



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

REVIEW OF METROPOLITAN HOME HEALTH PRODUCTS, INC.
REVIEW OF DURABLE MEDICAL EQUIPMENT SUPPLIES
PAID FROM
JANUARY 1, 2009 – DECEMBER 31, 2011

FINAL AUDIT REPORT
AUDIT #: 13-1434
CMS AUDIT [REDACTED]

James C. Cox
Medicaid Inspector General

October 2, 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 2, 2014

[REDACTED]
Metropolitan Home Health Products, Inc.
5359 Kings Highway
Brooklyn, New York 11203

Re: Final Audit Report
Audit #: 13-1434
CMS ID Number #: [REDACTED]

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report of IPRO's review of Metropolitan Home Health Products, Inc. (the Provider) billing of Durable Medical Equipment for the paid claims for enteral formula and supplies covering the period January 1, 2009, through December 31, 2011.

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

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.

The OMIG has attached the sample detail for the paid claims determined to be in error. Your response to the draft audit report dated March 14, 2014 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 \$2,372,487. The lower confidence limit of the amount overpaid is \$2,309,773. 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 \$2,309,773.

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 13-1434 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 professional staff conducts audits and reviews of Medicaid providers to assess compliance and 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; 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, penalties, and 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.

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.

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for durable medical equipment supplies complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to durable medical equipment supplies, this audit covered services paid by Medicaid from January 1, 2009, through December 31, 2011.

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INTRODUCTION

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

BACKGROUND:

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

IPRO conducted the audit of Metropolitan Home Health Products Inc. (Provider) 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 and regulations.
- 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.

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, 2009, through December 31, 2011. The universe of claims does not include all claims paid to the Provider by Medicaid during the audit period.

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

Documentation Reviewed

Copies of documentation and records to support services reimbursed by New York State Department of Health were electronically sent and reviewed at IPRO offices in Lake Success. No original records were made available for review by the Provider. After the review, the Provider was asked to provide the additional documents necessary to complete the audit (which included original support for previously submitted documentation), which were not located during the review. After the Exit Conference, additional copies of records were submitted electronically by the Provider to IPRO's Lake Success office for review. Original records were still not made available. Any changes to the findings presented at the Exit Conference, have been incorporated into this final audit report.

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 enteral formula and supplies.

An Exit Conference was held with the Provider and its representatives on July 18, 2013. The Provider's response to the Exit Conference, dated July 31, 2013, was considered in the preparation of the draft audit report and some findings were eliminated or changed as a result.

The Provider's response to the draft audit report dated March 14, 2014 (and subsequent copies of documentation submitted within the allowable time frames) was considered in the preparation of the Final Audit Report. 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: Metropolitan Home Health Products Inc.
Address: 5353 Kings Highway
Brooklyn, NY 11203

Provider Number: 
Provider Type: Durable Medical Equipment Supplier (DME)

AUDIT SCOPE:

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

The purpose of this audit was to ensure provider complied with applicable regulations when supplying enteral formula and supplies to Medicaid patients.

A universe of claims with payment dates from January 1, 2009, through December 31, 2011, was developed. Only claims with a paid amount greater than zero were included in this universe.

The universe included 1,666 services consisting of 19,457 claims with a total Medicaid payment of \$2,408,769.26. From this universe, a total of 250 claims totaling \$88,004.40 were 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 Metro's overall internal control structure. Accordingly, the auditors limited the internal control review to the controls related to any overpayments.

ANALYSIS OF FINDINGS:

Of the 250 claims reviewed, there were 250 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 claims (18 NYCRR Section 519.18). The mean per unit point estimate of the amount overpaid is \$2,372,487. The lower confidence limit of the amount overpaid is \$2,309,773. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit (Appendix B). This audit may be settled through repayment of the lower confidence limit amount of \$2,309,773.

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)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, Title 18 NYCRR Section 540.6, and other applicable program regulations.
- 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)

MONETARY FINDINGS

A review of 250 claims revealed 250 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. Missing Original Documentation

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 . . (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, "Audit and claim review. (a) Providers shall be subject to audit by the department and with respect to such audits will be required: ...(3) to reimburse the auditing agency for the costs incurred by the department in performing the audit where records are not maintained in a readily reviewable form;"

18 NYCRR Section 504.8

Regulations state, "Written orders for durable medical equipment, medical/surgical supplies, prosthetic or orthotic devices, or orthopedic footwear must be maintained by the provider submitting the claim for audit by the department or other authorized agency for six years from the date of payment."

18 NYCRR Section 505.5(c)(2)

Regulations state, "Fee-for-service providers. (1) All providers, who are not paid at rates or fees approved by the State Director of the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply, must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later."

18 NYCRR Section 517.3(b)

Regulations state," a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing and that, except as noted, no part thereof has been paid; that payment of fees and rates made in accordance with established schedules is accepted as payment in full for the care, services and supplies provided; that there has been compliance with title VI of the Federal Civil Rights Act of 1964 in furnishing care, services and supplies without discrimination on the basis of race, color or national origin; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment unless otherwise required by regulation, and information will be furnished

regarding any payment claimed therefore as the local social services agency or the State Department of Social Services may request; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided, however, that each bill need not contain the dated certification required by this paragraph in cases where the care, services or supplies (other than the services of a clinical laboratory) were furnished in a Canadian province or in a state other than the State of New York by a provider with a principal place of business outside the State of New York so long as the provider has previously filed with the department a certification containing all of the provisions required by this paragraph which will be applicable to all bills to be submitted by the provider during the period of the provider's participation in the medical assistance program.

18 NYCRR Section 540.7(a)(8)

Policy Guidelines state, "All medical/surgical supplies, durable medical equipment, prosthetic and orthotic appliances and orthopedic footwear must be supported by the original, signed written order of a licensed physician, dentist, podiatrist, physician assistant or nurse practitioner."

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

In 250 instances, the provider failed to supply the auditors with original documentation. Originals of fiscal orders/prescriptions and other applicable documents were not provided to IPRO despite repeated requests, and, as such, IPRO could not authenticate the copies that were provided.

The other findings identified below are based on the copies of documentation furnished to IPRO.

2. Medical/Surgical Supplies Provided in Excess of the Allowable Number of Refills

Regulations state, "The maximum number of refills permitted for medical/surgical supplies is found in the fee schedule for durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances and orthopedic footwear. The fee schedule for such equipment and supplies is available free of charge from the Medicaid fiscal agent's website."

18 NYCRR Section 505.5(b)(4)(ii)

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

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

In 36 instances, the enteral formula and supplies were refilled in excess of the prescriber's written order.

