



**Office of the  
Medicaid Inspector  
General**

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

**REVIEW OF LINDEN RX, INC.  
CLAIMS FOR DIABETIC TEST STRIP SUPPLIES  
PAID FROM  
JANUARY 1, 2009 – DECEMBER 31, 2011**

**FINAL AUDIT REPORT  
OMIG AUDIT #: 13-2450  
CMS AUDIT #: 1-10992287**

**Dennis Rosen  
Medicaid Inspector General**

**November 13, 2015**



Office of the  
Medicaid Inspector  
General

ANDREW M. CUOMO  
Governor

DENNIS ROSEN  
Medicaid Inspector General

November 13, 2015

[REDACTED]  
Brookdale Pharma, Inc.  
2568 Linden Boulevard  
Brooklyn, New York 11208-4904

Re: Final Audit Report  
OMIG Audit #: 13-2450  
CMS Audit #: 1-10992287  
Provider ID #: [REDACTED]  
NPI #: [REDACTED]

Dear [REDACTED]

The IPRO Healthcare Integrity Group (IPRO) has been contracted by the Centers for Medicare & Medicaid Services (CMS) to audit providers participating in the New York Medicaid program. Under authority of the Medicaid Integrity Program, IPRO conducted an audit claims for diabetic test strip supplies paid to Linden Rx, Inc. (Provider) between January 1, 2009, and December 31, 2011. IPRO issued a draft audit report to the Provider on March 13, 2015.

In accordance with the collaborative audit plan approved by the CMS and OMIG, OMIG is charged with reviewing IPRO's audit findings and issuing the enclosed final audit report.

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

The OMIG has attached the sample detail for the paid claims determined to be in error. This final audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report. The adjusted mean point estimate overpaid is \$62,360. The adjusted lower confidence limit of the amount overpaid is \$51,508. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the adjusted lower confidence limit of \$51,508.

[REDACTED]  
Page 2  
November 13, 2015

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED]. Please refer to report number 14-1956 in all correspondence.

Sincerely,

[REDACTED]  
Division of Medicaid Audit, Albany Office  
Office of the Medicaid Inspector General

[REDACTED]  
Enclosure

CERTIFIED MAIL # [REDACTED]  
RETURN RECEIPT REQUESTED

[REDACTED]

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## INTRODUCTION

### BACKGROUND

#### Medicaid Program

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.

#### New York State's Medicaid Program

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. In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including inpatient chemical dependency rehabilitation treatment claims.

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.

#### New York State's Pharmacy Program

Pharmacy is a professional practice, which includes a number of activities that are necessary for the provision of drugs for patients as ordered by persons authorized under State law to prescribe drugs. Pharmacies, which are licensed and currently registered by the New York State Board of Pharmacy, Department of Education, may dispense drugs and other medical/surgical supplies. The pharmacy must comply with all applicable provisions of State Law including Article 137 of the Education Law, Articles 1 and 33 of the Public Health Law, and the Pharmacy Guide to Practice (Pharmacy Handbook) issued by the Department of Education. The specific standards and criteria for pharmacies are outlined in Title 10 NYCRR Parts 80 and 85.20-22 and Title 18 NYCRR Section 505.3. The MMIS Provider Manual for Pharmacy also provides program guidance for claiming Medicaid reimbursement for pharmacy services.

## PURPOSE, SCOPE, AND METHODOLOGY

### Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for diabetic test strip supply claims complied with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

### Scope

The audit period covered payments to the Provider for diabetic test strip supply claims paid by Medicaid from January 1, 2009, through December 31, 2011. The audit universe consisted of 2,438 claims with a total Medicaid payment of \$226,290.14.

During this audit, IPRO did not review the overall internal control structure of the Provider. Rather, they limited the internal control review to the objective of the audit.

Auditors reviewed a random sample of 244 claims with \$27,946.77 in Medicaid payments. Of the 244 claims in the random sample, 94 claims had at least one error and did not comply with state requirements. Of the 94 noncompliant claims, some claims contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
No Explanation of Benefits (EOB)/Documentation for Medicare Covered Item	46
Missing Follow-Up Hard Copy Order for Medical Supplies	42
Pharmacy Billed in Excess of Prescribed Quantity	19
Other Insurance Payments Not Applied	11
Missing Information From Prescription/Fiscal Order	2

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$9,809.52 in sample overpayments with an extrapolated adjusted point estimate of \$62,360. The adjusted lower confidence limit of the amount overpaid is \$51,508.

