



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

REVIEW OF SJS PHARMACY, INC.
REVIEW OF DIABETIC TEST STRIP SUPPLIES
PAID FROM
JANUARY 1, 2008, – DECEMBER 31, 2010

FINAL AUDIT REPORT
AUDIT #12-3222
CMS AUDIT # [REDACTED]

James C. Cox
Medicaid Inspector General

October 16, 2014



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

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

October 16, 2014

[REDACTED]
SJS Pharmacy, Inc.
105 East Burnside Avenue
Bronx, New York 10453-4142

Re: Final Audit Report
OMIG Audit #: 12-3222
CMS ID Number: [REDACTED]

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report of IPRO's review of SJS Pharmacy, Inc. (Provider) billing of Medicaid paid claims for diabetic test strip supplies covering the period January 1, 2008, through December 31, 2010.

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

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.

The OMIG has attached the sample detail for the paid claims determined to be in error. Your response to the draft audit report dated October 15, 2013 is incorporated into this final audit report. Due to additional documentation received in response to the draft audit report, the findings changed from the draft audit report. The mean per unit point estimate overpaid is \$270,068. The lower confidence limit of the amount overpaid is \$249,403. 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 lower confidence limit of \$249,403.

If the Provider has any questions or comments concerning this final audit report, please contact me at [REDACTED] or through email at [REDACTED]. Please refer to report number 12-3222 in all correspondence.

Sincerely,

[REDACTED]

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

[REDACTED]
Enclosure

cc: [REDACTED]

CERTIFIED MAIL [REDACTED]
RETURN RECEIPT REQUESTED

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

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

DIVISION OF MEDICAID AUDIT

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

DIVISION OF MEDICAID INVESTIGATIONS

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

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

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

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

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

EXECUTIVE SUMMARY

BACKGROUND

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

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 AND SCOPE

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

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INTRODUCTION

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

BACKGROUND:

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

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

PROGRAM OBJECTIVES:

IPRO provider audits have the following objectives:

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

AUDIT PROCESS:

This provider audit was conducted in the following manner:

Overview

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

Statistical Sampling

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

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

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

Documentation Reviewed

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

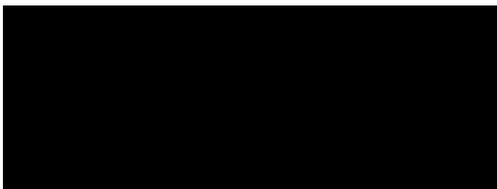
As part of this review, IPRO also reviewed five medical records from the ordering providers.

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

An exit conference was held with SJS and its representatives on March 21, 2013. The Provider's responses to the exit conference dated April 8, 2013 and April 9, 2013 was considered in the preparation of the Draft Audit Report. The Provider's response to the Draft Audit Report dated December 3, 2013 was considered in the preparation of the Final Audit Report, and certain findings were reduced or eliminated as a result. The results of the review are contained in Section III of this report.

AUDIT STAFF:

The following staff conducted this audit:



AUDIT PROFILE

PROVIDER PROFILE:

Name: SJS Pharmacy Inc.
Address: 105 East Burnside Avenue
Bronx, NY 10453-4142

Provider Number: 

Provider Type: Pharmacy

AUDIT SCOPE:

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

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

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

The universe included 464 cases consisting of 4,262 claims with a total Medicaid payment of \$326,498.78. From this universe, a total of 100 cases (1,394 claims) totaling \$117,881.26 was selected for review.

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

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

ANALYSIS OF FINDINGS:

Out of 100 cases (1,394 claims) reviewed, there were 90 cases (1,220 claims) with recoupable monetary findings. The Monetary Findings section explains the monetary findings and is supported by Appendix A, which lists all findings associated with the sample claims.

The statistical sampling methodology employed allows for extrapolation of the sample findings to the universe of cases (18 NYCRR Section 519.18). The adjusted mean per unit point estimate of the amount overpaid is \$270,068. The adjusted lower confidence limit of the amount overpaid is \$249,403. We are 95% certain that the actual amount of the overpayment is greater than the adjusted lower confidence limit (Appendix B). This audit may be settled through repayment of the adjusted lower confidence limit amount of \$249,403.

