



**Office of the  
Medicaid Inspector  
General**

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

**REVIEW OF MARTIN H. MANDELBAUM  
CLAIMS FOR DURABLE MEDICAL EQUIPMENT SERVICES  
PAID FROM  
JANUARY 1, 2006 – DECEMBER 31, 2009**

**FINAL AUDIT REPORT  
AUDIT #: 11-1007**

**Dennis Rosen  
Medicaid Inspector General**

**May 16, 2016**



Office of the  
Medicaid Inspector  
General

ANDREW M. CUOMO  
Governor

DENNIS ROSEN  
Medicaid Inspector General

May 16, 2016

[REDACTED]  
Martin H. Mandelbaum  
116 Oakland Avenue  
Port Jefferson, New York 11777-2172

Final Audit Report  
Suffolk County Demonstration Project  
Durable Medical Equipment, Appliances and  
Supplies (COS 321)  
Audit #: 11-1007  
Provider ID #: [REDACTED]

Dear [REDACTED]

This letter will serve as our final audit report of the recently completed review of payments made to Martin H. Mandelbaum under the New York State Medicaid Program.

The New York State Department of Health 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 Martin H. Mandelbaum for DME services paid by Medicaid for Suffolk County recipients from January 1, 2006, through December 31, 2009, was recently completed. During the audit period, \$436,845.47 was paid for 1,894 claims for services rendered. This review consisted of a random sample of 100 claims with Medicaid payments of \$18,375.87. 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.

Martin H. Mandelbaum'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 \$7,394.57.

The statistical sampling methodology employed allows for extrapolation of the sample findings to the universe of services (18 NYCRR Section 519.18). The adjusted mean per unit point estimate of the amount overpaid is \$136,527. The adjusted lower confidence limit of the amount overpaid is \$53,410. 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 \$53,410.

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 March 24, 2015. The attached Bridge Schedule indicates any changes to the findings as a result of your response.

## 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. Telephone or Fax Order Lacks Signed Follow Up Order**

Medicaid policy states, "In the event an order for durable medical equipment, medical-surgical supplies, or orthotic or prosthetic appliances has been telephoned or faxed to the provider, it is the provider's responsibility to obtain the signed fiscal order from the ordering practitioner within 30 calendar days."

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

In 12 instances pertaining to 9 patients, there was no written and signed follow up order resulting from a telephone/fax order. This resulted in a sample overpayment of \$4,611.52 (Exhibit II).

## **2. 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 1 instance, the written order for the item provided was missing. This resulted in a sample overpayment of \$1,554.50 (Exhibit III).

### 3. Missing Information on Written Order

Regulations state, "All orders must show . . . the name of the recipient for whom ordered."

*18 NYCRR Section 505.5(b)(2)*

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)*

In 5 instances pertaining to 5 patients, the written order did not contain all the required information. In 5 instances, the billed item was missing from the order (Sample #19, #21, #37, #88 and #98). This resulted in a sample overpayment of \$486.67 (Exhibit IV).

### 4. No Documentation of Service

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)*

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 517.3*

Medicaid policy states, "Federal Law and State Regulations require providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to Medicaid enrollees."

*NYS Medicaid Program Provider Manual Information for all Providers,  
Version 2004-1, Section II*

In 1 instance, the service billed was not documented. This resulted in a sample overpayment of \$410.00 (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 2 instances pertaining to 2 patients, the ordering prescriber on the claim conflicts with the ordering prescriber denoted on the fiscal order. This resulted in a sample overpayment of \$196.58 (Exhibit VI). For this category of findings, OMIG will disallow only the actual amount of the sample overpayment and will not extrapolate the sample findings to the universe of services.

#### **6. 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 1 instance, the incorrect procedure code was billed which resulted in a higher reimbursement than indicated in the fee schedule for the proper procedure code. This resulted in a sample overpayment of \$117.00 (Exhibit VII).

## **7. Durable Medical Equipment Billed in Excess of the Maximum Allowance**

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, or (b) the usual and customary price charged to the general public."

*18 NYCRR Section 505.5(d)(2)(i)(a)&(b)*

Medicaid policy states, "Reimbursement of durable medical equipment must not exceed the lower of: the price shown in the fee schedule for durable medical equipment; or the usual and customary price charged to the general public." The procedure code section of the Provider Manual for Durable Medical Equipment outlines the allowable fee for each item.

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

In 1 instance, Medicaid was billed in excess of the maximum allowance for durable medical equipment. This resulted in a sample overpayment of \$18.30 (Exhibit VIII).

Total sample overpayments for this audit amounted to \$7,394.57.

