NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Acting Medicaid Inspector General

April 3, 2015

[redacted]
Rite Surgical Supplies, Inc.
266 47th Street
Brooklyn, New York 11220

Final Audit Report
Durable Medical Equipment, Appliances and Supplies (COS 321)
Audit # 08-3380
Provider ID # [redacted]

Dear [redacted]:

This letter will serve as our final audit report of the recently completed review of payments made to Rite Surgical Supplies, Inc. (the Provider) under the New York State Medicaid Program.

The New York State Department of Health (DOH) is responsible for the administration of the Medicaid program. As part of this responsibility, the Office of the Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assessing provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Department of Health [Titles 10 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 18 NYCRR)] and the Medicaid Management Information System (MMIS) Provider Manuals.

Department regulations define durable medical appliances, equipment and supplies (DME) as follows: durable medical equipment is devices and equipment, other than prosthetic and orthotic appliances, which have been ordered by a practitioner in the treatment of a specific medical condition. Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment or orthopedic footwear, which have been ordered by a practitioner in the treatment of a specific medical condition. Orthotic appliances and devices are those used to support a weak or deformed body member, or to restrict or eliminate motion in a diseased or injured part of the body. Prosthetic appliances and devices (excluding artificial eyes and dental prostheses) are those ordered by a qualified practitioner, which replace any missing part of the body. Orthopedic footwear is shoes, shoe modifications, or shoe additions used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased part of the ankle or foot, or to form an integral part of a brace. The specific standards and criteria pertaining to DME are outlined in Title 18 NYCRR Section 505.5 and the MMIS Provider Manual for Durable Medical Equipment et al.

A review of payments to the Provider for DME services paid by Medicaid New York City recipients from January 1, 2006, through December 31, 2007, was recently completed. During the audit period, $3,727,808.85 was paid for services rendered to 6,001 patients. This review consisted of a random sample of 100 patients with Medicaid payments of $49,376.44. The purpose of this audit was to verify that: durable medical appliances, equipment and supplies (DME) were properly authorized by a licensed practitioner; Medicaid reimbursable equipment, supplies and services were rendered for the dates billed; appropriate procedure codes were billed for equipment, supplies and services rendered; vendor records contained the documentation required by the regulations; and claims for payment were submitted in accordance with Department regulations and the Provider Manuals for Durable Medical Equipment.

The Provider's failure to comply with Title(s) 10, or 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) and the MMIS Provider Manual for Durable Medical Equipment resulted in a total sample overpayment of $10,071.82.

The statistical sampling methodology employed allows for extrapolation of the sample findings to the universe of patients (18 NYCRR Section 519.18). The adjusted mean per unit point estimate of the amount overpaid is $493,024. The adjusted lower confidence limit of the amount overpaid is $273,310. We are 95% certain that the actual amount of the overpayment is greater than the adjusted lower confidence limit (Exhibit I).This audit may be settled through repayment of the adjusted lower confidence limit of $273,310.

The following detailed findings reflect the results of our audit. This audit report incorporates consideration of any additional documentation and information presented in response to the revised draft audit report dated May 5, 2014. The information provided resulted in no change to any of the disallowances. The findings in the final audit report are identical to those in the revised draft audit report.

DETAILED FINDINGS

In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . 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 . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (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." *18 NYCRR Section 504.3*

Regulations state: "Fee-for-service providers. (1) All providers ... must prepare and maintain contemporaneous records demonstrating their right to receive payment . . . All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor ... must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department ... for audit and review." *18 NYCRR Section 517.3(b)*

Regulations require that bills for medical care, services and supplies contain patient name, case number and date of service; itemization of the volume and specific types of care, services and supplies provided; the unit price and total cost of the care, services and supplies provided; and a dated certification by the provider that the care, services and supplies itemized have been in fact furnished; that the amounts listed are in fact due and owing; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided.

18 NYCRR Section 540.7(a)(1)-(3) and (8)

Regulations state: "An overpayment includes 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 Section 518.1(c)*

Regulations state: "Vendor payments for medical care and other items of medical assistance shall not be made unless such care or other items of assistance have been furnished on the basis of the appropriate authorization prescribed by the rules of the board and regulations of the department."

18 NYCRR Section 540.1

Regulations state: "The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim." *18 NYCRR Section 518.3(a)*

Regulations state: "The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished...."

