



**Office of the
Medicaid Inspector
General**

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

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

**FINAL AUDIT REPORT
OMIG AUDIT #: 13-1940
CMS AUDIT #: 1-17775416**

**Dennis Rosen
Medicaid Inspector General**

October 30, 2015



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

October 30, 2015

[REDACTED]
Neighborhood Diabetes
600 Technology Park Drive, Suite 201
Billerica, Massachusetts 01821-4127

Re: Final Audit Report
OMIG Audit #: 13-1940
CMS Audit #: 1-17775416
Provider ID #: [REDACTED]
NPI #: [REDACTED]

Dear [REDACTED]:

The IPRO Healthcare Integrity Group (IPRO) has been contracted by the Centers for Medicare & Medicaid Services (CMS) to audit providers participating in the New York Medicaid program. Under authority of the Medicaid Integrity Program, IPRO conducted an audit claims for diabetic test strip supplies paid to Shelbourn Chemists, Inc. (Provider) between January 1, 2009, and December 31, 2011. IPRO issued a draft audit report to the Provider on April 10, 2015.

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

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

The OMIG has attached the sample detail for the paid claims determined to be in error. This final audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report. The adjusted mean point estimate overpaid is \$939,323. The adjusted lower confidence limit of the amount overpaid is \$604,499. 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 \$604,499.

[REDACTED]
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October 30, 2015

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED]. Please refer to report number 13-1940 in all correspondence.

Sincerely,

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

[REDACTED]
Enclosure

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

[REDACTED]

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

New York State's Medicaid Program

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds. In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including inpatient chemical dependency rehabilitation treatment claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

New York State's Pharmacy Program

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

New York State's Durable Medical Equipment Program

Department regulations define durable medical appliances, equipment and supplies (DME) as follows: durable medical equipment are 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, SCOPE, AND METHODOLOGY

Purpose

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

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

Scope

The audit period covered payments to the Provider for diabetic test strip supply claims paid by Medicaid from January 1, 2009, through December 31, 2011. The audit universe consisted of 121,315 claims with a total Medicaid payment of \$12,685,714.52.

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

Auditors reviewed a random sample of 250 claims with \$38,172.78 in Medicaid payments. Of the 250 claims in the random sample, 66 claims had at least one error and did not comply with state requirements. Of the 37 noncompliant claims, some claims contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Item Billed in Excess of Quantity Ordered	15
Missing Documentation Confirming receipt/Delivery of Prescription/Fiscal Order	7
Missing Fiscal Order	5
Ordering Prescriber Conflicts with Claim Prescriber	5
Telephone or Fax Order Lacks Signed Follow-Up Order	2
Improper Medicaid billings for Medicare Crossover Patients	2

Other Insurance Payment Not Applied	1
No Explanation of Benefits (EOB)/Documentation for Medicare Covered Item	1
No Documentation of Service	1
Refilled Supplies Without Patient Authorization	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$4,357.50 in sample overpayments with an extrapolated adjusted point estimate of \$939,323. The adjusted lower confidence limit of the amount overpaid is \$604,499.

Methodology

To accomplish the objective, IPRO:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with the Provider’s management personnel to gain an understanding of the diabetic test strip supply program;
- ran computer programming application of claims in the Medicaid data warehouse that identified 121,315 paid diabetic test strip supply claims, totaling \$12,685,714.52;
- selected a random sample of 250 claims from the population of 121,315 claims; and,
- estimated the overpayment paid in the population of 121,315 claims.

Documentation Reviewed

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

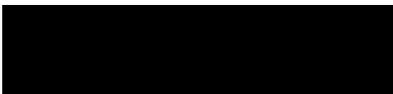
The documents collected were analyzed to identify any billing irregularities or deviations from Medicaid laws and regulations, and the Provider agreement. These documents included Prescriber Fiscal Orders/Prescriptions, delivery receipts, accounting records and patient information status.

The claims universe was focused on identifying paid claims for diabetic test strips.

The Provider’s response to the Draft Audit Report, dated May 15, 2015, 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 the Overpayments Section of this report.

Audit Staff:

The following staff conducted this audit:



LAWS, REGULATIONS, RULES AND POLICIES

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

- Departments of Health, Mental Hygiene and Social Services [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, Title 18 NYCRR Section 540.6.
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department." *18 NYCRR Section 504.3*

Regulations state: "Fee-for-service providers. (1) All providers . . . must prepare and maintain contemporaneous records demonstrating their right to receive payment . . . All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor . . . must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department . . . for audit and review." *18 NYCRR Section 517.3(b)*

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

be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided.

