NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

June 8, 2022

CERTIFIED MAIL/RETURN RECEIPT

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NYS – OMIG
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Angels in Your Home, LLC
1495 Lake Avenue
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RE: In the Matter of Angels in Your Home, LLC
Audit No. 18-7593

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter.

If the appellant did not win this hearing, the appellant may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the appellant wishes to appeal this decision, the appellant may wish to seek advice from the legal resources available (e.g. the appellant's attorney, the County Bar Association, Legal Aid, OEO groups, etc.). Such an appeal must be commenced within four (4) months after the determination to be reviewed becomes final and binding.

Sincerely,

Dawn MacKillop-Soller

Dawn MacKillop-Soller
Acting Chief Administrative Law Judge
Bureau of Adjudication

DXM:nm
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **ANGELS IN YOUR HOME, LLC** Medicaid ID: 03234122 from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.	COPY **DECISION AFTER HEARING** Audit Number: 18-7593

Before: Natalie J. Bordeaux
Administrative Law Judge

Hearing Dates: July 1, September 8, October 7-8, 2021, and February 2 and 4, 2022
The record closed May 18, 2022

Held via: WebEx videoconference

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
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By: Shelby Grynberg, Esq.

Angels in Your Home, LLC
1495 Lake Avenue
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JURISDICTION

The New York State Office of the Medicaid Inspector General (OMIG) determined to seek restitution of payments made under the Medicaid Program to Angels in Your Home, LLC (Appellant). The Appellant requested a hearing pursuant to Social Services Law § 22 and Department of Social Services (DSS) regulations at 18 NYCRR § 519.4 to review the OMIG's determination.

HEARING RECORD

OMIG witnesses:	Robert Hynes, Management Specialist 3
OMIG exhibits:	1-9, 10(a), 10(b), 10(c), 11, 12, 13(a), 13(b), 14, 15(a), 15(b), 16, 16(a), 16(b), 16(c), 23, 24, 27-30
Appellant witnesses:	Charles Falkner, Auditor 3, OMIG [redacted] PhD, Statistical Consultant David James Wegman, Owner, Angels in Your Home
Appellant exhibits:	A-C, E-M

A transcript of the hearing was made. (T 1-795.) Each party submitted two post-hearing briefs.

FINDINGS OF FACT

1. The Appellant is a licensed home care services agency and a home and community-based services/traumatic brain injury waiver provider enrolled in the Medicaid Program. (Exhibit 5.)

2. By letter dated September 24, 2018, the Appellant was advised that the OMIG would audit the Appellant's medical and fiscal records supporting claims for home and community-based, traumatic brain injury waiver services (TBI waiver services) paid by the Medicaid Program during the audit period January 1, 2013 through December 31, 2015. (Exhibit 1.)

3. During the audit period, the Appellant was paid $4,692,515.17 for 17,544 claims submitted to the Medicaid Program for TBI waiver services. (Exhibits 2-4.)

4. On October 18, 2018, OMIG auditors conducted an entrance conference with members of the Appellant's management. The nature and extent of the audit was discussed pursuant 18 NYCRR § 517.3(f). (Exhibit 9.)

5. After the October 18, 2018 entrance conference, the auditors gave the Appellant a list of 100 randomly selected TBI waiver services claims paid by the Medicaid Program during the audit period (the audit sample), for which the auditors required supporting documentation. (Exhibits 19, 20.)

6. On January 7, 2020, an exit, or closing conference was held pursuant to 18 NYCRR § 517.5(a), during which the auditors discussed their findings with the Appellant's representatives. Documentation deficiencies were organized into 14 disallowance categories. The auditors identified 86 claims with at least one error, for a total sample overpayment of $17,361.70. (Exhibit 2.)

7. In response to the preliminary findings identified in the exit conference, the Appellant submitted additional documentation to the auditors to support its entitlement to Medicaid payments for the sampled claims. (Exhibit 14.)

8. On March 9, 2020, the OMIG issued a draft audit report to the Appellant, which identified seventy-nine claims with at least one error organized into 13 disallowance categories, and disallowed payments totaling $14,816.31. The draft audit report also advised the Appellant that the audit employed a statistical sampling methodology to extrapolate the sample findings for disallowances in ten of the disallowance categories to an audit frame of all claims paid during the three-year audit period. Using the extrapolation and adding the total sample overpayment from

another three disallowance categories, OMIG determined preliminarily that the Medicaid overpayment received by the Appellant was $2,391,420. The draft audit report offered the Appellant the opportunity to object to the proposed findings and provide additional documentation to be considered in support of the objections pursuant to 18 NYCRR § 517.5. (Exhibit 3.)

9. On May 8, 2020, the Appellant submitted its response to the draft audit report, contesting the disallowances and resulting overpayment. The Appellant also enclosed documentation to counter the audit findings. (Exhibit 16, 16(a)-(c).)

10. On February 25, 2021, the OMIG issued a final audit report, which removed one disallowance category containing a duplicate finding and determined that 79 claims contained at least one error with overpayments totaling $14,816.31. The final audit report also advised the Appellant that the OMIG determined to seek restitution of Medicaid Program overpayments totaling $2,391,420, derived by projecting the value of errors found in the claims identified in disallowance categories 1, 4-6, and 8-12 to the claims universe, and adding the actual dollar disallowances for the errors found in the claims that were identified in categories 2, 3, and 7. (Exhibit 4.)

