallowances and the reasons for the disallowances. The exit conference to discuss the findings with Appellant took place on February 3, 2011. (T. 96-97, 212-214; OMIG Ex. 1, Book 7, pp. B1-1 to B1-43) The fact that Appellant was unaware that its drivers needed to be TLC licensed was discussed. All the other findings were also discussed with Appellant's attorneys. (OMIG Ex. 1, Book 7, pp. B1-1 to B1-43)

Appellant's attorneys submitted a substantial written response to the exit conference by letter dated February 18, 2011. (T. 97-98, 213; OMIG Ex. 1, Book 7, pp. A8-1 to A8-273)⁸ This response addressed each of the findings. It also resulted in an amendment of the findings in Appellant's favor. (OMIG Ex. 1, Book 7, pp. A6-1 to A6-42) For example, with respect to the finding that drivers were not TLC licensed, Appellant's attorneys provided information that resulted in fifteen findings being dropped as disallowances. (See. OMIG Ex. 1, Book 7, pp. B1-9 to B1-15 and A6-7 to A6-14) Samples 20, 31, 52, 82, 92, 103, 104, 105, 121, 126, 128, 130, 153, 170, and 175 were all removed from the audit disallowances between the exit conference and the draft audit report. The proposed disallowance for all the findings dropped from \$4,555,867 to \$4,157,006.

OMIG issued the DAR on August 30, 2011. (T. 98; OMIG Ex. 1, Book 7, pp. A6-1 to A6-42) Appellant's attorneys submitted an even more extensive response to the DAR. (OMIG Ex. 1, Books 2- 6, pp. A5-1 to A5-2375) The response to the DAR, in conjunction with the application of a new audit protocol, resulted in an amendment of the findings in Appellant's favor in the RDAR dated October 23, 2011. (T. 100-103; OMIG Ex. 1, Books 2, pp. A3-1 to A3-22) For example, with respect to the finding that drivers were not TLC licensed, twenty-eight findings were dropped as disallowances. Samples 8, 12, 16, 22, 26, 30, 35, 51, 63, 64, 68, 78, 99, 110, 120, 123, 124, 132, 135, 148, 158, 172, 177, 178, 180, 183, 187 and 191, were all removed from the audit disallowances. With respect to other findings, whole categories of findings disappeared from the RDAR.

⁸ Appellant's attorneys refer to this 02/18/2011 response as a response to the draft audit report. In fact, it was a response to the audit, but not the draft audit report which did not issue until 8/30/2011. A written provider response to the exit conference is actually not contemplated by statute or regulation, but was permitted by the audit team in this matter.

For example, the category for “no driver’s license provided” was eliminated from the RDAR.⁹ The proposed disallowance for all the findings dropped from \$4,157,006 to \$2,749,265 in the RDAR. The second to last paragraph in the letter portion of the DAR also invited the Appellant to call “if you have any questions.” (OMIG Ex. 1, Book 7, pp. A6-5)

OMIG issued the RDAR on October 23, 2013. (OMIG Ex. 1, Book 2, pp. A3-1-A3-22) Appellant’s attorneys submitted a written response to the RDAR. (T. 105-106; OMIG Ex. 1, Book 2, pp. A2a 600-A2a 858) Upon review, nothing was changed from the RDAR and a FAR issued on April 1, 2014. (OMIG Ex. 1, Book 1, pp. A1-1 to A1-24) Both the RDAR and the FAR invited the Appellant to call “if you have any questions.” (OMIG Ex. 1, Book 2, pp. A3-7; OMIG Ex. 12, p. 8)

The last procedural step prior to hearing was the issuance of a notice of hearing, which originally set the date of hearing as July 22, 2014, and the scheduling of a prehearing conference for June 30, 2014. (OMIG Ex. 2) The prehearing conference notice specifically indicated that the conference was to address “matters which would expedite the disposition of the proceeding.” If Appellant really had difficulty understanding what the findings meant, this was certainly another opportunity to ask questions.

At hearing, upon additional review, OMIG removed an additional three sample disallowances completely (samples 47, 98 and 154) and half of two more sample disallowances (sample 168 and 188) resulting in the total disallowance being sought at hearing to decline to \$2,659,293.15. (T. 57; OMIG Brief dated 4/1/2016, p. 9)

⁹ Sometimes findings removed from one finding category might be moved to another finding category because a disallowance might have had more than one basis for disallowance (a secondary or tertiary

Obviously, the audit process is replete with due process for providers. Opportunities for clarification of issues exist throughout the process and a provider may contact the auditors at any point with questions. Appellant's claims that it was forced to speculate as to what the audit found wrong was unsupported at hearing by any specifics. Indeed, Appellant's responses to the exit conference report and the DAR and RDAR indicate that Appellant fully understood the problems identified by the auditors.

