



**Office of the  
Medicaid Inspector  
General**

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

**REVIEW OF PROGRESSIVE ORTHOTICS, LTD.  
CLAIMS FOR DURABLE MEDICAL EQUIPMENT SERVICES  
PAID FROM  
JANUARY 1, 2007 – DECEMBER 31, 2009**

**FINAL AUDIT REPORT  
AUDIT #11-3016**

**Dennis Rosen  
Medicaid Inspector General**

**September 21, 2016**



**Office of the  
Medicaid Inspector  
General**

**ANDREW M. CUOMO**  
Governor

**DENNIS ROSEN**  
Medicaid Inspector General

September 21, 2016

██████████  
Progressive Orthotics, Ltd.  
280 Middle Country Road, Suite G  
Selden, New York 11784-2532

Final Audit Report  
Suffolk County Demonstration Project  
Audit # 11-3016  
Provider ID # ██████████

Dear ██████████

This letter will serve as our final audit report of the recently completed review of payments made to Progressive Orthotics, Ltd. (the Provider) under the New York State Medicaid Program. Since you did not respond to our draft audit report dated May 26, 2016, the findings in the final audit report are identical to those in the draft audit report.

The New York State Department of Health is responsible for the administration of the Medicaid program. As part of this responsibility, the Office of the Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assessing provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Department of Health [Titles 10 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 18 NYCRR)] and the Medicaid Management Information System (MMIS) Provider Manuals.

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.

A review of payments to the Provider for DME services paid by Medicaid for Suffolk County recipients from January 1, 2007, through December 31, 2009, was recently completed. During the audit period, \$330,275.27 was paid for 1557 claims for services rendered. This review consisted of a random sample of 100 claims with Medicaid payments of \$22,315.39. The purpose of this audit was to verify that: durable medical appliances, equipment and supplies (DME) were properly authorized by a licensed practitioner; Medicaid reimbursable equipment, supplies and services were rendered for the dates billed; appropriate procedure codes were billed for equipment, supplies and services rendered; vendor records contained the documentation required by the regulations; and claims for payment were submitted in accordance with Department regulations and the Provider Manuals for Durable Medical Equipment.

The Provider's failure to comply with Title(s) 10, or 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) and the MMIS Provider Manual for Durable Medical Equipment et al. resulted in a total sample overpayment of \$3,641.45.

The statistical sampling methodology employed allows for extrapolation of the sample findings to the universe of services (18 NYCRR Section 519.18). The adjusted mean per unit point estimate of the amount overpaid is \$26,712. The adjusted lower confidence limit of the amount overpaid is \$3,201. We are 95% certain that the actual amount of the overpayment is greater than the adjusted lower confidence limit (Exhibit I). This audit may be settled through repayment of the adjusted lower confidence limit of \$3,201.

The following detailed findings reflect the results of our audit. This audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report dated May 26, 2016. Since you did not respond to the draft audit report, the findings remain the same.

### **DETAILED FINDINGS**

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)*

## **1. Ordering Prescriber Conflicts with Claim Prescriber**

Medicaid policy states that the billing provider is to enter the New York State Medicaid ID number of the ordering prescriber on the claim. If the ordering prescriber is not enrolled in Medicaid, enter his/her license number.

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 New York State Medicaid ID number.

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

Regulations state: "The identity of the practitioner who ordered the ...medical/surgical supply, must be recorded by the provider on the claim for payment by entering in the license or MMIS provider identification number of the practitioner where indicated."

*18 NYCRR Section 505.5(c)(1)*

In 2 instances pertaining to 2 patients, the ordering prescriber on the claim conflicts with the ordering prescriber denoted on the fiscal order. This resulted in a sample overpayment of \$2,058 (Exhibit II). For this category of findings, OMIG will disallow only the actual amount of the sample overpayment and will not extrapolate the sample findings to the universe of services.

## **2. Other Insurance Payments Not Applied**

Regulations state, "MA program as payment source of last resort. Where a third party, such as 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 will pay only the amount by which the MA reimbursement rate for the services exceeds the amount of the third party liability."

*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, a third party insurance payment was not applied against the total purchase price of the item. This resulted in a sample overpayment of \$873.20 (Exhibit III).

## **3. Improper Medicaid Billings for Medicare Crossover Patients**

Regulations state, "MA program as payment source of last resort. Where a third party, such as 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 will pay only the amount by which the MA reimbursement rate for the services exceeds the amount of the third party liability."

*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 or B of Title XVIII of the Social Security Act (Medicare)."