3. Telephone or Fax Order Lacks Signed Follow Up Order

Policy Guidelines state, "When an order for DMEPOS not written on the serialized official prescription form has been telephoned or faxed to the provider, it is the DME or Pharmacy provider's responsibility to obtain the original signed fiscal order from the ordering practitioner within 30 calendar days."

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

Policy Guidelines state, "In the event a fiscal order for DME, 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 26 instances, the signed follow-up order was not obtained within the 30-day time limit.

4. No Written Order

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

18 NYCRR Section 505.5(b)(1)

Policy Guidelines state, "All medical/surgical supplies, durable medical equipment, prosthetic and orthotic appliances and orthopedic footwear must be supported by the original, signed written order of a licensed physician, dentist, podiatrist, physician assistant or nurse practitioner."

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

In 22 instances, a signed written fiscal order was missing.

5. 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)

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

"When a prescription or order originates from a hospital or clinic, and is written by an intern or resident, the supervising physician's Medicaid ID number should be entered. If the supervising physician is not enrolled in the Medicaid program, his or her state license number may be used instead. When the order is originated in an Article 28 facility and these numbers are unavailable, it is permissible to use the facility's Medicaid ID number."

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

For October 1, 2009 and Forward:

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

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

In 19 instances, the ordering prescriber conflicted with the claim prescriber.

6. Other Insurance Payments Not Applied

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

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

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

In 16 instances, other insurance payments were not applied.

7. Billing of Item Prior to Delivery

Policy Guidelines state, "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
Policy Guidelines, Version 2009-2, Section III*

In 13 instances, the item was billed before delivery.

8. Missing Documentation Confirming Receipt/Delivery of Item

Regulations state that by enrolling in the Medicaid program the provider agrees: "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health."

18 NYCRR Section 504.3(a)

Regulations state, "Written orders for durable medical equipment, medical/surgical supplies, prosthetic or orthotic devices, or orthopedic footwear must be maintained by the provider submitting the claim for audit by the department or other authorized agency for six years from the date of payment."

18 NYCRR Section 505.5(c)(2)

Regulations state, "All bills for medical care, services and supplies shall contain: ... a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing and that, except as noted, no part thereof has been paid; that payment of fees and rates made in accordance with established schedules is accepted as payment in full for the care, services and supplies provided; ... that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment unless otherwise required by regulation, and information will be furnished regarding any payment claimed therefore as the local social services agency or the State Department of Social Services may request; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided, .. ."

18 NYCRR Section 540.7(a)(8)

Regulations state, "Fee-for-service providers. (1) All providers, who are not paid at rates or fees approved by the State Director of the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply, must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later."

18 NYCRR Section 517.3

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

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

In 13 instances, the records provided did not contain delivery receipts for the items billed.

9. No Documentation of Service

Regulations state, "By enrolling the provider agrees:

(a) 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..."

18 NYCRR Section 504.3(a)

Regulations state, "Written orders for durable medical equipment, medical/surgical supplies, prosthetic or orthotic devices, or orthopedic footwear must be maintained by the provider submitting the claim for audit by the department or other authorized agency for six years from the date of payment."

18 NYCRR Section 505.5(c)(2)

Regulations state, "All 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, the Secretary of the United States Department of Health and Human Services, the Medicaid Fraud Control Unit or the New York State Department of Health for audit and review. This limitation does not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs an audit."

18 NYCRR Section 517.3

Regulations state, " a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing and that, except as noted, no part thereof has been paid; that payment of fees and rates made in accordance with established schedules is accepted as payment in full for the care, services and supplies provided; that there has been compliance with title VI of the Federal Civil Rights Act of 1964 in furnishing care, services and supplies without discrimination on the basis of race, color or national origin; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment unless otherwise required by regulation, and information will be furnished regarding any payment claimed therefor as the local social services agency or the State Department of Social Services may request; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided, however, that

each bill need not contain the dated certification required by this paragraph in cases where the care, services or supplies (other than the services of a clinical laboratory) were furnished in a Canadian province or in a state other than the State of New York by a provider with a principal place of business outside the State of New York so long as the provider has previously filed with the department a certification containing all of the provisions required by this paragraph which will be applicable to all bills to be submitted by the provider during the period of the provider's participation in the medical assistance program."

18 NYCRR Section 540.7(a)(8)

Policy Guidelines state, "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 recipients. Providers must furnish information regarding any payment claimed to authorized officials upon request of the DOH or the local department of social services."

*NYS Medicaid Program General Policy Guidelines
Versions 2004-1, Section II*

Policy Guidelines state, "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. Providers must furnish information regarding any payment claim to authorized officials upon request of the DOH or the LDSS."

*NYS Medicaid Program General Policy Guidelines
Section II, Versions 2008-2*

In 9 instances, no documentation of service was provided.

10. No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items

Policy Guidelines require that for items provided to Medicaid Recipients who are also Medicare beneficiaries, "All charges must first be billed to Medicare. Only after an Explanation of Medical Benefits (EOB) is received from the Medicare intermediary and payment made, where appropriate, may a claim be submitted for Medicaid reimbursement. The provider must maintain the EOB on file for six years following the date of payment for audit purposes."

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

Any insurance payments including Medicare must be collected prior to billing Medicaid and must be applied against the total price of the item.

*NYS Medicaid Program Durable Medical Equipment Manual
Policy Guidelines, Version 2009-2, Section III*

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

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

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

The Medicaid program is designed to provide payment for medical care and services only after all other resources available for payments have been exhausted; Medicaid is always payor of last resort. Providers must maximize all applicable insurance sources before

submitting claims to Medicaid. When coverage is available, payment from other insurance sources must be received before submitting a Medicaid claim.

- If the service is covered, or the provider does not know if the service is covered by Medicare and/or other available insurance, the provider must first submit a claim to Medicare and/or other insurer.

- Only when you are certain that Medicare or another insurer does not cover the service, can you bill Medicaid solely, and not bill other insurer first.

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

In 8 instances, Medicare EOBs were not made available for patients who had Medicare coverage and Medicaid was billed prior to billing Medicare.

11. Item Billed in Excess of Quantity Ordered

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

18 NYCRR Section 505.5(b)(3)

In 7 instances the item billed was in excess of quantity ordered.

12. Original Fiscal Order Filled Beyond Acceptable Timeframe

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

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

In 5 instances, a prescription/fiscal order was filled more than 60 days after its issuance.

13. Ordered Refilled More Than 180 Days After It Has Been Initiated by the Prescriber

Regulations state, "No order can be refilled more than 180 days from the original date ordered."

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

In 3 instances, an order was refilled more than 180 days after the initiated date.

14. No Signature on Written Order

Regulations state, "All orders must show the name, address, telephone number of the practitioner and the name and identification number 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 2 instances, the original signature was missing on the fiscal order.