11. The OMIG organized the disallowed claims into the following categories:

1. TBI Training Not Completed – Home and Community Support Services (HCSS) (sampled claims 2, 5-7, 10, 15-17, 19, 21, 25-27, 30, 31, 35, 37, 39, 40, 43-45, 47-50, 52-56, 59-62, 65, 66, 68, 70-73, 76, 77, 82, 84, 85, 87, 88, 90, 92, 93, 97, and 99.)
2. Failure to Complete Health Requirements (sampled claims 2, 5, 7, 9, 10, 12, 14, 19, 24, 30, 37, 49-55, 60, 76, 79, 82, 84, 85, 88, 90, 93, 94, and 99.)
3. Failure to Complete Required HCSS In Service Training (sampled claims 7, 12, 13, 16, 19, 21, 35, 36, 44, 47, 50, 55, 57, 58, 67, 76, 78, 79, 84, 85, 87, 90, 93, 99, and 100.)
4. Partial Services Hours were Billed Incorrectly (sampled claims 6, 11, 12, 16, 19, 22, 28, 41, 45, 51, 58, 65, 68, 77, 78, 87, and 92.)

5. Missing Documentation of Service (sampled claims 3, 4, 12, 15, 22, 23, 54, 61, 85, and 93.)
6. Billed Service not Included in the Service Plan (sampled claims 1, 7, 37, 40, 61, 65, and 92.)
7. Failure to Conduct Required Criminal History Check (sampled claims 20, 51, and 55.)
8. Services Performed by Unqualified Home and Community Support Services Staff (sampled claims 25, 87, and 93.)
9. Missing Documentation of Nursing Supervision Visit (sampled claims 13 and 34.)
10. Failed to Obtain Authorized Practitioner's Signature within Required Time Frame (sampled claims 30 and 41.)
11. Billed More Hours than Documented (sampled claim 43.)
12. TBI Training not Completed – Service Coordinator (sampled claim 74.)

(Exhibit 4.)

12. The OMIG has removed its findings in disallowance category 4, resulting in a reduction of the total overpayment to $2,376,559. (T 51.)

13. The Appellant is contesting all remaining disallowances. It is also contesting the OMIG's determination to extrapolate the disallowances set forth in categories 1, 5, 6, and 8-12 to the total universe of claims.. (Exhibit 5.)

ISSUES

Was the OMIG's determination to recover Medicaid Program overpayments from the Appellant correct?

Was the OMIG's determination to extrapolate the findings in categories 1, 5, 6, and 8-12 to the universe of claims correct?

APPLICABLE LAW

The Department of Health (Department) is the single state agency for the administration of the Medicaid Program in New York State. PHL § 201(1)(v); SSL § 363-a. The OMIG is an independent office within the Department with the authority to pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or

improper acts or unacceptable practices perpetrated within the Medicaid Program. Such actions may include the recovery of improperly expended Medicaid funds. PHL §§ 30-32.

By enrolling in the Medicaid Program, providers agree to prepare and to maintain contemporaneous records demonstrating the right to receive payment under the Medicaid Program and to furnish such records and information, upon request, to the Department. Such records must be maintained for at least six years from the date of service. 18 NYCRR § 504.3(a). Medicaid providers agree to permit audits by the Department of all books and records or, in the Department's discretion, a sample thereof, relating to services furnished and payments received under the Medicaid Program, including patient histories, case files and patient-specific data. 18 NYCRR § 504.3(g), § 517.3(b), § 540.7(a)(8). In addition, Medicaid providers must comply with the rules, regulations, and official directives of the Department. 18 NYCRR § 504.3(i).

When it is determined that a provider has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, the Department may require repayment of the amount determined to have been overpaid. 18 NYCRR § 504.8(a)(1) and § 518.1(b). An overpayment includes any amount not authorized to be paid under the Medicaid 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).

A Medicaid provider is entitled to a hearing to review the OMIG's final determination to require repayment of any overpayment or restitution. 18 NYCRR § 519.4. The Appellant has the burden of showing by substantial evidence that the OMIG's determination was incorrect and

that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR § 519.18(d)(1); SAPA § 306(1).

DISCUSSION

The Home and Community Based Services Waiver for Traumatic Brain Injury is a federally approved program that is administered centrally by the Department. Social Security Act, Title XIX; PHL § 2740. The waiver uses Medicaid funds to make certain services, not otherwise offered through the Medicaid Program, available to eligible individuals with traumatic brain injury to promote their successful inclusion in the community. HCBS NYS DOH Medicaid Waiver for Individuals with TBI Program Manual (TBI Program Manual), April 2009, Section I.

All providers, including those already approved to provide services under the Medicaid Program or another Medicaid waiver are required to be separately approved as a TBI waiver provider. Providers are responsible for knowing, understanding, and implementing the waiver in accordance with the policies and procedures issued by the Department, including those outlined in the TBI Program Manual or in any updates or changes to the Manual. TBI Program Manual, April 2009, Section III.

The Audit Findings

The findings were organized into 12 disallowance categories shown in the Final Audit Report. With the OMIG's removal of disallowance category 4, the Appellant is contesting the findings set forth in the remaining 11 disallowance categories.

Disallowance Category 1: TBI Training not Completed – Home and Community Support Services (HCSS).

Required training for TBI waiver service providers consists of three components: (1) basic orientation training; (2) service specific training; and (3) annual training. TBI Program Manual, Section VIII. An approved TBI waiver service provider agency is responsible for developing a written training curriculum to meet the training requirements described in the TBI Program Manual. In addition, the TBI waiver service provider agency must provide basic orientation training and the appropriate service specific training to all waiver providers prior to any unsupervised contact with a waiver participant. The provider agency must document all training in the employee file, including all related TBI program training, seminars and conferences attended, whether offered by the provider or other entities. Documentation in each employee's file must include the trainer's name and qualifications, record for all staff that attended training, date and place of the training, training goals and objectives, and evaluation tools. TBI Program Manual, Section VIII.