*18 NYCRR Section 360-7.7(a)*

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

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

Medicaid policy also states that, "Medicaid is required to pay the Medicare co-insurance and deductible for Medicare covered supplies, equipment and appliances provided to Medicaid recipients who are also Medicare beneficiaries. Medicaid will pay the difference between the Medicare approved amount and the Medicare paid amount."

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

In 2 instances pertaining to 2 patients, an incorrect Medicaid co-payment was billed for services also paid by Medicare. This resulted in a sample overpayment of \$425.25 (Exhibit IV).

**4. No Signature on Written Order**

Regulations state that a *written or fiscal order* means, "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, "The minimum information on a fiscal order is: . . . Original signature of the ordering practitioner. . . ."

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

Medicaid policy states, "The minimum information on a fiscal order is: . . . Original signature of the ordering practitioner. . . ."

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

In 2 instances pertaining to 2 patients, the written order lacked the required signature of the ordering practitioner. This resulted in a sample overpayment of \$245 (Exhibit V).

**5. Incorrect Procedure Code Billed**

Regulations state, "Payment for purchase of durable medical equipment must not exceed the lower of: (a) the maximum reimbursable amount as shown in the fee schedule for durable medical equipment, medical/surgical supplies, orthotics and prosthetic appliances and orthopedic footwear; the maximum reimbursable amount will be determined for each item of durable medical equipment based on an average cost of products representative of that item."

*18 NYCRR Section 505.5(d)(2)(i)(a)*

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 requires the use of the fee schedules for durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances and orthopedic footwear as contained in the NYS Medicaid Program Durable Medical Equipment Manual Procedure Codes, Version 2004-1, Section 4.0.

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

In 1 instance, the incorrect procedure code was billed which resulted in a higher reimbursement than indicated in the fee schedule for the proper procedure code. This resulted in a sample overpayment of \$40 (Exhibit VI).

**Additional reasons for disallowance exist regarding certain findings. These findings are identified in Exhibit VII.**

Total sample overpayments for this audit amounted to \$3,641.45.

## Repayment Options

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In accordance with 18 NYCRR Part 518, which regulates the collection of overpayments, your repayment options are described below.

**Option #1:** Make a 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** with the audit number included and be sent with the attached remittance advice to:

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2739  
Audit #11-3016  
Albany, New York 12237

**Option #2:** Enter into a repayment agreement with OMIG. 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%. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

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

Should you fail to select a payment option above, OMIG, in its discretion, may use any remedy allowed by law to collect the amount due. Pursuant to the State Finance Law §18(5), a collection fee equal to twenty two percent (22%) of the amount due, including interest, may be added to the amount owed. OMIG's remedies may include, without limitation, filing this Final Audit Report as the final administrative determination for purposes of obtaining a judgment lien pursuant to §145-a of the New York State Social Services Law; withholding Medicaid payments otherwise payable to the provider or its affiliates pursuant to 18 NYCRR 518.6; and imposing a sanction, pursuant to 18 NYCRR 515.2, against a provider who fails to reimburse the department for overpayments discovered by this audit.

## **Hearing Rights**

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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 OMIG would seek and defend the adjusted point estimate of \$26,712. 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]

In accordance with 18 NYCRR 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply along with your hearing request a signed authorization permitting that person to represent you at the hearing; you may call witnesses and present documentary evidence on your behalf.

For a full listing of hearing rights please see 18 NYCRR Part 519.

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.

Should you have any questions, please contact me at [REDACTED]

Thank you for the cooperation and courtesy extended to our staff during this audit.



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



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

**NAME AND ADDRESS OF AUDITEE**

██████████  
**PROGRESSIVE ORTHOTICS, LTD.  
280 MIDDLE COUNTRY ROAD, SUITE G  
SELDEN, NEW YORK 11784-2532**

**AMOUNT DUE: \$3,201.00**

**PROVIDER ID #** ██████████

**AUDIT #11-3016**

<b>AUDIT</b>	<input checked="" type="checkbox"/>	<b>PROVIDER</b>
	<input type="checkbox"/>	<b>RATE</b>
	<input type="checkbox"/>	<b>PART B</b>
<b>TYPE</b>	<input type="checkbox"/>	<b>OTHER:</b>

**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, B.A.M.  
GNARESP Corning Tower, Room 2739  
File #11-3016  
Albany, New York 12237-0048**