18 NYCRR Section 518.3(b)

Regulations state: "Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record." *18 NYCRR Section 518.3(b)*

1. **No Written Order**

Regulations state, "All durable medical equipment, medical/surgical supplies, may be furnished only upon a written order of a practitioner." *18 NYCRR Section 505.5(b)(1)*

Medicaid policy states, "All medical/surgical supplies, durable medical equipment . . . must be supported by the original, signed written order of a licensed physician, dentist, podiatrist, physician assistant or nurse practitioner."

NYS Medicaid Program Durable Medical Equipment Manual
Policy Guidelines, Version 2004-1, Section III

In 61 instances pertaining to 16 patients, the written order for the items provided was missing. For Samples #51, 53, 88 and 98, only the first occurrence of the fiscal order was extrapolated to the universe of patients. OMIG will disallow only the actual amount for subsequent occurrences. This resulted in a sample overpayment of $6,496.60 (Exhibit II).

2. **No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items**

Medicaid policy requires that, for items provided to Medicaid recipients who are also Medicare beneficiaries, "All charges must first be billed to Medicare. Only after an Explanation of Medical Benefits (EOB) is received from the Medicare intermediary and payment made, where appropriate, may a claim be submitted for Medicaid reimbursement. The provider must maintain the EOB on file for six years following the date of payment for audit purposes."

NYS Medicaid Program Durable Medical Equipment Manual Policy Guidelines, Version 2004-1, Section III

In 31 instances pertaining to 15 patients, no EOB was found for a Medicare eligible patient who received an item covered by Medicare. This resulted in a sample overpayment of $2,497.94 (Exhibit III).

3. **Incorrect Procedure Code Billed**

Regulations state, "Payment for purchase of durable medical equipment must not exceed the lower of: (a) the maximum reimbursable amount as shown in the fee schedule for durable medical equipment, medical/surgical supplies, orthotics and prosthetic appliances and orthopedic footwear; the maximum reimbursable amount will be determined for each item of durable medical equipment based on an average cost of products representative of that item."

18 NYCRR Section 505.5(d)(2)(i)(a)

Regulations state, "An overpayment includes 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 Section 518.1(c)

Medicaid policy requires the use of the fee schedules for durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances and orthopedic footwear as contained in the NYS Medicaid Program Durable Medical Equipment Manual Procedure Codes, Version 2004-1, Section 4.0.

NYS Medicaid Program Durable Medical Equipment Manual Policy Guidelines, Version 2004-1, Section III

In 4 instances pertaining to 1 patient, the incorrect procedure code was billed which resulted in a higher reimbursement than indicated in the fee schedule for the proper procedure code. For sample #3, only the first occurrence of the fiscal order was extrapolated to the universe of patients. OMIG will disallow only the actual amount for subsequent occurrences. This resulted in a sample overpayment of $616.12 (Exhibit IV).

4. **Improper Medicaid Billings for Medicare Crossover Patients**

Regulations state, "MA program as payment source of last resort. Where a third party, such as health insurer or responsible person, has a legal liability to pay for MA-covered services on behalf of a recipient, the department or social services will pay only the amount by which the MA reimbursement rate for the services exceeds the amount of the third party liability."

18 NYCRR Section 360-7.2

Regulations state, "The MA program will pay on behalf of qualified Medicare beneficiaries...the full amount of any deductible and coinsurance costs incurred under Part A or B of Title XVIII of the Social Security Act (Medicare)." *18 NYCRR Section 360-7.7(a)*

Medicaid policy requires that, for items provided to Medicaid recipients who are also Medicare beneficiaries, "All charges must first be billed to Medicare. Only after an Explanation of Medical Benefits (EOB) is received from the Medicare intermediary and payment made, where appropriate, may a claim be submitted for Medicaid reimbursement. The provider must maintain the EOB on file for six years following the date of payment for audit purposes."

NYS Medicaid Program Durable Medical Equipment Manual
Policy Guidelines, Version 2004-1, Section III

Medicaid policy also states that, "Medicaid is required to pay the Medicare co-insurance and deductible for Medicare covered supplies, equipment and appliances provided to Medicaid recipients who are also Medicare beneficiaries. Medicaid will pay the difference between the Medicare approved amount and the Medicare paid amount."