HCSS are utilized when oversight and/or supervision as a discrete service is necessary to maintain the health and welfare of a TBI waiver participant living in the community. HCSS may also include personal care assistance with activities of daily living and instrumental activities of daily living. TBI Program Manual, Section VI.

HCSS staff must attend basic orientation training and service specific training specified in Section VIII of the TBI Program Manual prior to providing any billable services. TBI Program Manual, Section VI. The auditors identified 54 instances (sampled claims 2, 5-7, 10, 15-17, 19, 21, 25-27, 30, 31, 35, 37, 39, 40, 43-45, 47-50, 52-56, 59-62, 65, 66, 68, 70-73, 76, 77, 82, 84, 85, 87, 88, 90, 92, 93, 97 and 99) in which HCSS were performed by staff who lacked

adequate documentation to establish that they successfully completed the required basic orientation and HCSS service specific training before the sampled claims' dates of service. (Exhibits 4, 10(a), 10(b), 11, 13(a).)

In multiple instances in sampled claims, submitted information showed that staff rendering HCSS successfully completed trainings for other programs, mainly, personal care aide training, home health aide training, and/or nursing home transition diversion training. Yet, no documentation was provided for those same individuals to show their successful completion of HCSS training before rendering services as TBI waiver service providers for which the Appellant billed the Medicaid Program.

In its response to the draft audit report, the Appellant incorrectly argued that disallowances were improper because HCSS staff received training to become a personal care aide or a home health aide, which was sufficient training to justify the Appellant's right to receive payment for HCSS in the sampled claims. (Exhibits 16, 16(a), 16(b).) Home Health Aide training or Personal Care Aide training is a prerequisite to HCSS training and serving in that capacity, and therefore will not suffice for HCSS training. TBI Program Manual, Section VI. HCSS staff must have a valid certificate showing successful completion of a 40-hour training program for Level II personal care assistance and successfully complete basic orientation and service specific training. TBI Program Manual, Sections VI and VIII.

The Appellant provided an undated PowerPoint presentation of its TBI waiver program basic orientation, which explains the program's training requirements (Exhibit B) and contended that the auditors incorrectly assumed that other trainings for which it provided documentation, such as certain employees' certificates of completion of agency orientation, corporate compliance, Home Health Aide training or Personal Care Aide training, did not contain the

elements of TBI waiver program basic orientation and service specific training. (T 330-32, 363-73.) Those trainings are distinct and unrelated to TBI waiver program-related training. The Appellant offered no documentation to prove that the employees attending and completing other training simultaneously received basic orientation training for the TBI waiver program.

Pursuant to Section VIII of the TBI Program Manual, providers are required to include documentation of all TBI waiver program-related training in each employee's file. (Exhibit 26, p. 584.) Absent documentation explicitly identifying the requisite training as having been completed for each employee identified in sampled claims, the auditors had no reason to conclude that other training offered by the Appellant met all TBI waiver program training requirements for HCSS staff. Auditors are not authorized to assume provider compliance with legal requirements.

The Appellant argues further that the auditors' search for and scrutiny of sign-in sheets and other documents as evidence of compliance with training requirements was based upon their own interpretation, and not rooted in specific requirements. (Appellant's April 22, 2022 Brief, pp. 19-21; Appellant's May 18, 2022 Brief, p. 21.) The TBI Program Manual specifically requires documentation showing employees' successful completion of required trainings that include the trainer's name and qualifications, record for all staff that attended training, date and place of the training, training goals and objectives, and evaluation tools. TBI Program Manual, Section VIII. The auditors' review of sign-in sheets, information regarding trainers, and certificates of completion reflects a literal comprehension of the requirements set forth in the TBI Program Manual.

The auditors sought information explicitly required by the TBI Program Manual, and when such information was not available, reviewed other information that the Appellant

provided in order to assess its compliance with program requirements. To the extent that the auditors considered documentation other than that specifically required by the TBI Program Manual, that documentation offered the Appellant further opportunity to establish compliance with requirements. Despite the Appellant's complaints, it has not attempted to show how documentation submitted to the OMIG auditors for any disallowance in this category met training documentation requirements. For the disallowances in this category, the Appellant's documentation did not demonstrate HCSS staff's successful completion of TBI-related required training.

The Appellant's arguments are further undermined by the fact that the auditors received adequate documentation to show that employees providing services in the other 46 sampled claims received the requisite basic orientation training, as well as HCSS training, prior to the sampled claims' dates of service. The disallowances in this category were properly disallowed.

Disallowance Category 2: Failure to Complete Health Requirements.

HCSS may only be provided by a Licensed Home Care Services Agency (LHCSA) licensed under Article 36 of the Public Health Law. All regulations governing the LHCSA apply to the provision of HCSS. Among other requirements, HCSS staff must meet all health requirements specified in 10 NYCRR § 766.11. TBI Program Manual, Section VI.

LHCSAs shall ensure that the health status of all new personnel is assessed and documented prior to assuming patient care duties. The assessment shall be of sufficient scope that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. 10 NYCRR § 766.11(c). Supporting

documentation for sampled claims 7, 10, 12, 24, 30, 37, 49, 51, 53, 55, 79, 85, and 88 did not include health assessments occurring before the date of service for certain HCSS staff rendering services. (Exhibits 10(a), 10(b), 11.)

