

cc: Ms. Daniels Rivera by Scan
Ms. Mailloux by Scan
Ms. Bordeaux by Scan
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SAPA File



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

March 10, 2025

CERTIFIED MAIL/RETURN RECEIPT

Enoch Ho Chun Kun, Esq.
NYS Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

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Nixon Peabody, LLP
677 Broadway, 10th Floor
Albany, New York 12207

RE: In the Matter of All Metro Care Services, Inc.

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,

A handwritten signature in black ink that reads "Natalie J. Bordeaux /dmj".

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB: cmg
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of	:	
	:	
All Metro Home Care Services, Inc.	:	Decision After
Medicaid ID #01634582	:	Hearing
	:	
from a determination by the NYS Office of the	:	
Medicaid Inspector General to recover Medicaid	:	
Program overpayments.	:	#18-6085
	:	

Before: John Harris Terepka
Administrative Law Judge

Held: May 29, August 21, October 9, 30, 2024
By videoconference
Record closed February 28, 2025

Parties: New York State Office of the Medicaid Inspector General
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JURISDICTION

The Department of Health acts as the single state agency to supervise the administration of the Medicaid Program in New York State. 42 USC 1396a; Public Health Law (PHL) 201(1)(v); Social Services Law (SSL) 363-a. The Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority 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. PHL 30, 31 and 32.

The OMIG determined to seek restitution of payments made under the Medicaid Program to All Metro Home Care Services, Inc. (the Appellant). The Appellant requested a hearing pursuant to SSL 145-a and New York State regulations at 18 NYCRR 519.4 to review the determination.

HEARING RECORD

OMIG witnesses:	Michael Livi, OMIG audit supervisor Dr. Karl W. Heiner, statistician
OMIG exhibits:	A-Q
Appellant witnesses:	Vicki Meyer, OMIG auditor James Watson, executive vice president [REDACTED], audit specialist [REDACTED], statistician
Appellant exhibits:	R-BBB (see Transcript II, page 3.) Documents attached to the Appellant's brief (Appendixes 2 & 3) were not offered or admitted into evidence at the hearing and are not part of this hearing record.

A transcript of the hearing was made. (Transcript I, pages 1-198; Transcript II, pages 1-227; Transcript III, pages 426-493; Transcript IV, pages 494-529.) After the parties each submitted two post hearing briefs the record closed on February 28, 2025.

SUMMARY OF FACTS

1. Appellant All Metro Home Care Services, Inc. is enrolled as a provider in the New York State Medicaid Program and is an approved provider under the Home and Community Based Services Waiver for Traumatic Brain Injury (HCBS/TBI) program. It has twelve branch locations in New York but bills the Medicaid Program under one Medicaid MMIS provider number. (Transcript I, pages 11, 13; Transcript II, pages 92-93.)

2. By audit notification letter dated June 22, 2018, the OMIG initiated an audit of the Appellant's records for HCBS/TBI services provided to Medicaid recipients and paid by the Medicaid Program during the period January 1, 2014 through December 31, 2016. The purpose of the audit was to determine whether the Appellant's records demonstrated compliance with Medicaid Program requirements. (Exhibit A.)

3. During the period January 1, 2014 through December 31, 2016, the Appellant was paid \$151,414,496.29 by the Medicaid Program for 460,589 claims for HCBS/TBI services to Medicaid recipients. The audit reviewed a random sample of 500 of these claims, paid in the total amount of \$154,886.44. (Exhibit B.)

4. The OMIG provided the Appellant an audit closing (exit) conference on November 3, 2021, at which the OMIG advised the Appellant of its preliminary audit findings. (Exhibit C.) On December 10, 2021, the Appellant submitted documentation and argument in response to the preliminary findings. (Exhibit D.)

5. The OMIG issued a draft audit report dated May 16, 2022, which identified proposed findings and afforded the Appellant an opportunity to present additional documentation and argument in objection to them. (Exhibit F.) On November

23, 2022, the Appellant submitted a response to the OMIG's draft audit report, along with additional documentation, which the OMIG reviewed. (Exhibits R, G.)

6. By final audit report dated November 8, 2023, the OMIG notified the Appellant that after reviewing the Appellant's response to the draft audit report, it had identified 59 violations of Medicaid Program requirements in 58 of the 500 submitted claims, and disallowed payments in the total amount of \$10,607.87. (Exhibit H.)

7. The final audit report advised the Appellant that the OMIG had determined to seek restitution of Medicaid Program overpayments in the amount of \$9,523,883. (Exhibit H.)

8. The restitution claim includes an extrapolation utilizing a statistical sampling method in which the value of the disallowances found among the randomly selected, stratified sample of 500 claims was projected to the total of 460,589 claims paid by the Medicaid Program during the audit period. (Exhibits P, Q.)

9. The final audit report organized the disallowed claims into six categories of deficiency in the documentation:

1. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame. Thirty-two claims. (Samples 3, 60, 74, 98, 105, 106, 149, 157, 168, 173, 185, 200, 217, 244, 281, 297, 325, 332, 338, 342, 351, 358, 380, 395, 431, 437, 438, 443, 449, 452, 464, 476.)
2. Billed More Hours than Documented. Eighteen claims. (Samples 13, 31, 136, 203, 217, 220, 253, 267, 276, 403, 409, 422, 494, 495, 496, 497, 498, 500.)
3. Overlapping of Services Not Authorized in Service Plan. Four claims. (Samples 70, 91, 268, 294.)
4. Billed More Hours than Authorized in the Service Plan. Three claims. (Samples 216, 299, 418.)
5. Missing Documentation of Service. One claim. (Sample 194.)
6. Missing Documentation of Nursing Supervision Visit. One claim. (Sample 385.)

The payment in sample 217, disallowed in two categories, was only disallowed once. (Exhibit H.)

10. At this hearing the OMIG withdrew the disallowance in sample 403, in the amount of \$10.68. (Transcript I, page 9.) This reduced the extrapolated overpayment to \$9,515,166.33. (OMIG brief, page 20.)

ISSUES

Was the OMIG's determination to recover Medicaid Program overpayments from Appellant All Metro Home Care Services, Inc. correct? If so, what is the amount of the overpayment?

APPLICABLE LAW

Medicaid providers are required, as a condition of their voluntary enrollment in the program, to prepare and to maintain contemporaneous records demonstrating their right to receive payment from the Medicaid Program and fully disclosing the nature and extent of the care, services and supplies they provide; and to furnish such records, upon request, to the Department. The information provided in relation to any claim must be true, accurate and complete. All records necessary to disclose the nature and extent of services furnished, including any fiscal order for services or supplies billed to the Medicaid Program, must be kept by the provider and are subject to audit for six years. 18 NYCRR 504.3(a)&(h), 504.8, 517.3(b), 540.7(a)(8). Notification to the provider of the Department's intent to audit shall toll the six-year period for record retention and audit. 18 NYCRR 517.3(c).

When the Department has determined that claims for medical services have been submitted for which payment should not have been made, it may require repayment of the amount determined to have been overpaid. 18 NYCRR 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 person is entitled to a hearing to have the Department's determination reviewed if the Department requires repayment of an overpayment. 18 NYCRR 519.4. At the hearing, the Appellant has the burden of showing that the determination of the Department was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR 519.18(d).

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. The Appellant, however, may submit expert testimony and evidence to the contrary, or an accounting of all claims paid in rebuttal to the Department's proof. 18 NYCRR 519.18(g).