15. 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 518.1(c)

General 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
Information for All Providers, General Policy, Version 2008-2, Section II*

In 2 instances, a claim for the same item for the same patient was submitted one day apart.

16. Item Billed Does Not Match Ordered Item

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. (3) 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 2 instances, an item billed does not match the item ordered.

17. Improper Medicaid Billings for Medicare Crossover Patients

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, "Payments of deductibles and coinsurance under title XVIII of the Social Security Act (Medicare). (a) The MA program will pay on behalf of qualified Medicare beneficiaries, as defined in subdivision

18 NYCRR Section 360-7.7(a)

Policy Guidelines state, "Any insurance payments including Medicare must be collected prior to billing Medicaid and must be applied against the total price of the item."

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

In 2 instances, an improper Medicaid billing claim was made for a Medicare patient.

SUMMARY OF OVERPAYMENTS

The identified overpayments after re-audit for the discrepant sampled claims totaled \$88,004.40. When extrapolated to the universe of claims from which the sample was drawn, the mean per unit point estimate of the overpayment is \$2,372,487. The lower confidence limit of the amount of the overpayment is \$2,309,773. 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 \$2,309,773. See **Appendices A and B** for detailed information.

RECOMMENDATIONS

Based on the findings cited in this audit report, Metropolitan Home Health Products is directed to:

1. Remit the lower confidence limit amount of \$2,309,773. 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 lower confidence limit amount of \$2,309,773, 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 #13-1434
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 lower confidence limit of \$2,309,773, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of \$2,372,487. 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

██████████
Metropolitan Home Health Products,
Inc.
5353 Kings Highway
Brooklyn, New York 11203

AMOUNT DUE: \$2,309,773

PROVIDER ID ██████████

AUDIT #13-1434

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 #13-1434
Albany, New York 12237

Thank you for your cooperation.

Sample #	Patient ID	Patient Name	Date of Service	Paid Date	Proc	Qty	Amount Paid	Receipt-amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	Error Code
1			05/16/11	08/17/11	B4153	450	\$ 988.00	\$ 988.00	2012	61.39%	\$ 614.67	X
2			03/17/09	03/03/09	B4153	450	\$ 895.50	\$ 895.50	2009	58.38%	\$ 520.37	X
3			04/14/09	04/27/09	B4153	450	\$ 832.50	\$ 832.50	2009	60.19%	\$ 501.08	X
4			05/14/09	05/25/09	B4153	450	\$ 832.50	\$ 832.50	2009	60.19%	\$ 501.08	X
5			06/18/09	06/29/09	B4153	450	\$ 832.50	\$ 832.50	2009	60.19%	\$ 501.08	X
6			07/24/09	08/17/09	B4153	450	\$ 832.50	\$ 832.50	2009	61.59%	\$ 512.74	X
7			09/01/09	09/03/09	B4153	450	\$ 832.50	\$ 832.50	2010	58.38%	\$ 489.34	X
8			10/03/09	10/13/09	B4153	450	\$ 832.50	\$ 832.50	2010	58.38%	\$ 489.34	X
9			11/06/09	11/23/09	B4153	450	\$ 832.50	\$ 832.50	2010	58.38%	\$ 489.34	X
10			12/10/09	12/16/09	B4153	450	\$ 832.50	\$ 832.50	2010	58.38%	\$ 489.34	X
11			01/07/10	02/01/10	B4153	450	\$ 832.50	\$ 832.50	2010	61.59%	\$ 512.74	X
12			02/24/10	03/15/10	B4153	450	\$ 832.50	\$ 832.50	2010	61.59%	\$ 512.74	X
13			06/10/10	06/21/10	B4153	450	\$ 832.50	\$ 832.50	2010	61.59%	\$ 512.74	X
14			07/14/10	07/19/10	B4153	450	\$ 832.50	\$ 832.50	2010	61.59%	\$ 512.74	X
15			08/13/10	08/23/10	B4153	450	\$ 832.50	\$ 832.50	2010	61.59%	\$ 512.74	X
16			09/16/10	10/10/10	B4153	450	\$ 832.50	\$ 832.50	2011	61.59%	\$ 512.74	X
17			02/08/11	03/07/11	B4153	450	\$ 832.50	\$ 832.50	2011	58.37%	\$ 489.26	X
18			05/25/11	06/06/11	B4153	450	\$ 832.50	\$ 832.50	2011	58.37%	\$ 489.26	X
19			06/22/11	07/06/11	B4153	450	\$ 832.50	\$ 832.50	2011	50.00%	\$ 416.25	X
20			01/06/09	01/19/09	B4161	600	\$ 810.00	\$ 810.00	2009	58.38%	\$ 476.12	X
21			03/19/09	03/03/09	B4161	600	\$ 810.00	\$ 810.00	2009	58.38%	\$ 476.12	X
22			04/17/09	05/11/09	B4161	600	\$ 810.00	\$ 810.00	2009	60.19%	\$ 487.54	X
23			05/29/09	06/08/09	B4161	600	\$ 810.00	\$ 810.00	2009	60.19%	\$ 487.54	X
24			06/26/09	07/13/09	B4161	600	\$ 810.00	\$ 810.00	2009	61.59%	\$ 498.88	X
25			08/10/09	08/24/09	B4161	600	\$ 810.00	\$ 810.00	2009	61.59%	\$ 498.88	X
26			09/09/09	09/21/09	B4161	600	\$ 810.00	\$ 810.00	2009	61.59%	\$ 498.88	X
27			10/06/09	10/20/09	B4161	600	\$ 810.00	\$ 810.00	2010	58.38%	\$ 476.12	X
28			07/29/09	08/13/09	B4161	600	\$ 810.00	\$ 810.00	2010	58.38%	\$ 476.12	X
29			10/07/09	10/19/09	B4161	600	\$ 810.00	\$ 810.00	2010	58.38%	\$ 476.12	X
30			11/17/09	11/23/09	B4161	600	\$ 810.00	\$ 810.00	2010	58.38%	\$ 476.12	X
31			12/11/09	12/21/09	B4161	600	\$ 810.00	\$ 810.00	2010	58.38%	\$ 476.12	X
32			01/21/10	02/01/10	B4161	600	\$ 810.00	\$ 810.00	2010	58.38%	\$ 476.12	X
33			02/16/10	02/26/10	B4161	600	\$ 810.00	\$ 810.00	2010	61.59%	\$ 498.88	X
34			03/08/10	03/25/10	B4161	600	\$ 810.00	\$ 810.00	2010	61.59%	\$ 498.88	X
35			01/19/10	02/22/10	B4161	600	\$ 810.00	\$ 810.00	2010	61.59%	\$ 498.88	X
36			01/18/10	02/15/10	B4161	600	\$ 810.00	\$ 810.00	2010	61.59%	\$ 498.88	X
37			03/05/10	03/15/10	B4161	600	\$ 810.00	\$ 810.00	2010	61.59%	\$ 498.88	X
38			02/22/10	03/11/10	B4161	600	\$ 810.00	\$ 810.00	2010	61.59%	\$ 498.88	X