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

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

18 NYCRR Section 518.1(c)

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

18 NYCRR Section 540.1

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

18 NYCRR Section 518.3(a)

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

18 NYCRR Section 518.3(b)

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

18 NYCRR Section 518.3(b)

AUDIT FINDINGS

The following detailed findings reflect the results of the audit:

1. 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)

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

18 NYCRR Section 504.3(f) and (h)

In 15 instances the item billed was in excess of quantity ordered.

2. Missing Documentation Confirming Receipt/Delivery of Prescription/Fiscal Order

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: "Audit and record retention. (a) Cost-based provider. (1) All fiscal and statistical records and reports of providers which are used for the purpose of establishing rates of payment made in accordance with the medical assistance program and all underlying books, records, documentation and reports which formed the basis for such fiscal and statistical records and reports are subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports filed by a provider with any State agency responsible for the establishment of rates of payment or fees must be kept and maintained by the provider for a period of not less than six years from the date of

filing of such reports, or the date upon which the fiscal and statistical records were required to be filed, or two years from the end of the last calendar year during any part of which a provider's rate or fee was based on the fiscal or statistical reports, whichever is later. In this respect, any rate of payment certified or established by the commissioner of the Department of Health or other official or agency responsible for establishing such rates will be construed to represent a provisional rate until an audit is performed and completed, or the period within which to conduct an audit has expired without such audit having been begun or notice of such audit having been issued, at which time such rate or adjusted rate will be construed to represent the final rate as to those items audited."

18 NYCRR Section 517.3(a)(1)

Regulations state: (2) "All required fiscal and statistical reports are subject to audit for a period of six years from the date of their filing or from the date when such reports were required to be filed, whichever is later. This limitation does not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this Part. Where reports and documentation have been submitted pursuant to a rate appeal of a provisional rate, such reports and documentation will likewise be subject to audit for a period of six years from the submission of material in support of such appeal or two years following certification of any revised rate resulting from such appeal, whichever is later."

18 NYCRR Section 517.3(a)(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)(1)

Regulations state: "(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, 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(b)(2)

Medicaid policy states: "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, Section I, Versions 2004-1, 2009-2*

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)

Regulations state that by enrolling, the provider agrees “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;”

18 NYCRR Section 504.3(e)

Regulations state that by enrolling, the provider agrees “to comply with the rules, regulations and official directives of the department.”

18 NYCRR Section 504.3(i)

In 7 instances, the records provided did not contain delivery receipts for the items billed. (The Provider used a delivery service (UPS and others, for example) to ship the items involved to Medicaid recipients.)

3. Missing Fiscal 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)

Medicaid policy states: “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, Section III, Versions 2004-1, 2009-2*

In 5 instances, there was no written order.

4. Ordering Prescriber Conflicts with Claim Prescriber

Regulations state: “By enrolling the provider agrees...to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission” and “that the information provided in relation to any claim for payment shall be true, accurate and complete.”

18 NYCRR Sections 504.3(f) and (h)

Regulations state: “The identity of the practitioner who ordered the durable medical equipment, medical/surgical supply, prosthetic or orthotic appliance or device, or orthopedic footwear 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 Sections 505.5(c) (1)

Medicaid policy states: “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 (or State Certification 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. Please refer to Appendix A – Codes for the Post Office state abbreviations.

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
Versions 2004-1 and 2009-1, Section II*

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 5 instances, the ordering prescriber conflicted with the claim prescriber.

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

5. Telephone or Fax Order Lacks Signed Follow Up Order

Medicaid policy states: “The maintenance and furnishing of information relative to care included on a Medicaid claim is a basic condition for participation in the Program. For auditing purposes, records on recipients must be maintained and be available to authorized Medicaid officials for six years following the date of payment. Failure to conform with these requirements may affect payment and may jeopardize a provider's eligibility to continue as a Medicaid participant.”

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

Medicaid policy states: “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, Versions 2009-2, Section I*

In 2 instances, there was no follow-up hard copy order for medical supplies.

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

(1) The MA program will pay the full amount of such deductible and coinsurance costs for care, services or supplies included in the MA program and for care, services or supplies that are included in the MA program.

(2) The MA program will pay the full amount of such deductible and coinsurance costs for qualified Medicare beneficiaries who are otherwise eligible for MA and for qualified Medicare beneficiaries who are not otherwise eligible for MA.”