Regulations of the former DSS most pertinent to this hearing decision are at 18 NYCRR Parts 505 (medical care), 517 (provider audits), 518 (recovery and withholding of payments or overpayments) and 519 (provider hearings). Also pertinent are regulations of the Department of Health at 10 NYCRR Part 763 (certified home health agencies), Part 766 (licensed home care services agencies) and the NYS DOH Traumatic Brain Injury Program Manual, April 2009 (Exhibit S).

DISCUSSION

The Appellant is a licensed home care services agency and an authorized provider of TBI Home Care Services in New York State. It billed well over \$151 million to the Medicaid Program for TBI services to Medicaid recipients during the three-year audit

period under review. The Appellant employed the health care staff who visited patients in their homes to provide services as authorized under a plan of care ordered by a physician for each patient and preapproved by the Medicaid Program. Services were billed to Medicaid by the day, at an hourly or per visit rate.

The issues addressed in the audit included verification that all services were documented; that authorization of medical need for the services was timely and appropriately documented; and that the services were properly billable to the Medicaid Program. Where disallowances were made, the OMIG determined that the services for which claims were submitted were not documented to have been provided in accordance with applicable Medicaid requirements.

The OMIG's audit procedures included a review of the Appellant's lengthy written responses to preliminary findings shared at a closing (exit) conference and then set forth in the draft audit report. (Exhibits C, D, E, F, G, R.) These documents were exchanged between the parties in accordance with audit procedures set forth at 18 NYCRR 517.5 and 517.6(a). The OMIG hardly denied the Appellant an opportunity to provide documentation to support its claims, nor did it ignore or refuse to consider such evidence as the Appellant did present. During the audit, after the OMIG identified its preliminary findings in each category, the Appellant came forward with additional information which the OMIG reviewed, and some findings were then removed. (Exhibit H, attachment D page 000418; Transcript I, pages 35-38, 42-43; Exhibits E, G, R.)

The final audit report set forth the OMIG's conclusions and reasons for each of several categories of disallowance and listed every disallowed claim. (Exhibit H.) The final audit report complies with the obligation to "clearly advise the provider... of the

nature and amount of the audit findings, the basis for the action and the legal authority therefore.” 18 NYCRR 517.6(b).

The Appellant claims it was authorized to and did provide the services in question, and argues that this alone establishes its entitlement to payment. (Transcript II, pages 7, 41; Appellant reply brief, page 4.) The audit report does not allege that these services were unauthorized or unnecessary nor is that required to be alleged or proved to establish 18 NYCRR Part 517 provider audit overpayments. The audit findings are that the Appellant failed to document its entitlement to payment. The Appellant itself pointed out that the Medicaid Policy Program Manual states: “Prior approval does not ensure payment.” (Transcript II, page 41; Exhibit W, page 010228.)

The Appellant also complains that the OMIG failed “to appreciate the context in which these services were rendered.” (Transcript I, page 19.) The relevant “context” for the audit was TBI Program services for which the Appellant billed the Medicaid Program. A provider cannot expect to be paid by the Medicaid Program for services not provided and documented in accordance with Medicaid requirements for that billing. The alleged “context” suggests no reason or need to overlook documentation and billing requirements that are conditions of payment by the Medicaid Program.

The Appellant argues that “ceasing services when a signed physician order is not obtained would be catastrophic to the patient,” and attempts to equate a failure by the Medicaid Program to pay for services with, “in other words,” a provider ceasing to provide them to the patients, which its witness [REDACTED] testified would be “life threatening because if we walk off and just leave them on their own they’re not safe.” (Transcript I, page 22; Transcript II, page 175; Appellant reply brief, pages 6-7.) None of

the services provided to these patients has been “denied” by this audit, and the audit findings are not requiring or suggesting that any provider should cease providing necessary services. Provision of the services was a responsibility the Appellant voluntarily undertook. Another responsibility it undertook was to document entitlement to payment for the claims it submitted if it expected payment from the Medicaid Program. They are not the same thing.

A TBI Program Manual statement that “the waiver has remained flexible and responsive to the needs of participants and providers” (Exhibit S, page 010057) hardly, as the Appellant contends, excuses providers from complying with regulatory requirements regarding entitlement to payment from the Medicaid Program. (Transcript II, page 99; Appellant reply brief, page 18.)

The Appellant’s invocation of 18 NYCRR 519.18(d), which provides “The appellant has the burden of:... (2) proving any mitigating factors affecting the severity of any sanction imposed” is also misplaced. (Appellant brief, page 22; reply brief, pages 4-5.) Sanctions are applicable in 18 NYCRR Part 515 actions charging unacceptable practices in the Medicaid Program. This is an 18 NYCRR Part 517 fiscal audit seeking to recover overpayments. Unacceptable practices have not been charged nor has any sanction been imposed.

A Medicaid provider agrees to comply with all program requirements as a prerequisite to payment and continued participation in the program. The provider certifies both at the time of enrollment and when submitting claims that it will comply or has complied with its responsibilities. 18 NYCRR 504.3, 540.7(a)(8). Provider compliance with these contractual documentation and recordkeeping obligations is

critical to the administration of the Medicaid Program, enabling it to employ a pay-first-and-audit-later system to ensure that providers are paid promptly. In return, however, all claims remain subject to post-payment audit. 18 NYCRR 504.3, 540.7(a)(8). The OMIG is authorized to recover overpayments when a provider has failed to maintain and produce for audit contemporaneous records demonstrating entitlement to payment. 18 NYCRR 504.3(a), 517.3(b), 518.1(c); A.R.E.B.A Casriel v. Novello, 298 A.D.2d 134, 748 N.Y.S.2d 547 (1st Dept. 2002), *lv. den.* 100 N.Y.2d 506, 763 N.Y.S.2d 812 (2003); Gignac/Saratoga Pharmacy (DOH hearing decision #07-4427&06-6710, December 19, 2008), *confirmed as Gignac v. Paterson*, 70 A.D.3d 1310, 894 N.Y.S.2d 801 (4th Dept. 2010), *lv. den.* 14 N.Y.3d 714, 905 N.Y.S.2d 128 (2010).

The audit findings.

1. Failed to Obtain Authorized Practitioner's Signature Within Required Time Frame. Thirty-two claims. (Samples 3, 60, 74, 98, 105, 106, 149, 157, 168, 173, 185, 200, 217, 244, 281, 297, 325, 332, 338, 342, 351, 358, 380, 395, 431, 437, 438, 443, 449, 452, 464, 476.)

It is not a minor issue that to be payable by the Medicaid Program, TBI services must be authorized by a physician. Patient care plans must be reviewed and ordered by a physician at least yearly. 10 NYCRR 766.4. Orders must be signed within 12 months after a change or prior to billing. 10 NYCRR 763.7(a)(3). In these instances the Appellant failed to obtain a signed physician's order for services within one year.

During the audit period, a change in the regulation extended the previous 30-day requirement to 12 months. The OMIG applied the extended period to all of the audited claims, even if the date of service preceded the regulatory change. (Transcript I, pages 57, 154.) The Appellant argues that the Department itself recognized, in extending the period to obtain a signature to 12 months, that providers were frequently encountering difficulties in obtaining signatures from ordering practitioners within 30 days. (Appellant brief, page 21.) This is hardly a persuasive argument for an Appellant entitlement to have the already extended 12-month period extended indefinitely or waived altogether.