1 Missing Clinical Documentation

2 Anatomical Supplies Provided in Error of the Allowed Number of Units

3 Coding Provider Confusion with Class Procedure

4 No Wrong Code

5 Other Invoice Payment Not Applied

6 Billing of Non-Fee in Detail

7 Missing Documentation Confirming Receipt of Item

8 No Documentation of Service

9 No Explanation of Benefits (EOB) Documentation for Student Care and Item

10 Original Code Not Applied

11 Denial in error of Quantity

12 Original Code Not Applied

13 Only Applied over the 180 Day After the Item Listed by the Provider

14 No Signature or Initial Code

15 Duplicate Payment

16 Non-Billed Date Not Match Entered Item

17 Improper Medical Usage for Student Care or Patient

Sample #	Patient ID	Patient Name	Date of Service	Paid Date	Proc.	Qty.	Amount Paid	Recovery Amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	1. Missing Original Documentation	2. Multiple Signed Copies Provided in Error of the Alternate Number of Bills	3. Missing Provider Contact with Case Provider	4. No Written Order	5. Other Insurance Payments Not Applied	6. Billing at Non Prior to Delivery	7. Missing Documentation (Including Receipt/Delivery of Item)	8. No Documentation of Service	9. No Documentation of Health (EOP) Documentation for Medicare Central Access	10. Original Order Filled beyond Acceptable Tolerance	11. Order Filled more than 180 Days After it has been received by the Provider	12. Duplicate Medical Billing for Student Consumer Patients	13. Duplicate Medical Billing for Student Consumer Patients		
39			01/19/10	01/27/10	04161	600	\$ 810.00	\$ 810.00	2010	81.59%	\$ 494.88	X														
40			04/02/10	04/27/10	04161	600	\$ 810.00	\$ 810.00	2010	81.59%	\$ 494.88	X														
41			04/19/10	04/29/10	04161	600	\$ 810.00	\$ 810.00	2010	81.59%	\$ 494.88	X														
42			05/13/10	05/24/10	04161	600	\$ 810.00	\$ 810.00	2010	81.59%	\$ 494.88	X														
43			05/14/10	05/24/10	04161	600	\$ 810.00	\$ 810.00	2010	81.59%	\$ 494.88	X														
44			06/17/10	06/23/10	04161	600	\$ 810.00	\$ 810.00	2010	81.59%	\$ 494.88	X														
45			07/15/10	07/26/10	04161	600	\$ 810.00	\$ 810.00	2010	81.59%	\$ 494.88	X														
46			08/18/10	09/03/10	04161	600	\$ 810.00	\$ 810.00	2010	81.59%	\$ 494.88	X														
47			09/28/10	10/04/10	04161	600	\$ 810.00	\$ 810.00	2011	81.59%	\$ 494.88	X														
48			10/23/10	11/08/10	04161	600	\$ 810.00	\$ 810.00	2011	81.59%	\$ 494.88	X														
49			11/26/10	12/06/10	04161	600	\$ 810.00	\$ 810.00	2011	81.59%	\$ 494.88	X														
50			12/23/10	01/07/11	04161	600	\$ 810.00	\$ 810.00	2011	81.59%	\$ 494.88	X														
51			01/23/11	01/23/11	04161	600	\$ 810.00	\$ 810.00	2011	81.59%	\$ 494.88	X														
52			02/25/11	02/25/11	04161	600	\$ 810.00	\$ 810.00	2011	81.59%	\$ 494.88	X														
53			03/24/11	04/04/11	04161	600	\$ 810.00	\$ 810.00	2011	81.59%	\$ 494.88	X														
54			04/23/11	05/02/11	04161	600	\$ 810.00	\$ 810.00	2011	81.59%	\$ 494.88	X														
55			05/23/11	06/03/11	04161	600	\$ 810.00	\$ 810.00	2011	81.59%	\$ 494.88	X														
56			06/03/11	06/23/11	04161	600	\$ 810.00	\$ 810.00	2011	81.59%	\$ 494.88	X														
57			07/21/11	08/01/11	04161	600	\$ 810.00	\$ 810.00	2011	81.59%	\$ 494.88	X														
58			08/17/10	09/07/10	04173	427	\$ 785.95	\$ 785.95	2010	81.59%	\$ 486.53	X														
59			09/09/10	09/29/10	04173	427	\$ 785.95	\$ 785.95	2010	81.59%	\$ 486.53	X														
60			10/73/10	10/23/10	04173	427	\$ 785.95	\$ 785.95	2010	81.59%	\$ 486.53	X														
61			11/17/10	11/27/10	04173	427	\$ 785.95	\$ 785.95	2010	81.59%	\$ 486.53	X														
62			07/24/11	08/03/11	04173	423	\$ 781.53	\$ 781.53	2012	81.59%	\$ 481.35	X														
63			06/24/11	06/24/11	04173	423	\$ 781.53	\$ 781.53	2012	81.59%	\$ 481.35	X														
64			08/24/11	12/06/11	04161	534	\$ 720.90	\$ 720.90	2012	81.59%	\$ 444.00	X														
65			11/08/11	12/01/11	04161	534	\$ 720.90	\$ 720.90	2012	81.59%	\$ 444.00	X														
66			10/06/11	12/01/11	04161	534	\$ 720.90	\$ 720.90	2012	81.59%	\$ 444.00	X														
67			12/08/11	12/28/11	04161	534	\$ 720.90	\$ 720.90	2012	81.59%	\$ 444.00	X														
68			01/23/09	01/23/09	09602	1	\$ 315.56	\$ 315.56	2009	58.78%	\$ 425.61	X														
69			01/16/09	01/08/09	09602	1	\$ 315.56	\$ 315.56	2009	58.78%	\$ 425.61	X														
70			01/16/09	01/08/09	09602	1	\$ 315.56	\$ 315.56	2009	58.78%	\$ 425.61	X														
71			03/01/09	03/03/09	09602	1	\$ 315.56	\$ 315.56	2009	58.78%	\$ 425.61	X														
72			03/01/09	03/03/09	09602	1	\$ 315.56	\$ 315.56	2009	58.78%	\$ 425.61	X														
73			09/23/09	09/23/09	09602	1	\$ 315.56	\$ 315.56	2009	58.78%	\$ 425.61	X														
74			10/74/09	10/23/09	09602	1	\$ 315.56	\$ 315.56	2010	58.78%	\$ 425.61	X														
75			12/28/09	12/28/09	09602	1	\$ 315.56	\$ 315.56	2010	58.78%	\$ 425.61	X														
76			06/09/10	07/05/10	09602	1	\$ 315.56	\$ 315.56	2010	81.59%	\$ 440.71	X														