If what Appellant really means is that the auditors should have told Appellant exactly what documentation the auditors would accept as proof, then Appellant is in error. An auditor may ask for information, but to ask for a specific piece of documentation could compromise the audit. (T. 101) An auditor needs documentation that is contemporaneous with the service. (T. 106) Documentation created subsequent to the service is not acceptable. Telling a provider exactly what proof is required could result in the creation of such proof. For example, one piece of documentation produced during the recipient portion of the audit in this case was also produced during the 200 sample portion of the audit, but the document had changed. (OMIG Ex. 1, Book 9, p. D6-347; OMIG Ex. 1, Book 2, p. A2a-705)

The portion of Appellant's notice objection stated as "the explanations [OMIG] provided for many of the disallowances are too general to be of any real value in assessing the claims of deficiency" is rejected. Appellant received ample due process under the law and even beyond that required under the law. The FAR states the basis and specific reasons for the determination, including reference to appropriate regulations, and the Appellant clearly understood these reasons. 18 NYCRR §51.3(a). More is certainly not required in an administrative action to recover overpayments with such

finding), although it could only be disallowed once.

extensive due process provided. See, Matter of Board of Education v. Commissioner of Education, 91 N.Y.2d, 667 N.Y.S.2d 671 (1997)(student disciplinary charges); Block v. Ambach, 73 N.Y. 323, 540 N.Y.S.2d 6 (1989)(professional misconduct charges: “in the administrative forum, the charges need only be reasonably specific, in light of all the relevant circumstances, to apprise the party whose rights are being determined.”); Ostad v. New York State Department of Health, 40 A.D.3rd 1251, 837 N.Y.S.2d 364 (3rd Dept. 2007)(given sufficient supplemental information prior to hearing); Mangini v. Christopher, 290 A.D.2d 740, 736 N.Y.S.2d 180 (3rd Dept. 2002)(showed no prejudice).

Another issue Appellant raised in its response on January 2, 2014, to the RDAR was that: “[S]ome services in this audit were provided more than eight years ago. Such an extraordinary delay has prejudiced the rights of the provider to defend itself in this audit, as witnesses disappear, memories fade and records are lost.” (OMIG Ex. 1, Book 2, pp. A2a-160 to A2a-181) This audit was first noticed in April of 2008 and the time period covered was noticed as January 1, 2005 to December 31, 2006. (OMIG Ex. 1, Book 7, pp. B2-1 to B2-8) This period was well within the six year timeframe that Appellant was required to maintain the records for its claims. 18 NYCRR § 504.3(a). After Appellant received the notice of audit, it was in Appellant’s interest, and its obligation, to be diligent in maintaining the documentation for the time period in issue. 18 NYCRR § 517.3(c). Moreover, there was evidence at hearing that Appellant had failed to provide even half the documents necessary for the initial scope of the audit by 2010 and it was Appellant’s obligation to make these available. The audit of 100 patients was indeed a large audit, but so were Appellant’s billings. The audit could have been an audit of all recipients and claims. Appellant cannot reasonably complain that because its

business is large, it cannot comply with the audit process. Medicaid participation is a voluntary program. No one forced Appellant to participate and OMIG did substantially reduce the scope of its review to accommodate Appellant.

The audit of 200 services was complete within less than a year. Appellant then produced a 273-page response to the exit conference. After the DAR was issued, Appellant provided a 2,375-page response. Again, OMIG reviewed the documentation, and the audit was revised significantly downward. Appellant provided a final response to the RDAR, and although this response did not result in a change in the audit, this response also required time to review. Appellant frequently requested and was granted more time to comply with requests for documents and to provide responses to the audit documents. Any delay in the completion of the audit in this case is at least in part due to Appellant.¹⁰

Finally, Appellant did not allege any specifics as to how it was prejudiced by the length of time it took to complete the audit. In the absence of any specifics and given the Appellant's complicity in the length of time it took to conduct the audit, Appellant's argument that the delay prejudiced its ability to defend is rejected.

The next issue Appellant raises in its response to the RDAR is that the audit "treats minor documentation issues, which are often matters of subjective interpretation, not necessarily expressed in regulation or having nothing to do with the service rendered,

¹⁰ In its reply brief (4/13/16), Appellant states that "Reliance does not argue that too much time had passed between the beginning of the audit period and the issuance of the Draft Audit Report. Reliance does not argue that the Audit violated any statute of limitations, nor does it argue that the auditors called for documents after the time to preserve them had elapsed. [The Appellant] argue[s] that OMIG abused its discretion by how it handled this audit." (p.3) And, at a prehearing conference Appellant stated that it would not make an argument that any hearing adjournments created prejudice. (Prehearing, 11/12/15, T. 5) But, an argument directed to "extraordinary delay" which "prejudiced the rights" of Appellants as phrased in its response to the RDAR, is a timeliness argument, at least in part, and Appellant's opening certainly suggested time was an issue. (T. 62-73)

as invalidating valid claims” Appellant further argues that: “The Medicaid documentation requirements were never intended to be used to deny payment for services actually rendered” In fact, the documentation requirements are designed to ensure that Medicaid recipients of services are supplied with safe, quality services, and that providers provide services in the manner which Medicaid requires. (T. 109-110, 116) If any transportation would do, recipients could use a taxi service. Providers enter an agreement with the Medicaid program to provide services in accord with the rules. If providers do not meet their obligations, they are in breach of that agreement. No provider is forced to participate in the Medicaid program, but if the provider becomes a participant, that provider must strictly adhere to program requirements. 18 NYCRR §§ 504, 515, 517 and 518. In addition, other than the arguments concerning TLC requirements, Appellant points to no other specific disallowance area in the audit that it alleges are “matters of subjective interpretation.” This argument in Appellant’s response to the RDAR is rejected.