The Appellant complains that this finding category was not in the OMIG's audit protocol in 2014-2016 when the audited services were provided. (Exhibit D, pages 000052-53; Transcript, II, page 11.) The finding category does appear in the 2018 audit protocol that was in effect at the time the audit was conducted. (Exhibit T, page 010196;

Transcript I, page 163.) The OMIG is not charging violation of a protocol, which is simply a guide for auditors to follow in conducting an audit. The OMIG is charging violation of regulations and Medicaid reimbursement requirements that were in effect at the time these services were rendered. The OMIG does not make these rules; they are established by the Department and the Medicaid Program. Every page of the OMIG protocol used in this audit and the protocol in effect at the time the Appellant submitted its claims, is imprinted:

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by OMIG and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person. (Exhibit D, page 000052; Exhibit T; Transcript II, page 24.)

Mr. Watson's testimony "Well, everybody builds their compliance program to include the components that are included in this set of protocol" (Transcript II, page 114) does not excuse the Appellant from complying with the actual, applicable rules and regulations governing Medicaid reimbursement of which it was obviously fully aware.

At the same time it suggests it was unfairly taken by surprise by this audit finding because it was not in the protocol when it submitted its claims, the Appellant demonstrated extensive awareness of the regulatory requirement at issue when it submitted the claims. Its own written policy on medical orders stated that written orders were required to be obtained within 30 days. (Exhibit R, pages 009941-42, 010020-22.) The Appellant's suggestion (Appellant brief, page 25; reply brief, pages 5-6) that it should be excused from a regulatory documentation requirement unless it has reason to know from its appearance in an OMIG audit protocol that it might be audited for it is rejected.

None of the disallowed orders was signed within a year. Some were not signed for as long as five years after the service period (samples 3, 60, 98, 105, 185, 281, 342, 395, 443, 449, 464, 476). Many of these signatures were obtained only after this audit undertaken in June 2018 revealed they were missing. Some orders were signed but not dated or were for the wrong patient (sample 173). Some were not signed at all (sample 168) or not signed by a physician (samples 157, 244, 297, 325, 332, 338, 351, 358, 380, 431, 437, 438, 452). Orders were not provided at all for samples 173 and 200. (Exhibit I; Transcript I, pages 52-55.)

According to the Appellant, all that matters is some showing of "diligence" in obtaining documentation for these claims. (Transcript I, page 22.) It points out that notes included in the auditors' copy of the 2018 audit protocol state:

The actions and controls in place by the provider to obtain the practitioner's signature should be evaluated. If the provider has a system to track order, has documentation that the system has been followed and the provider can document

diligent efforts to obtain the signed order, consideration should be given to allowing the claim. (Exhibit U, page 010210.)

The OMIG acknowledges that if diligence in obtaining signatures is documented, that can be taken into account. (Transcript I, page 155.) But it is up to the Appellant to demonstrate that there was a system and document that it was diligently followed. The Appellant's claim that the OMIG did not consider the Appellant's documentation of attempts to obtain orders is contrary to the evidence. (Transcript II, page 118; Appellant reply brief, pages 5-6.) Audit workpapers show the OMIG did review all documentation submitted. (Exhibits E, I.) The OMIG's failure to agree that the Appellant's documentation adequately established "diligent efforts" does not show it failed to consider that documentation. (Appellant reply brief, page 5.)

The Appellant faults the OMIG for not sufficiently investigating what policies for obtaining signed orders the Appellant had in place. The audit findings at issue are not that the Appellant failed to have a policy. They are that even though it did have one the Appellant failed to follow it or otherwise demonstrate diligent efforts obtain the required medical orders authorizing services for which it billed. Appellant witness [REDACTED] testified:

There's always been procedures to follow. Now, whether they got followed 100 percent all the time in every office, you know, is a different issue. But there always were very clear policies. (Transcript II, page 164.)

As another Appellant witness, OMIG auditor Vicki Meyer, testified: "A general 'this is what we do,' but if we're not seeing it on audit doesn't mean we don't take a finding." (Transcript II, page 49.)

The Appellant did have a written policy for obtaining medical orders. (Exhibit R, pages 010020-22.) The policy, which its witness [REDACTED] pointed out states that the provider is required to obtain signed orders within 30 days, also states that orders are reviewed every six months. (Exhibit R, page 010022.) [REDACTED] further pointed out that the policy required that orders be tracked, reviewed weekly, and that the provider was to be contacted if the orders were not returned. (Transcript II, pages 165-166, 171.) The Appellant offered little or no evidence of any such weekly tracking, and there is no evidence that in these cases orders that remained unsigned for as long as five years were reviewed and followed up in accordance with this policy.

The Appellant also had an "order log" for the tracking of order requests. While it produced an example of its order log showing instances in which it succeeded in obtaining signed orders, it did not produce log entries relevant to any of the disallowed claims in this audit to document the extent to which it had in those instances followed its claimed procedures for "diligent efforts" to obtain orders. (Exhibit R, pages 010010, 010039-42.)

For example, in sample 217 with a service date of April 28, 2016, the Appellant presented copies of three faxes sent in February, March and April 2016 requesting a physician's order. It did not offer evidence of any "tracking," further follow up or other efforts to obtain a signed order until August 23, 2019, over three years later and after this audit was commenced. (Exhibit I, pages 000503-509.) Signatures obtained only after audit findings were made and communicated to the Appellant do not demonstrate either a system of controls or diligence in complying with the one-year documentation requirement.

For sample 438, with a service date of July 21, 2014, the Appellant submitted copies of mail and fax requests dated January 13 and February 12, 2014, which was several months before the June 10, 2014 beginning of the certification period covered by the claim. It did not produce documentation of any efforts to secure a physician order applicable to the claim. (Exhibit I, Bates pages 000577-581.) This is not documentation of "diligent efforts" to secure the required signed order for the claim under review.

The Appellant elicited from its own witness, OMIG auditor Meyer, that the error rate for this finding was significantly higher than found in other audits of TBI providers. She testified: "I've never seen that many missing orders. We don't usually have this as a finding on our audits... We have done several TBI and NHTD audits and we have not seen this level of missing MD orders... Most of them were zero." (Transcript II, pages 36-37.) Its vice president James Watson also testified that the finding was never made by the OMIG in prior audits he was involved in. (Transcript II, page 112.) The Appellant's reply brief then apparently attempts to walk back these assertions made by its own witnesses to argue its error rate for missing orders was relatively low for a home care audit. (Appellant reply brief, pages 7-8.) Either way, this evidence hardly addresses or answers the findings in this audit.

The disallowances are affirmed.

2. Billed More Hours than Documented. Seventeen remaining claims. (Samples 13, 31, 136, 203, 217, 220, 253, 267, 276, 409, 422, 494, 495, 496, 497, 498, 500.)

In these instances the OMIG determined the Appellant billed for more hours of service in a day than its records show were provided. (Exhibit J.) Billing was done by the hour, and claims were paid only for full hours of service provided.

The OMIG agreed that portions of hours could be "banked," that is, portions of hours not billed on one day could be applied to the billing on a later day. (Transcript I, page 62.) If 10½ hours of service was provided one day, 10 hours could be billed. The extra ½ hour could then be used to bill 11 hours on a later day in which 10½ hours of service was also provided.