Error Codes

- 1. Missing Original Documentation
- 2. Multiple Signed Copies Provided in Error of the Alternate Number of Bills
- 3. Missing Provider Contact with Case Provider
- 4. No Written Order
- 5. Other Insurance Payments Not Applied
- 6. Billing at Non Prior to Delivery
- 7. Missing Documentation (Including Receipt/Delivery of Item)
- 8. No Documentation of Service
- 9. No Documentation of Health (EOP) Documentation for Medicare Central Access
- 10. Original Order Filled beyond Acceptable Tolerance
- 11. Order Filled more than 180 Days After it has been received by the Provider
- 12. Duplicate Medical Billing for Student Consumer Patients
- 13. Duplicate Medical Billing for Student Consumer Patients

Appendix A

Sample #	Patient ID	Patient Name	Date of Service	Prod Date	Pose	Qty.	Amount Paid	Reimpr- amt	Federal Fiscal Year	Federal Share %	Federal Share Amount	1. Missing Original Documentation	2. Medication Supplied Prescribed in Error or the Alternate Number of Units	3. No Written Order	4. Other Member Confers with Chain of Command	5. Missing of this Prior to Delivery	6. Missing Documentation Customizing Prescription of Item	7. No Expansion of Service	8. Item Added in Error of Quantity Ordered	9. Item Added in Error of Quantity Ordered	10. Original Order Filled Beyond Acceptable Tolerance	11. No Expansion of Service (ICOP) Documentation for Medication Control Items	12. Order Filled more than 70 Days After it Has Been Issued by the Prescriber	13. No Expansion of Service Order	14. Duplicate Payment	15. Item Added Date Not Match Order Item	16. Duplicate Medication Orders for Multiple Concurrent Patients	
77			08/04/10	08/06/10	016002	1	\$ 715.56	\$ 715.56	2010	61.59%	\$ 440.71	X																
78			09/18/10	10/24/10	016002	1	\$ 715.56	\$ 715.56	2011	61.59%	\$ 440.71	X																
79			06/03/10	10/23/10	016002	1	\$ 715.56	\$ 715.56	2011	61.59%	\$ 440.71	X																
80			11/02/10	12/31/10	016002	1	\$ 715.56	\$ 715.56	2011	61.59%	\$ 440.71	X																
81			11/07/10	01/07/11	016002	1	\$ 715.56	\$ 715.56	2011	58.77%	\$ 420.53	X																
82			12/07/10	02/04/11	016002	1	\$ 715.56	\$ 715.56	2011	58.77%	\$ 420.53	X																
83			01/25/11	04/23/11	016002	1	\$ 715.56	\$ 715.56	2011	58.77%	\$ 420.53	X																
84			06/08/11	06/23/11	016003	1	\$ 715.56	\$ 715.56	2011	58.77%	\$ 420.53	X																
85			06/14/11	06/23/11	016003	1	\$ 715.56	\$ 715.56	2011	58.77%	\$ 420.53	X																
86			04/09/11	09/30/11	016003	1	\$ 715.54	\$ 715.54	2011	59.00%	\$ 440.71	X																
87			12/13/11	12/26/11	016002	1	\$ 715.56	\$ 715.56	2012	61.59%	\$ 440.71	X																
88			06/09/09	06/23/09	04154	198	\$ 167.30	\$ 167.30	2009	60.10%	\$ 100.70	X																
89			09/23/10	10/13/10	041033	30	\$ 249.60	\$ 249.60	2011	58.77%	\$ 153.75	X																
90			11/03/10	01/03/11	041350	600	\$ 364.00	\$ 364.00	2011	58.77%	\$ 173.78	X																
91			06/24/11	10/27/11	041033	30	\$ 248.60	\$ 248.60	2012	61.59%	\$ 153.11	X																
92			02/22/10	10/08/10	041354	198	\$ 167.30	\$ 167.30	2010	61.59%	\$ 103.06	X																
93			01/29/11	01/03/11	041354	198	\$ 167.30	\$ 167.30	2011	58.77%	\$ 88.32	X																
94			06/11/09	07/06/09	04124	198	\$ 167.30	\$ 167.30	2009	61.59%	\$ 103.06	X																
95			10/03/11	10/27/11	041352	420	\$ 199.60	\$ 199.60	2012	61.59%	\$ 98.30	X																
96			09/08/09	09/21/09	041350	375	\$ 183.75	\$ 183.75	2009	61.59%	\$ 113.17	X																
97			07/29/10	08/28/10	04134	198	\$ 167.30	\$ 167.30	2010	61.59%	\$ 103.06	X																
98			02/10/09	02/23/09	041152	420	\$ 199.60	\$ 199.60	2009	58.78%	\$ 93.81	X																
99			07/24/11	09/29/11	041460	375	\$ 213.00	\$ 213.00	2011	58.77%	\$ 125.53	X																
100			07/16/09	08/02/09	041354	198	\$ 168.30	\$ 168.30	2009	61.59%	\$ 103.66	X																
101			07/14/11	07/25/11	041460	288	\$ 172.80	\$ 172.80	2011	59.00%	\$ 86.40	X																
102			03/17/11	03/28/11	041354	264	\$ 221.40	\$ 221.40	2011	58.77%	\$ 131.29	X																
103			06/25/10	07/05/10	041350	540	\$ 263.60	\$ 263.60	2010	61.59%	\$ 162.35	X																
104			06/08/10	06/21/10	04134	198	\$ 167.30	\$ 167.30	2010	61.59%	\$ 103.06	X																
105			06/20/11	07/01/11	041350	450	\$ 270.50	\$ 270.50	2011	59.00%	\$ 110.25	X																
106			07/16/10	07/26/10	041352	420	\$ 199.60	\$ 199.60	2010	61.59%	\$ 88.30	X																
107			08/26/09	09/02/09	04134	198	\$ 167.30	\$ 167.30	2009	61.59%	\$ 103.06	X																
108			01/03/11	01/24/11	041354	198	\$ 167.30	\$ 167.30	2011	58.77%	\$ 88.32	X																
109			10/23/10	12/31/10	041033	30	\$ 249.60	\$ 249.60	2011	61.59%	\$ 153.75	X																
110			01/24/09	04/06/09	041352	420	\$ 181.80	\$ 181.80	2009	60.10%	\$ 97.44	X																
111			10/08/09	10/19/09	04134	264	\$ 333.48	\$ 333.48	2009	58.78%	\$ 151.11	X																
112			08/27/10	09/09/10	041354	225	\$ 190.25	\$ 190.25	2010	61.59%	\$ 117.17	X																
113			12/23/09	01/04/10	041354	300	\$ 254.00	\$ 254.00	2010	61.59%	\$ 156.44	X																
114			10/26/09	10/26/09	041460	420	\$ 255.60	\$ 255.60	2010	58.78%	\$ 150.54	X																