## Methodology

To accomplish the objective, IPRO:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with the Provider's management personnel to gain an understanding of the diabetic test strip supply program;
- ran computer programming application of claims in the Medicaid data warehouse that identified 2,438 paid diabetic test strip supply claims, totaling \$226,290.14;
- selected a random sample of 244 claims from the population of 2,438 claims; and,
- estimated the overpayment paid in the population of 2,438 claims.

## Documentation Reviewed

Documentation and records to support services reimbursed by the 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. During 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 Linden to IPRO's Albany office for review.

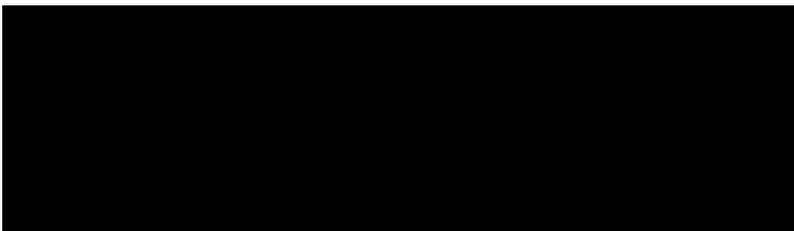
The claims universe was identified paid claims for diabetic test strips.

The documents collected were analyzed to identify any billing irregularities or deviations from Medicaid laws, regulations and policies, and the Provider Agreement. These documents included fiscal orders and individual patient history files.

The Provider's response to the Draft Audit Report dated April 14, 2015 that was prepared and submitted to IPRO by the prior owner's attorney, was considered in the preparation of the Final Audit Report. Specifically, IPRO considered the request "Under these circumstances in which our client will take responsibility as the former owner for repayment, it is requested that for the extrapolated disallowances that the universe be limited to the period of ownership which is January 1, 2009 until August 24, 2011 and the lower confidence limit be adjusted to reflect this." The Provider's response did not contain any additional documentation to refute the findings and therefore resulted in no monetary change to any of the disallowed claims. IPRO recognized the Provider's request and limited the extrapolation to the period of ownership. The results are contained in the Overpayments Section of this report.

## **Audit Staff:**

The following staff conducted this audit:



## 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, Mental Hygiene and Social Services [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)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, Title 18 NYCRR Section 540.6.
- 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)*

## AUDIT FINDINGS

The following detailed findings reflect the results of the audit:

### 1. No Explanation of Benefits (EOB) for Medicare Covered Items

Regulations state, "MA program as payment source of last resort. Where a third party, such as a 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 district will pay only the amount by which the MA reimbursement rate for the services exceeds the amount of the third party liability. The department or social services district will also pay if the third party payment will not be made within a reasonable time. The department or social services district will seek reimbursement for any payments for care and services it makes for which a third party is legally responsible. They will seek reimbursement to the extent of the third party's legal liability unless the amount reasonably expected to be recovered is less than the cost of making the recovery.

*18 NYCRR Section 360-7.2*

Regulations state: "The Medicaid program will pay on behalf of qualified Medicare beneficiaries ....the full amount of any deductible and coinsurance costs incurred under Part A of B of Title XVIII of the Social Security Act (Medicare)".

*18 NYCRR Section 360-7.7(a) and (g)*

Medicaid policy states: "For a service with both Medicare and Medicaid coverage, all charges for services must first be billed to Medicare. Only after Medicare payment information is received, may a claim be submitted for Medicaid reimbursement.

The pharmacist must maintain all Medicare payment information when Medicaid is billed on file for six years following the date of payment for audit purposes."

*NYS Medicaid Program Pharmacy Manual  
Policy Guidelines, Version 2008-1, 2009-1, 2010-1, 2010-2 and 2011-1; Section I*

Medicaid Policy states: "Utilization of Insurance Benefits-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 the payer of last resort....Medicaid requires providers to exhaust all existing benefits prior to the billing of the Medicaid Program. If an enrollee has third-party insurance coverage, he/she **must** inform the LDSS of that coverage and to use its benefits to the fullest extent before using Medicaid. Supplementary payments may be made by Medicaid when appropriate."