LAWS, REGULATIONS, RULES AND POLICIES

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

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

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."

18 NYCRR Section 504.3

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

18 NYCRR Section 517.3(b)

Regulations require that bills for medical care, services and supplies contain patient name, case number and date of service; itemization of the volume and specific types of care, services and supplies provided; the unit price and total cost of the care, services and supplies provided; and a dated certification by the provider that the care, services and supplies itemized have been in fact furnished; that the amounts listed are in fact due and owing; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the

date of payment; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided.

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

Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake."

18 NYCRR Section 518.1(c)

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

18 NYCRR Section 540.1

Regulations state: "The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim."

18 NYCRR Section 518.3(a)

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

18 NYCRR Section 518.3(b)

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

18 NYCRR Section 518.3(b)

MONETARY FINDINGS

A review of the 100 cases (1,394 claims) representing 100 patients revealed 1,220 claims with recoupable billing errors. Detailed information regarding monetary findings on the sampled claims is located in Appendix A.

The following detailed findings reflect the results of the audit.

1. Billing for Automatic Refill

Medicaid policy states: "Automatic refilling of prescriptions for prescription drugs, or fiscal orders for non-prescription drugs, medical surgical supplies or enteral products is not allowed under the Medicaid Program."

*NYS Medicaid Program Pharmacy Manual
Policy Guidelines, 2007-1, Section 1*

The Medicaid Update states: "Automatic refilling of prescriptions/orders for prescription drugs, over-the-counter products, medical surgical supplies and enteral products is NOT allowed under the Medicaid program.

What is allowed?

- Requests for a refill
 - A recipient or designated caregiver may contact the pharmacy to request necessary refills.
- Provider inquiry
 - A provider may initiate contact with a recipient to determine if a refill is necessary. Documentation of the need for a refill shall be maintained in the patient record and must include the date and time of contact, recipient or designated caregiver's name and contactor's identification. This documentation must be available for audit purposes."

DOH Medicaid Update, January 2004

In 85 cases (1,017 instances), there was no indication in the patient records that the recipient or representative was contacted before the prescription was refilled.

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

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

18 NYCRR Section 360-7.7(a)

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

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; Versions 2007-1, 2008-1, 2009-1, 2010-1; Section I*

The 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."

DOH Medicaid Update, December 2005

In 31 cases (445 instances), Medicare EOBs were not in the records of patients who had Medicare coverage and Medicaid was billed prior to billing Medicare.

3. Billing of Item Prior to Delivery

Medicaid policy states: "No item/service (including refills) may be billed prior to being furnished."

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

Regulations state: "All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing . . .; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment . . .; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided. . . ."

18 NYCRR Section 540.7(a)

Regulations state that 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)

In 73 cases (428 instances), the items were billed before delivery.

4. Ordering Prescriber Conflicts with Claim Prescriber

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)

Medicaid policy states: "Enter the Medicaid ID Number of the ordering/prescribing provider. If the orderer/prescriber is not enrolled in the Medicaid program, enter his/her License number. For orders originating in a hospital, clinic, or other health care facility, the following rules apply: When a prescription is written by an unlicensed intern or resident, the supervising physician's Medicaid ID number or license number should be entered in this field. The facility's Medicaid ID number may be entered **only** when the prescriber's or the supervising physician's Medicaid ID or license number is unavailable. When prescriptions have been written by a Physician's Assistant, the supervising physician's Medicaid ID number or license number should be entered in this field. Licenses issued to Nurse Practitioners certified to write prescriptions have seven characters which includes the letter "F" followed by six digits. **Example:** F012346. Certified Nurse Practitioners with licenses that contain six digits not preceded by the letter F can only write fiscal orders. If the prescribing provider is a Nurse Practitioner certified to write prescriptions, enter his/her Medicaid ID number or license number in this field. **Note: If the Medicaid ID or State License number of an authorized prescriber is not on the prescription, it is the pharmacist's responsibility to obtain it.**"

In addition, "If a license number is indicated in field 10A, the Profession Code that identifies the ordering/prescribing provider's profession must be entered in this field."

