



**Office of the
Medicaid Inspector
General**

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

**REVIEW OF GREENBAUM'S PHARMACY, INC.
CLAIMS FOR DIABETIC TEST STRIP SUPPLIES
PAID FROM
JANUARY 1, 2009 – DECEMBER 31, 2011**

**FINAL AUDIT REPORT
OMIG AUDIT #: 13-1942
CMS AUDIT #: 1-17775714**

**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]
Greenbaum's Pharmacy, Inc.
42 Main Street
Monsey, New York 10952-3000

Re: Final Audit Report
OMIG Audit #: 13-1942
CMS Audit #: 1-17775714
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 Greenbaum Pharmacy, Inc. (Provider) between January 1, 2009, and December 31, 2011. IPRO issued a draft audit report to the Provider on February 20, 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 dated February 20, 2015. The adjusted mean point estimate overpaid is \$12,283. The adjusted lower confidence limit of the amount overpaid is \$4,537. 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 \$4,537.

[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 13-1942 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 1,842 claims with a total Medicaid payment of \$251,815.48.

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 185 claims with \$20,017.16 in Medicaid payments. Of the 185 claims in the random sample, 29 claims had at least one error and did not comply with state requirements. Of the 29 noncompliant claims, one claim contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Ordering Prescriber Conflicts with Claim Prescriber	23
No Explanation of Benefits (EOB)/Documentation for Medicare Covered Item	4
Other Insurance Payments Not Applied	3

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$3,448.85 in sample overpayments with an extrapolated adjusted point estimate of \$12,283. The adjusted lower confidence limit of the amount overpaid is \$4,537.

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 1,842 paid diabetic test strip supply claims, totaling \$251,815.48;
- selected a random sample of 185 claims from the population of 1,842 claims; and,
- estimated the overpayment paid in the population of 1,842 claims.

Documentation Reviewed:

Documentation and records to support services reimbursed by New York 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 provided during the on-site review. These records were delivered by Greenbaum 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, delivery receipts, accounting records and patient information status.

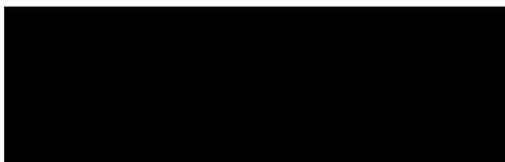
The claims universe was focused on identifying paid claims for diabetic test strips.

An exit conference was held with Greenbaum and its representatives on November 6, 2013. The Provider's response to the exit conference, dated November 21, 2013, was considered in the preparation of the Draft Audit Report. The Provider's response to the draft audit report, dated March 9, 2015, was considered in the preparation of the Final Audit Report but no adjustments were made to findings as the Provider's response did not specifically refute the findings. The results of the review are contained in Overpayments Section of this report.

This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated February 20, 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.

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. Ordering Prescriber Conflicts with Claim Prescriber

Medicaid policy states:

Prescriptions from Practitioners

Enter the Medicaid ID Number of the ordering/prescribing provider. If the orderer/prescriber is not enrolled in the Medicaid program, enter his/her License number.

Prescriptions from Facilities

For orders originating in a hospital, clinic, or other health care facility, the following rules apply: When a prescription is written by an unlicensed intern or resident, the supervising physician's Medicaid ID number or license number should be entered in this field. The facility's Medicaid ID number may be entered **only** when the prescriber's or the supervising physician's Medicaid ID or license number is unavailable. When prescriptions have been written by a Physician's Assistant, the supervising physician's Medicaid ID number or license number should be entered in this field. Licenses issued to Nurse Practitioners certified to write prescriptions have seven characters which includes the letter "F" followed by six digits.

Example: F012346. Certified Nurse Practitioners with licenses that contain six digits not preceded by the letter F can only write fiscal orders. If the prescribing provider is a Nurse Practitioner certified to write prescriptions, enter his/her Medicaid ID number or license number in this field. **Note: If the Medicaid ID or State License number of an authorized prescriber is not on the prescription, it is the pharmacist's responsibility to obtain it."**

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

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

Medicaid policy states:

Prescriptions from Practitioners

Enter the NPI of the ordering/prescribing provider

Prescriptions from Facilities

For orders originating in a hospital, clinic, or other health care facility, the following rules apply:

When a prescription is written by an unlicensed intern or resident, the supervising physician's NPI should be entered in this field.

*NYS Medicaid Program Pharmacy Manual
Billing Guidelines Version 2009-1, Section II*

Medicaid policy states:

Prescriptions from Practitioners

Enter the NPI of the ordering/prescribing provider.

Prescriptions from Facilities

For orders originating in a hospital, clinic, or other health care facility, the following rules apply:

When a prescription is written by an unlicensed intern or resident, the supervising physician's NPI should be entered in this field.