*NYS Medicaid Program, Information for all Providers  
General Policy, Version 2008-2, 2010-1, 2010-2, 2011-1 & 2011-2*

NYS Medicaid Update states: "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.”

*New York State Medicaid Update  
December 2005 (Vol. 20, No. 13) "Billing Requirements for  
Patients Eligible for Both Medicare and Medicaid or Who May Have Other Insurance*

In 46 instances, Medicare EOBs were not in the records of patients who had Medicare coverage and Medicaid was billed prior to billing Medicare.

## **2. Missing Follow-Up Hard Copy Order for Medical Supplies**

Regulations state: “Medical/surgical supplies means 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 and which are usually: (i) consumable; (ii) non-reusable; (iii) disposable; (iv) for a specific rather than incidental purpose; and (v) generally have no salvageable value.”

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

Regulations state: “The terms written order or fiscal order . . . 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)*

Regulations state: “Written order required. (1) All durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances and devices, and orthopedic footwear may be furnished only upon a written order of a practitioner.”

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

Medicaid policy states: “Medical/surgical supplies can only be obtained by presenting a signed, written order (fiscal order) from a qualified prescriber.”

*NYS Medicaid Program Pharmacy Manual  
Policy Guidelines, Version 2008-1, 2009-1, 2010-1, 2010-2 & 2011-1, Section I*

In 42 instances, a signed written order from the ordering practitioner as a follow-up to a telephone or fax order was not obtained by the provider.

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

### **3. Pharmacy Billed in Excess of Prescribed Quantity**

Regulations state: "By enrolling the provider agrees... 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" and "that the information provided in relation to any claim for payment shall be true, accurate and complete."

*18 NYCRR Sections 504.3(f) and (h)*

For medical/surgical supply orders, Medicaid policy states: "If the ordering practitioner requests a quantity that does not correspond to the pre-packaged unit, the pharmacist may supply the drug in the pre-packed quantity that most closely approximates the ordered amount."

*NYS Medicaid Program Pharmacy Manual  
Policy Guidelines, Version 2008-1, 2009-1, 2010-1, 2010-2 & 2011-1, Section I*

In 19 instances, the pharmacy billed in excess of the quantity ordered by the ordering practitioner.

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

### **4. Other Insurance Payments Not Applied**

Regulations state: "MA program as payment source of last resort. Where a third party, such as a 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 district will pay only the amount by which the MA reimbursement rate for the services exceeds the amount of the third party liability. The department or social services district will also pay if the third party payment will not be made within a reasonable time. The department or social services district will seek reimbursement for any payments for care and services it makes for which a third party is legally responsible. They will seek reimbursement to the extent of the third party's legal liability unless the amount reasonably expected to be recovered is less than the cost of making the recovery."

*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)*

In 11 instances, other insurance payment was not applied and the Provider billed Medicaid as primary.

### **5. Missing Information From Prescription/Fiscal Order**

Regulations state: "(2) All orders must show the name, address, telephone number of the practitioner and the name and identification number of the recipient for whom ordered. (3) . . .When used in the context of a nonprescription item, the order must also contain the following information: name of the item, quantity ordered, catalog number as necessary, directions for use, date ordered, and number of refills, if any."

*18 NYCRR Section 505.5(b)(2) and (3)*

Medicaid policy states: "All prescriptions and fiscal orders must bear: the name, address, age, and client identification number (CIN) of the patient for whom it is intended...; the date on which it was written; the name, strength, if applicable, and the quantity of the drug prescribed; directions for use, if applicable; and the name, address, telephone number, profession, DEA Number (if applicable) and signature of the prescriber who has written or initiated the prescription or fiscal order."

*NYS Medicaid Program Pharmacy Manual  
Policy Guidelines, Version 2008-1, 2009-1, 2010-1, 2010-2 & 2011-1, Section I*

In 2 instances, the written order did not have the minimum information required; the quantity of the diabetic test strip prescribed was missing.

**Note:** If this is the only finding, the disallowance amount is the amount paid in excess of the minimum allowable quantity. If there are other findings for the claim with this finding, the disallowance amount is the amount paid for the claim.

