



NEW YORK STATE  
DEPARTMENT OF HEALTH  
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF ALFA HEALTHCARE SUPPLY, INC.  
REVIEW DURABLE MEDICAL EQUIPMENT SUPPLIES  
PAID FOR FROM  
JANUARY 1, 2008 – DECEMBER 31, 2010

FINAL AUDIT REPORT  
AUDIT #12-2460

James C. Cox  
Medicaid Inspector General

January 21, 2014



STATE OF NEW YORK  
OFFICE OF THE MEDICAID INSPECTOR GENERAL  
800 North Pearl Street  
Albany, NY 12204

ANDREW M. CUOMO  
GOVERNOR

JAMES C. COX  
MEDICAID INSPECTOR GENERAL

January 21, 2014

[REDACTED]  
Alfa Healthcare Supply, Inc.  
261-12 E. Williston Avenue  
Floral Park, New York 11001

Re: Final Audit Report  
OMIG Audit #: 12-2460  
CMS ID Number: [REDACTED]  
IPRO Audit #: [REDACTED]

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report of IPRO's review of Alfa Healthcare Supply, Inc. (Provider) billing of Durable Medical Equipment for the paid claims for services and supplies covering the period January 1, 2008, through December 31, 2010.

In the attached final audit report, the OMIG has detailed the purpose and scope, procedures, laws, regulations, rules and policies, sampling technique, findings, and provider rights.

The OMIG has attached the sample detail for the paid claims determined to be in error. Your response to the draft audit report dated July 31, 2013 is incorporated into this final audit report. Due to additional documentation received in response to the draft audit report, the findings changed from the draft audit report. The computed overpayment is \$390,172. This audit may be settled through repayment of the computed overpayment of \$390,172.

[REDACTED]  
Page 2  
January 15, 2014

If the Provider has any questions or comments concerning this final audit report, please contact me at [REDACTED] or through email at [REDACTED]. Please refer to report number 12-2460 in all correspondence.

Sincerely,

[REDACTED]

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

Ver-4.0

[REDACTED]

cc: [REDACTED]

Enclosure

CERTIFIED MAIL [REDACTED]  
RETURN RECEIPT REQUESTED

## **OFFICE OF THE MEDICAID INSPECTOR GENERAL**

[www.omig.ny.gov](http://www.omig.ny.gov)

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds.

### **DIVISION OF MEDICAID AUDIT**

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to assess compliance with program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to assess the required involvement of professionals in planning care to program beneficiaries; to safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

### **DIVISION OF MEDICAID INVESTIGATIONS**

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries and penalties, and also improves the quality of care for the state's most vulnerable population.

### **DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION**

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

### **OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL**

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and state governments jointly fund and administer the Medicaid program. In New York State, the Department of Health (DOH) administers the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

### **PURPOSE AND SCOPE**

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for Durable Medical Equipment supplies complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to Durable Medical Equipment Supplies, this audit covered supplies paid by Medicaid from January 1, 2008, through December 31, 2010.

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## INTRODUCTION

This report is issued as a result of an audit conducted by the staff of IPRO, contracted by the Centers for Medicare & Medicaid Services (CMS), under the authority of the Medicaid Integrity Program, established by Section 1936 of the Social Security Act. The purpose of this audit was to determine Provider compliance with applicable Federal and State laws and regulations relative to paid claims for Medicaid services provided under New York State's Department of Health (New York).

### A. BACKGROUND:

IPRO has been contracted by CMS to audit Providers participating in the New York Medicaid program. These audits are conducted in accordance with the procedures specified in Public Law (Pub. L.), the Federal Register (FR), the Code of Federal Regulations (CFR), New York State Public Health Law, New York State Social Services Law, Titles 10 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR), NYS Provider Manual For Durable Medical Equipment, New York State Department of Health Medicaid Update Articles and "Government Auditing Standards" as issued by the United States Government Accountability Office. Audits under this program also utilize guidelines established by CMS.

IPRO conducted the audit of Alfa Healthcare Supply Inc. (Alfa) in accordance with the collaborative audit plan approved by CMS and the New York State Office of the Medicaid Inspector General (OMIG).

