



**Office of the
Medicaid Inspector
General**

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

**REVIEW OF ECKERD CORPORATION RITE AID 10826
CLAIMS FOR DIABETIC TEST STRIP SUPPLIES
PAID FROM
JANUARY 1, 2009 – DECEMBER 31, 2011**

**FINAL AUDIT REPORT
OMIG AUDIT #: 13-1941
CMS AUDIT #: 1-17775565**

**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]
Rite Aid of New York, Inc.
200 Newberry Commons
Etters, Pennsylvania 17319-9363

Re: Final Audit Report
OMIG Audit #: 13-1941
CMS Audit #: 1-17775565
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 Eckerd Corporation Rite Aid 10826 (Provider) between January 1, 2009, and December 31, 2011. IPRO issued a draft audit report to the Provider on March 13, 2015.

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

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

The OMIG has attached the sample detail for the paid claims determined to be in error. This final audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report. The adjusted mean point estimate overpaid is \$45,845. The adjusted lower confidence limit of the amount overpaid is \$32,564. 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 \$32,564.

[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 13-1941 in all correspondence.

Sincerely,

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

[REDACTED]
Enclosure

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

[REDACTED]

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INTRODUCTION

BACKGROUND

Medicaid Program

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

New York State's Medicaid Program

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

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

New York State's Pharmacy Program

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

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

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

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

Scope

The audit period covered payments to the Provider for diabetic test strip supply claims paid by Medicaid from January 1, 2009, through December 31, 2011. The audit universe consisted of 2,628 cases with a total Medicaid payment of \$265,129.82.

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 \$21,969.50 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 66 noncompliant claims, some claims contained more than one deficiency. Specifics are as follows:

| <u>Error Description</u> | <u>Number of Errors</u> |
|---|-------------------------|
| No Explanation of Benefits (EOB) for Medicare Covered Items | 45 |
| Missing Follow-Up Hard Copy Order for Medical Supplies | 12 |
| Pharmacy Billed in Excess of Prescribed Quantity | 10 |
| Missing Information From Prescription/Fiscal Order | 6 |
| Prescriber's Signature Missing on Prescription/Fiscal Order | 3 |
| Other Insurance Payment Not Applied | 1 |

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$4,924.45 in sample overpayments with an extrapolated adjusted point estimate of \$45,845. The adjusted lower confidence limit of the amount overpaid is \$32,564.

Methodology

To accomplish the objective, IPRO:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with the Provider's management personnel to gain an understanding of the diabetic test strip supply program;
- ran computer programming application of claims in the Medicaid data warehouse that identified 2,628 paid diabetic test strip supply claims, totaling \$265,129.82;
- selected a random sample of 250 claims from the population of 2,628 claims; and,
- estimated the overpayment paid in the population of 2,628 claims.

Documentation Reviewed

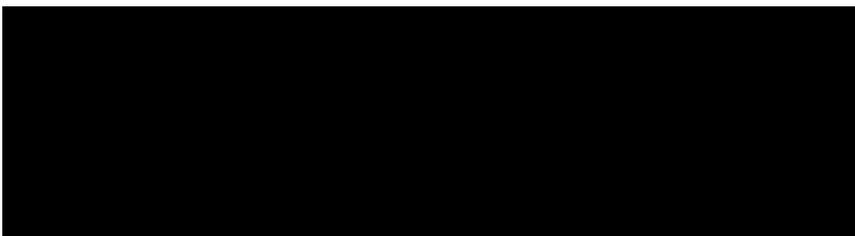
Documentation and records to support services reimbursed by the New York State Department of Health were copied and reviewed on-site at the Provider's facility. No original records were removed from the Provider's premises. During the on-site review, the Provider was asked to provide the additional documents necessary to complete the audit, which were not located during the on-site review. These records were delivered by Eckerd Corporation Rite Aid # 10826 to IPRO's Albany 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 fiscal orders/prescriptions, and individual patient history files. The claims universe was focused on identifying paid claims for diabetic test strips.