## OVERPAYMENTS

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2009, through December 31, 2011, identified 94 claims with at least one error, for a total sample overpayment of \$9,809.52 (Appendix A). The extrapolated adjusted point estimate overpayment is \$62,360 and the adjusted lower confidence limit overpayment of \$51,508.

The Provider's response to the Draft Audit Report dated April 14, 2015 that was prepared and submitted to IPRO by the prior owner's attorney, was considered in the preparation of the Final Audit Report. Specifically, IPRO considered the request "Under these circumstances in which our client will take responsibility as the former owner for repayment, it is requested that for the extrapolated disallowances that the universe be limited to the period of ownership which is January 1, 2009 until August 24, 2011 and the lower confidence limit be adjusted to reflect this." The Provider's response did not contain any additional documentation to refute the findings and therefore resulted in no monetary change to any of the disallowed claims. IPRO recognized the Provider's request and limited the extrapolation to the period of ownership. The results are contained in Section III of this report.

## 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 \$51,508, 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 #13-2450  
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

[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 \$62,360. 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.

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

**NAME AND ADDRESS OF AUDITEE**

██████████  
Brookdale Pharmacy, Inc.  
2568 Linden Boulevard  
Brooklyn, New York 11208-4904

**PROVIDER ID #** ██████████

**AUDIT #13-2450**

**AMOUNT DUE: \$51,508**

**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  
GNARESP Corning Tower, Room 2739  
File #13-2450  
Albany, New York 12237

*Thank you for your cooperation.*

Appendix A  
Findings for Each Sample Item

Sample #	Date of Service	Date of Payment	Procedure Code	Qty	RX	Amount Paid	Corrected Amount	Recoupment Amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	Error Codes				
												1. No Explanation of Benefits (EOB) for Medicare Covered Items	2. Missing Follow-Up Hard Copy Order for Medical Supplies**	3. Pharmacy Billed in Excess of Prescribed Quantity*	4. Other Insurance Payments Not Applied	5. Missing Information From Prescription/Fiscal Order*
3	02/28/11	03/07/11	53885024510	200	0343590	\$ 225.60	\$ -	\$ 225.60	2011	58.77%	\$ 132.59	X				
9	08/20/11	08/29/11	53885024510	200	0380459	\$ 225.60	\$ -	\$ 225.60	2011	50.00%	\$ 112.80		X	X		
12	05/26/10	06/21/10	53885024510	200	0319568	\$ 215.82	\$ -	\$ 215.82	2010	61.59%	\$ 132.92		X			
13	06/17/10	06/28/10	53885024510	200	0319568	\$ 215.82	\$ -	\$ 215.82	2010	61.59%	\$ 132.92		X			
14	07/09/10	07/19/10	53885024510	200	0319568	\$ 215.82	\$ -	\$ 215.82	2010	61.59%	\$ 132.92		X			
15	08/02/10	08/09/10	53885024510	200	0319568	\$ 215.82	\$ -	\$ 215.82	2010	61.59%	\$ 132.92		X			
16	08/24/10	08/30/10	53885024510	200	0319568	\$ 215.82	\$ -	\$ 215.82	2010	61.59%	\$ 132.92		X			
23	08/30/10	09/06/10	53885024510	200	0334260	\$ 214.82	\$ 107.41	\$ 107.41	2010	61.59%	\$ 66.15			X		
24	09/27/10	10/04/10	53885024510	200	0334260	\$ 214.82	\$ 107.41	\$ 107.41	2011	61.59%	\$ 66.15			X		
26	10/27/10	11/01/10	53885024510	200	0334260	\$ 214.82	\$ 107.41	\$ 107.41	2011	61.59%	\$ 66.15			X		
27	11/08/10	11/15/10	53885024510	200	0343590	\$ 214.82	\$ -	\$ 214.82	2011	61.59%	\$ 132.31	X				
28	11/23/10	11/29/10	53885024510	200	0334260	\$ 214.82	\$ 107.41	\$ 107.41	2011	61.59%	\$ 66.15			X		
30	12/07/10	12/13/10	53885024510	200	0343590	\$ 214.82	\$ -	\$ 214.82	2011	61.59%	\$ 132.31	X				
31	12/20/10	12/27/10	53885024510	200	0334260	\$ 214.82	\$ 107.41	\$ 107.41	2011	61.59%	\$ 66.15			X		
32	01/05/11	01/10/11	53885024510	200	0343590	\$ 214.82	\$ -	\$ 214.82	2011	58.77%	\$ 126.25	X				
33	01/19/11	01/31/11	53885024510	200	0334260	\$ 214.82	\$ 107.41	\$ 107.41	2011	58.77%	\$ 63.12			X		
34	01/31/11	02/07/11	53885024510	200	0343590	\$ 214.82	\$ -	\$ 214.82	2011	58.77%	\$ 126.25	X				
42	01/05/09	01/12/09	A4253	0	0253914	\$ 156.52	\$ -	\$ 156.52	2009	58.78%	\$ 92.00	X	X			
50	08/04/09	08/10/09	A4253	0	0283287	\$ 154.16	\$ -	\$ 154.16	2009	61.59%	\$ 94.95		X	X		
57	01/20/10	01/25/10	50924037350	100	0297270	\$ 127.40	\$ -	\$ 127.40	2010	61.59%	\$ 78.47		X			
62	02/01/11	02/07/11	53885024510	100	0340817	\$ 112.30	\$ 56.15	\$ 56.15	2011	58.77%	\$ 33.00			X		
63	02/16/11	02/21/11	53885024510	100	0344474	\$ 112.30	\$ -	\$ 112.30	2011	58.77%	\$ 66.00	X	X			
64	07/05/11	07/11/11	53885024510	100	0375149	\$ 113.30	\$ -	\$ 113.30	2011	50.00%	\$ 56.65		X			
66	05/04/11	05/09/11	53885024510	100	0367309	\$ 112.30	\$ -	\$ 112.30	2011	56.88%	\$ 63.88	X	X			
72	03/04/11	03/14/11	53885024510	100	0348332	\$ 112.30	\$ 56.15	\$ 56.15	2011	58.77%	\$ 33.00			X		
79	08/15/11	08/22/11	53885024510	100	0377338	\$ 112.30	\$ 56.15	\$ 56.15	2011	50.00%	\$ 28.08			X		
80	02/10/11	02/21/11	53885024510	100	0355893	\$ 112.30	\$ -	\$ 112.30	2011	58.77%	\$ 66.00	X				
81	02/21/11	02/28/11	53885024510	100	0354073	\$ 112.30	\$ -	\$ 112.30	2011	58.77%	\$ 66.00	X	X		X	