### B. PROGRAM OBJECTIVES:

IPRO Provider audits have the following objectives:

- To determine if services billed and paid under the State Medicaid program were provided and provided as ordered.
- To determine compliance with State and Federal Medicaid laws and regulations.
- To identify Provider billing and/or payment irregularities within the State's Medicaid program.

### C. AUDIT PROCESS:

This Provider audit was conducted in the following manner:

#### Overview

An understanding of the Provider's operations was discussed at the entrance conference and relevant information was obtained. This provided the audit staff with a basis for understanding how the Provider operates, including how billing is performed. Medical and related business records were obtained for review to determine if claims were coded appropriately, services were rendered, and services were medically necessary. These records were also used to calculate any estimated overpayment(s).

### Statistical Sampling

The audit was based on a valid probability sample drawn by OMIG.

The sample was drawn of claims meeting the requirements for this review. The sample was taken from the universe of Medicaid claims with paid dates during the period January 1, 2008, to December 31, 2010. The universe of claims does not include all claims paid to Alfa by Medicaid during the audit period.

Findings of irregularities found in the sample were then extrapolated to the universe of claims from which it was drawn.

### Documentation Reviewed

Documentation and records to support services reimbursed by New York State Department of Health were copied and reviewed on-site at the Provider's facility. No original records were removed from the Provider's premises. After the on-site review, the Provider was asked to provide the additional documents necessary to complete the audit, which were not located during the on-site review. These records were delivered by Alfa to IPRO's Lake Success office for review.

As part of this review, IPRO also reviewed five medical records from the ordering providers.

The documents collected were analyzed to identify any billing irregularities or deviations from Medicaid laws and regulations, and the Provider agreement. These documents included Prescriber Fiscal Orders, delivery receipts, accounting records and patient information status. The claims universe was focused on identifying paid claims for diabetic test strips.

An exit conference was held with Alfa and its representatives on January 17, 2013. The Provider's response to the exit conference dated January 29, 2013, was considered in the preparation of the Draft Audit Report. The Provider's response to the Draft Audit Report dated September 5, 2013, was considered in the preparation of the Final Audit Report, and certain findings were reduced or eliminated as a result. The results of the review are contained in Section III of this report.

#### D. AUDIT STAFF:

The following staff conducted this audit:

Rasheed Ally, Fiscal Auditor  
Michael Prestia, Fiscal Auditor  
Eloise Tate, Fiscal Auditor  
Jay Levine, Fiscal Auditor  
Deborah Nurmi, RN  
Julianne Gorsage, RN, UR Manager

## AUDIT PROFILE

### A. PROVIDER PROFILE:

Name: Alfa Healthcare Supply Inc.  
Address: 261-12 E. Williston Avenue  
Floral Park, NY 11001

Provider Number: [REDACTED]

Provider Type: Durable Medical Equipment Supplier (DME)

### B. AUDIT SCOPE:

The scope of this audit was limited to determining compliance with Federal Medicaid laws and regulations and related State laws and regulations cited in New York Statute, Regulations, Manuals and Bulletins.

The purpose of this audit was to identify overpayments resulting from the supplying of diabetic test strips to Medicaid patients.

A universe of claims with payment dates from January 1, 2008, through December 31, 2010 was developed. Only claims with a paid amount greater than zero were included in this universe.

The universe included 458 cases consisting of 3,749 claims with a total Medicaid payment of \$569,832.31. From this universe, a total of 100 cases (919 claims) totaling \$139,334.17 was selected for review.

The audit was not intended to discover all possible errors in billing or record keeping. Any omission of other errors from this report does not mean such practice is acceptable. Because of the limited nature of this review, no inferences as to the overall level of Provider performance should be drawn solely from this report.

Achieving the objectives of the audit did not require the review of Alfa's overall internal control structure. Accordingly, the auditors limited the internal control review to the controls related to any overpayments.

