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

REVIEW OF KIRKER MICHAEL CLAIMS FOR TRANSPORTATION SERVICES PAID FROM JANUARY 1, 2007 – DECEMBER 31, 2009

FINAL AUDIT REPORT
AUDIT #11-2871

Thomas R. Meyer
Acting Medicaid Inspector General

January 26, 2015

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

THOMAS R. MEYER
Acting Medicaid Inspector General

January 26, 2015

[redacted]
Kirker Michael
1011 91st Street
Niagara Falls, New York 14304-2815

Re: Final Audit Report
County Demonstration Project
Niagara County
Audit #: 11-2871
Provider ID #: [redacted]

Dear [redacted]:

This letter will serve as our final audit report of the recently completed review of payments made to Kirker Michael (the Provider) under the New York State Medicaid Program. Since you did not respond to our draft audit report dated August 29, 2014, the findings in the final audit report are identical to those in the draft audit report.

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 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 the Medicaid Management Information System (MMIS) Provider Manuals.

Medicaid reimbursement in New York State is available to lawfully authorized ambulance, ambulette and taxi providers for transportation services furnished to Medicaid eligible persons going to or from the site of Medicaid covered medical services. Other carriers are specifically approved to transport Medicaid recipients to and from prescribed day treatment services. Transportation providers and their drivers must comply with all applicable state, county and municipal requirements for legal operation, including those for licensing, inspection, training, staffing and equipment. Applicable regulations of the State Departments of Transportation, Health and Motor Vehicles are referenced in the Department's governing regulation, Title 18 NYCRR Section 505.10.

A common requirement for all Medicaid transportation providers is the need to obtain prior authorization for all non-emergency services that are provided. Once authorized, a service must be rendered to receive reimbursement. Each billing claim for service submitted for Medicaid payment must conform to the billing requirements contained in the MMIS Provider Manual for Transportation and rate schedules issued by county social service districts as part of their local transportation plans.

A review of payments to the Provider for transportation services paid by Medicaid for Niagara County recipients from January 1, 2007, through December 31, 2009, was recently completed. During the audit period, $468,698.90 was paid for 5,380 services rendered to 444 recipients. This review consisted of a random sample of 150 services involving 78 recipients with Medicaid payments of $12,988.50. The purpose of this audit was to verify that: drivers and/or vehicles were properly licensed, certified and/or registered; prior authorizations were obtained; all billing and rate requirements were met; Medicaid reimbursable services were rendered for the dates billed; appropriate procedure codes were billed for 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 Transportation.

The Provider's failure to comply with Title(s) 10, 14 and/or 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) and the MMIS Provider Manual for Transportation resulted in a total sample overpayment of $4,980.

The statistical sampling methodology employed allows for extrapolation of the sample findings to the universe of cases (18 NYCRR Section 519.18). The mean per unit point estimate of the amount overpaid is $178,616. The lower confidence limit of the amount overpaid is $149,250. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit (Exhibit I).

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 draft audit report dated August 29, 2014.

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 Documentation/Missing Documentation

Regulations state: "By enrolling 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)*

Medicaid policy states: "Payment to ambulette, taxi/livery/van and day treatment transportation providers who transport Medicaid recipients Medicaid-covered services will only be made for services documented in contemporaneous records.
Documentation shall include the following:

- The recipient's name and Medicaid identification number;
- The origination of the trip;
- The destination of the trip;
- The date and time of service; and,
- The name of the driver transporting the recipient.

For auditing purposes, Medicaid recipient records must be maintained and be available to authorized officials for six (6) years following the date of payment."

MMIS Transportation Manual Policy Guidelines, Version 2006-1 (effective 20 Oct 06), Section II
Version 2006-2 (effective 1 Dec 06), Section II
Version 2007-1 (effective 9 Jan 07), Section II

Medicaid policy states: "Payment to ambulette, taxi/livery/van and day treatment transportation providers who transport Medicaid enrollees to Medicaid-covered services will only be made for services documented in contemporaneous records. Documentation shall include the following:

- The Medicaid enrollee's name and Medicaid identification number;
- Both the origination and destination of the trip;
- The date and time of service; and,
- The name of the driver transporting the Medicaid enrollees.

For auditing purposes, Medicaid enrollee records must be maintained and available to authorized officials for six (6) years following the date of payment."

MMIS Transportation Manual Policy Guidelines, Version 2008-1 (effective 1 Jun 08), Section II
Version 2008-2 (effective 25 Jun 08), Section II
Version 2008-3 (effective 1 Sept 08), Section II

Medicaid policy states: "Payment to ambulette, taxi/livery/van and day treatment transportation providers who transport Medicaid beneficiaries to Medicaid-covered services will only be made for services documented in contemporaneous records. Documentation shall include the following:

- Medicaid beneficiary's name and Medicaid client identification number (CIN);
- **Both** the origination and destination of the trip;
- Date and time of service; and,
- Name of the driver transporting the beneficiary.

For auditing purposes, Medicaid beneficiary records must be maintained and available to authorized officials for six (6) years following the date of service."

MMIS Transportation Manual Policy Guidelines, Version 2009-1 (effective 1 Jan 09), Section II
Version 2009-2 (effective 15 Apr 09), Section II

Medicaid policy states: "Payment to ambulette, taxi/livery/van and day treatment transportation providers who transport Medicaid beneficiaries to Medicaid-covered services will only be made for services documented in contemporaneous records. Documentation shall include the following:

- Medicaid beneficiary's name and Medicaid client identification number (CIN);
- **Both** the origination and destination of the trip;
- Date and time of service; and,
- Name of the driver transporting the beneficiary.

As there is no assumption of a round trip, a trip is considered to be one way. Therefore, trip records, as described above, are required for *each trip* performed in a day. Failure to maintain adequate trip documentation may result in payment disallowance.

Per 18 NYCRR §517.3(b), for auditing purposes, Medicaid beneficiary records must be maintained and available to authorized officials for six (6) years following the date of service."

MMIS Transportation Manual Policy Guidelines, Version 2009-3 (effective 5 May 09), Section II
Version 2009-4 (effective 1 Sept 09), Section II

In 42 instances pertaining to 21 recipients, contemporaneous documentation of a transportation service was missing. This resulted in a sample overpayment of $2,920 (Exhibit II).

In 21 instances pertaining to 17 recipients, contemporaneous documentation supporting the name of the driver was missing. This resulted in a sample overpayment of $1,694 (Exhibit III).

In 5 instances pertaining to 4 recipients, contemporaneous documentation supporting the name of the driver for the 1st leg of the trip was missing. This resulted in a sample overpayment of $222 (Exhibit IV).

In 2 instances pertaining to 2 recipients, contemporaneous documentation of a transportation service for the 2nd leg of the trip was missing. This resulted in a sample overpayment of $80 (Exhibit V).

In 1 instance, contemporaneous documentation supporting the name of the recipient was missing. This resulted in a sample overpayment of $64 (Exhibit VI).

Total sample overpayments for this audit amounts to $4,980.

Additional reasons for disallowance exist regarding certain findings. These findings are identified in Exhbit VII.

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 lower confidence limit amount of $149,250, 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, B.A.M.
GNARESP Corning Tower, Room 2739
File #: 11-2871
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 lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the meanpoint estimate of $ 178,616. 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
Office of the Medicaid Inspector General

cc: [redacted]

[redacted]
Enclosure

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