\* If Error #3 or #5 is the only error, recoupment amt. is the amt. paid for the excess quantity.  
\*\* If Error #2 is the only error, the recoupment amt. is not extrapolated.

**Appendix A**  
**Findings for Each Sample Item**

Sample #	Date of Service	Date of Payment	Procedure Code	Qty	RX	Amount Paid	Corrected Amount	Recoupment Amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	Error Codes				
												1. No Explanation of Benefits (EOB) for Medicare Covered Items	2. Missing Follow-Up Hard Copy Order for Medical Supplies**	3. Pharmacy Billed in Excess of Prescribed Quantity*	4. Other Insurance Payments Not Applied	5. Missing Information From Prescription/Fiscal Order*
92	07/26/11	08/01/11	53885024510	100	0377547	\$ 112.30	\$ -	\$ 112.30	2011	50.00%	\$ 56.15		X			
93	05/19/10	05/31/10	53885024510	100	0315307	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X				
94	11/02/10	11/08/10	53885024510	100	0324768	\$ 107.91	\$ -	\$ 107.91	2011	61.59%	\$ 66.46	X			X	
97	10/27/09	11/02/09	53885024510	100	0282560	\$ 101.85	\$ 50.93	\$ 50.93	2010	61.59%	\$ 31.36			X		
100	09/21/10	09/27/10	53885024510	100	0325787	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X				
101	06/23/10	06/28/10	50924037350	100	0325997	\$ 110.10	\$ -	\$ 110.10	2010	61.59%	\$ 67.81		X			
107	01/13/11	01/24/11	53885024510	100	0352388	\$ 106.91	\$ -	\$ 106.91	2011	58.77%	\$ 62.83		X			
110	06/29/10	07/05/10	53885024510	100	0326815	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85		X			
114	10/12/10	10/18/10	53885024510	100	0339819	\$ 106.91	\$ -	\$ 106.91	2011	61.59%	\$ 65.85		X			
119	02/25/10	03/08/10	53885024510	100	0310439	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X				
121	11/30/09	12/07/09	53885024510	100	0290775	\$ 101.85	\$ 50.93	\$ 50.93	2010	61.59%	\$ 31.36			X		
122	07/28/10	08/09/10	53885024510	100	0311782	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X			X	
124	09/30/10	10/11/10	53885024510	100	0338216	\$ 106.91	\$ -	\$ 106.91	2011	61.59%	\$ 65.85	X	X			