*NYS Electronic Medicaid System eMedNY 000301 Billing Guidelines
Pharmacy Version, 2010-1, Section 2.4.1*

Medicaid policy states:

For orders originating in a hospital, clinic, or other health care facility, the following rules apply:

When a prescription is written by an unlicensed intern or resident, the supervising physician's NPI should be entered in this field.

NYS eMedNY Billing Guidelines Pharmacy Version, 2011-1, Section 2.4.1

NYS Medicaid Update states:

Only the provider identification number, or license number and profession code, of the actual practitioner who is licensed to order, refer or prescribe should be entered as the ordering/referring/prescribing provider on a Medicaid claim.

*New York State Medicaid Update
January 2008 (Vol. 24, No. 1)*

Use the Correct Provider Identification Number on Medicaid Claims

NYS Medicaid Update states:

Beginning December 2, 2010, all pharmacy claims should include the Prescriber NPI in the Prescriber ID field (411-DB) and a "01" in the Provider ID Qualifier field (465-EY).

*New York State Medicaid Update
October 2010 (Vol. 26, No. 12)*

UPDATE: Prescriber's National Provider Identifier (NPI)

NYS Medicaid Update states:

All pharmacy claims should include the prescriber's NPI in the Prescriber ID field (NCPDP field 411-DB) and a "01" in the Prescriber ID Qualifier field (NCPDP field 466-EZ).

*New York State Medicaid Update November 2010 (Vol. 26, No. 13)
Additional Information/Reminder; Prescriber's Individual National Provider Identifier (NPI)
Required on All Pharmacy Claims Submissions*

In 23 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.

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

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 beneficiariesthe 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)

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 & 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, Version 2010-1, Version 2010-2, Version 2011-1, Version 2011-2*

NYS Medicaid Update states:

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

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

The Medicaid program is designed to provide payment for medical care and services only after all other resources available for payments have been exhausted; Medicaid is always payor of last resort. Providers must maximize all applicable insurance sources before submitting claims to Medicaid. When coverage is available, payment from other insurance sources must be received before submitting a Medicaid claim.

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

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

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

In 4 instances, Medicare EOBs were not supplied for patients who had Medicare coverage and Medicaid was billed prior to billing Medicare.

3. 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 3 instances, patients had other insurance that was not applied.

OVERPAYMENTS

The OMIG’s review of Medicaid claims paid to the Provider from January 1, 2009, through December 31, 2011 identified 29 claims with at least one error, for a total sample overpayment of \$3,448.85 (Appendix A). The extrapolated adjusted point estimate overpayment is \$12,283 and the adjusted lower confidence limit overpayment of \$4,537. The Provider’s response to the Draft Audit Report, dated March 9, 2015, was considered in the preparation of the Final Audit Report but no adjustments were made to the findings as the Provider’s response did not specifically refute the findings. The results of the review are contained in Section III of this report.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the adjusted lower confidence limit amount of \$4,537, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order within 20 days of the date of the final audit report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #13-1942
Albany, New York 12237

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final audit report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until the agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
[REDACTED]

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the adjusted point estimate of \$12,283. 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]
Greenbaum's Pharmacy, Inc.
42 Main Street
Monsey, New York 10952-3000

PROVIDER ID # [REDACTED]

AUDIT #13-1942

AMOUNT DUE: \$4,537

AUDIT
TYPE

PROVIDER
 RATE
 PART B
 OTHER:

CHECKLIST

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

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #13-1942
Albany, New York 12237

Thank you for your cooperation.