Error Codes

1. Missing Original Documentation
2. Medication Supplied Prescribed in Error or the Alternate Number of Units
3. No Written Order
4. Other Member Confers with Chain of Command
5. Missing of this Prior to Delivery
6. Missing Documentation Customizing Prescription of Item
7. No Expansion of Service
8. Item Added in Error of Quantity Ordered
9. Item Added in Error of Quantity Ordered
10. Original Order Filled Beyond Acceptable Tolerance
11. No Expansion of Service Order
12. Duplicate Payment
13. Duplicate Medication Orders for Multiple Concurrent Patients
14. Item Added Date Not Match Order Item
15. Duplicate Medication Orders for Multiple Concurrent Patients

Sample #	Patient ID	Patient Name	Date of Service	Paid Date	Proc. Qty.	Amount Paid	Repayment Amount	Federal Fiscal Year	Federal Share %	Federal Amount	1. Among Original Discharge	2. Medication System Provided in Error of the Abusive Member of Family	3. Telephone or Fax under Lack of Sign-off Order	4. No Written Order	5. Changing Provider Under with Claim Provider	6. Over Insurance Payments Not Applied	7. Billing of Item Prior to Delivery	8. Missing Documentation Containing Receipt/History of Item	9. No Documentation of Service	10. No Explanation of Benefits (EOB) Documentation for Medicare Claim Item	11. Item Billed in error of Quantity/Procedure	12. Original Order Filed under Acceptable Procedure	13. Order Rejected under EOB Data After 60 Days After 60 Days from Invoiced by the Provider	14. No Signature on Written Order	15. Diagnostic Payment	16. Item Billed Over Non Health Covered Item	17. Improper Medical Billing for Medicare Coverage Period		
115			02/08/11	02/21/11	264	\$ 175.48	\$ 175.48	2011	58.37%	\$ 103.84	X																		
116			05/24/11	03/20/11	264	\$ 340.80	\$ 340.80	2011	58.37%	\$ 200.38	X																		
117			06/17/10	10/18/10	242	\$ 199.50	\$ 199.50	2011	61.59%	\$ 122.87	X																		
118			10/02/09	10/16/09	261	\$ 267.55	\$ 267.55	2010	58.38%	\$ 156.02	X																		
119			09/05/09	09/21/09	241	\$ 159.60	\$ 159.60	2009	61.59%	\$ 98.30	X																		
120			06/21/10	06/28/10	261	\$ 167.30	\$ 167.30	2010	61.59%	\$ 103.04	X																		
121			10/27/11	11/07/11	261	\$ 201.75	\$ 201.75	2012	61.59%	\$ 125.85	X																		
122			02/17/11	02/28/11	261	\$ 167.30	\$ 167.30	2011	58.37%	\$ 98.32	X																		
123			12/22/09	01/11/10	261	\$ 167.30	\$ 167.30	2010	61.59%	\$ 103.04	X																		
124			05/27/09	06/08/09	261	\$ 240.60	\$ 240.60	2009	60.09%	\$ 130.23	X																		
125			06/27/10	03/01/10	261	\$ 340.80	\$ 340.80	2010	61.59%	\$ 209.90	X																		
126			06/24/11	06/01/11	261	\$ 167.30	\$ 167.30	2011	50.00%	\$ 83.65	X																		
127			02/26/09	03/09/09	261	\$ 167.30	\$ 167.30	2009	58.38%	\$ 98.34	X																		
128			02/11/11	02/28/11	261	\$ 167.30	\$ 167.30	2011	58.37%	\$ 98.32	X																		
129			08/17/09	02/23/09	261	\$ 167.30	\$ 167.30	2009	60.19%	\$ 100.30	X																		
130			12/09/09	12/11/09	261	\$ 168.30	\$ 168.30	2010	58.38%	\$ 98.93	X																		
131			06/24/09	09/07/09	261	\$ 175.48	\$ 175.48	2009	61.59%	\$ 108.03	X																		
132			06/01/09	06/15/09	261	\$ 269.68	\$ 269.68	2009	60.19%	\$ 160.73	X																		
133			06/20/11	06/27/11	261	\$ 219.50	\$ 219.50	2011	58.37%	\$ 129.00	X																		
134			10/14/10	10/25/10	261	\$ 167.30	\$ 167.30	2011	61.59%	\$ 103.04	X																		
135			07/06/10	07/16/10	261	\$ 167.30	\$ 167.30	2010	61.59%	\$ 103.04	X																		
136			02/22/09	03/09/09	261	\$ 110.25	\$ 110.25	2009	58.38%	\$ 64.80	X																		
137			03/18/09	03/26/09	261	\$ 110.25	\$ 110.25	2009	58.38%	\$ 64.80	X																		
138			04/12/10	04/12/10	261	\$ 127.80	\$ 127.80	2010	61.59%	\$ 78.71	X																		
139			05/04/09	05/18/09	261	\$ 127.80	\$ 127.80	2009	60.19%	\$ 76.82	X																		
140			11/10/09	11/23/09	261	\$ 109.25	\$ 109.25	2010	58.38%	\$ 64.22	X																		
141			06/29/10	05/18/10	261	\$ 109.25	\$ 109.25	2010	61.59%	\$ 67.29	X																		
142			06/23/10	07/08/10	261	\$ 110.25	\$ 110.25	2010	61.59%	\$ 67.90	X																		
143			08/14/09	06/27/09	261	\$ 112.20	\$ 112.20	2009	60.19%	\$ 67.53	X																		
144			10/07/10	10/16/10	261	\$ 109.25	\$ 109.25	2011	61.59%	\$ 67.29	X																		
145			06/08/09	05/18/09	261	\$ 118.70	\$ 118.70	2009	60.19%	\$ 71.45	X																		
146			06/17/10	06/28/10	261	\$ 127.80	\$ 127.80	2010	61.59%	\$ 78.71	X																		
147			06/19/10	06/19/10	261	\$ 119.70	\$ 119.70	2010	61.59%	\$ 73.72	X																		
148			06/19/10	05/26/10	261	\$ 110.25	\$ 110.25	2010	61.59%	\$ 67.90	X																		
149			09/02/10	11/28/10	261	\$ 110.25	\$ 110.25	2011	61.59%	\$ 67.90	X																		
150			10/04/10	11/19/10	261	\$ 110.25	\$ 110.25	2011	61.59%	\$ 67.90	X																		
151			04/12/10	04/29/10	261	\$ 110.25	\$ 110.25	2010	61.59%	\$ 67.90	X																		
152			04/12/10	04/29/10	261	\$ 109.25	\$ 109.25	2010	61.59%	\$ 67.29	X																		

