STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of

ALLCARE TRANSPORTATION, INC.,

DECISION

Medicaid # 01242933

Audit # 2017Z31-199W

for a hearing pursuant to Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18 NYCRR)

Before: Tina M. Champion
Administrative Law Judge

Held At: New York State Department of Health
Bureau of Adjudication
150 Broadway, Suite 510
Menands, New York 12204

Date of Hearing: October 3, 2018

Record Closed: December 10, 2018

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Patrick F. Scully, Esq.

Allcare Transportation, Inc.
750 Middleline Road
Ballston Spa, New York 12020
By: Michael Evola

JURISDICTION

Pursuant to New York State Public Health Law (PHL) § 201(1)(v) and New York State Social Services Law (SSL) § 363-a, the Department of Health (Department) acts as the single state agency to supervise the administration of the medical assistance program (Medicaid) in New York State. The Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority pursuant to PHL §§ 30, 31 and 32 to pursue administrative enforcement actions against any individual or entity that engages in fraud, abuse, or unacceptable practices in the Medicaid program and to recover improperly expended Medicaid funds.

The OMIG determined to recover Medicaid overpayments made to Allcare Transportation, Inc. (Appellant) for the period March 1, 2012, through December 31, 2015. Appellant requested a hearing to challenge the overpayment determination pursuant to SSL § 22 and 18 NYCRR 519.4.

HEARING RECORD

OMIG Exhibits:

1 – 18 NYCRR 504.3
2 – 18 NYCRR 505.10
3 – 18 NYCRR 518.1
4 – DOH Medicaid Update, November 2004, Volume 19, Number 11
5 – eMedNY Transportation Manual Policy Guidelines – Version 2011-2
6 – eMedNY Transportation Manual Policy Guidelines – Version 2012-1
7 – eMedNY Transportation Manual Policy Guidelines – Version 2012-2
8 – eMedNY Transportation Manual Policy Guidelines – Version 2012-3
9 – eMedNY Transportation Manual Policy Guidelines – Version 2012-4
10 – eMedNY Transportation Manual Policy Guidelines – Version 2013-1
11 – eMedNY Transportation Manual Policy Guidelines – Version 2013-2
12 – eMedNY Transportation Manual Policy Guidelines – Version 2014-1
13 – Audit Worksheet
14 – Draft Audit Report
15 – Final Audit Report
16 – USPS Certified Mail Receipts and Return Cards
17 – Correspondence to OMIG from Michael Evola, 5/16/18
18 – Correspondence to OMIG from Lippes Mathias, 5/2/18
19 – Correspondence to OMIG from Lippes Mathias, 5/2/18
20 – Safe Care Medicaid Provider Form
21 – Notice of Hearing
22 – Notice of Prehearing Conference
23 – Statement of Prehearing Conference (w/out exhibits)

24 – Amended Statement of Prehearing Conference (w/out exhibits)
25 – Provider Inquiry

Appellant Exhibits: None

OMIG Witnesses: Katie Wood, OMIG – Management Specialist
Rita Guido, CSRA – Provider Services Outreach Supervisor and Regional Representative
Sandra Noonan, OMIG – Management Specialist 3
Christina Farrell, OMIG – Management Specialist 2

Appellant Witnesses: Michael Evola, owner of Allcare Transportation, Inc.
Ashley Evola, daughter of Michael Evola

Transcript: Pages 1 – 150

Post-hearing Briefs:[1] OMIG – November 26, 2018

FINDINGS OF FACT

1. The Appellant was enrolled in the New York State Medicaid Program as a transportation provider from July 26, 1991, to November 30, 2015. (OMIG Ex. 25.)

2. The Appellant was owned and operated by Michael Evola until August 26, 2015, when Mr. Evola sold the assets of the company. Mr. Evola continued to manage the company after selling its assets until approximately September 1, 2017. (Tr. at 143-144.)[2]

3. The OMIG completed an audit (# 2017Z31-199W) of the Medicaid claims for transportation services paid to Appellant for payment dates of March 1, 2012 through December 31, 2015. The audit was a "system match unit audit," which is a type of audit that reviews all the claims submitted by a provider that meet certain defined audit criteria instead of a statistical

[1] A post-hearing submission schedule was set requiring post-hearing briefs to be submitted no later than November 26, 2018 and any reply briefs to be submitted no later than December 10, 2018. Mr. Evola made a post-hearing email submission on December 16, 2018. This email, and a response by Mr. Scully dated December 17, 2018, were not considered in rendering this decision.