\* If Error #3 or #5 is the only error, recoupment amt. is the amt. paid for the excess quantity.  
 \*\* If Error #2 is the only error, the recoupment amt. is not extrapolated.

### Appendix A Findings for Each Sample Item

Sample #	Date of Service	Date of Payment	Procedure Code	Qty	RX	Amount Paid	Corrected Amount	Recoupment Amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	Error Codes				
												1. No Explanation of Benefits (EOB) for Medicare Covered Items	2. Missing Follow-Up Hard Copy Order for Medical Supplies**	3. Pharmacy Billied in Excess of Prescribed Quantity*	4. Other Insurance Payments Not Applied	5. Missing Information From Prescription/Fiscal Order*
125	03/29/10	04/05/10	53885024510	100	0311545	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X				
126	10/07/10	10/18/10	53885024510	100	0330299	\$ 107.91	\$ -	\$ 107.91	2011	61.59%	\$ 66.46	X				
129	06/04/10	06/14/10	53885024510	100	0314071	\$ 107.91	\$ 53.96	\$ 53.96	2010	61.59%	\$ 33.23			X		
130	12/30/10	01/10/11	53885024510	100	0344000	\$ 106.91	\$ -	\$ 106.91	2011	58.77%	\$ 62.83	X				
133	06/29/10	07/05/10	53885024510	100	0326644	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X	X			
134	06/02/10	06/07/10	53885024510	100	0323467	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X	X			
136	11/15/10	11/22/10	53885024510	100	0341331	\$ 106.91	\$ -	\$ 106.91	2011	61.59%	\$ 65.85	X	X			
137	04/09/10	04/19/10	53885024510	100	0310439	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X				
140	02/12/10	02/22/10	53885024510	100	0291375	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X				
142	10/05/09	10/12/09	53885024510	100	0291262	\$ 101.85	\$ 50.93	\$ 50.93	2010	61.59%	\$ 31.36			X		
144	04/29/10	05/10/10	53885024510	100	0302151	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X	X			
146	04/01/10	04/12/10	53885024510	100	0315077	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X				
152	12/21/09	12/28/09	53885024510	100	0289221	\$ 101.85	\$ -	\$ 101.85	2010	61.59%	\$ 62.73	X				
155	11/29/10	12/06/10	53885024510	100	0336347	\$ 106.91	\$ -	\$ 106.91	2011	61.59%	\$ 65.85		X			
159	10/26/10	11/01/10	53885024510	100	0326590	\$ 106.91	\$ -	\$ 106.91	2011	61.59%	\$ 65.85	X				
162	09/14/10	09/20/10	53885024510	100	0335905	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85		X			
163	09/29/10	10/04/10	53885024510	100	0338171	\$ 106.91	\$ -	\$ 106.91	2011	61.59%	\$ 65.85		X			
165	11/02/09	11/09/09	53885024510	100	0295257	\$ 101.85	\$ -	\$ 101.85	2010	61.59%	\$ 62.73		X			
167	08/09/10	08/16/10	53885024510	100	0331621	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85		X			
169	04/01/10	04/12/10	53885024510	100	0315110	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X	X			
170	12/13/10	12/20/10	53885024510	100	0333248	\$ 106.91	\$ -	\$ 106.91	2011	61.59%	\$ 65.85	X	X	X		
173	08/25/10	08/30/10	53885024510	100	0333732	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85		X			
174	10/28/10	11/08/10	53885024510	100	0326858	\$ 106.91	\$ -	\$ 106.91	2011	61.59%	\$ 65.85	X	X			
177	01/20/11	01/31/11	53885024510	100	0353233	\$ 107.91	\$ -	\$ 107.91	2011	58.77%	\$ 63.42		X			
180	01/31/11	02/07/11	53885024510	100	0345301	\$ 106.91	\$ -	\$ 106.91	2011	58.77%	\$ 62.83	X				
181	07/26/10	08/02/10	53885024510	100	0324447	\$ 106.91	\$ -	\$ 106.91	2010	61.59%	\$ 65.85	X		X		
184	07/24/09	08/03/09	A4253	0	0267485	\$ 76.58	\$ -	\$ 76.58	2009	61.59%	\$ 47.17	X		X		
185	07/21/09	07/27/09	A4253	0	0266016	\$ 76.58	\$ -	\$ 76.58	2009	61.59%	\$ 47.17	X	X			