For all personnel prior to employment or affiliation, except for personnel with no clinical or patient contact responsibilities, an initial individual tuberculosis (TB) risk assessment, symptom evaluation, and TB test, and annual assessments thereafter. Positive findings shall require appropriate clinical follow-up. 10 NYCRR § 766.11(d)(4).

Tuberculosis test results for several HCSS providers were not included in documentation for sampled claims 2, 5, 50, 54, 60, and 93. (Exhibits 10(a), 10(b), 11.) The portions of these sampled claims related to those providers were therefore properly disallowed. Although PPD test (a tuberculin skin test) results were provided for sampled claims 9, 14, 19, 52, and 94 (Exhibits 10(a), 10(b), 11,) the results were read by a licensed practical nurse (LPN), which is outside the scope of an LPN's practice. New York Education Law § 6902(2). While a registered nurse may assign the actual intra-dermal injection of the PPD to an LPN, the description of the PPD skin test results must be communicated to the registered nurse, who determines whether the result is positive or negative and devises a care plan. New York State Department of Education – Office of the Professions, Nursing Practice Alerts and Guidelines, PPD Protocol, June 2009.

For sampled claim 84, the Appellant was unable to provide documentation that an HCSS provider who had previously tested positive for tuberculosis received clinical follow-up for her symptoms as required by 10 NYCRR § 766.11(d)(4). (Exhibits 10(b), 11.) As such, the portion of sampled claim 84 attributable to that provider's services was appropriately disallowed. The disallowances made for sampled claims 2, 5, 7, 9, 10, 12, 14, 19, 24, 30, 37, 49-55, 60, 76, 79, 82, 84, 85, 88, 90, 93, 94, and 99 are all upheld.

Disallowance Category 3: Failure to Complete Required HCSS In Service Training

In addition to successful completion of a forty-hour training program for personal care aides, and attendance of basic orientation and service specific trainings for the TBI waiver program, HCSS staff must also attend six hours of in-service education per year that includes TBI waiver program-specific training. TBI Program Manual, Section VI.

The training documentation for HCSS staff rendering services billed for in sampled claims 12, 19, 21, 36, 44, 47, 55, 57, 76, 79, 84, 85, 90, 99, and 100 showed that staff attended less than six hours of in-service training. With respect to sampled claims 7, 13, 16, 35, 50, 58, 67, 78, 87, and 93, documentation of in-service training was not provided for all HCSS staff rendering billed services. (Exhibits 10(a), 10(b), 11.) The disallowances in this category are upheld.

Disallowance Category 5: Missing Documentation of Service

Record keeping of all TBI waiver program services is required for both clinical reasons and to document the expenditure of Medicaid funds. All records must be maintained for at least seven years after the termination of services. Providers must document each encounter with a TBI waiver program participant, which must include the date, location, time, and a description of the activities, which are related to the goals established in a detailed plan. TBI Program Manual, Section VII. The Appellant failed to provide documentation describing how HCSS staff assisted the TBI waiver program participant and how such assistance related to the participant's care plan for sampled claims 3, 4, and 22. (Exhibits 10(a), 11.) With respect to sampled claims 12, 15, 23, 54, 61, 85, and 93, the service documentation provided by the Appellant failed to substantiate the total number of hours billed. (Exhibits 10(a), 10(b), 11.) The disallowances in this category are upheld.

Disallowance Category 6: Billed Service not Included in the Service Plan

TBI waiver program services may only be furnished in accordance with a plan of care approved by the Department. 42 CFR § 441.301(b)(1)(i). Only those services which are provided by a Department-approved provider and included in the service plan will be reimbursed. TBI Program Manual, Section VI.

The Appellant was not the authorized service provider for services billed in sampled claims 1, 40, 61, 65, and 92 (Exhibits 10(a), 10(b), 11), and was consequently not entitled to payment for those services. Supporting documentation for sampled claims 7 and 37 did not include a listing of approved waiver services for the participant. (Exhibits 10(a)-(b), 11.) The Appellant was therefore unable to establish that billed services were rendered in accordance with the participant's approved plan of care. The disallowances in this category are upheld.

Disallowance Category 7: Failure to Conduct Required Criminal History Check

Home health agencies are required to submit a request to the Department for a criminal history record check for all prospective employees and maintain documentation to show compliance with this requirement. 10 NYCRR § 402.6 and §§ 402.9(a)&(c). The Appellant failed to initiate the required criminal history record check for HCSS providers rendering services billed in sampled claims 20, 51, and 55. (Exhibits 10(a), 10(b), 11.) These disallowances are upheld.

Disallowance Category 8: Services Performed by Unqualified HCSS Staff

HCSS staff must complete State-approved personal care aide level II or home health aide training prior to completing basic orientation and service-specific training for the TBI waiver program. TBI Program Manual, Section VI; 18 NYCRR § 505.14(e) and 18 NYCRR §

505.23(2)(iii). The Appellant failed to document the required training for HCSS staff members who rendered billed services in sampled claims 25, 87, and 93.

The auditors also consulted the home care worker registry (T 211), a database maintained by the Department that contains information regarding individuals' successful completion of State approved training programs for home health aides and personal care aides. 10 NYCRR § 403.4. The auditors' attempts to independently verify training information offered the Appellant another means of establishing compliance with all requirements even when the Appellant was unable to give the auditors the required documentation.

Upon reviewing the home care worker registry, the auditors found no information whatsoever for HCSS staff members who rendered billed services in sampled claims 25, 87, and 93. (Exhibits 10(a), 10(b), 11.) Other than its general objections discussed below, the Appellant offered no information to refute these findings. The disallowances in this category are all upheld.