### C. ANALYSIS OF FINDINGS:

Out of 100 cases (919 claims) reviewed, there were 97 cases (780 claims) with recoupable monetary findings. Section III explains the monetary findings and is supported by Appendix A, which lists all findings associated with the sample claims.

The statistical sampling methodology employed allows for extrapolation of the sample findings to the universe of cases (18 NYCRR Section 519.18). The adjusted mean per unit point estimate of the amount overpaid is \$422,052.00. The adjusted lower confidence limit of the amount overpaid is \$390,172. We are 95% certain that the actual amount of the overpayment is greater than the adjusted lower confidence limit (Appendix B). This audit may be settled through repayment of the adjusted lower confidence limit amount of \$390,172.

## LAWS, REGULATIONS, RULES AND POLICIES

The following are applicable Laws, Regulations, Rules, and Policies of the Medicaid program referenced when conducting this audit:

- Departments of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)], and State Education Department [Title 8 of the Official Compilation of Codes, Rules and Regulations of the State of New York (8 NYCRR Part 200)].
- Medicaid Management Information System and eMedNY Provider Manual, including applicable updates by the New York State Department of Health with the New York State Education Department.
- Specifically, Title 18 NYCRR Section 540.6, and other applicable program regulations, for example, 14 NYCRR Part 822.

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)*

## **MONETARY FINDINGS**

A review of the 100 cases (919 claims) representing 100 patients revealed 780 claims with recoupable billing errors. Detailed information regarding monetary findings on the sampled claims is located in Appendix A.

The following detailed findings reflect the results of the audit:

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: "All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are 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)*

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)*

### **1. Item Billed in Excess of Quantity Ordered**

Regulations state, "When used in the context of an order for a prescription item, the order must also meet the requirements for a prescription under section 6810 of the Education Law. When used in the context of a nonprescription item, the order must also contain the following information: name of the item, quantity ordered, size, catalog number as necessary, directions for use, date ordered, and number of refills, if any."

*18 NYCRR Section 505.5(b)(3)*

Regulations also 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)*

In 90 cases (508 instances) the item billed was in excess of quantity ordered.

In response to this finding discussed at the exit conference, the provider stated, "*Alfa had utilized a procedure of sending patients a two month supply of blood glucose strips and related supplies and would not exceed the prescribers' original order including refills. This was done to save time, labor and shipping costs. Nevertheless this procedure has now been eliminated and is no longer within the Alfa operations protocol.*"

However, in response to this finding discussed in the Draft Audit Report, Alfa did not advance the same argument it did in response to the exit conference. Instead, Alfa submitted letters from several prescribers (with affected patients listed) as well as from 83 patients and explained that there was an ongoing "contemporaneous" understanding between Alfa, the prescribers and affected patients that Alfa would double up the submission of supplies but would deduct future refills from the patient orders to balance out what was delivered with the actual intended quantity ordered from the prescriber. Alfa went on to say that while it "recognizes that this process did not exactly comport with New York Medicaid guidelines, it did not exceed prescriber's total authorized quantities."

While IPRO appreciates the fact that the provider has changed the "procedure of sending patients a two month supply," the procedure was not in compliance with the prescriber's orders, and, as such, IPRO stands by this finding. Further the letters submitted are not contemporaneous documentation and, as such, are not acceptable.

**Note:** If this is the only finding, the recoupment amount is the amount paid for the excess quantity billed. If there are other findings for the claim with this finding, the recoupment amount is the amount paid for the claim.

## **2. No Explanation of Benefits (EOB) for Medicare Covered Item**

The Durable Medical Equipment Manual Policy Guidelines 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*

Per DOH Medicaid Update (December 2005, Vol. 20, No. 13):

Medicaid law and regulations require that, when a recipient is eligible for both Medicare and Medicaid or has other insurance benefits:

The provider must bill Medicare or the other insurance first for covered services prior to submitting a claim to Medicaid.

The Medicaid program is designed to provide payment for medical care and services only after all other resources available for payments have been exhausted; Medicaid is always payor of last resort. Providers must maximize all applicable insurance sources before submitting claims to Medicaid. When coverage is available, payment from other insurance sources must be received before submitting a Medicaid claim.