The OMIG further agreed that it would accept banked time from any prior period if it was documented as such in a running account. (Transcript I, pages 64-65.) At the

hearing it withdrew the disallowance in sample 403, in the amount of \$10.68, when the auditor found upon rechecking the calculations that the Appellant did have the necessary "banked" time to allow such a billing. (Transcript I, pages 9, 143-144.) The Appellant claims it should have received credit for other banked hours, but it failed to show any other uncredited and allegedly banked hours were documented in a running account demonstrating they were available and not used. (Transcript I, pages 59-61, 64-66.)

The Appellant's complaint that the OMIG did not "look across the entire time frame" "from the start of care" and so may have "missed" banked hours (Transcript I, pages 18-19; Appellant reply brief, page 9) misrepresents the audit finding and the responsibilities of the parties. This audit was a review of 500 specific claims for specific dates of service. In these instances the Appellant billed for more hours in a day than were actually provided that day. The burden of proving entitlement to payment for the additional hours billed on that day is not on the OMIG, it is on the Appellant, which failed to come forward with documentation to substantiate any banked hours were available to be applied to the claimed service dates. (Transcript I, pages 119-120.)

The Appellant's similar complaint that the audit did not attempt to find and credit it for unbilled hours is also without merit. (Appellant reply brief, pages 2-3; Transcript I, pages 132-133.) The burden remains on the Appellant to come forward with documentation of any such hours. Contrary to the Appellant's suggestion, the OMIG's allowing for "banked time" did not in any way constitute looking for and crediting underpayments for documented but unbilled hours. (Transcript I, page 139.) It constituted allowing documentation that was presented to support billed hours for a sampled claim.

██████████ objection (Exhibit R, pages 009994-95) that the findings were not statistically valid because the OMIG did not give credit for underbilled hours to "cancel out" overbilled hours demonstrated confusion about these billing requirements. Banked hours was precisely the method by which the Appellant could obtain credit for partial unbilled hours. It was not entitled to simply round up partial hours in a day, it was only entitled to bank and use those partial hours on a later day.

The disallowances are affirmed.

3. Overlapping of Services Not Authorized in Service Plan. Four claims. (Samples 70, 91, 268, 294.)

Services may only be furnished in accordance with a plan of care approved by the Department. 42 CFR 441.301(b)(1)(i). According to the OMIG, the care plan must specifically authorize billing for two services during the same hours to be allowable. (Transcript I, pages 70-74; OMIG brief, page 16.)

The audit report relies on the TBI Program Manual:

There are also occasions when two services must be provided or authorized for the same time period to ensure consistent and effective service provision. Services must be clinically justified and time limited... The overlap of services must be documented in the Service Plan in order for both services to be reimbursed. TBI Program Manual, Section V, page 3. (Exhibit S, page 010089.)

In these instances, the OMIG found billings for more than one service provided during the same time period. The OMIG's analysis of overlapping services is given in Exhibit K. The audit disallowed the Appellant's billing for overlapping time.

The Appellant points out, and OMIG auditor Meyer agreed, that none of these disallowances involved an overlap of services both of which were billed by the Appellant. (Transcript II, page 61.) It objects that because it was not the service coordinator for these patients' services it is not responsible for any overlapping services that may have been provided. The Appellant also argues that as the OMIG did not look at the provider of the other service (Transcript II, pages 62, 127), there is no indication the OMIG considered whether it was the other provider that was responsible for the overpayment. (Appellant reply brief, page 14.)

The audit report finding is that "there was no authorization in the Service Plan to support the overlap of services." (Exhibit H, page 000388.) The OMIG does not claim the overlapping services in these instances were not both authorized, but according to the OMIG the patient's service plan did not authorize an overlapping billing for both. The OMIG argues that the service plan documentation must state that a billing overlap was authorized. (Transcript I, pages 78-79, 82-83; OMIG brief, page 16.)

The manual states "the overlap of services must be documented," not "the overlap of services must be authorized." (Exhibit S, page 010089.) There is no dispute in these instances that the services were both "authorized" in that the service plans included both. OMIG auditor Livi acknowledged: "If they are clinically justified, they are clinically justified, then they can be billed at the same time." (Transcript I, page 84.) Nowhere has the OMIG pointed out where the manual actually says, as Mr. Livi went on to claim: "But it has to be authorized to be billed at the same time." (Transcript I, page 84.) The question then, is whether overlapping was necessary in order to provide both services.

For sample 70, on March 10, 2015 the Appellant claimed 24 hours of home and community support service (HCSS), and 2 hours of behavioral service were also paid. (Exhibit K, page 000661.) [REDACTED] testified the behavioral services were not provided by the Appellant. She said that because the patient was approved for 24 hours HCSS, and the social worker who provided behavioral services was not approved to provide personal care, it was appropriate for both personal care and behavioral care providers to be there. (Transcript II, pages 180-182; Exhibit TT, page 010460.) She testified that this service plan therefore authorized overlapping services. (Transcript II, page 184.)

It makes little sense to require or look for explicit authorization to bill two services if the provider of one service cannot provide the service given by the other provider. The OMIG did not dispute [REDACTED] testimony that the social worker who provided behavioral services was not authorized to provide personal care. The patient was approved for 24 hours personal care on the date of claim. Behavioral services were also authorized on the date of claim. Non-overlapping behavioral and personal care services on the date of claim, both of which were authorized in the plan of care, was not possible. The disallowance is reversed.

For sample 91, September 22, 2014, the Appellant claimed 23 hours HCSS, and 4 hours of behavioral services were also paid. (Exhibit K, page 000665.) The patient was authorized to receive 24 hours of HCSS at the time. (Exhibit UU, pages 010566, 010601, 010616; Transcript II, pages 186-188.)

The Appellant's witness [REDACTED] testified that the proposed calendar (Exhibit UU, page 010614) shows that the two hours for behavioral services that overlapped with the HCSS claimed by the Appellant was an approved evaluation for positive behavioral intervention services (PBIS). (Transcript II, pages 189-190.) According to [REDACTED], again, the PBIS service provider was not able to provide personal care. (Transcript II, page 189.) The disallowance is reversed.

For sample 268, Wednesday, October 28, 2015, the Appellant claimed 12 hours HCSS. (Exhibit K, page 000673; Exhibit VV, pages 010770; Transcript II, page 202.) Four hours structured day program (SDP) was also paid. [REDACTED] agreed that the patient was "not supposed to have an aide with him during structured day program." (Transcript II, page 194.) She claimed however, that there was no overlap because the calendar relied on by the OMIG (Exhibit VV, page 010715) indicated the patient attended the SDP Wednesday and Friday when he only attended on Friday.

[REDACTED] claimed a report from the SDP provider stated the patient was only attending on Friday. The document she relied on to show there was a change to one day per week did not cover the date on which the claim was disallowed. It was for the period ending July 15, 2015, and further indicated that the patient "is interested in picking up another half day" of SDP. (Exhibit VV, page 010716; Transcript II, pages 194-195.) [REDACTED] conceded "I don't have the next report" to support the Appellant's "sort of conjecturing that, based on the trajectory that he likely only has one day STP [*sic*]" and so was not attending SDP on October 28, 2015. (Transcript, II, pages 202-205.) The disallowance is affirmed.

For sample 294, Saturday, October 18, 2014, the Appellant claimed 16 hours of HCSS, and consumer directed personal assistance program (CDPAP) hours were also claimed. (Exhibit K, page 000679.) The OMIG determined that the service plan did not allow overlapping services between HCSS and CDPAP. (Transcript II, page 208.) The audit finding detail states "Service Plan Does Not Allow Overlapping Services Between HCSS and CDPAP." (Exhibit C, addendum page 0001541.)