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

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 \$53,410, 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  
 GNARESP Corning Tower, Room 2739  
 File #11-1007  
 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 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 point estimate of \$136,527. 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, NY 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

[REDACTED]

[REDACTED]

[REDACTED]

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

██████████  
Martin Mandelbaum  
116 Oakland Avenue  
Port Jefferson, New York 11777-2172

PROVIDER ID # ██████████

AUDIT #11-1007

AMOUNT DUE: \$53,410

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:

██████████  
New York State Department of Health  
Medicaid Financial Management, B.A.M.  
GNARESP Corning Tower, Room 2739  
File #11-1007  
Albany, New York 12237-0048

*Thank you for your cooperation.*

EXHIBIT I

MARTIN H. MANDELBAUM  
 DURABLE MEDICAL EQUIPMENT AUDIT  
 AUDIT #11-1007  
 AUDIT PERIOD: 01/01/06 – 12/31/09

EXTRAPOLATION OF SAMPLE FINDINGS

Total Sample Overpayments	\$ 7,394.57
Less Overpayments Not Projected*	<u>(196.58)</u>
Sample Overpayments for Extrapolation Purposes	\$ 7,197.99
Services in Sample	100
Overpayments Per Sampled Service	\$ 71.9799
Services in Universe	1,894
Meanpoint Estimate	\$ 136,330
Add Overpayments Not Projected*	<u>197</u>
Adjusted Meanpoint Estimate	<u>\$ 136,527</u>
Lower Confidence Limit	\$ 53,213
Add Overpayments Not Projected*	<u>197</u>
Adjusted Lower Confidence Limit	<u>\$ 53,410</u>

\* The actual dollar disallowance for the following finding was subtracted from the total sample overpayment and added to the Point Estimate and Lower Confidence Limit:

- **Finding #5 - Ordering Prescriber Conflicts with Claim Prescriber**

The dollar disallowance associated with this finding was not used in the extrapolation. However, this does not apply if an extrapolated finding was also identified for a sampled claim

## MARTIN H MANDELBAUM

MMIS #: [REDACTED]

Audit #: 11-1007

## Telephone or Fax Order Lacks Signed Follow Up Order

<b>Sample #</b>	<b>Date of Service</b>	<b>Formulary Code</b>	<b>Amount Disallowed</b>
8	11/30/2007	L2385	\$64.00
9	4/3/2007	L2220	\$30.02
12	5/13/2008	L2620	\$330.00
25	11/30/2007	L2037	\$1,554.50
48	10/3/2007	L2220	\$111.00
57	9/25/2007	L2036	\$1,554.50
60	11/8/2007	L3221	\$49.50
65	5/13/2008	L2620	\$330.00
68	5/1/2008	L2250	\$182.50
72	5/26/2006	L2220	\$55.50
73	11/15/2007	L2820	\$210.00
74	8/1/2006	L3890	\$140.00
<b>Total Services:</b>	<b>12</b>		<b>\$4,611.52</b>

## MARTIN H MANDELBAUM

MMIS #: [REDACTED]

Audit #: 11-1007

## No Written Order

Sample #	Date of Service	Formulary Code	Amount Disallowed
71	7/18/2006	L2037	\$1,554.50
<b>Total Services:</b>	<b>1</b>		<b>\$1,554.50</b>

MARTIN H MANDELBAUM

MMIS #: [REDACTED]

Audit #: 11-1007

Missing Information on Written Order

Sample #	Date of Service	Formulary Code	Amount Disallowed
19	9/12/2007	L2270	\$53.89
21	7/29/2008	L2830	\$145.20
37	7/14/2009	L2275	\$67.44
88	9/5/2008	L2760	\$128.00
98	4/2/2008	L2768	\$92.14
<b>Total Services:</b>	<b>5</b>		<b>\$486.67</b>

MARTIN H MANDELBAUM

MMIS #: [REDACTED]

Audit #: 11-1007

No Documentation of Service

Sample #	Date of Service	Formulary Code	Amount Disallowed
39	12/16/2006	L1940	\$410.00
<b>Total Services:</b>	<u>1</u>		<u>\$410.00</u>

MARTIN H MANDELBAUM

MMIS #: [REDACTED]

Audit #: 11-1007

**Ordering Prescriber Conflicts with Claim Prescriber**

Sample #	Date of Service	Formulary Code	Amount Disallowed
56	10/14/2008	L3221	\$46.58
84	8/10/2007	L2275	\$150.00
<b>Total Services:</b>	<b>2</b>		<b>\$196.58</b>

MARTIN H MANDELBAUM

MMIS #: [REDACTED]