NYS Medicaid Program Durable Medical Equipment Manual
Policy Guidelines, Version 2004-1, Section III

In 5 instances pertaining to 4 patients, an incorrect Medicaid co-payment was billed for services also paid by Medicare. This resulted in a sample overpayment of $422.69 (Exhibit V).

5. **Ordering Prescriber Conflicts with Claim Prescriber**

Medicaid policy states that the billing provider is to enter the New York State Medicaid ID number of the ordering prescriber on the claim. If the ordering prescriber is not enrolled in Medicaid, enter his/her license number.

When a prescription or order originates from a hospital or clinic, and is written by an intern or resident, the supervising physician's Medicaid ID number should be entered. If the supervising physician is not enrolled in the Medicaid program, his or her state license number may be used instead. When the order is originated in an Article 28 facility and these numbers are unavailable, it is permissible to use the facility's New York State Medicaid ID number.

NYS Medicaid Program Durable Medical Equipment Manual
Billing Guidelines, Version 2004-1, Section II
NYS Medicaid Program Durable Medical Equipment Manual
Billing Guidelines, Version 2009-1, Section II

Regulations state: "The identity of the practitioner who ordered the ...medical/surgical supply, must be recorded by the provider on the claim for payment by entering in the license or MMIS provider identification number of the practitioner where indicated."

18 NYCRR Section 505.5(c)(1)

In 1 instance, the ordering prescriber on the claim conflicts with the ordering prescriber denoted on the fiscal order. This resulted in a sample overpayment of $38.34 (Exhibit VI). For this category of findings, OMIG will disallow only the actual amount of the sample overpayment and will not extrapolate the sample finding to the universe of patients.

6. **Missing Documentation Confirming Receipt/Delivery of Item**

Regulations state, "Written orders for durable medical equipment, medical/surgical supplies, prosthetic or orthotic devices, or orthopedic footwear must be maintained by the provider submitting the claim for audit by the department or other authorized agency for six years from the date of payment." *18 NYCRR Section 505.5(c)(2)*

Regulations require that the Medicaid provider agrees, "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 . . . all records necessary to disclose the nature and extent of services furnished. . . ." *18 NYCRR Section 504.3(a)*

Regulations also require that bills for medical care, services and supplies contain a certification that such records as are necessary to disclose fully the services provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years. These records must be furnished to the Department upon request.

18 NYCRR Section 540.7(a)(8) and Section 517.3

Medicaid policy states, "For audit purposes, . . . written orders, in addition to other supporting documentation such as invoices and delivery receipts, must be kept on file for six years from the date the service was furnished or billed, whichever is later."

NYS Medicaid Program Durable Medical Equipment Manual
Policy Guidelines, Version 2004-1, Section I

In 1 instance, documentation confirming receipt/delivery of item was missing. This resulted in a sample overpayment of $0.13 (Exhibit VII).

Additional reasons for disallowance exist regarding certain findings. These findings are identified in Exhibit VIII.

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the adjusted lower confidence limit amount of $273,310, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order within 20 days of the date of the final audit report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File #08-3380
Albany, New York 12237-0048

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final audit report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until the agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
Phone #: [redacted]
Fax#: [redacted]

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the adjusted meanpoint estimate of $493,024. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Questions regarding the request for a hearing should be directed to Office of Counsel at [redacted].

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing you have the right to:

a) be represented by an attorney or other representative, or to represent yourself;
b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

Should you have any questions, please contact me at [redacted].

Thank you for the cooperation and courtesy extended to our staff during this audit.

Sincerely,

[redacted]

Division of Medicaid Audit, Albany
Office of the Medicaid Inspector General

[redacted]

CERTIFIED MAIL #[redacted]
RETURN RECEIPT REQUEST
[redacted]

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

[redacted]

Rite Surgical Supplies, Inc.
266 47th Street
Brooklyn, New York 11220

PROVIDER ID # [redacted]

AUDIT #08-3380

AUDIT TYPE	[X] PROVIDER [ ] RATE [ ] PART B [ ] OTHER:

AMOUNT DUE: $273,310

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

[redacted]

New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File #08-3380
Albany, New York 12237-0048

Thank you for your cooperation.