The Provider's response to the Draft Audit Report, dated April 20, 2015, was considered in the preparation of the Final Audit Report and resulted in changes to the findings. Two findings for "Prescriber's Signature Missing on Prescription/Fiscal Order" were reversed. In addition, documentation was provided for two claims categorized as "Missing Fiscal Order" and as result of IPRO's review one was reclassified as "Missing Follow up Hard Copy for Medical Supplies" and the second was reclassified as "Pharmacy Billed in Excess of Prescribed Quantity" and was repriced accordingly. The results are contained in the Overpayments Section of this report.

Audit Staff:

The following staff conducted this audit:



LAWS, REGULATIONS, RULES AND POLICIES

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

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

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

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

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

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

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

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

18 NYCRR Section 518.1(c)

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

18 NYCRR Section 540.1

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

18 NYCRR Section 518.3(a)

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

18 NYCRR Section 518.3(b)

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

18 NYCRR Section 518.3(b)

AUDIT FINDINGS

A review of the 250 claims revealed 66 claims with overpayments. Detailed information regarding overpayments on the sampled claims is located in Appendix A.

The following detailed findings reflect the results of the audit:

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

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

18 NYCRR Section 360-7.2

Regulations state: "The 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)".

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

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

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

NYS Medicaid Program Pharmacy Manual

Policy Guidelines, Version 2008-1, 2009-1, 2010-1, 2010-2 and 2011-1, Section I

Medicaid Policy states: "Utilization of Insurance Benefits-The Medicaid Program is designed to provide payment for medical care and services only after all other resources available for payments have been exhausted; Medicaid is the payer of last resort.....Medicaid requires providers to exhaust all existing benefits prior to the billing of the Medicaid Program. If an enrollee has third-party insurance coverage, he/she **must** inform the LDSS of that coverage and to use its benefits to the fullest extent before using Medicaid. Supplementary payments may be made by Medicaid when appropriate."

NYS Medicaid Program, Information for all Providers

General Policy, Version 2008-2, 2010-1, 2010-2, 2011-1 & 2011-2, Section I

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

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

The Medicaid program is designed to provide payment for medical care and services only after all other resources available for payments have been exhausted; Medicaid is always

payor of last resort. Providers must maximize all applicable insurance sources before submitting claims to Medicaid. When coverage is available, payment from other insurance sources must be received before submitting a Medicaid claim.

- If the service is covered, or the provider does not know if the service is covered by Medicare and/or other available insurance, the provider must first submit a claim to Medicare and/or other insurer.
- Only when you are certain that Medicare or another insurer does not cover the service, can you bill Medicaid solely, and not bill other insurer first.

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

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

In 45 instances, Medicare EOBs were not in the records of patients who had Medicare coverage and Medicaid was billed prior to billing Medicare.

2. Missing Follow-Up Hard Copy Order For Medical Supplies

Regulations state: “Medical/surgical supplies means items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment, or orthopedic footwear which have been ordered by a practitioner in the treatment of a specific medical condition and which are usually: (i) consumable; (ii) non-reusable; (iii) disposable; (iv) for a specific rather than incidental purpose; and (v) generally have no salvageable value.”

18 NYCRR Section 505.5(a)(2)

Regulations state: “The term written order or fiscal order are used interchangeably in this section and mean any original, signed written order of a practitioner which requests durable medical equipment, prosthetic or orthotic appliances and devices, medical/surgical supplies, or orthopedic footwear.”

18 NYCRR Section 505.5(a)(8)

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

18 NYCRR Section 505.5(b)(1)

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

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

In 12 instances, a signed written order from the ordering practitioner, as a follow-up to a telephone or fax order was not obtained by the Provider.

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

3. Pharmacy Billed in Excess of Prescribed Quantity

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

18 NYCRR Sections 504.3(f) and (h)

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

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

In 10 instances, the pharmacy billed in excess of the quantity ordered by the ordering practitioner.

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

4. Missing Information From Prescription/Fiscal Order

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

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

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

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

In 6 instances, the written order did not have the minimum information required; the quantity of the diabetic test strip prescribed was missing.