**Thank you for your cooperation.**

**EXHIBIT I**

**PROGRESSIVE ORTHOTICS, LTD.  
DURABLE MEDICAL EQUIPMENT AUDIT  
AUDIT # 11- 3016  
AUDIT PERIOD: 01/01/07 – 12/31/09**

**EXTRAPOLATION OF SAMPLE FINDINGS**

Total Sample Overpayments	\$	3,641.45
<b>Less Overpayments Not Projected*</b>		<u>(2,058.00)</u>
Sample Overpayments for Extrapolation Purposes	\$	1,583.45
Services in Sample		100
Overpayments Per Sampled Service	\$	15.8345
Services in Universe		1,557
Meanpoint Estimate	\$	24,654
<b>Add Overpayments Not Projected*</b>		<u>2,058</u>
Adjusted Meanpoint Estimate	\$	<u>26,712</u>
Lower Confidence Limit	\$	1,143
<b>Add Overpayments Not Projected*</b>		<u>2,058</u>
Adjusted Lower Confidence Limit	\$	<u>3,201</u>

\* The actual dollar disallowance for the following finding was subtracted from the total sample overpayment and added to the Meanpoint Estimate and the Lower Confidence Limit:

**Finding #1 – Ordering Prescriber Conflicts with Claim Prescriber**

The dollar disallowance associated with this finding was not used in the extrapolation. However, this does not apply if an extrapolated finding was also identified for a sampled claim.

**PROGRESSIVE ORTHOTICS LTD**

MMIS #: [REDACTED]

Audit #: 11-3016

**Ordering Prescriber Conflicts with Claim Prescriber**

Sample #	Date of Service	Formulary Code	Amount Disallowed
44	12/31/2008	L2770	\$58.00
93	12/8/2008	L5701	\$2,000.00
<b>Total Services:</b>	<u>2</u>		<u>\$2,058.00</u>

**PROGRESSIVE ORTHOTICS LTD**

MMIS #: [REDACTED]

Audit #: 11-3016

**Other Insurance Payments Not Applied**

<b>Sample #</b>	<b>Date of Service</b>	<b>Formulary Code</b>	<b>Amount Disallowed</b>
53	7/23/2007	L5321	\$873.20
<b>Total Services:</b>	<b>1</b>		<b>\$873.20</b>

**PROGRESSIVE ORTHOTICS LTD**

MMIS #: [REDACTED]

Audit #: 11-3016

**Improper Medicaid Billings for Medicare Crossover Patients**

<b>Sample #</b>	<b>Date of Service</b>	<b>Formulary Code</b>	<b>Amount Disallowed</b>
34	6/25/2008	L2830	\$231.34
62	5/23/2008	L2820	\$193.91
<b>Total Services:</b>	<u>2</u>		<u>\$425.25</u>

**PROGRESSIVE ORTHOTICS LTD**

MMIS #: [REDACTED]

Audit #: 11-3016

**No Signature on Written Order**

Sample #	Date of Service	Formulary Code	Amount Disallowed
54	2/23/2007	L2820	\$210.00
77	4/3/2009	L4210	\$35.00
<b>Total Services:</b>	<u>2</u>		<u>\$245.00</u>

**PROGRESSIVE ORTHOTICS LTD**

MMIS #: [REDACTED]

Audit #: 11-3016

**Incorrect Procedure Code Billed**

<b>Sample #</b>	<b>Date of Service</b>	<b>Formulary Code</b>	<b>Amount Disallowed</b>
100	6/27/2007	L2830	\$40.00
<b>Total Services:</b>	<u>1</u>		<u>\$40.00</u>

**PROGRESSIVE ORTHOTICS LTD.  
DURABLE MEDICAL EQUIPMENT AUDIT  
AUDIT # 11 - 3016  
AUDIT PERIOD: 1/1/2007-12/31/2009**

**ADDITIONAL FINDINGS PERTAINING TO SAMPLED ITEMS**

<u>Sample #</u>	<u>Primary Finding</u>	<u>Other Findings Pertaining to Sampled Item</u>
77	No Signature on Written Order	Telephone or Fax Order Lacks Signed Follow Up Order *
100	Incorrect Procedure Code Billed	Ordering Prescriber Conflicts with Claim Prescriber

\* **Telephone or Fax Order Lacks Signed Follow Up Order**

Medicaid policy states, "In the event an order for durable medical equipment, medical-surgical supplies, or orthotic or prosthetic appliances has been telephoned or faxed to the provider, it is the provider's responsibility to obtain the signed fiscal order from the ordering practitioner within 30 calendar days."

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