The service plan covering the service date states the patient "receives 24-hour oversight from both HCSS and CDPAP. [Patient] requires 24-hour HCSS protective oversight and supervision at all times in order to ensure his safety and well-being whenever he is not receiving oversight from other providers." (Exhibit WW, page 010781.)

Where in samples 91 and 268 the evidence is that the overlapping services could not be provided by one caregiver, the service plan in this instance states the patient received both CDPAP and HCSS supervision and goes on to specifically state that the HCSS was required "whenever he is not receiving oversight from other providers." The care plan, then, explicitly states that the HCSS is not required when it overlaps with CDPAP.

██████████ claimed the CDPAP service included medication administration that the HCSS aide "was not allowed to do." (Transcript II, pages 207, 215-216.) ██████████ also acknowledged, however, that the patient's mother could also be called upon if there was a medication issue. "In his case it's medication administration... When the mother is not available there is consumer direct person that she trained to do that in her place." (Transcript II, pages 207, 210, 215.)

██████████ also maintained that there was no overlap between the HCSS provided by the Appellant, and the CDPAP, because the hours in question were at SDP, where HCSS was authorized and CDPAP was not. She pointed out that the patient service plan covering the service date stated he "continues to require HCSS oversight while at his SDP." (Exhibit WW, pages 010781; Transcript II, pages 210-211.)

██████████ maintained the error was in the OMIG's reliance on a "Proposed Sample Weekly Schedule" in the service plan that had not been corrected to reflect the addition of the Saturday SDP. (Transcript II, pages 216-217; Exhibit WW, page 010794.)

If the patient was at SDP on Saturday, he was accompanied by HCSS but not CDPAP because "the consumer person doesn't do the structured day with him." ██████████ claimed that there could be no overlap with CDPAP services on that Saturday because the patient was at SDP, appropriately accompanied by his HCSS aide. (Transcript II, pages 213-214.)

The Appellant's time record for the service date records six hours of HCSS care provided at the SDP, not at the patient's home. (Exhibit WW, page 010835.) The time sheets also record, however, another nine hours of HCSS care in the home. (Exhibit W, page 010833.) ██████████ claim that HCSS was provided at SDP for part of the day does not rule out the overlapping hours of care in the home. The disallowance is affirmed.

The disallowance in samples 70 and 91 are reversed. The disallowances in samples 268 and 294 are affirmed.

4. Billed More Hours than Authorized in the Service Plan. Three claims. (Samples 216, 299, 418.)

Services must be furnished under a written plan of care approved by the Department. 42 CFR 441.301(b)(1)(i). Only those services included in the service plan will be reimbursed. TBI Program Manual, Section VI. In these instances the Appellant billed for more hours than were authorized by the ordering physician and the approved plan of care.

Where aides were providing services to more than one patient at a time, the OMIG allocated the hours between the patients. For example, if one aide was caring for two patients, the Appellant was entitled to payment for one half hour for each patient for each hour spent. (Transcript I, pages 87-91.) The Appellant argued there frequently was a shared aide and that OMIG did not look at all hours for all patients in the week, but did not attempt to demonstrate how its records account for the claimed hours. (Transcript II, pages 128-129.) It repeatedly argued that the OMIG auditors failed to thoroughly review its records but the Appellant, which had the burden of proof, did not come forward with the records it claims should have been considered and which account for the billed time. (Appellant reply brief, pages 16-18.)

For sample 216, July 21, 2015, the Appellant claims the schedule relied upon by the OMIG was only a proposed schedule and was “not the final determination of the number of hours authorized for any given day.” (Exhibit XX, page 010932; Transcript II, page 65.) The Appellant also argues there should be flexibility and that it did not exceed the hours approved for that week. (Exhibit E, page 000327; Exhibit L, pages 000682-683.) (Transcript II, page 67.) Mr. Watson testified the schedule authorized 70 hours/week plus 135 yearly hours for emergencies. (Transcript II, pages 134-136.) He objected that OMIG did not examine the record for the entire week for this claim (Transcript II, page 131) and also claimed the 135 floating hours for emergency care was not considered. Mr. Watson did not attempt to demonstrate which of these explanations, whether weekly or floating hours, actually documents and accounts for the claim. To the contrary, Mr. Watson later admitted on cross “I’m not even saying they used any of these emergency hours during the cited overservice... it would be more likely that we did not exceed the number of service – number of hours that were authorized in a given week.” (Transcript II, pages 147-148.) The Appellant is unable, then, even to identify the basis on which it claims to have documented entitlement to payment, much less produce the documentation. (Appellant reply brief, pages 16-17.)

For sample 299, Mr. Watson testified the proposed schedule (Exhibit YY, page 011159) allowed 47 hours/week without emergency hours, but that the plan of care (Exhibit YY, page 011105) recommended an additional 25 hours/year for accompaniment on medical appointments. (Transcript II, page 138.) Again, he did not attempt to explain how or show that the Appellant documented the disallowed hours were allowable and used for a medical appointment. (Appellant reply brief, page 17.)

For sample 418, Mr. Watson claimed that while the proposed schedule did not authorize the hours, a Protective Oversight plan mentioned rescheduling of hours. (Transcript II, pages 141-142; Exhibit ZZ, pages 011290, 011313.) He claimed that because the schedule might change that should be taken into consideration, but the Appellant again failed to demonstrate how any change of this patient's schedule affected the reported hours for this claim or how they were documented. (Appellant reply brief, page 18.)

The Appellant failed to meet its burden of proving the OMIG auditors' calculations and determinations of the overpayments were not correct. (Exhibit L; Transcript I, pages 103-104.) The disallowances are affirmed.

5. Missing Documentation of Service. One claim. (Sample 194.)

Providers must document each encounter with a TBI waiver program participant, which must include date, location, time, and a description of activities related to goals established in a detailed care plan. TBI Program Manual, Section VII. One claim was not supported by documentation that a service was provided. (Exhibit M; Transcript I, pages 110-111.) [REDACTED] testified that "billing is not allowed to go through without a physical time slip," but this bootstrap assertion does not meet the Appellant's burden of maintaining and producing for audit, documentation demonstrating entitlement to payment, and [REDACTED] conceded the disallowance was justified. (Transcript II, pages 222-223.) The disallowance is affirmed.

6. Missing Documentation of Nursing Supervision Visit. One claim. (Sample 385.)

A Registered Nurse (RN) must conduct an initial home visit on the day staff begins providing services to the participant. TBI Program Manual, Section VI. No such RN home visit with aide present was documented for this patient in the six months before the June 28, 2016 date of service. The Appellant claimed during the audit that a nursing visit was conducted but failed to produce any documentation of such a visit. It submitted only an aide plan of care dated March 2, 2016 which does not document any home visit by a nurse or aide. (Exhibit D, pages 000162-73; Exhibit N; Transcript I, page 114; Transcript II, pages 74-75.) The disallowance is affirmed.

III. Medicaid Program overpayments.

The 500-claim audit sample was randomly selected from an audit frame of all claims that the Department's billing and payment records show were paid by the Medicaid Program to the Appellant during the three-year audit period. Computer generated documents prepared by the Department or its fiscal agent to show the nature

and amount of payments made under the Medicaid Program will be presumed, in the absence of direct evidence to the contrary, to constitute an accurate itemization of the payments made to a provider. 18 NYCRR 519.19(f). The Appellant did not challenge or offer any evidence to rebut this presumption.