The final objection raised in Appellant’s response to the RDAR was a challenge to the sampling and extrapolation method for conducting the 200 claims sample. 10 NYCRR § 519.18(g) states: “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. The appellant may submit expert testimony challenging the extrapolation by the department or an actual accounting of all claims paid in rebuttal to the department’s proof.” OMIG provided affidavits certifying the validity of the sampling and the extrapolation methodologies. (OMIG Ex. 3; OMIG Ex. 4; OMIG Ex.

8) Appellant produced no evidence at hearing to challenge either. Appellant dropped this objection at hearing. (T. 6-9, 12-13; OMIG Ex. 3; OMIG Ex. 4; OMIG Ex. 8)

At hearing and in its post-hearing briefs, Appellant raised new and additional issues not raised in its various responses to the audit reports. Appellant argued that the entire audit should be disallowed because it was burdensome and “arbitrary, capricious and an abuse of discretion” to the Appellant.¹¹ Appellant argued that because Medicaid instituted a “computerized program edit” to reject claims that did not include provider identification that it was not responsible for claims, with inaccurate or incomplete information, that were paid.¹² Appellant argued, admittedly for the first time, that auditors were responsible for misfiling documents, and that perhaps Appellant could have provided documentation to overcome a disallowance.¹³ (T. 553-554) Finally, for the first time at hearing, Appellant argued that a driver identified as “██████████” by Appellant, who was not qualified as required under Article 19A of the Vehicle and Traffic Law, was actually “██████████” who was 19A qualified.¹⁴

An Appellant may not raise issues at hearing regarding . . . “any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action.” 18 NYCRR § 519.18(a). *See, Rego Park Nursing Home v. Perales*, 206 A.D.2d 781, 615 N.Y.S.2d 773 (3rd Dept. 1994)(failed to raise issues in response); *In Re Westmount Health Facility v. Bane*, 195 A.D.2d 129, 606 N.Y.S.2d 832

¹¹ Appellant was a large provider of services. It has a legal obligation to maintain records. It was Appellant’s obligation to maintain records in such a manner as to make it possible for it to retrieve needed documentation.

¹² Nothing in Medicaid law relieves a provider of the responsibility to provide complete, accurate information on its claims simply because Medicaid paid the claim.

¹³ Appellant never raised this objection at any point in the audit process or in its responses. No specific instance of misfiling was ever mentioned. This objection is completely speculative. (T. 553-554)

¹⁴ In any event, the service in issue occurred on ██████████ 2005, and “██████████” was never shown to be 19A qualified in 2005. (See Sample number 63; OMIG Ex. 1, Book 1, p. A1-22)

(3rd Dept. 1994)(failed to give sufficient notice of grounds for objections and, therefore, failed to preserve objections for hearing). 18 NYCRR § 517.5 provides in relevant part that:

(b) the issues to be addressed at an administrative hearing will be limited to those matters contained in any objection to the proposed action.

(c) Any objections must include a statement detailing the specific items of the draft report to which the provider objects and provide any additional material or documentation which the provider wishes to be considered in support of the objections.

Department auditors can only consider arguments and documentation presented to them before the final audit determination is prepared. This hearing is limited to a review of information provided prior to or in response to the DAR and the RDAR. 18 NYCRR 519.18(a).

One last argument made by Appellant in its own defense is that OMIG has not asserted that the services claimed were not provided. While this is true, it is also true that OMIG was not conducting an audit to determine whether services were provided. OMIG conducted a compliance audit to ensure Appellant was complying with its documentary obligations under the Medicaid program. (T. 364, 368)

In conclusion, it is Appellant’s burden to prove that the “determination of the department was incorrect and that all claims submitted and denied were due and payable under the program.” 18 NYCRR § 519.18(d)(1). The Appellant has failed to carry its burden of proof.¹⁵

¹⁵ OMIG made multiple findings (secondary and tertiary) with respect to many of the claims in this audit. (T. 399-404; OMIG Ex. 1, Book 1, pp. A1-23 to A1-24) Secondary and tertiary findings were made because, if the primary reason for a claim disallowance was proven invalid at hearing, OMIG would then claim a disallowance for the second reason. Only one disallowance can be taken for a specific claim, but if a primary reason for a disallowance was refuted, then a secondary reason for disallowance could be considered to disallow the claim and, if a secondary reason for a disallowance was refuted, a third reason

DECISION:

OMIG's determination to recover Medicaid overpayments in the amount of \$2,659,293.15 is affirmed. This decision is made by Denise Lepicier, who has been designated to make such decisions.

DATED:
August 23, 2016
New York, New York

Denise Lepicier
Administrative Law Judge

could be considered. Since this decision upholds the primary findings made, this decision does not consider the secondary and tertiary reasons for disallowance.