*NYS Medicaid Program Pharmacy Manual
Billing Guidelines, Version 2008-1, Section II*

In 30 cases (136 instances), the ordering prescriber conflicted with the claim prescriber.

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

5. Pharmacy Billed for Different Item than Ordered

Duties of the provider. By enrolling the provider agrees:

(f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claim submission;.....

(h) that the information provided in relation to any claim for payment shall be true, accurate and complete”.

18 NYCRR Section 504.3(f)&(h)

In 3 cases (36 instances), the pharmacy billed for an item different than the item ordered.

6. Item Billed in Excess of Quantity Ordered

Regulations state: “that the information provided in relation to any claim for payment shall be true, accurate and complete”.

18 NYCRR Section 504.3(h)

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 6 cases (21 instances), the item billed was in excess of quantity ordered.

7. Missing Prescription/Fiscal Order

Regulations state: “(b) 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)

Regulations also 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)

Medicaid policy states: “Non-prescription drugs, also known as over-the-counter (OTC) drugs, can only be obtained by presenting a signed written order (fiscal order) from a qualified prescriber... 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 2007-1, Section 1*

In 3 cases (11 instances), a signed written fiscal order was missing.

8. Order Refilled Beyond 180 Days of Issuance

Regulations state: "All . . . medical/surgical supplies . . . may be furnished only upon a written order of a practitioner." An order cannot be refilled more than 180 days from the original date ordered.

18 NYCRR Section 505.5(b)(1)and (4)(iii)

Medicaid policy states: "No prescription or fiscal order for a drug or supply may be refilled 180 days after it has been initiated by the prescriber."

*NYS Medicaid Program Pharmacy Manual
Policy Guidelines, Version 2007-1, Section I*

In 3 cases (3 instances), the order was filled beyond 180 days of issuance.

9. Original Order Filled Beyond 60 Days of Issuance

Medicaid policy states: "A pharmacist may not fill an original fiscal order for a non-prescription drug more than sixty (60) days after it has been initiated by the prescriber." Furthermore, a provider may not fill an original fiscal order for medical/surgical supplies more than sixty (60) days after it has been initiated by the prescriber.

*NYS Medicaid Program Pharmacy Manual
Policy Guideline; Versions 2008-1, 2009-1, 2010-1; Section I*

In 2 cases (2 instances), a prescription/fiscal order was filled more than 60 days after its issuance.

10. Other Insurance 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 1 case (2 instances), patients had other insurance that was not applied.

11. Duplicate Payment

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 states: "unacceptable practices include, but are not limited to the following:

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

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

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

SUMMARY OF OVERPAYMENTS

The identified overpayments for the discrepant sampled claims totaled \$103,314.56. When extrapolated to the universe of claims from which the sample was drawn, the adjusted mean per unit point estimate of the overpayment is \$270,068. The adjusted lower confidence limit of the amount of the overpayment is \$249,403. 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 \$249,403. See **Appendices A and B** for detailed information.

RECOMMENDATIONS

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

1. Remit overpayment of \$249,403 to New York State Department of Health, or make other payment arrangements as noted below.
2. Comply with all Federal and State laws and regulations and billing instructions provided under the Medicaid program. Continued violation(s) may result in the termination or suspension of your eligibility to provide services to Medicaid clients.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the adjusted lower confidence limit amount of \$249,403, 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 #12-3222
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


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 \$270,068. 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.

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

NAME AND ADDRESS OF AUDITEE

SJS Pharmacy, Inc.
105 East Burnside Avenue
Bronx, New York 10453-4142

PROVIDER ID [REDACTED]

AUDIT #12-3222

AMOUNT DUE: \$249,403

AUDIT

TYPE

PROVIDER

RATE

PART B

OTHER:

CHECKLIST

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

[REDACTED]
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File #12-3222
Albany, New York 12237

Thank you for your cooperation.