

cc: Ms. Daniels Rivera by Scan
Ms. Mailloux by Scan
Ms. Bordeaux by Scan
Ms. Marks 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

February 11, 2025

CERTIFIED MAIL/RETURN RECEIPT

Timothy Osho, Esq.
NYS Office of the Medicaid Inspector General
90 Church Street, 14th Floor
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Gregory Smith, Esq.
Carmen Jule, Esq.
Sheppard, Mullin, Richter & Hampton, LLP
30 Rockefeller Plaza
New York, New York 10112

RE: In the Matter of Children's Aid Society – Lord Memorial Clinic

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 blue ink that reads "Natalie J. Bordeaux".

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

Children's Aid Society – Lord Memorial Clinic
Medicaid ID: 00245423

from a determination by the NYS Office of the Medicaid
Inspector General to recover Medicaid Program overpayments.

**Decision After
Hearing**

Audit No.: 22-4185

Before: Natalie J. Bordeaux
Administrative Law Judge

Held via: Webex videoconference

Hearing Dates: November 21 and December 17, 2024
The record closed December 17, 2024.

Parties: New York State Office of the Medicaid Inspector General
90 Church Street, 14th Floor
New York, New York 10007
By: Timothy Osho, Esq.

Children's Aid Society – Lord Memorial Clinic
4600 Broadway
New York, New York 10040
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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 Children's Aid Society – Lord Memorial Clinic (Appellant). The Appellant requested a hearing pursuant to Social Services Law (SSL) § 145-a and Department of Social Services (DSS) regulations at 18 NYCRR § 519.4 to review the OMIG's determination.

FINDINGS OF FACT

1. At all times relevant hereto, the Appellant operated a diagnostic and treatment center (DTC), certified pursuant to Article 28 of the Public Health Law (PHL). It is enrolled as a provider in the New York State Medicaid Program. (OMIG Exhibits 3, 4, 6; T 10, 67.)
2. By letter dated July 28, 2022, the OMIG advised the Appellant that it would conduct a review of the Appellant's medical and fiscal records supporting its claims for DTC services paid by the New York State Medicaid Program from January 1, 2017 through December 31, 2019. (OMIG Exhibit 1.)
3. During the period January 1, 2017 through December 31, 2019 (audit period), the Appellant was paid \$4,324,251.90 by the Medicaid Program for 24,082 claims submitted for DTC services. The audit consisted of a review of a random sample of 100 claims paid in the total amount of \$17,103.57. (OMIG Exhibits 2, 4, 6.)
4. On August 17, 2022, OMIG auditors held an entrance conference with several members of the Appellant's staff to explain the audit process and audit scope. (T 32.)
5. On April 18, 2023, an exit, or closing, conference was held, during which the auditors informed the Appellant that 56 claims in the audit sample were found to contain at least

one error for a total sample overpayment of \$10,815.46. The Appellant was given a summary of those findings. (OMIG Exhibit 2; T 32.)

6. On May 19, June 20, and July 21, 2023, the Appellant sent the auditors additional documentation regarding errors identified at the exit conference. (OMIG Exhibit 3.)

7. On August 2, 2023, the OMIG issued a draft audit report to the Appellant. After reviewing additional information supplied by the Appellant during and after the exit conference, the OMIG determined that 44 sampled claims contained at least one error, and disallowed a total of \$8,295.60 in payments. The OMIG also advised the Appellant that the audit employed a statistical sampling methodology allowing for extrapolation of the sample findings to the universe of claims paid during the audit period. By using the extrapolation, the OMIG determined preliminarily that the point estimate of the Medicaid overpayment received by the Appellant is \$1,997,746. (OMIG Exhibit 4.)

8. On October 6, 2023, the Appellant submitted its response to the OMIG's draft audit report, contesting the disallowances and the extrapolation methodology employed by the OMIG in its determination to recover \$1,997,746. (OMIG Exhibit 5.)