Error Codes

Appendix A

Sample #	Patient ID	Patient Name	Date of Service	Paid Date	Proc.	Qty.	Amount Paid	Recovery-amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	1. Moving Original Documentation	2. Merchandise/Super Provided in Error or the Assignable Number of Rights	3. Payment in Error	4. Other Payment Payment Not Applied	5. Moving Documentation Containing Repeating/Deleting of Item	6. No Documentation of Service	7. Item Billed in error of Quantity/Date	8. No Documentation of Goods (ICD) Documentation for Medical Control Items	9. No Documentation of Service	10. No Documentation of Service	11. Item Billed in error of Quantity/Date	12. Original Order Filed beyond Appropriate Timeframe	13. Order Modified more than 180 Days after D that then issued by the Provider	14. No Signature on Invoice Order	15. Duplicate Payment	16. Item Billed Does Not Match Ordered Item	17. Repeated Medical Billing for Multiple Encounter Patients		
153			08/13/10	08/13/10	04150	225	\$ 110.25	\$ 110.25	2010	61.59%	\$ 67.90	X																		
154			04/01/11	04/25/11	04154	132	\$ 110.25	\$ 110.25	2011	58.77%	\$ 65.15	X																		
155			12/22/10	04/03/11	04158	225	\$ 110.25	\$ 110.25	2011	58.77%	\$ 64.70	X																		
156			04/01/11	04/25/11	04154	132	\$ 110.25	\$ 110.25	2011	58.77%	\$ 65.15	X																		
157			05/06/11	05/10/11	04158	300	\$ 148.00	\$ 148.00	2011	58.77%	\$ 85.80	X																		
158			01/28/10	02/15/10	04153	315	\$ 118.70	\$ 118.70	2010	61.59%	\$ 73.11	X																		
159			04/25/09	05/04/09	04158	315	\$ 104.37	\$ 104.37	2009	60.19%	\$ 62.82	X																		
160			04/26/11	05/02/11	04158	300	\$ 147.00	\$ 147.00	2011	58.77%	\$ 86.19	X																		
161			08/05/10	08/16/10	04158	225	\$ 110.25	\$ 110.25	2010	61.59%	\$ 67.20	X																		
162			04/15/11	04/25/11	04158	225	\$ 110.25	\$ 110.25	2011	58.77%	\$ 64.70	X																		
163			08/05/10	08/16/10	04158	216	\$ 105.84	\$ 105.84	2010	61.59%	\$ 65.10	X																		
164			11/13/09	11/23/09	04158	225	\$ 110.25	\$ 110.25	2010	58.78%	\$ 64.80	X																		
165			09/09/09	04/03/09	04158	225	\$ 109.25	\$ 109.25	2009	61.59%	\$ 67.20	X																		
166			02/24/10	03/08/10	04158	225	\$ 109.25	\$ 109.25	2010	61.59%	\$ 67.20	X																		
167			09/24/09	09/12/09	04158	225	\$ 110.25	\$ 110.25	2010	58.78%	\$ 64.80	X																		
168			06/16/10	08/02/10	04158	225	\$ 110.25	\$ 110.25	2010	61.59%	\$ 67.90	X																		
169			02/25/10	03/08/10	04160	212	\$ 127.80	\$ 127.80	2010	61.59%	\$ 78.71	X																		
170			01/28/10	03/08/10	04154	132	\$ 111.20	\$ 111.20	2010	61.59%	\$ 68.40	X																		
171			03/20/09	06/12/09	04158	300	\$ 146.00	\$ 146.00	2009	60.19%	\$ 87.88	X																		
172			09/10/09	09/21/09	04158	225	\$ 109.25	\$ 109.25	2009	61.59%	\$ 67.20	X																		
173			12/20/10	12/27/10	04158	100	\$ 147.00	\$ 147.00	2011	61.59%	\$ 90.34	X																		
174			06/08/10	06/21/10	04160	212	\$ 127.80	\$ 127.80	2010	61.59%	\$ 78.71	X																		
175			07/16/09	08/03/09	04158	225	\$ 109.25	\$ 109.25	2009	61.59%	\$ 67.20	X																		
176			02/20/09	03/02/09	04154	132	\$ 111.20	\$ 111.20	2009	58.78%	\$ 65.16	X																		
177			11/03/10	11/15/10	04158	225	\$ 109.25	\$ 109.25	2011	61.59%	\$ 67.20	X																		
178			03/08/10	04/05/10	04160	212	\$ 137.80	\$ 137.80	2010	61.59%	\$ 78.71	X																		
179			12/12/10	12/20/10	04158	225	\$ 109.25	\$ 109.25	2011	61.59%	\$ 67.20	X																		
180			03/24/10	04/22/10	04152	315	\$ 118.70	\$ 118.70	2010	61.59%	\$ 73.11	X																		
181			01/06/09	01/19/09	04158	300	\$ 147.00	\$ 147.00	2009	58.78%	\$ 86.41	X																		
182			09/24/09	09/03/09	04158	225	\$ 109.25	\$ 109.25	2009	61.59%	\$ 67.20	X																		
183			08/21/09	08/21/09	04158	225	\$ 109.25	\$ 109.25	2009	61.59%	\$ 67.20	X																		
184			06/22/11	07/04/11	04152	315	\$ 118.70	\$ 118.70	2011	50.09%	\$ 59.33	X																		
185			05/18/09	06/01/09	04158	225	\$ 110.25	\$ 110.25	2009	60.19%	\$ 66.38	X																		
186			09/24/10	10/11/10	04158	225	\$ 109.25	\$ 109.25	2011	61.59%	\$ 67.20	X																		
187			05/28/10	06/14/10	04158	225	\$ 109.25	\$ 109.25	2010	61.59%	\$ 67.20	X																		
188			01/22/10	01/29/10	04160	212	\$ 127.80	\$ 127.80	2010	61.59%	\$ 78.71	X																		
189			06/30/12	07/11/12	04152	315	\$ 119.70	\$ 119.70	2011	50.00%	\$ 59.85	X																		
190			01/26/09	02/02/09	04152	300	\$ 115.00	\$ 115.00	2009	58.78%	\$ 66.42	X																		