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

5. Prescriber's Signature Missing on Prescription/Fiscal Order

Regulations state: "The term written order or fiscal order are used interchangeably in this section and mean any original, signed written order of a practitioner which requests durable medical equipment, prosthetic or orthotic appliances and devices, medical/surgical supplies, or orthopedic footwear."

18 NYCRR Section 505.5(a)(8)

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

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

In 3 instances, the prescriber's signature was missing on the prescription/fiscal order.

6. Other Insurance Payment 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, other insurance payment was not applied and the Provider billed Medicaid as primary.

OVERPAYMENTS

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2009, through December 31, 2011, identified 66 claims with at least one error, for a total sample overpayment of \$4,924.45 (Appendix A). The extrapolated adjusted point estimate overpayment is \$45,845 and the lower confidence limit overpayment of \$32,564. This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated March 13, 2015. The information provided resulted in no change to any of the disallowances. The findings in the Final Audit Report are identical to those in the Draft Audit 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 \$32,564, 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 \$45,845. 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

██████████
Rite Aid of New York, Inc.
200 Newberry Commons
Etters, Pennsylvania 17319-9363

PROVIDER ID # ██████████

AUDIT #13-1941

AUDIT
TYPE

PROVIDER
 RATE
 PART B
 OTHER:

AMOUNT DUE: \$32,564

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 #13-1941
Albany, New York 12237

Thank you for your cooperation.