Disallowance Category 9: Missing Documentation of Nursing Supervision Visit

Home and Community Support Services (HCSS) must be provided under the direction and supervision of a registered nurse based on an assessment of an individual's needs and supported by physicians' orders. The registered nurse must conduct an initial home visit on the day and time HCSS staff begins providing services to the participant. TBI Program Manual, Section VI.

Supporting documentation for sampled claims 13 and 34 (involving the same TBI waiver program participant) did not include an initial home visit as required by the TBI Program Manual. (Exhibits 10(a), 10(b), 11.) The Appellant offered no information to disprove these findings. The disallowances in this category are upheld.

Disallowance Category 10: Failed to Obtain Authorized Practitioner's Signature within Required Time Frame

Licensed home care services agencies (including TBI waiver program service providers) are required to ensure that an order from a patient's authorized practitioner is established and documented for the health care services the agency provides to patients who: (1) are being actively treated by an authorized practitioner for a diagnosed health care problem; (2) have a health care need or change in physical status requiring medical intervention; or (3) are advanced home health aide, home health aide, or personal care services patients of a certified home health agency. 10 NYCRR § 766.4(a). Such orders shall be reviewed and revised as the needs of the patient dictate but no less frequently than every six months, except where an authorized practitioner orders personal care services for up to one year for a Medicaid patient. 10 NYCRR § 766.4(c). The confidential clinical record maintained for each patient accepted for service must include medical orders signed by the authorized practitioner within 30 days after the issuance of any change in medical orders or prior to billing, whichever is sooner. 10 NYCRR § 763.7(a)(3).

On reviewing supporting documentation for sampled claim 30, the auditors found that the medical order most immediately preceding the billed [redacted] 2015 date of service was not effectuated within six months of that date, as it was valid from [redacted] 2014 through [redacted], 2015. That order was only renewed after the six-month period applicable to the [redacted] 2015 date of service. (Exhibits 10(a), 11.) Similarly, with respect to sampled claim 41, the auditors were not provided with a medical order that encompassed the billed [redacted] 2013 date of service. (Exhibits 10(b), 11.) The disallowances in this category are upheld.

Disallowance Category 11: Billed More Hours than Documented

The auditors determined to disallow one hour of billed home and community support services (HCSS) for the [redacted] 2014 billed date of service in sampled claim 43 after noting that the HCSS staff member documented providing only eight hours of services and the Appellant billed the Medicaid Program for nine hours of services. (Exhibit 10(b); T 217-22.) This disallowance is upheld.

Disallowance Category 12: TBI Training not Completed – Service Coordinator

In sampled claim 74, the Appellant billed for service coordination, a monthly charge. However, the Appellant provided no documentation to show that the billing service coordinator received and successfully completed basic orientation and service coordination training, as required. (Exhibits 10(b), 11; T 222-24.) TBI Program Manual, Section VIII. This disallowance is upheld.

The Appellant's Broader Arguments Regarding the Disallowances

Loss of Documentation

During this hearing, the Appellant asserted that it was unable to produce documentation requested during the audit because former employees stole numerous, unspecified documents in 2015. It had previously alleged in governmental filings, and communications with patients and the alleged perpetrators that files were either removed or copied (actions with very different meanings), but that files regarding home care services were not impacted by those ex-employees' actions. (Exhibits 29, G, H.) These issues were not mentioned in the Appellant's May 8, 2020 response to the Draft Audit Report (Exhibit 16) or its April 26, 2021 hearing request (Exhibit 5), but were communicated informally to the auditors. Most importantly, the Appellant failed to

immediately, or at any time before this audit occurred more than three years later, notify the OMIG's Self-Disclosure Unit of an alleged documentation loss in 2015.

According to the Appellant, from [redacted] through [redacted], 2015[1], [redacted] (its then CEO) and several other office-based employees, removed, copied and/or tampered with employee and patient files to be used by a competing home health care agency, [redacted]). (Exhibit G.) Those office-based employees then left the Appellant's employ to work for [redacted] (T 713; Exhibit 29.)

Mr. David Wegman testified that the Appellant also lost at least 30 patients, and a similar number of home health employees to service those patients, to help [redacted] business immediately. (T 715.) He asserted that [redacted] took employment files and encouraged the defection of home health employees to ensure its compliance with legal requirements. (T 715-16.)

The Appellant emphasized its attempts to notify governmental entities of the situation. It offered an extensive account of litigation and other actions involving the dispute with [redacted] (Exhibit 29; Exhibit G, H.) Notably absent from these documented efforts was any attempt to notify the OMIG's Self-Disclosure Unit of the purported loss of documentation to justify its billings to the Medicaid Program. In the May 2015 Medicaid Update, Medicaid providers were advised that they are required to notify the Self-Disclosure Unit "immediately upon discovery" of unexpected damage, loss, or destruction of records necessary to fully describe services rendered to Medicaid enrollees. (Exhibit 28.) The Appellant did not comply with this requirement, despite its allegation that documentation was lost only a few months after the dissemination of this update. Instead, it now complains that no governmental unit ever

[1] In its April 22, 2022 brief, page 25, the Appellant contends that the purported theft of records occurred from [redacted] 2015 through [redacted] 2015.

directed the Appellant to disclose its purported loss to the OMIG. (Appellant's April 22, 2022 Brief, pp. 11-13.) Medicaid providers are responsible for keeping up with changes to rules, regulations, and official directives of the Department. 18 NYCRR § 504.3(i).