9. On June 18, 2024, the OMIG issued a final audit report which revised the findings set forth in the draft audit report, reducing the number of errors identified to only one category (incorrect servicing provider on claim), and the number of sampled claims containing errors to 42. The final audit report advised the Appellant that the OMIG determined to seek restitution of Medicaid Program overpayments totaling \$1,941,407, derived by projecting the value of the 42 disallowed claims in the audit sample to the total 24,082 claims paid by the Medicaid Program during the audit period. (OMIG Exhibit 6.)

10. The disallowed claims were identified as sample numbers 1, 7-9, 11, 12, 15, 17, 22, 23, 29, 32, 33, 38, 41, 43, 44, 46-48, 51, 55, 58, 59, 66-69, 71, 75, 77, 79, 82, 83, 86-89, 92, 97, 99 and 100. (OMIG Exhibit 6.)

11. At the hearing, the Appellant waived its objection to the OMIG's disallowances of samples 8, 22, 47, 48, 77, and 88. (T 8.)

ISSUES

Was the OMIG's determination to recover Medicaid Program overpayments from the Appellant correct? If so, what is the amount of the overpayment?

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; *see also* Social Security Act § 1902(a)(5). 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 maintain contemporaneous records demonstrating their 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 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

At the hearing, the OMIG presented the audit file and summarized the case, as required by 18 NYCRR § 519.17. The OMIG presented documents (Exhibits 1 - 12) and one witness, Martin Molloy, Medicaid Integrity Specialist 2, who served as the Audit Supervisor of the team that conducted this audit. (T 29-105.)

The Appellant presented seven exhibits (Exhibits 1-4, 6), and the following witnesses: (1) [REDACTED], Healthcare Consultant (T 113-56); and (2) [REDACTED] the Appellant's Medical Director and Chief Medical Officer during the audit period (T 157-81).

Each party made a closing statement, after which the hearing record was closed. A transcript of the hearing was made on both hearing dates. (T 1-201.)

The Audit Findings

A DTC is a medical facility with one or more organized health services not part of an inpatient hospital facility or vocational rehabilitation center primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician or, in the case of a dental service or dispensary, of a dentist. 10 NYCRR § 700.2(a)(9) and § 751.1. The DTC is responsible for all care provided within its facility and determines bills and charges. 10 NYCRR §§ 600.8(c)(4)(i) and (c)(5)(i).

The purpose of this audit was to determine whether the Appellant's medical and fiscal records supported its claims submitted to the Medicaid Program for DTC services paid during the audit period. (OMIG Exhibit 1.) By final audit report dated June 18, 2024, the OMIG determined to disallow Medicaid payments for 42 claims that contained an incorrect servicing provider. (OMIG Exhibit 6.) The disallowances resulted from claims submitted for dates of service in which the name of a provider who had not rendered services to the patient was listed as the provider on the claim. (OMIG Exhibits 6-8.)

In identifying disallowances, the OMIG reviewed the medical records maintained by the Appellant supporting its submitted claims and compared the information within those records to the claims. It disallowed claims in which a practitioner was identified as the individual rendering services (servicing provider) or as the ordering provider when supporting medical documentation did not show any involvement by that individual in the patient's care on that date of service. (T 35-36, 45; OMIG Exhibits 6-8.) The Appellant raised several arguments in its response to the draft audit report and reiterated those arguments in its hearing presentation.

Adherence to Medicare Claims Instructions

The Appellant argues that it satisfied Medicare requirements by identifying the patient's attending provider on claims, instead of identifying a servicing provider. To justify its reliance on Medicare-related definitions, the Appellant contends that the Department has provided no definition or explanation of who is an "attending provider." According to the Appellant, Medicare guidelines define an attending provider as the provider with overall responsibility for the patient's medical care and treatment reported in the claim encounter. (OMIG Exhibit 5; T 20, 128, 131-32, 150.)

The Appellant's emphasis on its understanding of Medicare guidelines ignores the fact that this is a Medicaid audit. The issue for this hearing is whether the Appellant correctly identified an individual provider on its claims who rendered a service to a patient on the claimed date of service pursuant to the requirements of the Medicaid Program.