[2] Mr. Evola testified that Safe Care Mobility purchased the assets of Allcare Transportation, Inc. (Tr. at 143.) At the outset of the hearing, Mr. Scully advised that the OMIG initially believed that Safe Care Mobility Services, Inc. was an affiliate of Appellant but that OMIG has since determined that it is not and that "separate action is being taken to discontinue all relevant proceedings against Safe Care Mobility Services." (Tr. at 24-25; see also OMIG Exs. 13-15, 18-19.)

sample of claims submitted that is used in an audit with extrapolated findings. (OMIG Exs. 14-15; Tr. at 34-37.)

4. The audit reviewed Medicaid fee-for-service transportation claims for Medicaid recipients who were hospital inpatients on the date of service, and transportation claims for ambulette services. The purpose of the review was to verify that the vehicle license number and driver's license number reported on each claim was authorized on the date of service. (OMIG Ex. 14.)

5. The OMIG issued a Draft Audit Report on February 13, 2018 in which it preliminarily identified $29,298.43, inclusive of interest, in Medicaid overpayments. Pursuant to 18 NYCRR 517.5, the Draft Audit Report advised the Appellant that it could "submit additional documentation and written arguments in objection to this determination and proposed action within 30 days of receiving [the] Draft Audit Report". (OMIG Ex. 14.)

6. Four categories of audit findings are included in the Draft Audit Report. The only audit finding identified as resulting in overpayments is categorized as "Transportation Claims for Ambulette Services with Incorrect/Missing Driver's License for Date of Service." (OMIG Ex. 14.)

7. The Appellant telephoned the OMIG on February 26, 2018 regarding the Draft Audit Report but did not submit a response with objections to the findings. (Tr. at 17-20, 51, 54-56.)

8. The OMIG issued a Final Audit Report on April 2, 2018 in which the $29,298.43 overpayment identified in the Draft Audit Report was unchanged. Pursuant to 18 NYCRR 517.6, the Final Audit Report advised the Appellant of its right to a hearing to appeal the audit findings. (OMIG Ex. 15.)

9. By letter dated May 16, 2018, Appellant requested a hearing to review the OMIG's overpayment determination. (Tr. at 51; OMIG Ex. 17.)

ISSUE

Has the Appellant established that the OMIG's determination to recover overpayments in the amount of $29,298.43 was not correct?

APPLICABLE LAW

Medicaid providers are subject to audit and claim review by the Department. 18 NYCRR 504.8[a]. "When the department has determined that any person has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, it may require repayment of the amount determined to have been overpaid." 18 NYCRR 518.1[c]. Overpayments include "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 518.1[c].

The Appellant has the burden of showing that the OMIG's determination "was incorrect and that all claims submitted and denied were due and payable under the program, or that all costs claimed were allowable." 18 NYCRR 519.18[d][1].

By enrolling in the Medicaid Program, a provider agrees, pursuant to 18 NYCRR 504.3:

> (a) 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 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 and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health;
>
> [¶]…[¶]
>
> (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.

With respect to payment for transportation for medical care and services provided to Medicaid (MA) recipients, 18 NYCRR 505.10(e)(6) states, in pertinent part:

> In order to receive payment for services provided to an MA recipient, a vendor must be lawfully authorized to provide transportation services on the date the services are rendered. A vendor of transportation services is lawfully authorized to provide such services if it meets the following standards:
>
> […]
>
> (ii) Ambulette services must be authorized by the Department of Transportation. Ambulette drivers must be qualified under Article 19-A of the Vehicle and Traffic Law. Ambulette services and their drivers must comply with all requirements of the Department of Transportation and the Department of Motor Vehicles or have a statement in writing from the appropriate department or departments verifying that the ambulette services or their drivers are exempt from such requirements.

The New York State Medicaid Program issues Provider Manuals that are available to all providers and include policy guidelines, fee schedules, and billing guidelines. (OMIG Exs. 5-12; *see also,* www.eMedNY.org.) The Department also issues Medicaid Updates, which are monthly publications with information relevant to providers. (OMIG Ex. 4; s*ee also,* www.health.ny.gov/health_care/medicaid/program/update/main.)