Error Codes

Sample #	Patient ID	Patient Name	Date of Service	Paid Date	Price	Qty.	Amount Paid	Receipt - net	Federal Fiscal Year	Federal Share %	Federal Share Amount	1 Missing Original Documentation	2 Medical/Surgical Supplies Placed in Error of the Alaska Number of Units	3 Response or Fax into Lack Signed Order (ip) Only	4 No Written Order	5 Ordering Prescriber Confers with Case Prescriber	6 Date Invoice Payment Not Applied	7 Wrong of Item Price or Delivery	8 Missing Documentation Correcting Prescription or Item	9 No Documentation of Service	10 No Explanation of Benefit (DOB) Documentation for Medicare Covered Item	11 Item Billed in error of Quantity Ordered	12 Original Order Filled beyond Available Treatment	13 Order Filled more than 180 Days After it Has Been Received by the Prescriber	14 No Signature on Written Order	15 Duplicate Payment	16 Item Billed Over Max Units Allowed Item	17 Employer Medical Billing for Member Covered Person			
181			08/20/10	08/06/10	B4136	150	\$ 72.50	\$ 72.50	2010	61.59%	\$ 44.65	X																			
182			01/07/09	01/10/09	B4934	30	\$ 56.40	\$ 56.40	2009	58.78%	\$ 33.15	X																			
183			12/31/09	02/09/10	B4934	30	\$ 6.12	\$ 6.12	2010	61.59%	\$ 3.77	X																			
184			05/21/09	06/01/09	B4190	143	\$ 85.80	\$ 85.80	2009	60.19%	\$ 51.64	X																			
185			08/31/10	10/29/10	B4130	150	\$ 72.50	\$ 72.50	2011	61.59%	\$ 44.65	X																			
186			04/06/11	05/09/11	B4132	240	\$ 45.22	\$ 45.22	2011	58.77%	\$ 26.58	X																			
187			03/12/08	02/23/09	B4934	30	\$ 3.74	\$ 3.74	2009	58.78%	\$ 2.20	X																			
188			04/18/10	06/16/10	B4933	30	\$ 12.56	\$ 12.56	2010	61.59%	\$ 7.74	X																			
189			05/15/09	03/25/09	B4130	120	\$ 58.80	\$ 58.80	2009	60.19%	\$ 35.39	X																			
200			11/02/10	12/13/10	B4130	150	\$ 72.50	\$ 72.50	2011	61.59%	\$ 44.65	X																			
201			04/29/10	05/10/10	B4130	150	\$ 73.50	\$ 73.50	2010	61.59%	\$ 45.27	X																			
202			07/19/10	08/20/10	B4934	30	\$ 6.12	\$ 6.12	2010	61.59%	\$ 3.77	X																			
203			08/01/09	08/28/09	B4130	150	\$ 72.50	\$ 72.50	2009	61.59%	\$ 44.65	X																			
204			01/20/11	03/17/11	B4160	142	\$ 85.20	\$ 85.20	2011	58.77%	\$ 50.87	X																			
205			11/23/11	12/19/11	B4130	250	\$ 10.70	\$ 10.70	2012	61.59%	\$ 6.50	X																			
206			10/12/10	11/06/10	B4932	1	\$ 4.61	\$ 4.61	2011	61.59%	\$ 2.84	X																			
207			12/03/09	11/13/10	B4934	30	\$ 6.12	\$ 6.12	2011	61.59%	\$ 3.77	X																			
208			01/06/09	01/10/09	B4100	64	\$ 33.02	\$ 33.02	2009	58.78%	\$ 19.64	X																			
209			03/12/09	03/22/09	B4130	150	\$ 72.50	\$ 72.50	2009	58.78%	\$ 42.62	X																			
210			09/27/10	10/04/10	B4130	150	\$ 72.50	\$ 72.50	2011	61.59%	\$ 44.65	X																			
211			12/11/10	12/20/10	B4130	153	\$ 34.97	\$ 34.97	2011	61.59%	\$ 46.17	X																			
212			12/02/08	01/05/09	B4934	30	\$ 3.74	\$ 3.74	2009	58.78%	\$ 2.20	X																			
213			10/01/11	10/17/11	B4932	1	\$ 60.00	\$ 60.00	2012	61.59%	\$ 36.95	X																			
214			09/16/10	09/27/10	B4160	143	\$ 85.20	\$ 85.20	2010	61.59%	\$ 52.47	X																			
215			05/17/10	05/26/10	B4130	150	\$ 72.50	\$ 72.50	2010	61.59%	\$ 44.65	X																			
216			06/26/10	10/16/10	B4934	30	\$ 6.12	\$ 6.12	2011	61.59%	\$ 3.77	X																			
217			06/06/10	06/28/10	B4100	60	\$ 20.30	\$ 20.30	2010	61.59%	\$ 12.44	X																			
218			09/15/10	06/21/10	B4130	142	\$ 2.69	\$ 2.69	2010	61.59%	\$ 4.86	X																			
219			12/11/04	02/01/10	B4130	350	\$ 72.50	\$ 72.50	2010	61.59%	\$ 44.65	X																			
220			03/04/10	03/01/10	B4130	132	\$ 63.64	\$ 63.64	2010	61.59%	\$ 39.23	X																			
221			07/01/11	07/25/11	B4152	210	\$ 79.80	\$ 79.80	2011	50.00%	\$ 19.96	X																			
222			01/03/09	01/13/09	B4034	30	\$ 35.40	\$ 35.40	2009	58.78%	\$ 21.26	X																			
223			07/28/10	08/21/10	B4134	450	\$ 90.37	\$ 90.37	2010	61.59%	\$ 55.76	X																			
224			10/01/04	10/12/09	B4130	150	\$ 75.50	\$ 75.50	2010	58.78%	\$ 42.62	X																			
225			08/03/10	08/24/10	B4132	210	\$ 78.80	\$ 78.80	2010	61.59%	\$ 48.33	X																			
226			06/24/10	07/03/10	B4160	72	\$ 43.28	\$ 43.28	2010	61.59%	\$ 26.61	X																			
227			11/02/09	12/28/09	B4134	450	\$ 68.38	\$ 68.38	2010	58.78%	\$ 40.19	X																			
228			09/03/10	09/13/10	B4152	210	\$ 81.88	\$ 81.88	2010	61.59%	\$ 49.94	X																			

Error Codes

Appendix B

Metropolitan Home Health Products, Inc.

Extrapolation of Sample Findings

Total Sample Recoupment	\$	88,004.40
Sample Recoupment for Extrapolation Purposes	\$	88,004.40
Claims in Sample		250
Overpayments Per Sampled Claim	\$	352.02
Claims in Universe		19,457
Meanpoint Estimate	\$	2,272,487
Lower Confidence Limit	\$	2,309,773