Audit #: 11-1007

**Incorrect Procedure Code Billed**

Sample #	Date of Service	Formulary Code	Amount Disallowed
28	7/17/2006	L4210	\$117.00
<b>Total Services:</b>	<b>1</b>		<b>\$117.00</b>

MARTIN H MANDELBAUM

MMIS #: [REDACTED]

Audit #: 11-1007

**Durable Medical Equipment Billed in Excess of the Maximum Allowance**

Sample #	Date of Service	Formulary Code	Amount Disallowed
29	12/19/2008	L3216	\$18.30
<b>Total Services:</b>	<u>1</u>		<u>\$18.30</u>

**MARTIN H. MANDELBAUM**  
**DURABLE MEDICAL EQUIPMENT, APPLIANCES AND SUPPLIES SERVICES AUDIT**  
**AUDIT #11-1007**  
**AUDIT PERIOD: 01/01/06 – 12/31/09**

**ADDITIONAL FINDINGS PERTAINING TO SAMPLED ITEMS**

<u>Sample #</u>	<u>Primary Finding</u>	<u>Other Findings Pertaining to Sampled Item</u>
37	Missing Information on Written Order	Other Insurance Payments Not Applied *
39	No Documentation of Service	Missing Documentation Confirming Receipt/Delivery of Item **
48	Telephone or Fax Order Lacks Signed Follow Up Order	Ordering Prescriber Conflicts with Claim Prescriber
57	Telephone or Fax Order Lacks Signed Follow Up Order	No Written Order
60	Telephone or Fax Order Lacks Signed Follow Up Order	No Signature on Written Order ***

**\* Other Insurance Payments Not Applied**

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, "Any insurance payments including Medicare must be applied against the total purchase price of the item."

*18 NYCRR Section 505.5(d)(1)(v)*

**\*\* 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*

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### **No Signature on Written Order**

Regulations state that a *written or fiscal order* means, "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)*

Medicaid policy states, "The minimum information on a fiscal order is: . . . Original signature of the ordering practitioner. . . ."

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

## FINAL DISPOSITION FOR SAMPLED SELECTIONS CHANGED FROM DRAFT TO FINAL AUDIT REPORT

MARTIN H. MANDELBAUM  
DURABLE MEDICAL EQUIPMENT, APPLIANCES AND SUPPLIES SERVICES AUDIT  
AUDIT #11-1007  
AUDIT PERIOD: 01/01/06 - 12/31/09

## BRIDGE SCHEDULE

SAMPLE #	FINDING	DRAFT REPORT AMOUNT DISALLOWED	FINAL REPORT AMOUNT DISALLOWED	CHANGE
3	Ordering Prescriber Conflicts with Claim Prescriber	\$ 106.72	\$ -	\$ (106.72)
5	Missing Information on Written Order	150.00	\$ -	(150.00)
16	No Documentation of Item Delivered	1,110.00	\$ -	(1,110.00)
20	Incomplete Information on Written Order	150.00	\$ -	(150.00)
44	Incomplete Information on Written Order	55.50	\$ -	(55.50)
45	Incomplete Information on Written Order	120.00	\$ -	(120.00)
55	Ordering Prescriber Conflicts with Claim Prescriber	21.00	\$ -	(21.00)
61	Incomplete Information on Written Order	65.00	\$ -	(65.00)
64	Ordering Prescriber Conflicts with claim Prescriber	40.00	\$ -	(40.00)
66	No Documentation of Item Delivered	222.00	\$ -	(222.00)
69	Incomplete Information on Written Order	150.00	\$ -	(150.00)
76	Incomplete Information on Written Order	300.00	\$ -	(300.00)
78	Incomplete Information on Written Order	55.50	\$ -	(55.50)
82	Ordering Prescriber Conflicts with Claim Prescriber	222.00	\$ -	(222.00)
84	Ordering Prescriber Conflicts with Claim Prescriber	150.00	\$ 150.00	-
87	Incomplete Information on Written Order	187.72	\$ -	(187.72)
93	Ordering Prescriber Conflicts with Claim Prescriber	214.16	\$ -	(214.16)
94	Incomplete Information on Written Order	55.50	\$ -	(55.50)
97	Incomplete Information on Written Order	240.00	\$ -	(240.00)
99	Incomplete Information on Written Order	55.50	\$ -	(55.50)
<b>TOTALS</b>		<u>\$ 3,670.60</u>	<u>\$ 150.00</u>	<u>\$ (3,520.60)</u>

Note: The adjustments shown above only reflect those that were revised as a result of the provider's response. All other financial adjustments remain the same as shown in the Draft Audit Report.