\* If Error #3 or #5 is the only error, recoupment amt. is the amt. paid for the excess quantity.  
 \*\* If Error #2 is the only error, the recoupment amt. is not extrapolated.

### Appendix A Findings for Each Sample Item

Sample #	Date of Service	Date of Payment	Procedure Code	Qty	RX	Amount Paid	Corrected Amount	Recoupment Amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	Error Codes					
												1. No Explanation of Benefits (EOB) for Medicare Covered Items	2. Missing Follow-Up Hard Copy Order for Medical Supplies**	3. Pharmacy Billed in Excess of Prescribed Quantity*	4. Other Insurance Payments Not Applied	5. Missing Information From Prescription/Fiscal Order*	
187	07/16/09	07/27/09	A4253	0	0275216	\$ 76.58	\$ -	\$ 76.58	2009	61.59%	\$ 47.17	X					
188	01/06/09	01/12/09	A4253	0	0251649	\$ 77.76	\$ -	\$ 77.76	2009	58.78%	\$ 45.71	X				X	
189	02/21/09	03/02/09	A4253	0	0260509	\$ 77.76	\$ -	\$ 77.76	2009	58.78%	\$ 45.71	X	X				
190	06/03/09	06/08/09	A4253	0	0267485	\$ 76.58	\$ -	\$ 76.58	2009	60.19%	\$ 46.09	X		X			
192	01/05/09	01/12/09	A4253	0	0238880	\$ 77.76	\$ -	\$ 77.76	2009	58.78%	\$ 45.71		X				
193	01/23/09	02/02/09	A4253	0	0256352	\$ 78.76	\$ -	\$ 78.76	2009	58.78%	\$ 46.30					X	
197	01/26/09	02/02/09	A4253	0	0252553	\$ 78.76	\$ -	\$ 78.76	2009	58.78%	\$ 46.30					X	

\* If Error #3 or #5 is the only error, recoupment amt. is the amt. paid for the excess quantity.

\*\* If Error #2 is the only error, the recoupment amt. is not extrapolated.