Medicaid Update, Volume 19, Number 11, requires providers billing for ambulette services (category of service 0602) to include the driver license number of the individual driving the vehicle and the license plate number of the vehicle used to transport the Medicaid client on each claim. This Medicaid Update, which was issued in November 2004, further advised that providers should "diligently update their billing systems to comply with this requirement." (OMIG Ex. 4.)

Policy Guidelines set forth in the Provider Manuals for Transportation applicable to the payment dates at issue in this audit also state:

> On claims for which an ambulette vehicle was ***used***, providers are required to include ***both***:
>
> - the driver license number of the individual driving the vehicle; and

- the license plate number of the vehicle used to transport the enrollee.

> If a different driver and/or vehicle returns the enrollee from the medical appointment, the license number of the driver and vehicle used for the origination of the trip should be reported on the claim.

(OMIG Exs. 6-12.)

DISCUSSION

The OMIG's Draft Audit Report was issued on February 13, 2018, and duly delivered in compliance with 18 NYCRR 517.5(c). (OMIG Ex. 14.) The Appellant received the Draft Audit report, as Mr. Evola telephoned Katie Wood at the OMIG on February 26, 2018 regarding that report. However, the Appellant did not submit a response with objections to the findings at any time. (Tr. at 17-20, 51, 54-56.) The OMIG then issued the Final Audit Report on April 2, 2018, in which it determined that the overpayments were the same as those identified in the Draft Audit Report and in which it advised the Appellant of its right to a hearing. (OMIG Ex. 15.) By letter dated May 16, 2018, the Appellant requested a hearing to review the overpayment determination. (Tr. at 51; OMIG Ex. 17.)

The OMIG made four findings in the Final Audit Report, only one of which resulted in overpayments. (OMIG Ex. 15; Tr. at 13.) The finding at issue in this hearing was:

> A review of transportation claims submitted for ambulette services with payment dates from March 1, 2012 through December 31, 2015 showed that the driver's license number listed on the claim was incorrect or missing.

As a result of that finding, the OMIG determined that "$25,233.34…was inappropriately billed to Medicaid, resulting in Medicaid overpayments" and that "accrued interest of $4,065.09…is now owed." The total amount due, in accordance with 18 NYCRR 518.1 and 518.4, is $29,298.43. (OMIG Ex. 15.)

The Appellant was given notice of the findings by his receipt of the Draft Audit Report. Pursuant to the process set forth at 18 NYCRR 517.5, the Appellant had an opportunity to respond

and submit additional documents before a final determination was issued. Again at the hearing, the Appellant had an opportunity to offer documentation showing entitlement to payment for the claims at issue. The Appellant has failed to come forward with any contemporaneous documentation demonstrating entitlement to the payments.

At the hearing, pursuant to 18 NYCRR 519.17(a), the Department produced an OMIG representative to present the audit file and summarize the case. The OMIG's findings are set forth in the Draft and Final Audit Reports, along with Attachment III thereto. (OMIG Exs. 14-15.) All of OMIG's disallowances were made because driver's license numbers were missing from the claims submitted by Appellant. (Tr. at 40-41.) The claims data gathered by OMIG during the audit showed a blank space in the field for a driver's license number. (OMIG Ex. 14 at Attachment III; Tr. at 46-49.) For the payment dates of March 1, 2012 through December 31, 2015 included in the audit, the OMIG identified "roughly six hundred and thirty-seven" claims submitted by the Appellant that lacked a driver's license number. (Tr. at 48.)

Mr. Evola maintains that the electronic claim system would not have allowed him to submit claims if they were missing driver's license numbers. He alleges that eMedNY "wouldn't accept them" and that they "would just get kicked back. We wouldn't be able to bill. We wouldn't be able to do anything." (Tr. at 30.) Ashley Evola, who handled some of the billing for the Appellant, also maintained that the driver's license number was a required field and that claims would get "sent back and you would have to redo the claim" if the required fields were not completed. (Tr. at 133-134.)