- If the service is covered, or the provider does not know if the service is covered by Medicare and/or other available insurance, the provider must first submit a claim to Medicare and/or other insurer.
- Only when you are certain that Medicare or another insurer does not cover the service, can you bill Medicaid solely, and not bill other insurer first.

It is important to maintain appropriate financial documentation supporting your determination of available resources, collection efforts and the receipt of funds, as well as their application. These records must be made available to authorized Department personnel for audit purposes.

In 48 cases (447 instances) Medicare EOBs were not made available for patients who had Medicare coverage and Medicaid was billed prior to billing Medicare. (At the entrance conference, the provider admitted that they did not bill Medicare for diabetic strips, but has started billing Medicare after the audit started.)

In response to this finding discussed at the exit conference, the provider stated, *"...Alfa staff had problems correctly identifying who had Medicare coverage".* The provider went on to state that *"...Alfa would bill these products to Medicaid and there was no rejection by the Medicaid billing system,"* and added that the provider relied on the June 2007 Medicaid Update *"for confirmation that the billings submitted on or after July 2, 2007 would be rejected by NYS Medicaid when an enrolled is both Medicare/Medicaid dually eligible."*

In response to this finding discussed in the Draft Audit Report, the provider acknowledged that "some claims for known Medicare patients did go through the Medicaid billing system and were paid." However, Alfa asserted that it "relied on the Medicaid computer system to implement what the Medicaid Update stated in June 2007 and reject any claims for Medicare eligible patient supplies."

IPRO finds the provider's response unpersuasive and stands by this finding. For example, the provider's own documentation furnished to IPRO indicated that several patients had Medicare coverage. (For example, for sample numbers 1 and 2 Alfa maintained a "Patient Face Sheet-HME" which clearly indicated that the primary insurance carrier for both these recipients was Medicare, with Medicaid as a secondary payor.)

### **3. Billing for Automatic Refill**

The Medicaid Update states: "Confirmation of needed delivery shall be maintained in the patient record. Automatic refills will not be permitted . . . ."

*DOH Medicaid Update June 2000 Vol. 15, No. 6, Office of Medicaid Management*

Regulations state, "A fiscal order for medical-surgical supplies may be refilled when the prescriber has indicated on the order the number of refills and the recipient has requested the refill.

"The recipient or representative must request each refill because their medical condition and/or living situation may change over the course of the fiscal order. Examples of medical-surgical supplies include: diabetic supplies, enteral formulas, incontinence products and wound dressings.

"The following are unacceptable practices:

- Automatic refilling and claiming for medical-surgical supplies;
- Refilling in excess of the number of refills indicated on the fiscal order;
- Knowingly making a claim for unnecessary medical-surgical supplies;
- Claiming for medical-surgical supplies when a recipient is hospitalized or moves into a skilled nursing facility, because medical-surgical supplies are included in the Medicaid rate paid to the facility."

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

In 54 cases (210 instances) there was no indication in the patient record(s) that the recipient or representative was contacted before the prescription was refilled.

In response to this finding discussed in the Draft Audit Report, Alfa challenged this finding on the basis that it "is not included on the OMIG DME Audit Protocols and should be removed on that basis alone." However, Alfa did submit additional documentation to show contact was indeed made with the patient before delivery of supplies.

Based on these submissions, this finding went down from 92 cases (492 instances) in the Draft Audit Report to 54 cases (210 instances) in this Final Audit Report.

IPRO also would like to note that OMIG's published protocol document(s) states that it "is intended solely for guidance." It goes on to say that the guidance "may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person." With respect to this finding, IPRO would like to point out that various Medicaid Updates (May 2010 edition, for example) have emphasized that Automatic refill are not allowed under the New York State Medicaid program.

#### **4. Ordering Prescriber Conflicts with Claim Prescriber**

Regulations state: "By enrolling the provider agrees: . . . 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(h)*

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)*

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 518.1(c)*

Prior to October 1, 2009:

Regulations state, "Enter the ordering provider's Medicaid ID number in this field. If the ordering provider is not enrolled in Medicaid, enter his/her license number. If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. ...."