A DTC such as the Appellant must submit an 837I (electronic claim for institutional providers) to the Medicaid Program for payment for DTC services. (T 11, 15-16, 60, 70-71, 125-27.) The 837I contains a "Patient Detail" section, which includes individual spaces for the rendering provider, attending provider, and referring provider. *See* Centers for Medicare and Medicaid Services (CMS) Standard Companion Guide Health Care Claim Institutional (837I), available at: https://www.cmsmedicare.com/pdf/edi/837I_compguide.pdf.

As the single state agency tasked with administering the Medicaid Program in New York, the Department issued guidance regarding requirements for Medicaid providers long before the audit period. The Department issued the HIPAA Transactions Standard Companion Guide on October 25, 2012 to explain how entries on claim forms are interpreted by the Medicaid

Program. The guide explicitly distinguishes between providers who are ordering, prescribing, referring, and attending. (Appellant Exhibit 3.)

The New York State Medicaid Program has consistently required claims to identify the clinician performing the billed service as the “attending provider.” New York State Department of Health, Medicaid Update – December 2013, Volume 29- Number 13, available at:

https://www.health.ny.gov/health_care/medicaid/program/update/2013/dec13_muspec.pdf.

This requirement was reiterated in additional guidance to Medicaid providers in the State of New York. For instance, in a letter from the New York State Office of Mental Health (OMH), Article 31 clinics were reminded of the December 2013 Medicaid Update, and explicitly advised, that for claims submitted to the Medicaid Program, the “attending field of the claim must be completed with the practitioner who provided the service.” This policy is consistent with CMS guidelines for Medicaid claims. *See, OMH, ATTENTION ALL OMH-LICENSED ARTICLE 31 MENTAL HEALTH CLINICS CLAIMS SUBMISSION REMINDER REGARDING ATTENDING AND REFERRING PROVIDERS* (July 24, 2020), available at:

https://omh.ny.gov/omhweb/clinic_restructuring/docs/attending_referring_guidance.pdf.

Entries for servicing, ordering, and referring providers on claim forms are also relevant for Medicaid claims submissions. The December 2013 Medicaid Update, Volume 29 – Number 13, repeatedly refers to a “servicing/rendering professional.” For practitioners who cannot be enrolled as Medicaid providers, an enrolled physician who signed a treatment plan, or the supervisor of an individual who cannot be enrolled as a Medicaid provider, should also be included on the claim in the “referring provider” field. New York State Department of Health, Medicaid Update – December 2013, Volume 29- Number 13, available at:

https://www.health.ny.gov/health_care/medicaid/program/update/2013/dec13_muspec.pdf.

Federal regulations applicable to the Medicaid Program require all provider claims to include the following statement in bold type above a claimant's signature or, if on the reverse page, referencing the statements immediately above the claimant's signature: "This is to certify that the foregoing information is true, accurate, and complete." 42 CFR § 455.18. States are required to screen Medicaid providers and ensure that all ordering and referring physicians or other professionals providing services under a state plan are enrolled as participating providers. 42 CFR § 455.400 - § 455.470; CMS CMCS Informational Bulletin, *Medicaid/CHIP Provider Screening and Enrollment* (December 23, 2011), available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-23-11.pdf>.

By enrolling in the Medicaid Program, Medicaid providers agree that the information provided in relation to any claim for payment shall be true, accurate, and complete. 18 NYCRR § 504.3(h). A claim is not true, accurate, and complete when the name of a practitioner who had no involvement in a patient's care is inserted on a claim for payment. The Appellant has failed to establish that its interpretation of what should be deemed acceptable (i.e., substituting one individual's name as the provider for another's name on a claim form) comports with the rules, regulations, and official directives of the Department. 18 NYCRR § 504.3(i).

Ambulatory Patient Group (APG) Methodology and Article 28 Clinics

The Appellant contends that the name of the individual practitioner rendering services on the disallowed claim is irrelevant because the Appellant clinic is the payee (billing provider) and it must submit claims using the APG methodology, which is a remittance for a bundling of procedure codes. (T 19, 24, 67-68, 133, 149.) [REDACTED] explained that multiple providers could render services on the same day, all of which would be listed on one claim with just one attending provider. (T 153-54.) Her explanation is not responsive to the basis for the audit

disallowances because the individual identified as the provider on the disallowed claims did not participate in any services rendered to the patient on the claimed date of service.