Appendix A Findings for Each Sample Item

| Sample # | Date of Service | Date of Payment | Proc Code | Qty | RX | Amount Paid | Corrected Amount | Recoupment Amount | Federal Fiscal Year | Federal Share % | Federal Share Amount | Error Codes | | | | | |
|----------|-----------------|-----------------|-------------|-----|--------|-------------|------------------|-------------------|---------------------|-----------------|----------------------|---|---|--|---|--|--|
| | | | | | | | | | | | | 1. No Explanation of Benefits (EOB) for Medicare Covered Item | 2. Missing Follow up Hard Copy Order for Medical Supplies** | 3. Pharmacy Billed in Excess of Prescribed Quantity* | 4. Missing Information From Prescription/Fiscal Order | 5. Prescriber's Signature Missing on Prescription/Fiscal Order/No Signature on Written Order | 6. Other Insurance Payment Not Applied |
| 1 | 10/06/10 | 10/11/10 | 53885024510 | 200 | 225834 | \$ 214.82 | \$ - | \$ 214.82 | 2011 | 61.59% | \$ 132.31 | X | | | | | |
| 6 | 11/22/11 | 11/28/11 | 99073070827 | 200 | 295185 | \$ 222.72 | \$ - | \$ 222.72 | 2012 | 50.00% | \$ 111.36 | X | | X | | | |
| 10 | 01/20/10 | 01/25/10 | 99073070827 | 200 | 164918 | \$ 206.24 | \$ - | \$ 206.24 | 2010 | 61.59% | \$ 127.02 | X | | | | | |
| 19 | 01/11/11 | 01/17/11 | 53885024510 | 200 | 225834 | \$ 214.82 | \$ - | \$ 214.82 | 2011 | 58.77% | \$ 126.25 | X | | | | | |
| 24 | 03/22/10 | 03/29/10 | 193708050 | 200 | 158486 | \$ 218.46 | \$ 163.85 | \$ 54.62 | 2010 | 61.59% | \$ 33.64 | | | X | | | |
| 29 | 03/24/10 | 03/29/10 | 99073070827 | 200 | 166279 | \$ 215.31 | \$ 161.48 | \$ 53.83 | 2010 | 61.59% | \$ 33.15 | | | X | | | |
| 31 | 05/04/10 | 05/10/10 | 50924038110 | 100 | 189267 | \$ 111.10 | \$ 55.55 | \$ 55.55 | 2010 | 61.59% | \$ 34.21 | | | X | | | |
| 35 | 10/01/10 | 10/11/10 | 99073070827 | 100 | 215978 | \$ 106.66 | \$ - | \$ 106.66 | 2011 | 61.59% | \$ 65.69 | | X | | | | |
| 37 | 12/28/09 | 01/04/10 | 99073070827 | 100 | 152508 | \$ 102.62 | \$ - | \$ 102.62 | 2010 | 61.59% | \$ 63.20 | X | | | | | |