"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 Medicaid ID number."

*NYS Medicaid Program Durable Medical Equipment, Billing Guidelines  
Versions 2004-1 and 2009-1, Section II*

For October 1, 2009 and Forward:

Regulations state, "For Ordering Provider: enter the ordering provider's National Provider Identifier (NPI) in this field."

*NYS Medicaid Program Durable Medical Equipment, Billing Guidelines  
Version 2009-2, Section II*

In 12 cases (57 instances), the ordering prescriber conflicted with the claim prescriber.

In response to this finding discussed in the Draft Audit Report, the provider submitted additional documentation. Based on these submissions, this finding went down from 15 cases (68 instances) in the Draft Audit Report to 12 cases (57 instances) in this Final Audit Report.

Alfa also provided a letter from an attending physician explaining his working relationship with several nurse practitioners servicing patients.

In the State of New York, Nurse Practitioners have prescriptive privileges and, as such, an attending physician's attestation is not required. As the two nurse practitioners in question were properly licensed in New York State during the period under review, they should have been listed as the prescribing practitioner's as required by policy. Therefore, IPRO stands by this finding.

**Note:** If this is the only finding for the claim, the finding will not be extrapolated.

##### **5. Original Fiscal Order Filled Beyond 60 Days of Issuance**

Regulations state: "An original fiscal order for Medical/Surgical Supplies may not be filled more than 60 days after it has been initiated by the ordering practitioner unless prior approval is required."

*NYS Medicaid Program Durable Medical Equipment, Fee Schedule  
Version 2005-1, Section 4.0  
NYS Medicaid Program Durable Medical Equipment Manual, Procedure Codes,  
Version 2008-1, Section 4.0*

In 23 cases (25 instances) a prescription/fiscal order was filled more than 60 days after its issuance.

In its response, Alfa acknowledged that there may have been instances where the actual day of ordering had not been confirmed and properly identified in their billing system, which has now been corrected going forward. It claimed that the diabetic blood glucose supplies were needed by the affected patients and the use of the diabetic blood glucose strips was needed by these diabetic patients. It requested that these findings not be recovered.

No change in finding is warranted.

#### **6. Missing Fiscal Order**

Regulations state: "All . . . medical/surgical supplies, . . . may be furnished only upon a written order of a practitioner."

*18 NYCRR Section 505.5(b)(1)*

The Durable Medical Equipment Manual Policy Guidelines states: "All medical/surgical supplies, durable medical equipment, prosthetic and orthotic appliances and orthopedic footwear 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, Section III, Versions 2004-1, 2009-2*

In 5 cases (8 instances) a signed written fiscal order was missing.

In response to this finding discussed in the Draft Audit Report, Alfa submitted additional documentation. Based on these submissions, this finding went down from 19 cases (24 instances) in the Draft Audit Report to 5 cases (8 instances) in this Final Audit Report.

#### **7. Missing Documentation Confirming Receipt/Delivery of Item**

Regulations state that by enrolling in the Medicaid program the 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 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 department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health"

*18 NYCRR Section 504.3(a)*

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 state, "All bills for medical care, services and supplies shall contain: . . . a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing and that, except as noted, no part thereof has been paid; that payment of fees and rates made in accordance with established schedules is accepted as payment in full for the care, services and supplies provided; . . . 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 unless otherwise required by regulation, and information will be furnished regarding any payment claimed therefore as the local social services agency or the State Department of Social Services may request; 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)(8)*

Regulations state, “Fee-for-service providers. (1) All providers, who are not paid at rates or fees approved by the State Director of the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply, 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.”

*18 NYCRR Section 517.3(b)*

The Durable Medical Equipment Manual Policy Guidelines states: “In addition to meeting the general record-keeping requirements outlined in the General Information Section of this manual, the provider filling an order for durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances and orthopedic footwear must keep on file the fiscal order signed by the prescriber and the delivery statement signed by the recipient for any item for which Medicaid payment is claimed.”