The Appellant has requested consideration of Audit Directive No. 23, issued on June 24, 2010, entitled "Destruction of Records by Flood, Fire, or Other Unforeseen, Unintentional Event" (Exhibit I), despite the issuance of a subsequent, superseding Audit Directive (No. 5) effective July 1, 2015, which reiterated the notification requirements explained in the May 2015 Medicaid Update (Exhibit 30). (Appellant's April 22, 2022 Brief, p. 14; Appellant's May 18, 2022 Brief, p. 17.) The July 1, 2015 audit directive advised auditors that providers must immediately notify the OMIG's Self-Disclosure Unit of lost or destroyed documents, while the June 24, 2010 audit directive did not include such guidance. The Appellant offered no legal justification for considering and applying outdated audit instructions and ignoring an applicable Medicaid Update given directly to providers in reviewing the disallowances at issue here.

The Appellant also seeks consideration of standards recommended by the Centers for Medicare and Medicaid Services (CMS) in Chapter 3 of the Medicare Program Integrity Manual. (Appellant's April 22, 2022 Brief, pp. 16-17.) It is the CMS Medicaid Integrity Program Manual, not the Medicare Program Integrity Manual, which pertains to audits of Medicaid payments. The Medicaid manual defers to processes and policies devised by each state's Medicaid agency when conducting audits. Medicaid Program Integrity Manual, Chapter 1, versions effective 4-3-18 and 10-9-20, the latter being accessible at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mpi115c01.pdf.

The applicable Medicaid policy is clear in this case. The Appellant did not notify the Self-Disclosure Unit of documentation loss or destruction as required. Its attempts to establish

mitigating circumstances to justify a lack of supporting documentation are insufficient to waive Medicaid record-keeping requirements.

The Appellant made no attempt before, during or after the audit, at the hearing, or in its post-hearing submissions, to identify the documentation that it believes to have been removed by or on behalf of [redacted] Instead, the Appellant contends that "[t]here is no evidence that the stolen records were somehow limited only to *non*-TBI program records." (Appellant's May 18, 2022 Brief, p. 18.) This argument improperly shifts the Appellant's burden of proof onto the OMIG. The more appropriate analysis is that no evidence was presented to show that stolen or ransacked records (to the extent that records were taken) involved the Appellant's provision of TBI waiver services.

The audit findings are more indicative of the Appellant's non-compliance with TBI waiver program requirements than efforts by departing staff to comb through employee files and abscond with documentation that would nullify the Appellant's payments for TBI waiver services. The documentation submitted for this audit included several training certificates for staff that were insufficient to authorize them to render care as TBI waiver service providers but would authorize them to render other services for the Appellant's agency.

For a significant number of sampled claims, the Appellant was unable to provide documentation of staff's attendance at annual HCSS in-service training, compliance with health requirements, or documentation of services provided. While some of this documentation must be kept in employee files (i.e., training documentation, health assessments, immunization records, criminal history record checks), other items are to be stored in patient files (i.e., documentation of services, service plans, nursing supervision visit, medical orders for services.)

The Appellant's employees frequently work for multiple lines of the Appellant's business. (T 782-85.) The range and quantity of missing documentation, and the Appellant's inability to provide any detail regarding documentation that was purportedly removed from its premises, do not show errors in the OMIG's determination, but rather, a consistently informal approach by the Appellant to assign unqualified staff to its TBI waiver program.

TBI Program Manual as Illegitimate Basis for Disallowances

The Appellant argues that the audit disallowances are improper as they are based upon requirements set forth in the TBI Program Manual, rather than regulatory or statutory authority. (Exhibit 5; T 426, 448-49; Appellant's April 22, 2022 Brief, pp. 17-18.) The Department has the authority to make such rules, regulations and official directives (including manuals, Medicaid Updates, administrative directives) as are necessary to implement the regulations, and providers are required to abide by them. 18 NYCRR § 504.3(i); *PSSNY v. Pataki*, 58 A.D.3d 924 (3rd Dept. 2009); *Lock v. NYS Department of Social Services*, 220 A.D.2d 825 (3rd Dept. 1995.)

The Appellant was explicitly advised that it was required to abide by Department policies and the TBI Program Manual when rendering TBI waiver services. TBI Program Manual, April 2009, Section III. The TBI Program Manual "neither contradicts, nor adds significantly to, the conditions for payment set forth in applicable regulations." *Lock*, 220 A.D.2d at 827. It compiles applicable requirements found in multiple regulations and provides additional explanations for those requirements into one document to facilitate provider compliance.

The Appellant's Receipt of Payment After Submitting Claims

The Appellant contends that the OMIG's determinations are improper since the Medicaid Program had already remitted payment for the submitted claims and should therefore be "permitted to correct claims and justify them on audit with contemporaneous documentation." In

support of this argument, the Appellant cites *Chelsea Express Transportation, Inc.*, Dept. of Health Admin. Hearing Decision, ALJ William J. Lynch, May 24, 2019. (Exhibit 5; Appellant's April 22, 2022 Brief, pp. 22-23.) The Appellant's reliance upon the holding in that decision is misplaced, as that hearing reviewed the OMIG's determination to disallow claims based upon missing information or clerical errors in claims submissions in the absence of inadequacies in the documentation supporting those claims. In the case at hand, the OMIG made no finding that the Appellant's claims contained clerical errors. The audit identified multiple issues with the Appellant's supporting documentation for paid claims, which the Appellant was already afforded multiple opportunities during the audit process to address.