EXHIBIT I

RITE SURGICAL SUPPLIES INC
DURABLE MEDICAL EQUIPMENT AUDIT
AUDIT # 08-3380
AUDIT PERIOD: 01/01/06 – 12/31/07

EXTRAPOLATION OF SAMPLE FINDINGS

Sample Overpayments	$	10,071.82
Less Overpayments Not Projected*		(1,887.58)
Sample Overpayments for Extrapolation Purposes	$	8,184.24
Cases in Sample		100
Overpayments Per Sampled Case	$	81.8424
Cases in Universe		6,001
Meanpoint Estimate	$	491,136
Add Overpayments Not Projected*		1,888
Adjusted Meanpoint Estimate	$	493,024
Lower Confidence Limit	$	271,422
Add Overpayments Not Projected*		1,888
Adjusted Lower Confidence Limit	$	273,310

* The actual dollar disallowance for the **"Ordering Prescriber Conflicts with Claim Prescriber"** finding was subtracted from the total sample overpayment and added to the Meanpoint Estimate and the Lower Confidence Limit. The dollars associated with this finding were not used in the extrapolation.

The asterisked actual dollar disallowance for Samples 51, 53, 88 and 98, **"No Written Order"**, were subtracted from the total sample overpayment and added to the Meanpoint Estimate and the Lower Confidence Limit.

The asterisked actual dollar disallowance for Sample 3, **"Incorrect Procedure Code Billed"**, were subtracted from the total sample overpayment and added to the Meanpoint Estimate and the Lower Confidence Limit.

The asterisked amounts for these samples were not used in the extrapolation since the claims stem from the same fiscal order. OMIG will extrapolate only for the first occurrence and any subsequent claims from the sampled fiscal order are not extrapolated.

RITE SURGICAL SUPPLIES INC
Provider Number: [redacted]
Audit Number: 08-3380

No Written Order

Sample #	Date of Service	Procedure Code	Amount Disallowed
37	09/06/05	B4150	$109.25
46	03/26/07	E0240	$38.34
51	09/01/05	B4152	$120.08
	10/01/05	B4152	$120.08*
	11/01/05	B4152	$120.08*
	12/01/05	B4152	$120.08*
53	12/22/05	A4322	$1.01
	03/11/06	A6407	$19.10
	04/03/06	E0274	$101.85
	05/27/06	A6219	$2.20
	11/08/06	T4523	$97.92
	11/08/06	A4554	$84.00
	11/08/06	T4927	$4.55
	12/08/06	T4523	$97.92*
	12/08/06	A4554	$84.00*
	12/08/06	A4927	$4.55*
	01/08/07	A4554	$84.00*
	01/08/07	A4927	$4.55*
	01/08/07	T4523	$97.92*
	02/08/07	A4554	$84.00*
	02/08/07	A4927	$4.55*
	02/08/07	T4523	$97.92*
54	12/31/06	K0001	$280.39
	12/31/06	E0143	$130.03

RITE SURGICAL SUPPLIES INC
Provider Number: [redacted]
Audit Number: 08-3380

No Written Order

Sample #	Date of Service	Procedure Code	Amount Disallowed
54	12/31/06	E2603	$110.77
	12/31/06	E0990	$302.40
	12/31/06	E2611	$297.45
	12/31/06	E0247	$89.83
	01/05/07	E0163	$103.63
56	08/24/07	E0163	$103.63
	08/24/07	E0247	$89.83
73	05/09/07	E0240	$38.34
	05/10/07	E0990	$302.40
	05/10/07	E2601	$68.85
	05/10/07	E0973	$100.13
	05/10/07	E0143	$130.03
	05/10/07	K0001	$280.39
82	10/24/05	T4522	$96.92
85	05/17/07	A7005	$15.19
	05/17/07	E0570	$117.89
88	10/23/06	A4554	$83.00
	11/23/06	A4554	$83.00*
	12/23/06	A4554	$83.00*
	01/22/07	A4554	$83.00*
89	11/14/06	A7005	$15.19
	11/14/06	E0570	$117.89
	11/21/06	A4216	$11.60
	11/21/06	A6234	$16.07