The amount disallowed for each claim in the audit sample is set forth in the exhibits attached to the final audit report. The overpayment in the sample, with the withdrawal of the disallowance in sample 403 in the amount of \$10.68, is \$10,597.19. The reversal herein of sample 70 in the amount of \$42.72 and sample 91 in the amount of \$58.02, reduces the total overpayment in the sample to \$10,496.45.

The claims disallowed in this audit, as affirmed in this hearing decision, were not authorized to be paid under the Medicaid Program because they were not supported by documentation demonstrating compliance with Medicaid Program requirements. The OMIG is entitled to recover the overpayments made.

IV. The statistical sampling and extrapolation.

The draft audit report (Exhibit F) and the final audit report (Exhibit H) explained and set forth the manner in which the extrapolation was made. These documents identified the disallowed claims, the audit frame to which they were extrapolated, and the method of estimation.

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 certifications, dated March 26, 2024 and April 10, 2024 from Dr. Karl W. Heiner, the statistical consultant who designed the sampling and

estimation methodology and the computer program that implemented it; and from Jeffrey C. Cahill, the OMIG employee who implemented the methodology to establish the audit frame and select the random sample. (Exhibits P, Q.) Dr. Heiner also testified at this hearing.

The OMIG's statistical sampling and estimation methodology has consistently been upheld in New York State Medicaid Program administrative hearings and by the New York courts, including the New York Court of Appeals. Mercy Hospital v. NYS DSS, 79 N.Y.2d 197, 581 N.Y.S.2d 628 (1992); Enrico v. Bane, 213 A.D.2d 784, 623 N.Y.S.2d 25 (3rd Dept. 1995); Clin Path, Inc. v. NYS DSS, 193 A.D.2d 1034, 598 N.Y.S.2d 583 (3rd Dept. 1993).¹ The Appellant failed to overcome the presumption of accuracy in the extrapolated overpayment.

¹ Additional reported decisions affirming the 18 NYCRR 519.18(g) extrapolation methodology used in this audit include: David Wegman d/b/a Angels in Your Home v. DOH, 229 A.D.3rd 862, 215 N.Y.S.3rd 562 (3rd Dept. 2024); Beth Israel Medical Center v. OMIG, 221 A.D.3d 446, 198 N.Y.S.3d 64 (1st Dept. 2023); West Midtown Management Group, Inc. v. State of N.Y., 31 N.Y.3d 533, 81 N.Y.S.3d 343 (2018); Sarfo v. Glass, 243 A.D.2d 824, 663 N.Y.S.2d 894 (3rd Dept. 1997); Tsakonas v. Dowling, 227 A.D.2d 729, 642 N.Y.S.2d 342 (3rd Dept. 1996); Lala v. Dowling, 226 A.D.2d 933, 640 N.Y.S.2d 933 (3rd Dept. 1996); Piasecki v. DSS, 225 A.D.2d 310, 639 N.Y.S.2d 319 (1st Dept. 1996); Polanco v. DSS, 212 A.D.2d 443, 622 N.Y.S.2d 932 (1st Dept. 1995); Kuchment v. DSS, 222 A.D.2d 806, 634 N.Y.S.2d 849 (3rd Dept. 1995); Enaw v. Dowling, 220 A.D.2d 942, 632 N.Y.S.2d 715 (3rd Dept. 1995); Lock v. DSS, 220 A.D.2d 825, 632 N.Y.S.2d 300 (3rd Dept. 1995); Ghosal v. Bane, 204 A.D.2d 215, 612 N.Y.S.2d 399 (1st Dept. 1994), *lv. denied* 84 N.Y.2d 805, 618 N.Y.S.2d 6; Ogunkoya v. DSS, 204 A.D.2d 122, 612 N.Y.S.2d 7 (1st Dept. 1994); Newman v. Dowling, 210 A.D.2d 552, 619 N.Y.S.2d 794 (3rd Dept. 1994); State v. Khan, 206 A.D.2d 732, 615 N.Y.S.2d 771 (3rd Dept. 1994); Roggeman v. Bane, 206 A.D.2d 622, 614 N.Y.S.2d 593 (3rd Dept. 1994), *lv. denied* 84 N.Y.2d 809, 621 N.Y.S.2d 518; Adrien v. Kaladjian, 199 A.D.2d 57, 605 N.Y.S.2d 33 (1st Dept. 1993); Lalani v. Bane, 199 A.D.2d 80, 605 N.Y.S.2d 48 (1st Dept. 1993); Metzies Shoe Brooklyn NY Corp. v. DSS, 151 A.D.2d 675, 542 N.Y.S.2d 731 (2nd Dept. 1989).

Recent New York State Department of Health administrative hearing decisions rejecting challenges to the OMIG's 18 NYCRR 519.18(g) extrapolation methodology include: NewCo ALP, Inc/Island Assisted Living (19-4606, issued 12/11/2023); Angels

The Appellant presented [REDACTED] as an expert witness to challenge the OMIG's statistical sampling method. [REDACTED] written report dated November 23, 2022 was included in the Appellant's response to the revised draft audit report. (Exhibit R, pages 009973-009998.) It is understandable that [REDACTED] November 2022 report did not review or comment on Dr. Heiner's March 2024 certification (Exhibit R, page 009998), because Dr. Heiner's certification did not yet exist. But neither in his October 2024 testimony at this hearing did [REDACTED] mention that he subsequently read or was even aware of Dr. Heiner's certification.

After [REDACTED] testified, Dr. Heiner appeared in rebuttal to address his objections.

1. Proportions in the strata. [REDACTED] report noted as a "statistical concern" that under Dr. Heiner's sampling plan, the strata proportions in the sample were at variance with the strata proportions in the universe. According to [REDACTED], the highest payment stratum (1) would have an expected sample of 131.38 claims if proportionate to the universe, but only 87 claims were selected in it. (Exhibit R, pages 009979, 009980-82; page 009981, Table 3.) However, [REDACTED] report also stated:

18. However, it is important to note that these specific proportional differences are not immediately disqualifying given that the sample was obtained through *stratified* sampling. The application of stratum level weights to each of the sample stratum results can account for these particular discrepancies when determining stratum level and overall estimates **if each of the randomly drawn stratum samples are themselves representative of their respective stratum.**

...

21. A sampler may also allocate the overall sample size across the strata by other procedures. One method, referred as *Neyman allocation*, aims to increase the

in Your Home, Inc. (#18-7593, issued 6/8/2022), *affirmed*, 229 A.D.3rd 862, 215 N.Y.S.3rd 562 (3rd Dept. 2024); Harry's Nurses Registry (#18-3900, issued 10/4/2021); Madison York Assisted Living Community (#14-3479, issued 10/30/2020); Beth Israel Medical Center (#17-8064, issued 4/24/2020), *affirmed*, 221 A.D.3d 446, 198 N.Y.S.3d 64 (1st Dept. 2023); Byram Healthcare Centers (#14-2289, issued 12/16/2019); UCPA of Putnam & Southern Dutchess (#13-5288, issued 6/17/2019).

precision of the overall sample estimate (i.e., a narrower confidence interval) over that which would result from proportional allocation.