Failure to Establish Practices were Motivated by Fraud, Waste, or Abuse

Citing *Statewide Ambulette Service Inc.*, Dept. of Health Admin. Hearing Decision, ALJ John Harris Terepka, Oct. 28, 2015, the Appellant argues that the OMIG has failed to establish that the Appellant's "practices were motivated by fraud, waste, or abuse." (Exhibit 5; Appellant's April 22, 2022 Brief, pp. 18, 22.) That argument is irrelevant to this matter, as the OMIG has not charged the Appellant with unacceptable practices and has made no determination to sanction the Appellant pursuant to 18 NYCRR Part 515. Instead, the OMIG has determined to seek restitution of Medicaid Program overpayments pursuant to 18 NYCRR Parts 517 and 518.

Licensed Home Care Services Agency (LHCSA) Survey

The Appellant also argues that the period audited overlapped with a September 23, 2015 LHCSA survey in which the Appellant was found to be in substantial compliance with LHCSA regulatory requirements, as well as requirements pertaining to the TBI and Nursing Home Transition Diversion (NHTD) waiver programs. (T 272-79; Appellant's April 22, 2022 Brief, pp. 4-6, 24-25.) The Appellant did not raise this issue in any of its communications with the

OMIG during the audit, in response to the draft audit report, or at any time before this hearing commenced (Exhibits 5, 16; T 283) and is therefore precluded from doing so now. 18 NYCRR § 519.18(a).

In any event, a LHCSA survey of the Appellant's operations in no way precludes the OMIG from conducting this claims audit. The LHCSA survey included a review of five participant records and six personnel/training records of professional and para-professional staff. The resulting Statement of Deficiencies explicitly states that the survey reviewed the Appellant's Quality Assurance activities, complaint procedures, incident reporting and training curriculum. (Exhibit A.) The auditors did not review the same aspects of the Appellant's operations (Exhibit 27) and disallowances are unrelated to the items previously surveyed. (Exhibits 3, 4; T 412.) Unlike this audit and contrary to the Appellant's assertions (Appellant's May 18, 2022 Brief, p. 10,) the LHCSA survey did not review claims submitted to and paid by the Medicaid Program and supporting documentation. (Exhibit A.)

The Appellant failed to establish that the OMIG's auditing of claims for TBI waiver services paid by the Medicaid Program during the period January 1, 2013 through December 31, 2015, after the occurrence of a September 2015 LHCSA survey of certain aspects of the Appellant's TBI waiver services, constitutes a violation of applicable law or guidance (T 298).

The OMIG's Extrapolation of Audit Findings to the Universe of Claims

The OMIG extrapolated the findings from categories 1, 4-6, and 8-12 totaling $13,624.19 to the universe of 17,544 claims for which it received total payments of $4,692,515.17, resulting in a point estimate of $2,390,228. The disallowances identified in categories 2, 3, and 7 were not extrapolated. Instead, those sample overpayments totaling $1,192 were added to the point estimate for a total overpayment of $2,391,420. (Exhibit 4.)

The OMIG's use of statistical sampling methodology for extrapolation of the sample findings was explained to the Appellant in the exit conference summary (Exhibit 2), the draft audit report (Exhibit 3), and the final audit report (Exhibit 4.) During the exit conference, the Appellant was also given a compact disk containing information about the universe of claims in the audit period and sample information about the claims selected for audit. (Exhibit 2.)

An extrapolation based upon an audit utilizing a statistical sampling method certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made. 18 NYCRR § 519.18(g).

The OMIG submitted the required certifications in the form of affidavits from Dr. Karl W. Heiner, the statistical consultant who designed the sampling and estimation methodology used, and Theresa Gulum, the OMIG employee who applied the methodology to establish the audit frame and select the random sample. (Exhibits 23, 24.)

The Appellant asserts that the OMIG's extrapolation of audit findings did not comport with guidelines propounded by CMS in the Medicare Program Integrity Manual, Chapter 8. (Exhibit 5, Appellant's April 22, 2022 Brief, pp. 7-8.) As already noted, the Medicare Program Integrity Manual is not binding authority in an audit of claims paid by the Medicaid Program. Furthermore, the Medicare Manual explicitly states that failure to follow its guidelines should not be construed as necessarily affecting the validity of statistical sampling or the projection of an overpayment. Medicare Program Integrity Manual § 8.4.1.1, accessible at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c08.pdf.

CMS' Medicaid Program Integrity Manual pertains to Medicaid audits and defers to state Medicaid policies regarding extrapolation. Medicaid Program Integrity Manual § 1.7.3, versions effective 4-3-18 and 10-9-20, the latter being accessible at: https://www.cms.gov/Regulations-

and-Guidance/Guidance/Manuals/Downloads/mpi115c01.pdf. New York State Medicaid audits employ the statistical sampling method described in Dr. Heiner's certification and authorized by state law and Department regulations.

The OMIG's authority to determine overpayments by extrapolating audit findings to the claims universe or population within the audit frame is well-settled. *Yorktown Medical Laboratory, Inc. v. Perales, 948 F.2d 84 (2d Cir. 1991); Mercy Hospital of Watertown v. New York State Dept. of Social Services*, 79 N.Y.2d 197 (1992); *Piasecki v. DSS*, 225 A.D.2d 310 (1st Dep't 1996); *Tsakonas v. Dowling*, 227 A.D.2d 729 (3d Dep't 1996); *Enaw v. Dowling*, 220 A.D.2d 942 (3d Dep't 1995); *Enrico v. Bane*, 213 A.D.2d 784 (3d Dep't 1995); *State v. Khan*, 206 A.D.2d 732 (3d Dep't 1994); *Adrien v. Kaladjian*, 199 A.D.2d 57 (3d Dep't 1993); *Clin Path, Inc. v. New York State Dep't of Social Servs.*, 193 A.D.2d 1034 (3d Dep't 1993). These reported cases all upheld the very same extrapolation methodology employed again in this audit.