The OMIG agreed there are "edits" in place that prevent submission of claims in certain circumstances where required fields are not completed. Its witness Rita Guido also testified, however, that these edits permit submission of claims lacking required information in other circumstances. The OMIG described an edit as "an instruction that the computer program has" and stated that that an edit checks a claim "to see if it's meeting the requirements of a particular rule." (Tr. at 76.) Ms. Guido explained that Medicaid providers can be enrolled with multiple

categories of service, and that if a provider "has two categories of service [and] one of those categories of service doesn't need to have the driver's license on the claim, then the system defaults to that category [of] service and assumes that the claim is being submitted under this provider's other category." (Tr. at 77-78.) The Appellant had categories of service other than ambulette, and at least one of those other categories of service did not require a driver's license number submitted on a claim. (Tr. 78-80.)

Mr. Evola rejects the OMIG's theory that any of his claims for ambulette services, identified as Category of Service 0602, would have been accepted during the electronic claims submission process due to having multiple categories of service. He maintains that he never applied for any category of service other than ambulette and that has been Appellant's only category of service "from the beginning of time." (Tr. at 80-82.) Provider Enrollment Status documentation provided by OMIG, however, identifies the Appellant's categories of service as 0602 – Invalid Coach[3], 0603 – Taxi, and 0606 – Trans Day Treatment. (OMIG Ex. 25; Tr. at 95-96.) The documentation further shows that all of those categories of service were active during the payment dates of the claims disallowed in this audit. (OMIG Exs. 14-15, 25.)

In support of his claim that the Appellant never applied for any category of service other than ambulette, Mr. Evola raises the point that:

> …with the basic stuff, like my address and phone number [being inaccurate on the Provider Inquiry], how can we trust the [category of service] information on here because I've never applied for a taxi? I just did [0602] for my category of service. (Tr. at 101.)

Sandra Noonan, OMIG Management Specialist 3, pointed out that enrolling as a Medicaid provider is "not mandatory" and providers "voluntarily decide to enroll." (Tr. 98-99.) She further testified that information on file for a provider would have originated from the provider's application for enrollment and that any changes for dates of enrollment would have had to have been reported

[3] Invalid coach services are also referred to as ambulette services. (Tr. at 96.)

by the provider. (Tr. at 101-103.) Additionally, Christina Farrell, OMIG Management Specialist 2, testified that a category of service "is something that the provider is enrolled in and applies for at the outset of their enrollment. Or if they'd like to amend their enrollment. Beyond that it's invisible to the providers. They don't see it on the claim." (Tr. at 122.)

The Appellant provided no documentary evidence, such as his enrollment application, to support his claim that the category of service information in the OMIG's enrollment files is not trustworthy.

The evidence in the record supports that the Appellant was enrolled in categories of service other than ambulette, that the categories of service would have originated from the Appellant, and that the existence of categories of service other than ambulette could have allowed a claim to be electronically submitted without the inclusion of information in the driver's license field. The evidence in the record also supports that the Appellant submitted claims without required driver's license numbers and that it received payment from Medicaid for those claims.

As a final issue, it is noted that the OMIG maintains that in order to change its determinations disallowing these claims, the Appellant would have to produce documentation showing it had included the driver's license numbers on its claims. The OMIG maintains that documentation showing that the driver actually provided the services and was qualified would be insufficient in and of itself because it would only matter if the "documentation proves what he billed was correct." (Tr. at 68-69.)

According to the OMIG, then, the Appellant could not prevail even if it was able to produce contemporaneous documentation demonstrating its provision of these services in compliance with all relevant Medicaid rules. It could comply with all Medicaid requirements in providing a service, but if it made an error on the claim submission, it would not be entitled to payment of the claim. If this position is credited, it is difficult to understand how one would distinguish the disallowances in this case, where a driver's license was not accurately reported, from a claim in which the name of the driver or Medicaid recipient was misspelled.

It is unnecessary to reach the issue of what documentation would be sufficient to establish entitlement to payment for the claims submitted in this case because the Appellant has offered no documentation whatsoever to demonstrate entitlement to payment.

Mr. Evola and his [redacted] presented as truthful at the hearing, and it is believable that they both felt they were meeting claims submission requirements. There is no evidence that omissions of driver's license numbers were intentional. This, however, does not excuse the Appellant's need to comply with provider requirements and the Appellant has failed to meet its burden to prove entitlement to payment for the disallowed claims.

DECISION

The OMIG's determination to recover Medicaid Program overpayments from Allcare Transportation, Inc. in the total amount of $29,298.43, inclusive of interest, is affirmed.

March 5, 2019
Albany, New York

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Tina M. Champion
Administrative Law Judge