RITE SURGICAL SUPPLIES INC
Provider Number: [redacted]
Audit Number: 08-3380

No Written Order

Sample #	Date of Service	Procedure Code	Amount Disallowed
89	12/06/06	E0260	$869.49
90	10/09/06	E0990	$15.12
	10/09/06	K0001	$28.04
	10/11/06	E0240	$38.34
	10/14/06	K0001	$28.04
	10/14/06	E0990	$15.12
94	04/26/07	E0147	$306.70
95	11/30/07	E0163	$103.63
96	05/26/05	A4217	$6.32
98	09/05/05	B4150	$109.25
	10/05/05	B4150	$109.25*
	01/15/06	B4150	$109.25*
	02/15/06	B4150	$109.25
Total Services:	**61**		**$6,496.60**

RITE SURGICAL SUPPLIES INC
Provider Number: [redacted]
Audit Number: 08-3380

No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items

Sample #	Date of Service	Procedure Code	Amount Disallowed
13	02/01/05	E0260	$55.56
21	05/20/05	E0260	$869.49
24	05/04/06	E0185	$12.79
27	11/30/06	E2603	$12.23
28	10/27/06	E0163	$103.63
	06/30/07	K0001	$28.04
	07/31/07	E0990	$15.12
	07/31/07	K0001	$28.04
38	03/01/06	E0143	$130.03
44	12/13/05	K0001	$28.04
	01/13/06	K0001	$28.04
	02/13/06	K0001	$28.04
	03/13/06	K0001	$28.04
	06/13/06	K0001	$28.04
	07/13/06	K0001	$28.04
	08/13/06	K0001	$28.04
	09/13/06	K0001	$28.04
57	12/20/06	E0971	$0.65
59	02/18/05	E0192	$44.61
63	01/27/06	E0990	$302.40
	01/27/06	K0001	$280.39

RITE SURGICAL SUPPLIES INC
Provider Number: [redacted]
Audit Number: 08-3380

No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items

Sample #	Date of Service	Procedure Code	Amount Disallowed
74	09/21/06	A4217	$3.74
81	07/02/06	E0961	$0.53
	07/02/06	K0001	$10.31
	07/02/06	E0990	$3.58
	07/02/06	E0971	$0.87
	07/02/06	E0973	$1.97
86	03/02/06	E0990	$302.40
87	08/15/07	E0143	$24.08
91	04/06/07	K0001	$28.04
	04/06/07	E0990	$15.12
Total Services:	31		**$2,497.94**

Exhibit: IV

RITE SURGICAL SUPPLIES INC
Provider Number: [redacted]
Audit Number: 08-3380

Incorrect Procedure Code Billed

Sample #	Date of Service	Procedure Code	Amount Disallowed
3	09/21/05	B4158	$154.03
	10/21/05	B4158	$154.03*
	11/21/05	B4158	$154.03*
	12/21/05	B4158	$154.03*
Total Services:	**4**		**$616.12**

Exhibit: V

RITE SURGICAL SUPPLIES INC
Provider Number: [redacted]
Audit Number: 08-3380

Improper Medicaid Billings for Medicare Crossover Patients

Sample #	Date of Service	Procedure Code	Amount Disallowed
22	05/07/07	E2209	$85.73
44	03/13/06	K0003	$4.01
	04/13/06	K0003	$4.01
67	08/09/05	E0260	$58.86
86	03/02/06	K0001	$270.08
	Total Services:	**5**	**$422.69**

Exhibit: VI

RITE SURGICAL SUPPLIES INC
Provider Number: [redacted]
Audit Number: 08-3380

Ordering Prescriber Conflicts with Claim Prescriber

Sample #	Date of Service	Procedure Code	Amount Disallowed
7	09/02/05	E0240	$38.34*
Total Services:	1		**$38.34***

Exhibit: VII

RITE SURGICAL SUPPLIES INC
Provider Number: [redacted]
Audit Number: 08-3380

Missing Documentation Confirming Receipt/Delivery of Item

Sample #	Date of Service	Procedure Code	Amount Disallowed
53	03/20/06	A6402	$0.13
Total Services:	1		**$0.13**

Exhibit: VIII

RITE SURGICAL SUPPLIES INC
Provider Number: [redacted]
Audit Number: 08-3380

Additional Findings Pertaining to Sampled Items

Sample #	Date of Service	Procedure Code	Primary Finding	Other Findings Pertaining to Sampled Item
90	10/09/2006	E0990	No Written Order	No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items
90	10/09/2006	K0001	No Written Order	No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items
90	10/09/2006	E0240	No Written Order	No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items
90	10/09/2006	K0001	No Written Order	No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items
90	10/09/2006	E0990	No Written Order	No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items