18 NYCRR Section 360-7.7(a)

Medicaid policy states: “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*

Medicaid policy states: “Reimbursement amounts are payment in full. Pricing is based on line item invoices. No separate or additional payments will be made for shipping, handling, delivery, or necessary fittings and adjustments. Any insurance payments including Medicare must be collected prior to billing Medicaid and must be applied against the total price of the item. Payment will not be made for items provided by a facility or organization when the cost of these items is included in the facility's Medicaid rate, per Department regulation at Title 18 NYCRR 505.5 (d) (1) (iii). It is the dispensing provider's responsibility to verify with the facility whether the item is included in the facility's Medicaid rate.”

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

In 2 instances, Medicaid paid incorrectly for Medicare eligible patients. In 1 instance (Sample #18), Medicaid paid the full amount though the Medicare remittance statement showed that Medicare had denied the claim and the provider submitted no documentation to show that Medicare was re-billed prior to billing Medicaid. In another instance (Sample #27), Medicaid paid a higher amount than the Medicare co-insurance indicated on the Medicare remittance statement.

7. Other Insurance Payments Not Applied

Regulations state: “MA program as payment source of last resort. Where a third party, such as a health insurer or responsible person, has a legal liability to pay for MA-covered services on behalf of a recipient, the department or social services district will pay only the amount by which the MA reimbursement rate for the services exceeds the amount of the third party liability. The department or social services district will also pay if the third party payment will not be made within a reasonable time. The department or social services district will seek reimbursement for any payments for care and services it makes for which a third party is legally responsible. They will seek reimbursement to the extent of the third party's legal

liability unless the amount reasonably expected to be recovered is less than the cost of making the recovery.”

18 NYCRR Section 360-7.2

Regulations state: “Any insurance payments including Medicare must be applied against the total purchase price of the item.”

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

In 1 instance, the patient had Tricare Champus insurance, but the Provider gave no documentation to indicate that the Tricare Champus was billed prior to billing Medicaid.

8. No Explanation of Benefits (EOB) / Documentation for Medicare Covered Item

Medicaid policy states: “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*

Medicaid policy states: “Reimbursement amounts are payment in full. Pricing is based on line item invoices. No separate or additional payments will be made for shipping, handling, delivery, or necessary fittings and adjustments. Any insurance payments including Medicare must be collected prior to billing Medicaid and must be applied against the total price of the item. Payment will not be made for items provided by a facility or organization when the cost of these items is included in the facility's Medicaid rate, per Department regulation at Title 18 NYCRR 505.5 (d) (1) (iii). It is the dispensing provider's responsibility to verify with the facility whether the item is included in the facility's Medicaid rate.”

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

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.

NYS Medicaid Update December, 2005 (Vol. 20, No. 13)

In 1 instance, the Medicare EOB was not in the record of the patient who had Medicare coverage and Medicaid was billed prior to billing Medicare.

9. No Documentation of Service

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(b)

Medicaid policy states: “To permit audits of all books and records or a sample thereof relating to services furnished and payments received under the Medicaid Program.”

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

Medicaid policy states: "Federal Law and State Regulations require providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to Medicaid enrollees. Providers must furnish information regarding any payment claim to authorized officials upon request of the DOH or the LDSS.

For medical facilities subject to inspection and licensing requirements provided in Article 28 of the Public Health Law, the State Hospital Code contains specific details concerning content and maintenance of medical records. Practitioners providing diagnostic and treatment services must keep medical records on each enrollee to whom care is rendered. At a minimum, the contents of the enrollee's hospital record should include:

- enrollee information (name, sex, age, etc.);
- conditions or reasons for which care is provided;
- nature and extent of services provided;
- type of services ordered or recommended for the enrollee to be provided by another practitioner or facility;
- the dates of service provided and ordered.

The maintenance and furnishing of information relative to care included on a Medicaid claim is a basic condition for participation in the Program.

For auditing purposes, records on enrollees must be maintained and be available to authorized Medicaid officials for six years following the date of payment. Failure to conform to these requirements may affect payment and may jeopardize a provider's eligibility to continue as a Medicaid participant."

*NYS Medicaid Program Provider Manual Information for all Providers
General Policy, Version 2008-2, Section II*

In 1 instance, there was no documentation of service. (*The Provider only submitted patient intake information.*)

10. Refilled Supplies Without Patient Authorization

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: "The beneficiary or representative must request each refill because their medical condition and/or living situation may change over the course of the fiscal order. Examples of medical-surgical supplies include: diabetic supplies, enteral formulas, incontinence products and wound dressings."

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

In 1 instance, the Provider refilled supplies beyond the patient's needs in that the Provider refilled the prescription though the patient said the refill was not required.