*NYS Medicaid Program Durable Medical Equipment Manual  
Policy Guidelines, Section I, Versions 2004-1, 2009-2*

In 2 cases (2 instances) the records provided did not contain delivery receipts for the items billed.

In response to this finding discussed in the Draft Audit Report, the provider submitted additional documentation. Based on these submissions, this finding went down from 9 cases (11 instances) in the Draft Audit Report to 2 cases (2 instances) in this Final Audit Report.

#### **8. No Signature on Written Order**

Regulations state: “The terms written order or fiscal order are used interchangeably in this section and mean any original, signed written order of a practitioner which requests durable medical equipment, prosthetic or orthotic appliances and devices, medical/surgical supplies, or orthopedic footwear

*18 NYCRR Section 505.5(a)(8)*

The Durable Medical Equipment Manual Policy Guidelines states:

“All medical/surgical supplies, durable medical equipment, prosthetic and orthotic appliances and orthopedic footwear 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, Section III Versions 2004-1, 2009-2*

In 1 case (3 instances) the original signature was missing on the fiscal order.

In response to this finding discussed in the Draft Audit Report, the provider enclosed as Exhibit 14 "a letter from the prescribing physician confirming her orders." The letter from the physician is undated but is evidently a post-facto confirmation of prescriptions written by her. 18 NYCRR Section 504.3(a) requires the provider "to prepare and to maintain contemporaneous records demonstrating its right to receive payment." A subsequently signed letter does not fulfill the requirement. As such, IPRO cannot accept the physician's letter and therefore stands by this finding.

## 9. Duplicate Billing

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 518.1(c)

The NYS Medicaid Program Provider Manual states, "unacceptable practices include, but are not limited to the following:

- Knowingly making a claim for an improper amount or for unfurnished, inappropriate or unnecessary care, services or supplies; ..."

*NYS Medicaid Program Provider Manual  
Information for All Providers, General Policy, Section II, Versions 2004-1 and 2008-2*

In 1 case (1 instance) a claim for the same item for the same patient was submitted one day apart.

In response to this finding discussed in the Draft Audit Report, the provider stated that "*Alfa accidentally generated back to back deliveries to the particular patient*" and that "*this should not have occurred.*"

## **SUMMARY OF OVERPAYMENTS**

The identified overpayments after re-audit for the discrepant sampled claims totaled \$105,765.92. When extrapolated to the universe of claims from which the sample was drawn, the calculated overpayment is \$ 390,172. The total amount due to New York State Department of Health is \$ 390,172. See **Appendices A and B** for detailed information.

## **RECOMMENDATIONS**

Based on the findings cited in this audit report, Alfa is directed to:

1. Remit overpayment of \$390,172 to New York State Department of Health, or make other payment arrangements as noted above.
2. Comply with all Federal and State laws and regulations and billing instructions provided under the Medicaid program. Continued violation(s) may result in the termination or suspension of your eligibility to provide services to Medicaid clients.

## PROVIDER RIGHTS

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 \$390,172, 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:

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
File #12-2460  
Albany, New York 12237

**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 15% withhold after 20 days until the agreement is established.

Furthermore, the OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. 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. The OMIG will notify you no later than 5 days after initiating such action. If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

Bureau of Collections Management  
New York State Office of the Medicaid Inspector General  
800 North Pearl Street  
Albany, New York 12204  
[REDACTED]

If within 20 days, you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to recover payment and liquidate the adjusted lower confidence limit amount, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.

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 \$422,052. 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

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.

**NEW YORK STATE  
OFFICE OF THE MEDICAID INSPECTOR GENERAL  
REMITTANCE ADVICE**

**NAME AND ADDRESS OF AUDITEE**

Alfa Healthcare Supply, Inc.  
261-12 E. Williston Avenue  
Floral Park, New York 11001

**PROVIDER ID** [REDACTED]

**AUDIT #12-2460**

**AMOUNT DUE: \$390,172**

**AUDIT**

**TYPE**

**PROVIDER**

**RATE**

**PART B**

**OTHER:**

**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 #12-2460  
Albany, New York 12237

*Thank you for your cooperation.*