| 38 | 10/26/09 | 11/02/09 | 50924088401 | 102 | 144522 | \$ 100.21 | \$ 50.11 | \$ 50.11 | 2010 | 61.59% | \$ 30.86 | | | X | | | |
| 39 | 02/05/10 | 02/15/10 | 50924088401 | 102 | 137726 | \$ 105.71 | \$ - | \$ 105.71 | 2010 | 61.59% | \$ 65.11 | X | | | | | |
| 44 | 04/25/11 | 05/02/11 | 53885024510 | 100 | 234085 | \$ 112.30 | \$ - | \$ 112.30 | 2011 | 56.88% | \$ 63.88 | | X | | | | |
| 49 | 12/10/10 | 12/20/10 | 53885024510 | 100 | 227095 | \$ 106.91 | \$ - | \$ 106.91 | 2011 | 61.59% | \$ 65.85 | X | | | | | |
| 56 | 11/25/09 | 11/30/09 | 99073070827 | 100 | 152508 | \$ 102.62 | \$ - | \$ 102.62 | 2010 | 61.59% | \$ 63.20 | X | | | | | |
| 62 | 07/27/10 | 08/02/10 | 50924088401 | 102 | 180286 | \$ 104.71 | \$ - | \$ 104.71 | 2010 | 61.59% | \$ 64.49 | | X | | | | |
| 65 | 10/06/09 | 10/12/09 | 65702010410 | 100 | 139776 | \$ 99.21 | \$ - | \$ 99.21 | 2010 | 61.59% | \$ 61.10 | X | | | | | |
| 75 | 03/30/10 | 04/05/10 | 99073070827 | 100 | 148729 | \$ 106.66 | \$ - | \$ 106.66 | 2010 | 61.59% | \$ 65.69 | X | | | | | |
| 79 | 11/13/10 | 11/22/10 | 99073070827 | 100 | 235635 | \$ 106.66 | \$ - | \$ 106.66 | 2011 | 61.59% | \$ 65.69 | X | | | | | |
| 88 | 06/23/11 | 07/04/11 | 53885024510 | 100 | 289171 | \$ 112.30 | \$ 56.15 | \$ 56.15 | 2011 | 50.00% | \$ 28.08 | | | X | | | |
| 91 | 10/06/10 | 10/18/10 | 53885024510 | 100 | 225942 | \$ 106.91 | \$ - | \$ 106.91 | 2011 | 61.59% | \$ 65.85 | X | | | | | |
| 101 | 04/16/09 | 04/27/09 | A4253 | 100 | 76844 | \$ 77.58 | \$ - | \$ 77.58 | 2009 | 60.19% | \$ 46.70 | X | | | | | |
| 103 | 12/07/09 | 12/14/09 | 53885024450 | 50 | 154861 | \$ 50.43 | \$ - | \$ 50.43 | 2010 | 61.59% | \$ 31.06 | X | | | | | |
| 104 | 03/17/09 | 03/23/09 | A4253 | 100 | 73118 | \$ 38.38 | \$ - | \$ 38.38 | 2009 | 58.78% | \$ 22.56 | X | X | | | | |
| 106 | 02/02/09 | 02/09/09 | A4253 | 100 | 76844 | \$ 39.38 | \$ - | \$ 39.38 | 2009 | 58.78% | \$ 23.15 | X | | | | | |
| 117 | 01/11/09 | 01/19/09 | A4253 | 100 | 60014 | \$ 38.38 | \$ - | \$ 38.38 | 2009 | 58.78% | \$ 22.56 | X | | | | | |
| 118 | 09/14/09 | 09/21/09 | A4253 | 100 | 134284 | \$ 37.79 | \$ - | \$ 37.79 | 2009 | 61.59% | \$ 23.27 | X | | | | | X |