### Appendix A Findings for Each Sample Item

Sample #	Date of Service	Date of Payment	Procedure Code	Qty	RX	Amount Paid	Corrected Amount	Recoupment Amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	Error Codes					
												1. No Explanation of Benefits (EOB) for Medicare Covered Items	2. Missing Follow-Up Hard Copy Order for Medical Supplies**	3. Pharmacy Billied in Excess of Prescribed Quantity*	4. Other Insurance Payments Not Applied	5. Missing Information From Prescription/Fiscal Order*	
198	03/25/09	03/30/09	A4253	0	0255559	\$ 78.76	\$ 39.38	\$ 39.38	2009	58.78%	\$ 23.15					X	
199	01/16/09	01/26/09	A4253	0	0255559	\$ 78.76	\$ 39.38	\$ 39.38	2009	58.78%	\$ 23.15					X	
200	07/03/09	07/13/09	A4253	0	0269778	\$ 76.58	\$ -	\$ 76.58	2009	61.59%	\$ 47.17		X				
201	05/13/09	05/18/09	A4253	0	0272080	\$ 76.58	\$ -	\$ 76.58	2009	60.19%	\$ 46.09		X				
202	01/28/09	02/02/09	A4253	0	0245265	\$ 77.76	\$ -	\$ 77.76	2009	58.78%	\$ 45.71	X				X	
203	09/01/09	09/07/09	A4253	0	0275034	\$ 76.58	\$ -	\$ 76.58	2009	61.59%	\$ 47.17	X					
204	05/07/09	05/18/09	A4253	0	0265971	\$ 76.58	\$ -	\$ 76.58	2009	60.19%	\$ 46.09					X	
207	05/18/09	05/25/09	A4253	0	0269321	\$ 76.58	\$ -	\$ 76.58	2009	60.19%	\$ 46.09					X	
211	08/19/09	08/24/09	A4253	0	0269778	\$ 76.58	\$ -	\$ 76.58	2009	61.59%	\$ 47.17		X				
217	09/09/09	09/14/09	A4253	0	0273489	\$ 37.79	\$ -	\$ 37.79	2009	61.59%	\$ 23.27		X				
218	07/24/09	08/03/09	A4253	0	0282141	\$ 37.79	\$ -	\$ 37.79	2009	61.59%	\$ 23.27	X					
221	02/20/09	03/02/09	A4253	0	0244840	\$ 39.38	\$ -	\$ 39.38	2009	58.78%	\$ 23.15	X				X	
225	01/23/09	02/02/09	A4253	0	0256265	\$ 38.38	\$ -	\$ 38.38	2009	58.78%	\$ 22.56	X					
229	05/09/09	05/18/09	A4253	0	0271618	\$ 37.79	\$ -	\$ 37.79	2009	60.19%	\$ 22.75	X					
234	08/22/09	08/31/09	A4253	0	0281466	\$ 37.79	\$ -	\$ 37.79	2009	61.59%	\$ 23.27					X	
236	06/01/09	06/08/09	A4253	0	0264491	\$ 38.79	\$ -	\$ 38.79	2009	60.19%	\$ 23.35	X					
243	06/11/09	06/22/09	A4253	0	0271205	\$ 37.79	\$ -	\$ 37.79	2009	60.19%	\$ 22.75		X				
244	07/24/09	08/03/09	A4253	0	0273489	\$ 37.79	\$ -	\$ 37.79	2009	61.59%	\$ 23.27		X				
						\$ 10,907.92	\$ 1,098.42	\$ 9,809.52				\$ 5,903.48	46	42	19	11	2

Federal Share Summary*	
Federal FY	Total Federal Share Amount
2009	\$ 1,183.68
2010	\$ 2,249.21
2011	\$ 2,470.59
<b>TOTAL</b>	<b>\$ 5,903.48</b>

\* The Extrapolated Federal Share is \$31,113.30

\* If Error #3 or #5 is the only error, recoupment amt. is the amt. paid for the excess quantity  
 \*\* If Error #2 is the only error, the recoupment amt. is not extrapolated.

## **Appendix B Sample Design**

The sample design used for Audit #13-2450 was as follows:

- Universe - Medicaid claims for diabetic test strip supplies paid during the period January 1, 2009, through December 31, 2011.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for diabetic test strip supplies paid during the period January 1, 2009, through December 31, 2011.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2009, through December 31, 2011.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 244 claims.

**Appendix C**  
**Extrapolation of Sample Findings**

Total Sample Recoupment	\$ 9,809.52
<b>Less Recoupments Not Projected*</b>	<u>(3,028.11)</u>
Sample Recoupment for Extrapolation Purposes	\$ 6,781.41
Services in Sample	244
Overpayments Per Sample Service	\$ 27.79
Services in Universe	2,438
Mean Point Estimate	\$ 59,332
<b>Add Overpayments Not Projected*</b>	<u>3,028</u>
Adjusted Mean Point Estimate	<u>\$ 62,360</u>
Lower Confidence Limit	\$ 48,480
<b>Add Overpayments Not Projected*</b>	<u>3,028</u>
Adjusted Lower Confidence Limit	<u>\$ 51,508</u>

\* The actual dollar disallowance for the **"Missing Follow-Up Hard Copy Order for Medical Supplies and Pharmacy Billed in Excess of Prescribed Quantity"** findings were subtracted from the total sample overpayment and added to the Meanpoint Estimate and the Lower Confidence Limit. The dollars associated with these findings were not used in the extrapolation.