An Appellant may, however, submit expert testimony challenging the extrapolation by the Department or an actual accounting of all claims paid in rebuttal to the Department's proof. 18 NYCRR § 519.18(g). The Appellant presented Dr. [redacted] as its expert witness to challenge the extrapolation. Dr. [redacted] is biostatistics professor at the University of Pennsylvania School of Medicine. In addition to his academic achievements, Dr. [redacted] is a statistics consultant who has advised various state and local government agencies regarding audit procedures for Medicare and Medicaid claims reviews, as well as health care providers contesting determinations of audits of Medicare and Medicaid claims. (Exhibit K.) Most pertinent to this proceeding, Dr. [redacted] performed statistical consulting work for another Medicaid provider audited by the OMIG. In the resulting administrative decision, Dr. [redacted] opinion was not found persuasive in contesting the validity of the OMIG's extrapolation

methodology. *CVS/Caremark Corporation, Dunkirk Store # 309*, Dept. of Health Admin. Hearing Decision, ALJ Jeffrey Armon, July 20, 2009.

At the hearing, Dr. [redacted] asserted that "rare events", such as disallowance categories with only one identified error, should not be extrapolated to the universe of claims. (T 671-74.) Disallowance categories 11 and 12 each contain one sampled claim.

Disallowances can be categorized in a multitude of ways. Due to the seeming overlap between disallowance categories 1 (HCSS TBI Training Not Completed), 8 (Services Performed by Unqualified HCSS Staff), and 12 (Service Coordinator TBI Training not Completed), they could easily have been combined into one category, thus eliminating even a superficial, unsubstantiated charge that one finding is a rarity in the universe of claims. The Appellant does not dispute the substantive similarities between multiple disallowance categories. It concurs that "[t]he vast majority of the cited errors are related to training and related documentation alleged to have been inadequate." (Exhibit 5; Appellant's April 22, 2022 Brief, p. 24.)

The Appellant is lacking a material and substantial amount of documentation necessary to justify its claims submitted to the Medicaid Program for which it received payment during the audited period, including training documentation. Regardless of the distinctions by category, missing documentation, especially with respect to required training, was not an unusual or aberrant finding in the claims sampled.

Dr. [redacted] also opined that claims for which the Appellant received no payment should not be included in the universe of claims. (T 615-17, 668-69.) The OMIG did not include claims for which no payment was made in the universe. (Exhibit 19.)

Finally, Dr. [redacted] testified that a sample size of 100 claims, as employed in this audit, is not always appropriate. (T 620-22, 670.) However, he did not provide information specific to

this audit and agreed that a larger sample size would not guarantee a lesser overpayment. (T 670-71.)

The Appellant also challenged the OMIG's use of the March 9, 2018 audit protocol applicable to service dates before September 1, 2017 (Exhibit 27) which directed the extrapolation of findings regarding missing documentation for basic orientation and service-specific training, unlike the previous audit protocol revised July 3, 2015 (Exhibit E). (T 270-71.) Mr. Hynes testified that the decision was made in the 2018 audit protocol to extrapolate findings pertaining to the initial training requirements because they are deemed essential and fundamental and must be completed before any services are rendered. (T 266.) Findings related to annual training requirements (in-service training) were not extrapolated to the universe of claims because those omissions pose a negative impact to services rendered within 12 months, a shorter period of time than omissions regarding a failure to train and orient staff members regarding the fundamental elements of the TBI waiver program and specific job requirements. The OMIG's determination to follow the audit protocol in effect at the time the audit was conducted was appropriate and within its discretion.

Extrapolation affords the OMIG an efficient means of assessing a provider's compliance with all or most applicable program requirements while also affording the provider an efficient means of establishing its compliance. Despite being afforded the ability to dispute the OMIG's substantive findings and computations regarding the 100 claims sampled and/or an actual accounting of all claims paid, the Appellant has not shown any error.

In its post-hearing submissions, the Appellant contended that the OMIG must also consider factors enumerated in 18 NYCRR § 516.3 to determine whether extrapolation is fair and reasonable. (Appellant's April 22, 2022 Brief, pp. 6-7; Appellant's May 18, 2022 Brief, p.

20.) An overpayment amount derived by extrapolation is not a monetary penalty (*see* 18 NYCRR § 516.3(a)(1)), but rather a statistical method of computing the total amount of Medicaid payments received by a provider during the period audited when, such as in this audit, the provider failed to prepare and/or maintain contemporaneous documentation demonstrating its right to receive payment. The factors to be considered in determining the imposition of a monetary penalty are inapplicable to an overpayment computed by extrapolation.

The Appellant has failed to overcome the presumption of validity afforded the statistical sampling methodology that the OMIG employed for extrapolating its audit findings, and which was certified to be valid. 18 NYCRR § 519.18(g).

DECISION

The OMIG's determination to recover Medicaid Program overpayments from the Appellant was correct and is affirmed.

The OMIG's determination to extrapolate the findings in categories 1, 5, 6, and 8-12 to the universe of claims correct was correct and is affirmed.

Dated: June 8, 2022
Menands, New York

Natalie J. Bordeaux
Administrative Law Judge