22. Accordingly, even if the distribution of stratum sample sizes does not match the proportional distribution within the universe of observations, appropriately weighting the stratum level sample results can yield a valid estimate. (Exhibit R, pages 009982-83.) (*Emphasis in original.*)

Dr. Heiner testified that the "Neyman allocation" was precisely the method he used in designing the audit sample, and it was that method of allocation that determined the number of claims in each stratum. (Transcript IV, pages 504, 526.) At the hearing, [REDACTED] conceded "I don't believe I had any criticism of the allocation methodology that was used." (Transcript III, page 478.)

2. Stratification by locations. [REDACTED] main objection to the extrapolation methodology was that variability introduced by multiple service locations was not considered. During the period covered by this audit, the Appellant operated at twelve service locations which held separate operating licenses from the Department of Health. (Transcript II, page 92.) [REDACTED] claimed the audit sample is unreliable because it stratified by amounts only, and that it should have been stratified by location. (Exhibit R, pages 009983-93; Transcript III, pages 439, 453.)

There is no evidence, nor did the Appellant claim, that the services it provided in its various locations differed. All 500 of the audited claims were for TBI waiver services. Of these 500 services, 485 were claimed under rate code 9863 for hourly Home and Community Support Services (HCSS), 14 under rate code 9851 for Monthly Service Coordination, and one under code 9858 for hourly Independent Living Skills Training (ILST). Of the 59 disallowances, 58 were under rate code 9863 for hourly HCSS services and one under rate code 9858 for hourly ILST. (Exhibit H, Attachment C.)

██████ said “location for a variety of reasons can be a meaningful factor in how – in the ability to adhere to certain rules and regulations at issue in this matter” (Transcript III, page 445), but he acknowledged that he relied on the Appellant’s witnesses’ opinions about this when he identified it as a sampling error. (Transcript III, pages 438-439.) The Appellant’s claim is that its locations “operate differently” and this “leads to systematic differences among how services are rendered and billed across these locations.” (Transcript I, page 17; Transcript II, page 144; Appellant brief, pages 14-15.)

Beyond claiming its locations “operate differently,” the Appellant offered little specific evidence to show just what kinds of differences it was talking about or why those differences might be relevant to its entitlement to payment of its Medicaid claims. It did not explain what its claimed “extensive evidence of variability by geography and across All Metro branch locations” (Appellant reply brief, page 3) consists of or means, other than simply the obvious fact that it had service locations throughout the state.

The Appellant’s main argument about the significance of location concerned finding category 1, failure to obtain a physician’s order. The Appellant’s claim is that physician’s orders were harder to obtain in some locations. The Appellant quotes a NYS Register comment, regarding the statewide extension of time to obtain orders from 30 days to 12 months, about “the difficulty in obtaining signed physician orders within the current timeframes.” The Appellant does not mention that this comment does not suggest that a home care service provider’s location in the state, or a recognition that different home care service providers “operate differently,” was the issue. (Appellant brief, page 14.) The fuller comment mentions “the increased reliance on the use of hospitalists” statewide, not variance in service provider location; and the regulatory change to a 12

month period was made specifically to address that issue. (Appellant brief, page 21.) The Appellant did not offer any reason why any of the other categories of audit finding might be affected by service location.

The Appellant failed to explain why findings of noncompliance with billing or documentation requirements for these hourly claims, nearly all submitted under one rate code, should depend on the service location. The Appellant, as the one Medicaid provider for all locations, is responsible for compliance with billing requirements that are the same for all locations. As Appellant witness [REDACTED] observed, "they all function under the same rule book... the compliance rules are all based on the regulations so the rules are the same." (Transcript II, page 153.) What matters for this audit of Medicaid payments is that for these claims - all submitted by and paid to the Appellant under its one MMIS provider number (Transcript II, page 13) - care, documentation and billing requirements are the same throughout the state.

The obligation to comply with documentation and billing requirements does not differ by location. Because the documentation and billing requirements were the same for all locations, [REDACTED] criticism of a variance in universe and sample proportions among these locations is unpersuasive. (Exhibit R, pages 009985-87.)

[REDACTED] analysis breaking out all of the claims by stratum, location and disallowance category in an attempt to show the failure to stratify by location was inappropriate ignores that, as Dr. Heiner pointed out, in an audit for claim overpayments the error amount in dollars paid per claim is the variable of interest. (Transcript IV, page 502.) Dr. Heiner further pointed out that the introduction of both location and payment

amount strata would lead to a very large number of strata which would create other problems with precision and sample size. (Transcript IV, pages 506-508, 518-520.)

Contrary to the Appellant's claim in its brief (pages 7, 13-14), emails between OMIG auditors to which Dr. Heiner was not a party do not document an auditor's recommendation to stratify by location. They document that the auditors relied on Dr. Heiner to design a statistically valid sample because, as the auditor remarked, "that's why we have him." (Exhibit CC.) Dr. Heiner recommended increasing the sample size to 500 claims to reflect the size of the audit universe and variance in amounts of paid claims, and testified that the existence of several locations had nothing to do with either the size or design of the audit sample. (Transcript IV, pages 518-522.) Dr. Heiner said there would be no reason to stratify by location "unless you know that location was a better stratification variable than the paid claim amount." (Transcript IV, pages 507-508.)

There were 12 locations and 4 cost strata, for a total of 48 combinations of cost strata and location. [REDACTED] offered figures regarding the variance between universe and sample proportions for 6 of these combinations of location and strata (Exhibit R, page 009988, Table 8), and they are reflective of the proportions within the universe within 33% or less. [REDACTED] did not mention the variances for the remaining 42 combinations. His other tables show that the distribution of samples by location within each stratum was consistently and reasonably close to the distribution in the universe. (Exhibit R, pages 009985-87, Tables 4, 5, 6, 7.)

[REDACTED] analysis shows no obvious and egregiously unrepresentative pattern of disallowance rates among locations. (Exhibit R, pages 009992-009993, Table 11.)

Regarding a claimed overrepresentation of the New York City location six in strata 1 and 4 (Transcript III, page 447), [REDACTED] testified:

So to the extent that the New York location was predisposed to having a more difficult time or less of an ability to consistently adhere to rules or regulations at issue in this matter, the sample results would generally be predisposed to overstating the errors. (Transcript III, page 449.)

The Appellant then complained that location seven was not represented at all in the sample. Location seven, to which the Appellant objects "alleged errors from other branch locations were attributed" because it was not represented in the sample, is in Queens, New York City. (Appellant brief, pages 14-15.)

[REDACTED] pointed out, furthermore, that location seven had proportions in the universe in the amounts of 0%, .03%, .18%, and .16% for each stratum. (Exhibit R, pages 009985-9987.) As there were only 426 location seven claims in the universe of 460,589 claims (Exhibit R, page 009987 point 32), location seven contributed less than one in a thousand of the universe claims. The absence of a sample claim from that location in any of the four strata is hardly surprising.

[REDACTED] assertion that the sample is not statistically valid because it was not stratified by location is unpersuasive. (Exhibit R, page 009989, point 35). Dr. Heiner's opinion that the error amount in dollars paid per claim is the variable of interest, that the stratified sample of 500 claims was statistically valid, and that variances in location that are the substance of [REDACTED] criticisms do not render the sampling and extrapolation statistically invalid, is more persuasive and it is credited.