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

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

Appendix A Findings for Each Sample Item

| Sample # | Date of Service | Date of Payment | Proc Code | Qty | RX | Amount Paid | Corrected Amount | Recoupment Amount | Federal Fiscal Year | Federal Share % | Federal Share Amount | Error Codes | | | | | |
|----------|-----------------|-----------------|-------------|-----|--------|-------------|------------------|-------------------|---------------------|-----------------|----------------------|---|---|--|---|--|--|
| | | | | | | | | | | | | 1. No Explanation of Benefits (EOB) for Medicare Covered Item | 2. Missing Follow up Hard Copy Order for Medical Supplies** | 3. Pharmacy Billed in Excess of Prescribed Quantity* | 4. Missing Information From Prescription/Fiscal Order | 5. Prescriber's Signature Missing on Prescription/Fiscal Order/No Signature on Written Order | 6. Other Insurance Payment Not Applied |
| 123 | 07/26/09 | 08/03/09 | A4253 | 100 | 123685 | \$ 38.79 | \$ 19.40 | \$ 19.40 | 2009 | 61.59% | \$ 11.95 | | | X | | | |
| 124 | 07/15/09 | 07/20/09 | A4253 | 100 | 121302 | \$ 37.79 | \$ - | \$ 37.79 | 2009 | 61.59% | \$ 23.27 | X | | | | | |
| 125 | 04/01/09 | 04/06/09 | A4253 | 100 | 80526 | \$ 76.58 | \$ - | \$ 76.58 | 2009 | 60.19% | \$ 46.09 | X | | | | | |
| 128 | 12/08/10 | 12/13/10 | 99073070822 | 50 | 241564 | \$ 59.34 | \$ - | \$ 59.34 | 2011 | 61.59% | \$ 36.55 | X | | | | | |
| 133 | 07/22/09 | 07/27/09 | A4253 | 102 | 114379 | \$ 76.58 | \$ - | \$ 76.58 | 2009 | 61.59% | \$ 47.17 | | X | | | | |
| 138 | 03/24/09 | 03/30/09 | A4253 | 200 | 94923 | \$ 78.76 | \$ - | \$ 78.76 | 2009 | 58.78% | \$ 46.30 | | X | | | | |
| 141 | 08/14/09 | 08/24/09 | A4253 | 200 | 127752 | \$ 76.58 | \$ 57.44 | \$ 19.15 | 2009 | 61.59% | \$ 11.79 | | | X | | | |
| 143 | 08/06/09 | 08/17/09 | A4253 | 100 | 125984 | \$ 37.79 | \$ - | \$ 37.79 | 2009 | 61.59% | \$ 23.27 | X | X | | | | |
| 144 | 01/06/09 | 01/12/09 | A4253 | 102 | 69288 | \$ 77.76 | \$ - | \$ 77.76 | 2009 | 58.78% | \$ 45.71 | X | | | | X | |
| 147 | 05/30/09 | 06/08/09 | A4253 | 100 | 87642 | \$ 76.58 | \$ 19.14 | \$ 57.44 | 2009 | 60.19% | \$ 34.57 | | | | X | | |
| 149 | 09/22/11 | 10/03/11 | 53885024450 | 50 | 311158 | \$ 55.65 | \$ - | \$ 55.65 | 2012 | 50.00% | \$ 27.83 | X | | | | | |
| 153 | 04/06/09 | 04/13/09 | A4253 | 102 | 62631 | \$ 76.58 | \$ - | \$ 76.58 | 2009 | 60.19% | \$ 46.09 | X | | | | | |
| 156 | 01/26/09 | 02/02/09 | A4253 | 100 | 69028 | \$ 77.76 | \$ - | \$ 77.76 | 2009 | 58.78% | \$ 45.71 | | | | | | X |
| 161 | 06/09/09 | 06/15/09 | A4253 | 102 | 105144 | \$ 76.58 | \$ 38.29 | \$ 38.29 | 2009 | 60.19% | \$ 23.05 | | | | X | | |
| 165 | 11/19/10 | 11/29/10 | 99073070822 | 50 | 237130 | \$ 59.34 | \$ - | \$ 59.34 | 2011 | 61.59% | \$ 36.55 | | X | | | | |
| 166 | 11/18/09 | 11/23/09 | 56151081001 | 100 | 119990 | \$ 40.70 | \$ - | \$ 40.70 | 2010 | 61.59% | \$ 25.07 | X | | | | | |
| 167 | 01/08/09 | 01/19/09 | A4253 | 102 | 62631 | \$ 78.76 | \$ - | \$ 78.76 | 2009 | 58.78% | \$ 46.30 | X | | | | | |
| 172 | 06/09/09 | 06/15/09 | A4253 | 100 | 113074 | \$ 76.58 | \$ - | \$ 76.58 | 2009 | 60.19% | \$ 46.09 | X | | | | | |
| 179 | 12/10/09 | 12/21/09 | 53885024450 | 50 | 155688 | \$ 50.43 | \$ - | \$ 50.43 | 2010 | 61.59% | \$ 31.06 | X | | | | | |
| 180 | 07/16/09 | 07/27/09 | A4253 | 102 | 112341 | \$ 37.79 | \$ 18.89 | \$ 18.90 | 2009 | 61.59% | \$ 11.64 | | | | X | | |
| 181 | 09/24/09 | 10/05/09 | A4253 | 100 | 130077 | \$ 76.58 | \$ - | \$ 76.58 | 2010 | 61.59% | \$ 47.17 | X | | | | | |
| 184 | 07/17/09 | 07/27/09 | A4253 | 100 | 107359 | \$ 37.79 | \$ - | \$ 37.79 | 2009 | 61.59% | \$ 23.27 | X | | | | | |
| 189 | 02/11/09 | 02/16/09 | A4253 | 100 | 62455 | \$ 38.38 | \$ - | \$ 38.38 | 2009 | 58.78% | \$ 22.56 | X | | | | | |
| 195 | 08/17/09 | 08/24/09 | A4253 | 100 | 127779 | \$ 76.58 | \$ 38.29 | \$ 38.29 | 2009 | 61.59% | \$ 23.58 | | | | X | | |
| 199 | 02/20/09 | 03/02/09 | A4253 | 100 | 87315 | \$ 38.38 | \$ - | \$ 38.38 | 2009 | 58.78% | \$ 22.56 | X | | | | | |
| 207 | 01/05/11 | 01/17/11 | 99073070822 | 50 | 241564 | \$ 61.69 | \$ - | \$ 61.69 | 2011 | 58.77% | \$ 36.26 | X | | | | | |

