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

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

August 31, 2012

LINCARE INC.
[redacted]
3556 Lake Shore Rd
Blasdell, New York 14219-1445

FINAL AUDIT REPORT
Audit #2010Z58-099C
Provider [redacted]

Dear [redacted]:

The New York State Office of the Medicaid Inspector General (the "OMIG") completed an audit of Medicaid claims paid for Durable Medical Equipment services provided to patients. In accordance with Section 517.6 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18 NYCRR), this report represents the final determination on issues found during the OMIG's review.

After reviewing your response to the OMIG's January 11, 2012 Draft Audit Report, the OMIG reduced the Draft Audit Report disallowances in the Final Report. Also, upon further review of the claims contained in the Draft Audit Report, the OMIG has removed additional claims from this Final Report. The total disallowances have been reduced from $1,410.50 to $979.46. A detailed explanation of the revision is included in the Final Report.

Based on this determination, restitution of the overpayments as defined in 18 NYCRR 518.1 is required in the amount of $979.46, inclusive of interest.

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 report. The check should be made payable to the New York State Department of Health and be sent with the enclosed Remittance Advice form, signed and dated, to:

New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
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 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. 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:

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

Do not submit claim voids or adjustments in response to this Final Audit Report.

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 secure payment and liquidate the overpayment 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.

The Facility has the right to challenge this action and determination by requesting an administrative hearing within sixty (60) days of the date of this notice. In accordance with 18 NYCRR Section 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 you wish to request a hearing, the request must be submitted in writing to:

General Counsel
Division of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

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.

Questions concerning this audit may be directed to [redacted] at [redacted]

Sincerely,

[redacted]

Bureau of Business Intelligence
Office of the Medicaid Inspector General

Enclosure

CERTIFIED MAIL #[redacted]
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

LINCARE Inc.
3556 Lake Shore Rd
Blasdell, New York 14219-1445

AMOUNT DUE: $979.46

Provider [redacted]

AUDIT #2010Z58-099C

AUDIT TYPE	[X] 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]
Medicaid Financial Management
New York State Department of Health
GNARESP Corning Tower, Room 2739
File #2010Z58-099C
Albany, New York 12237

5. If the provider number shown above is incorrect, please enter the correct number below.

CORRECT PROVIDER NUMBER

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

FINAL REPORT

LINCARE INC.
3556 LAKE SHORE RD
BLASDELL, NEW YORK 14219-1445

DME MEDICAID MEDICARE CROSSOVER
#2010Z58-099C

ISSUED AUGUST 31, 2012

TABLE OF CONTENTS

	PAGE
BACKGROUND, PURPOSE AND SCOPE	2
FINDINGS	3 - 4
EXHIBITS	
EXHIBIT I	DME Medicaid Claims with Medicare Crossover billed Incorrectly
EXHIBIT III	There is no evidence in the CMS Medicare payment file that Medicare was billed or paid for the Service

BACKGROUND, PURPOSE AND SCOPE

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.

The purpose of this audit was to compare the amounts paid by Medicare Part B with the amounts reported on New York's Medicaid system. Specifically, the amounts Medicare approved and paid were matched to the Medicaid claims, as were the coinsurance and deductible amounts. Medicare Part B payment information was obtained from the Department of Health and Human Services' Center for Medicare and Medicaid Services (CMS). The review found instances where Medicaid overpayments were made to you due to misreporting or failure to report correct Medicare payments.

To accomplish this, claims for DME services paid by Medicaid with service dates from January 1, 2006 through December, 31, 2009 were reviewed.

Please note that due to the implementation of the National Provider Identifier (NPI) on September 1, 2008, there may be multiple Provider Identification Numbers associated with the Primary Provider Identification Number. The NPI is linked to the Primary Provider Identification Number. The Primary Provider Identification Number is used for correspondence and recoupment.

DETAILED FINDINGS

The detailed finding of our audit is as follows:

1. Match of Claims Submitted to Medicare and Medicaid

The regulations cited below are specifically for Medicaid payments for recipients who are also Medicare beneficiaries.

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)

The Medicaid Durable Medical Equipment Manual 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

The Medicaid Durable Medical Equipment Manual 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

The DOH 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.

- 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."***

DOH Medicaid Update December 2005 Volume n 20, No.13

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)

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)

Exhibit I is a list of Medicaid recipients who are also Medicare eligible. A Medicare claim was billed and incorrectly reported on the Medicaid claim. A match of the provider's Medicare payment files with the Medicare amounts reported on the Medicaid claim identified Medicaid overpayments of $80.43.

Exhibit II is a list of Medicaid recipients who are also Medicare eligible. A Medicare claim was billed and correctly reported on the Medicaid Claim. A match of the provider's Medicare payment files with the medicare amounts reported on the Medicaid claim identified Medicaid had incorrectly paid these claims. There is a Medicaid overpayment of $0 .00. These claims do not have interest applied.

Exhibit III is a list of Medicaid recipients who are also Medicare eligible. There is no evidence in the CMS Medicare payment file that Medicare was billed or paid for the Medicare covered service. In addition, there is no evidence on the Medicaid claim that Medicare payments were received. Because Medicaid must be billed only after payment is sought from Medicare, we have identified overpayments totaling $821.19.

DETERMINATION

Lincare'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 Medicaid overpayment.

In accordance with 18 NYCRR 518.4, interest may be collected on any overpayments identified in this audit and will accrue at the current rate from the preliminary determination of the overpayment. For the overpayments identified in this audit, the OMIG has determined that accrued interest totals $77.84.

Based on this determination, the total amount of overpayment, as defined in 18 NYCRR 518.1(c) is $979.46 inclusive of interest. Restitution of $979.46 is due the New York State Department of Health.