3. "Audit induced measurement bias." [REDACTED] objection in his report (Exhibit R, pages 009994-95) that in disallowance category 2 the OMIG did not give credit for underbilled partial hours to "cancel out" overbilled hours exhibited a confused

understanding of the finding. “Banked hours” was precisely the method by which credit for partial hours was given. The Appellant was not entitled to round up partial hours in a day. It was only entitled to document, bank and use those partial hours on a later day.

██████ objection at the hearing (Transcript III, pages 455-456, 467, 482) that the audit did not review the entire patient history for such things as unbilled hours also misunderstands the nature of this audit of 500 specifically dated individual claims. (Appellant reply brief, pages 2-3.) The burden of documenting entitlement to payment of those specifically dated claims is on the Appellant, not the OMIG. The Appellant was offered ample opportunity through the audit process and in this hearing but failed to come forward with any evidence to meet that burden. There is, consequently, no “audit induced measurement bias” in the category 2 audit findings.

The Appellant’s reliance on Bulmahn v. OMIG, 106 A.D.3d 1504, 964 N.Y.S.2d 853 (4th Dept. 2013) for its objection that the OMIG did not review the entirety of its records to look for audit underpayments is misplaced. Bulmahn relied on a CMS Medicare audit provision to hold that an acknowledged underpayment of a specific claim in an audit sample should be considered in the extrapolation. The Appellant points out:

And as the Appellate Division noted in *Bulmahn*, the Medicare Program Integrity Manual instructs auditors that “[s]ampling units found to be underpayments, in whole or in part, are recorded as negative overpayments and **shall be used** in calculating the estimated overpayment (*emphasis added*).” (Appellant brief, page 11.)

The Appellant has not even identified, let alone substantiated by documentation, any claim in this audit sample for which it alleges an underpayment. Underpayments and overpayments of claims that are not in the sample are simply irrelevant to the audit or to the statistical sampling and extrapolation methodology.

The Appellant also criticized Dr. Heiner because he “did not consider or opine on the ‘**audit methodology**’ that was employed by OMIG auditors’.” (Appellant brief, pages 12-13, *emphasis in original*.) Dr. Heiner did not opine on the OMIG auditors’ “methodology” for auditing the 500 sampled claims because statistics has nothing to do with that methodology. As has already been discussed, [REDACTED] opinion that “OMIG’s audit methodology” included “measurement bias” because the auditors did not look for underpayments reflects a significant misunderstanding of the “audit methodology” at the level of individual claims in the sample. Each claim was audited to determine whether it was supported by records demonstrating entitlement to Medicaid Program payment of that claim. The Appellant had the burden of coming forward with documentation of any alleged underpayments in any sampled claim. It failed even to identify, let alone prove an underpayment of any sampled claim.

There was no “systematic measurement bias” in the OMIG’s failure to hunt for and credit the Appellant with payment for claims it did not submit, or for services that were not in the audit sample, or for which the Appellant offered no evidence that it might have been entitled to be paid.

4. Error rate for individual disallowance categories. The Appellant claims a less than 1 percent error rate in disallowance categories 3-6 is not statistically significant or valid for extrapolation. (Appellant brief, pages 29, 36, 42-43; reply brief, page 19.) [REDACTED] [REDACTED] also claimed that the lower confidence limit was less than zero in categories 4, 5 and 6 and so not statistically significant (Exhibit R, page 009995-96, points 50-52; Transcript III, pages 458-460.) These objections ignore that the classification of

disallowance categories in the audit report is essentially arbitrary and of no significance for the statistical extrapolation.

██████ objection, like the Appellant's argument that the OMIG improperly used a 2018 audit protocol, confuses the manner in which audit findings were organized and summarized with the findings of disallowance themselves. The appropriateness of extrapolation is not determined by or dependent on the various ways in which either an audit protocol or final audit report might categorize and list disallowances. As ██████ himself noted in his report:

However, the six error finding types could reasonably be combined in multiple ways, and each successive combination would increase the percentages of these more general finding types. (Exhibit R, page 009991, point 39.)

The audit report organized the disallowances into categories that followed the audit protocol used. As has already been pointed out, the protocol categories are largely irrelevant to the audit other than as an organizing guide for the auditors to use in conducting it. While there may have been numerous items listed in the protocol used by OMIG auditors to guide and focus their review, that is a number that is irrelevant to the audit findings themselves, which are based upon the failure to document entitlement to payment of the claims as required by Medicaid reimbursement rules and regulations. That the manner in which an audit report lists its findings does not determine the appropriateness of extrapolation has been recognized in a recent Appellate Division decision:

... the isolated error challenged by petitioner related to missing documentation, which was an error that related to the majority of the cited errors in other findings, and therefore was not an unusual finding that precluded extrapolation. David Wegman d/b/a Angels in Your Home v. DOH, supra.

In fact, the audit report found the error rate in the sample was 58 claims out of 500, over 11% of the sampled claims, all of which were disallowed for failure to document entitlement to payment.

5. Confidence level. [REDACTED] objected that the 90 percent confidence interval the OMIG used to calculate its high and low estimates of the overpayment amounts produced a wider margin of error than he would “typically target.” (Transcript III, pages 433-434; Exhibit R, pages 009996-7.) Dr. Heiner’s certification pointed out that statisticians can construct an interval for any desired level of confidence. He agreed that both 90 and 95 percent intervals are common, but concluded “[f]or audits of this type HHS CMS prefers that their auditors use 90% confidence intervals.” (Exhibit P, point 12.)

[REDACTED] criticisms of the 90 percent confidence level used by the OMIG are irrelevant to this hearing, where it is the midpoint estimate that the OMIG defends and seeks to recover. (Exhibit H, page 000393.) The midpoint does not change with any change in the confidence level selected for generating the low point estimate.

The OMIG’s final audit report did offer to accept repayment at the low point of the confidence interval in settlement of the audit, but also made it clear that it would seek and defend the midpoint at this administrative hearing. (Exhibit H, page 000379.) This was entirely within the OMIG’s authority. West Midtown Management Group, Inc. v. State of N.Y., *supra*. The Appellant argues that the low point estimate should be used in this hearing as a way to “control for the sample’s imprecision.” (Appellant reply brief, page 4.) Dr. Heiner’s certification recommended the midpoint estimate as a commonly accepted projection that is unbiased and does not tend to either overestimate or

underestimate the overpayment. (Exhibit P, point 12.) The OMIG's reliance on the midpoint as a valid and appropriate estimate for recovery has been consistently upheld by the courts (see cited decisions, *supra*) and it is appropriate in this case.

V. Conclusion

The overpayment must be recalculated in accordance with the methodology set forth in the certification (Exhibits P, Q) to reflect the withdrawal of sample 403 and the reversal of samples 70 and 91. The overpayment for extrapolation is \$10,496.45. A restitution claim in the extrapolated amount is authorized under 18 NYCRR 518.1 and 518.3.

DECISION: The disallowance of sample 403 is withdrawn. The disallowances of samples 70 and 91 are reversed. All other disallowances are affirmed.

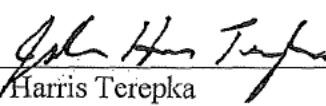
The overpayment for the audit sample is in the total amount of \$10,496.45.

The OMIG's determination to extrapolate the overpayments is affirmed.

The OMIG is directed to recalculate the overpayment in accordance with this decision.

This decision is made by John Harris Terepka, who has been designated to make such decisions.

DATED: Rochester, New York
March 7, 2025



John Harris Terepka
Bureau of Adjudication