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

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

Appendix A Findings for Each Sample Item

| Sample # | Date of Service | Date of Payment | Proc Code | Qty | RX | Amount Paid | Corrected Amount | Recoupment Amount | Federal Fiscal Year | Federal Share % | Federal Share Amount | Error Codes | | | | | | |
|----------|-----------------|-----------------|-------------|-----|--------|-------------|------------------|-------------------|---------------------|-----------------|----------------------|---|---|--|---|--|--|---|
| | | | | | | | | | | | | 1. No Explanation of Benefits (EOB) for Medicare Covered Item | 2. Missing Follow up Hard Copy Order for Medical Supplies** | 3. Pharmacy Billed in Excess of Prescribed Quantity* | 4. Missing Information From Prescription/Fiscal Order | 5. Prescriber's Signature Missing on Prescription/Fiscal Order/No Signature on Written Order | 6. Other Insurance Payment Not Applied | |
| 212 | 06/19/09 | 06/29/09 | A4253 | 100 | 115611 | \$ 76.58 | \$ - | \$ 76.58 | 2009 | 60.19% | \$ 46.09 | X | | | | X | | |
| 221 | 02/17/09 | 02/23/09 | A4253 | 102 | 86540 | \$ 77.76 | \$ - | \$ 77.76 | 2009 | 58.78% | \$ 45.71 | | X | X | | | | |
| 227 | 04/19/09 | 04/27/09 | A4253 | 102 | 100957 | \$ 76.58 | \$ - | \$ 76.58 | 2009 | 60.19% | \$ 46.09 | X | | | | | | |
| 230 | 08/16/09 | 08/24/09 | A4253 | 100 | 127993 | \$ 77.58 | \$ - | \$ 77.58 | 2009 | 61.59% | \$ 47.78 | X | | | | | | |
| 231 | 04/20/09 | 04/27/09 | A4253 | 100 | 101300 | \$ 76.58 | \$ 19.14 | \$ 57.44 | 2009 | 60.19% | \$ 34.57 | | | | X | | | |
| 233 | 01/23/09 | 02/02/09 | A4253 | 100 | 80425 | \$ 77.76 | \$ - | \$ 77.76 | 2009 | 58.78% | \$ 45.71 | X | | | | | X | |
| 235 | 05/01/09 | 05/11/09 | A4253 | 102 | 82544 | \$ 76.58 | \$ - | \$ 76.58 | 2009 | 60.19% | \$ 46.09 | X | | | | | | |
| 236 | 03/15/09 | 03/23/09 | A4253 | 102 | 82544 | \$ 77.76 | \$ - | \$ 77.76 | 2009 | 58.78% | \$ 45.71 | X | | | | | | |
| 239 | 01/19/09 | 01/26/09 | A4253 | 100 | 79153 | \$ 77.76 | \$ - | \$ 77.76 | 2009 | 58.78% | \$ 45.71 | X | X | | | | | |
| 240 | 04/18/10 | 04/26/10 | 56151081001 | 100 | 165132 | \$ 40.70 | \$ - | \$ 40.70 | 2010 | 61.59% | \$ 25.07 | X | X | | | | | |
| 241 | 01/20/09 | 01/26/09 | A4253 | 100 | 59242 | \$ 38.38 | \$ - | \$ 38.38 | 2009 | 58.78% | \$ 22.56 | X | | | | | | |
| 245 | 09/19/09 | 09/28/09 | A4253 | 100 | 122218 | \$ 77.58 | \$ 38.79 | \$ 38.79 | 2009 | 61.59% | \$ 23.89 | | | X | | | | |
| 246 | 01/26/09 | 02/02/09 | A4253 | 100 | 80863 | \$ 77.76 | \$ - | \$ 77.76 | 2009 | 58.78% | \$ 45.71 | X | | | | | | |
| 247 | 04/13/09 | 04/20/09 | A4253 | 100 | 73118 | \$ 76.58 | \$ - | \$ 76.58 | 2009 | 60.19% | \$ 46.09 | X | X | | | | | |
| | | | | | | | | \$ 4,924.45 | | | | \$ 2,944.15 | 45 | 12 | 10 | 6 | 3 | 1 |

| Federal Share Summary* | |
|------------------------|----------------------------|
| Federal FY | Total Federal Share Amount |
| 2009 | \$ 1,280.93 |
| 2010 | \$ 801.11 |
| 2011 | \$ 722.93 |
| 2012 | \$ 139.19 |
| TOTAL | \$ 2,944.15 |

* The Extrapolated Federal Share is \$19,523.85

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

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

Appendix B Sample Design

The sample design used for Audit #13-1941 was as follows:

- Universe - Medicaid claims for diabetic test strip supplies paid during the period January 1, 2010, through December 31, 2012.
- 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, 2010, through December 31, 2012.
- 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 | \$ 4,924.45 |
| Less Recoupments Not Projected* | <u>(538.35)</u> |
| Sample Recoupment for Extrapolation Purposes | \$ 4,386.10 |
| Services in Sample | 250 |
| Overpayments Per Sample Case | \$ 17.54 |
| Services in Universe | 2,628 |
| Mean Point Estimate | \$ 45,307 |
| Add Overpayments Not Projected* | <u>538</u> |
| Adjusted Mean Point Estimate | <u>\$ 45,845</u> |
| Lower Confidence Limit | \$ 32,026 |
| Add Overpayments Not Projected* | <u>538</u> |
| Adjusted Lower Confidence Limit | <u>\$ 32,564</u> |

* The actual dollar disallowance for the "**Missing Follow-Up Hard Copy Order for Medical Supplies**" 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.