OVERPAYMENTS

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2009, through December 31, 2011 identified 37 claims with at least one error, for a total sample overpayment of \$4,357.50 (Appendix A). The extrapolated adjusted point estimate overpayment is \$939,323 and the adjusted lower confidence limit overpayment of \$604,499. The Provider's response to the Draft Audit Report, dated May 14, 2015, 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 the Audit Findings section of this report.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the adjusted lower confidence limit amount of \$604,499, 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 #13-1941
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 \$939,323. 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

[REDACTED]
Neighborhood Diabetes
600 Technology Park Drive, Suite 201
Billerica, Massachusetts 01821-4127

PROVIDER ID # [REDACTED]

AUDIT #13-1940

AMOUNT DUE: \$604,499

AUDIT	<input checked="" type="checkbox"/>	PROVIDER
	<input type="checkbox"/>	RATE
	<input type="checkbox"/>	PART B
TYPE	<input type="checkbox"/>	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
GNARESP Corning Tower, Room 2739
File #13-1940
Albany, New York 12237

Thank you for your cooperation.

APPENDIX A
 Findings for Each Sample Item

Sample #	Date of Service	Date of Payment	Qty	Procedure Code	Amount Paid	Corrected Amount	Recoupment Amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	Errors										
											1. Item Billed in Excess of Quantity Ordered*	2. Missing Documentation Confirming Receipt/Delivery of Prescription/Fiscal Order	3. Missing Fiscal Order	4. Ordering Prescriber Conflicts with Claim Prescriber **	5. Telephone or Fax Order Lacks Signed Follow Up Order	6. Improper Medicaid Billing for Medicare Crossover Patients	7. Other Insurance Payments Not Applied	8. No Explanation of Benefits (EOB) / Documentation for Medicare Covered Item	9. No Documentation of Service	10. Refilled Supplies Without Patient Authorization	
206	02/16/11	02/28/11	100	A4253	\$ 59.03	\$ -	\$ 59.03	2011	58.77%	\$ 34.69											X
208	01/26/09	02/02/09	2	A4253	\$ 78.76	\$ 39.38	\$ 39.38	2009	58.78%	\$ 23.15	X										
211	01/10/09	06/22/09	2	A4253	\$ 45.74	\$ -	\$ 45.74	2009	60.19%	\$ 27.53		X									
213	11/26/10	12/06/10	100	A4253	\$ 59.02	\$ -	\$ 59.02	2011	61.59%	\$ 36.35		X									
232	07/13/10	09/20/10	50	A4253	\$ 29.51	\$ -	\$ 29.51	2010	61.59%	\$ 18.18					X						
235	12/04/10	02/07/11	50	A4253	\$ 29.51	\$ -	\$ 29.51	2011	58.77%	\$ 17.34			X								
242	07/09/08	04/27/09	2	A4253	\$ 13.78	\$ -	\$ 13.78	2009	60.19%	\$ 8.29			X								
							\$ 4,357.50				\$ 2,602.31	15	7	5	5	2	2	1	1	1	1

Federal FY	Federal Share
2009	\$ 1,239.35
2010	\$ 633.58
2011	\$ 60.34
2012	\$ 669.05
Total	\$ 2,602.31

**The Extrapolated Federal Share is \$359,611.76

*If this is the only error for the claim, the recoupment amount is the amount paid for the excess quantity billed.

**If this is the only error for the claim, the recoupment amount is not extrapolated in the Draft Audit Report.

Appendix B Sample Design

The sample design used for Audit #13-1940 was as follows:

- Universe - Medicaid claims for diabetic test strip supplies paid during the period January 1, 2009, through December 31, 2011.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for diabetic test strip supplies paid during the period January 1, 2009, through December 31, 2011.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2010, through December 31, 2012.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 250 claims.

Appendix C
Extrapolation of Sample Findings

Total Sample Recoupment	\$ 4,357.50
Less Recoupments Not Projected*	<u>(821.57)</u>
Sample Recoupment for Extrapolation Purposes	\$ 3,535.93
Services in Sample	250
Overpayments Per Sample Case	\$ 14.14
Services in Universe	121,315
Mean Point Estimate	\$ 938,501
Add Overpayments Not Projected*	<u>822</u>
Adjusted Mean Point Estimate	<u>\$ 939,323</u>
Lower Confidence Limit	\$ 603,678
Add Overpayments Not Projected*	<u>822</u>
Adjusted Lower Confidence Limit	<u>\$ 604,499</u>

* The actual dollar disallowance for the "**Ordering Prescriber Conflicts with Claim Prescriber**" finding was subtracted from the total sample overpayment and added to the Meanpoint Estimate and the Lower Confidence Limit. The dollars associated with this finding were not used in the extrapolation.