Appendix C
Findings for Each Sample Item

Sample #	Date of Service	Date of Payment	Rx	Procedure Code	Amount Paid	Recoupment Amount	Federal Fiscal Year	Federal Share %	Federal Share Amount	Error Codes		
										1. Ordering Prescriber Conflicts with Claim Prescriber *	2. No Explanation of Benefits (EOB) Documentation for Medicare Covered Item	3. Other Insurance Payments Not Applied
2	04/12/10	04/19/10	1328815	00193708050	\$ 217.46	\$ 217.46	2010	61.59%	\$ 133.93	X		
8	01/30/11	02/07/11	1370297	00193707025	\$ 214.60	\$ 214.60	2011	58.77%	\$ 126.12		X	
9	07/12/11	07/18/11	1427653	53885024510	\$ 225.60	\$ 225.60	2011	50.00%	\$ 112.80	X		
19	09/11/11	09/19/11	1489737	00193707025	\$ 214.60	\$ 214.60	2011	50.00%	\$ 107.30	X		
20	11/03/10	11/08/10	1372644	53885024510	\$ 214.82	\$ 214.82	2011	61.59%	\$ 132.31	X		
26	04/24/11	05/02/11	1445104	00193707025	\$ 214.60	\$ 214.60	2011	56.88%	\$ 122.06	X		
34	11/26/10	12/06/10	1396720	99073070822	\$ 119.67	\$ 119.67	2011	61.59%	\$ 73.70			X
36	12/09/09	12/14/09	1286700	99073070822	\$ 116.14	\$ 116.14	2010	61.59%	\$ 71.53	X		
38	03/24/11	04/04/11	1436016	99073070822	\$ 124.38	\$ 124.38	2011	56.88%	\$ 70.75	X		
42	01/18/09	01/26/09	1186118	A4253	\$ 166.98	\$ 166.98	2009	58.78%	\$ 98.15	X		
53	11/01/09	11/09/09	1262547	99073070822	\$ 116.14	\$ 116.14	2010	61.59%	\$ 71.53	X		
59	02/06/11	02/14/11	1420088	00193708050	\$ 114.40	\$ 114.40	2011	58.77%	\$ 67.23		X	
65	08/07/09	08/17/09	1261070	A4253	\$ 135.98	\$ 135.98	2009	61.59%	\$ 83.75	X		
72	08/08/11	08/15/11	1479479	00193708050	\$ 113.40	\$ 113.40	2011	50.00%	\$ 56.70	X		
78	08/06/09	08/17/09	1230783	A4253	\$ 134.98	\$ 134.98	2009	61.59%	\$ 83.13	X		
87	11/30/09	12/07/09	1289041	00193708050	\$ 108.23	\$ 108.23	2010	61.59%	\$ 66.66	X	X	
88	02/03/10	02/08/10	1286700	99073070822	\$ 116.14	\$ 116.14	2010	61.59%	\$ 71.53	X		
94	10/25/11	10/31/11	1503172	53885024510	\$ 112.30	\$ 112.30	2012	50.00%	\$ 56.15		X	
99	03/21/11	03/28/11	1422637	50924098850	\$ 111.75	\$ 111.75	2011	58.77%	\$ 65.68	X		
104	10/25/09	11/02/09	1272601	53885024510	\$ 134.98	\$ 134.98	2010	61.59%	\$ 83.13	X		
119	08/24/09	08/31/09	1264808	A4253	\$ 70.98	\$ 70.98	2009	61.59%	\$ 43.72			X
138	04/07/10	04/12/10	1327145	00193708050	\$ 53.62	\$ 53.62	2010	61.59%	\$ 33.02	X		
145	07/22/09	07/27/09	1257391	A4253	\$ 8.20	\$ 8.20	2009	61.59%	\$ 5.05	X		
161	02/08/09	02/16/09	1202325	A4253	\$ 14.52	\$ 14.52	2009	58.78%	\$ 8.53	X		
166	11/02/09	11/30/09	1267562	98302000118	\$ 65.00	\$ 65.00	2010	61.59%	\$ 40.03	X		
168	01/02/09	01/12/09	1185180	A4253	\$ 70.98	\$ 70.98	2009	58.78%	\$ 41.72			X
171	02/04/10	02/15/10	1311079	00193707025	\$ 52.90	\$ 52.90	2010	61.59%	\$ 32.58	X		
175	02/20/09	03/02/09	1183018	A4253	\$ 14.52	\$ 14.52	2009	58.78%	\$ 8.53	X		
179	08/17/09	08/24/09	1263064	A4253	\$ 70.98	\$ 70.98	2009	61.59%	\$ 43.72	X		
					\$ 3,448.85				\$ 2,011.07	23	4	3

Federal Share Summary**	
Federal FY	Federal Share Amount
2009	\$ 416.31
2010	\$ 603.96
2011	\$ 934.65
2012	\$ 56.15
Total	\$ 2,011.07

* If "Ordering Prescriber Conflicts with Claim Prescriber" is the only error recoupment amount will not be extrapolated.

**The extrapolated Federal Share is \$2,637.07

Appendix B Sample Design

The sample design used for Audit #13-1942 was as follows:

- Universe - Medicaid claims for diabetic test strip supplies paid during the period January 1, 2009, through December 31, 2011.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for diabetic test strip supplies paid during the period January 1, 2009, through December 31, 2011.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2009, through December 31, 2011.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 185 claims.

**Appendix C
Extrapolation of Sample Findings**

Total Sample Recoupment	\$ 3,448.85
Less Recoupments Not Projected*	<u>(2,637.69)</u>
Sample Recoupment for Extrapolation Purposes	\$ 811.16
 Services in Sample	 185
 Overpayments Per Sample Service	 \$ 4.38
 Services in Universe	 1,842
 Mean Point Estimate	 \$ 9,645
Add Overpayments Not Projected*	<u>2,638</u>
Adjusted Mean Point Estimate	<u>\$ 12,283</u>
 Lower Confidence Limit	 \$ 1,899
Add Overpayments Not Projected*	<u>2,638</u>
Adjusted Lower Confidence Limit	<u>\$ 4,537</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.