



STATE OF NEW YORK  
OFFICE OF THE MEDICAID INSPECTOR GENERAL  
800 North Pearl Street  
Albany, New York 12204

DAVID A. PATERSON  
GOVERNOR

JAMES G. SHEEHAN  
MEDICAID INSPECTOR GENERAL

August 10, 2010

United Intermanagement LTD  
[REDACTED]

3102 Quentin Road  
Brooklyn, NY 11234

Final Audit Report

Audit #08-3379

Provider ID [REDACTED]

Dear [REDACTED]

This letter will serve as our final audit report of the recently completed review of payments made to United Intermanagement LTD under the New York State Medicaid Program.

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 ensuring provider compliance 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 (10 NYCRR, 14 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 United Intermanagement LTD for DME services paid by Medicaid for New York City recipients from January 1, 2006, through December 31, 2007, was recently completed. During the audit period, \$2,596,706.53 was paid for services rendered to 1,345 patients. This review consisted of a random sample of 100 patients with Medicaid payments of \$230,742.42. The purpose of the audit was to ensure 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.

United Intermanagement LTD's failure to comply with Title(s) 10, 14 and/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 \$5,963.69.

The statistical sampling methodology employed allows for extrapolation of the sample findings to the universe of cases (18 NYCRR Section 519.18). The mean per unit point estimate of the amount overpaid is \$27,114.00. The lower confidence limit of the amount overpaid is \$10,602.00. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit (Exhibit I). This audit may be settled through repayment of the lower confidence limit of \$10,602.00.

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 report dated April 12, 2010.

### **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: "All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing . . . ; 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)

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: "An unacceptable practice is conduct by a person which is contrary to: . . . (2) the published fees, rates, claiming instructions or procedures of the department" and "(3) the official rules and regulations of the Departments of Health, Education and Mental Hygiene. . . ."

*18 NYCRR Section 515.2(a)*

Furthermore, according to regulations, all providers must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. In addition, the provider must keep, for a period of six years, all records necessary to disclose the nature and extent of services furnished and the medical necessity therefor, including any prescription or fiscal order for the service or supply. This information is subject to audit for a period of six years and must be furnished, upon request.

*18 NYCRR Section 517.3(b)*

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

Regulations state, "...an unacceptable practice...includes...(2)False statements. (i) Making, or causing to be made any false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a medical assistance payment, or for use in determining the right to payment."

*18 NYCRR Section 515.2(b)*

Regulations state, "...By enrolling the provider agrees...that the information provided in relation to any claim for payment shall be true, accurate and complete..."

*18 NYCRR Section 504.3(h)*

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

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

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, "...By enrolling the provider agrees...that the information provided in relation to any claim for payment shall be true, accurate and complete..."

*18 NYCRR Section 504.3(h)*

The Medicaid Durable Medical Equipment Manual directs the billing provider 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 2008-1*

In 84 instances pertaining to 5 patients, the ordering prescriber conflicts with the claim prescriber. This resulted in a sample overpayment of \$4,264.89 (Exhibit II).

**2. Item Billed Does Not Match Ordered Item**

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

*18 NYCRR Section 505.5(b)(3)*

In 3 instances pertaining to 3 patients, the item billed does not match the ordered item. This resulted in a sample overpayment of \$566.86 (Exhibit III).

**3. No Documentation of Service**

Regulations require that the Medicaid provider agrees, "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years . . . all records necessary to disclose the nature and extent of services furnished. . . ."

*18 NYCRR Section 504.3(a)*

Regulations also require that bills for medical care, services and supplies contain a certification that such records as are necessary to disclose fully the services provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years. These records must be furnished to the Department upon request.

*18 NYCRR Section 540.7(a)(8) and Section 517.3*

In 2 instances pertaining to 1 patient, the services were not documented. This resulted in a sample overpayment of \$562.15 (Exhibit IV).

**4. No Written Order**

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

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

The Medicaid Durable Medical Equipment Manual also states, "All medical/surgical supplies, durable medical equipment . . . must be supported by the original, signed written order of a licensed physician, dentist, podiatrist, physician assistant or nurse practitioner."

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

In 1 instance, there was no written order for the items provided. This resulted in a sample overpayment of \$334.40 (Exhibit V).

**5. Item Billed in Excess of Quantity Ordered**

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

*18 NYCRR Section 505.5(b)(3)*

Regulations also 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)*

In 5 instances pertaining to 3 patients, the item was billed in excess of the quantity prescribed by the orderer. This resulted in a sample overpayment of \$142.45 (Exhibit VI).

#### 6. Order Refilled Beyond 180 Days of Issuance

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

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

In 1 instance, the order was refilled after 180 days lapsed from the original order date. This resulted in a sample overpayment of \$47.96 (Exhibit VII).

#### 7. No EOB for Medicare Covered Item

The Durable Medical Equipment Manual Policy Guidelines 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*

Per DOH Medicaid Update (December 2005 Vol 20, No.13): Medicaid law and regulations require that, when a recipient is eligible for both Medicare and Medicaid or has other insurance benefits: The provider must bill Medicare or the other insurance first for **covered** services **prior** to submitting a claim to Medicaid.

- 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 insurance.
- **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.**

In 2 instances pertaining to 2 patients, no EOB was found for a Medicare eligible patient who received an item covered by Medicare. This resulted in a sample overpayment of \$23.02 (Exhibit VIII).

#### 8. Original Order Filled Beyond Acceptable Timeframe

The Medicaid Durable Medical Equipment Manual states, "An original fiscal order for Medical/Surgical Supplies may not be filled more than 60 days after it has been initiated by the ordering practitioner unless prior approval is required." "An original fiscal order for Durable Medical Equipment, Orthotics, Prescription Footwear, and Prosthetics may not be filled more than 180 days after it has been ordered by the ordering practitioner.

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

In 1 instance, the original order was filled after 60 days lapsed. This resulted in a sample overpayment of \$17.75 (Exhibit IX).

**9. No Documentation of Item Delivered**

The Medicaid Durable Medical Equipment Manual states, "For audit purposes, . . . written orders, in addition to other supporting documentation such as invoices and delivery receipts, must be kept on file for six years from the date the service was furnished or billed, whichever is later."

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

In 1 instance, there was no documentation that the item was delivered. This resulted in a sample overpayment of \$4.21 (Exhibit X).

Total sample overpayments for this audit amounted to \$5,963.69.

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

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the lower confidence limit amount of \$10,602.00, 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 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, B.A.M.  
 GNARESP Corning Tower, Room 1237  
 Albany, New York 12237-0048

**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 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 report, the OMIG will impose a 15% withhold after 20 days until the agreement is established.

Furthermore, the OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. 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. The OMIG will notify you no later than 5 days after initiating such action. If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

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

**If within 20 days, you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to recover payment and liquidate the lower confidence limit amount, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.**

If you choose not to settle this audit through repayment of the lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the meanpoint estimate of \$27,114.00. 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, New York 12204

Questions regarding the request for a hearing should be directed to [REDACTED]  
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.

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

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

Sincerely,

[REDACTED]

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

cc:

[REDACTED]

[REDACTED]  
Enclosure

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

**NAME AND ADDRESS OF AUDITEE**

United-Intermanagement LTD  
3102 Quentin Road  
Brooklyn, NY 11234  
[REDACTED]

**PROVIDER ID** [REDACTED]

**AUDIT #08-3379**

**AMOUNT DUE: \$10,602.00**

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

**CHECKLIST**

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

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management, B.A.M.  
GNARESP Corning Tower, Room 1237  
File #08- 3379  
Albany, New York 12237-0048

Thank you for your cooperation.