The OMIG auditors evaluated whether the provider named on submitted claims was documented as having any relationship to the patient's care on the billed dates of service, not whether just one provider rendered services to a patient. (T 45.) The Department has issued billing guidelines for Article 28 Clinics which explicitly recognize the use of APG coding as part of clinics' routine billing. The New York electronic Medicaid system (eMedNY) Policy Guidelines Manual for Article 28 Certified Clinics explicitly states that patient records must accurately reflect who provided the necessary service to the Medicaid-eligible patient. The procedure code rendered on the claim must reflect the actual service rendered to the patient and must be consistent with the scope of practice, certification and/or profession of the rendering provider. eMedNY Policy Guidelines Manual for Article 28 Certified Clinics, version 2007-2, available at:

https://www.emedny.org/ProviderManuals/Clinic/PDFS/Clinic_Policy_Guidelines_2007-2.pdf.

The OMIG would only be able to ascertain compliance with these requirements if claims include the identity of servicing providers.

Given that the Appellant's own electronic health records (EHR) contain the identities of the billing provider, supervising provider, and even have separate entries for the rendering provider and servicing provider, the Appellant's errors in the disallowed claims are puzzling. (Appellant Exhibit 1; T 151-52.) The Appellant does not dispute that it has maintained more accurate information internally. (OMIG Exhibit 5.) The accuracy of its internal records is not an adequate justification for ignoring the inaccuracy of its submitted claims.

Claims submitted to the Medicaid Program must be corroborated by supporting medical and other fiscal records. Medicaid providers are required to maintain contemporaneous documentation in patient files of the identity and contact information of all ordering, referring, prescribing, attending, and servicing professionals. New York State Department of Health, Medicaid Update – December 2013, Volume 29- Number 13. However, internal documentation alone does not establish compliance with all Department laws, rules, and directives when those internal documents contradict the information presented to the Medicaid Program for payment.

Contrary to the Appellant's suggestion that the OMIG ignored the reality of its clinic-setting practice, the OMIG's approach to this audit demonstrates flexibility and a practical understanding of the nature of services rendered at an Article 28 clinic. As Audit Supervisor Martin Molloy explained, the Appellant was not precluded from including the name of a supervising provider, as long as the individual who rendered the billed services was also identified on the claim. (T 45.) Providers such as physicians and nurse practitioners are able to enroll in the Medicaid Program and must therefore be listed as the servicing/rendering provider on a claim when they render the services billed. The auditors accepted claims in which the physician or nurse practitioner rendering services was identified as the servicing and/or ordering provider on the claim. (T 4-54.)

Mr. Molloy also testified that the auditors accepted claims for which the Appellant's documentation showed that the individual named on the claim had signed a progress note or was at all active in the patient's activity for the date of service and helped perform the billed health service as documented in patient records even by simply viewing a progress note. If a minimal relationship by a provider named on the claim was documented for the date of service, the

auditors allowed the claim, even if other providers were also identified in the patient's record on the date of service. (T 31, 35-36.)

On the other hand, if the named practitioner on the claim was simply "in the clinic physically" but patient documentation showed no record of that practitioner's involvement with the patient on the date of service, the claim was disallowed. As Mr. Molloy explained, some providers "were in [on] the actual date...but we don't have any knowledge that they were involved in the patient's care that day in the claim." (T 36.)

The Department's rules regarding Medicaid claims have been clear and consistent across varying disciplines. Its interpretation of applicable regulations is entitled to deference unless irrational. *Wegman v. New York State Department of Health*, 215 N.Y.S.3d 562 (App. Div. 3d Dep't 2024); *Odd Fellow & Rebekah Rehabilitation and Health Care Center, Inc., v. Commissioner of Health* 966 N.Y.S.2d 587 (App. Div. 3d Dep't 2013). Accurate claims enable auditors to assess whether the services rendered are within a provider's scope of practice and therefore justify payment. (T 57.) It is entirely rational to require Medicaid providers seeking payment to remit true, accurate, and complete claims that identify the person who actually provided the care. The Appellant has failed to establish that the OMIG incorrectly interpreted applicable requirements.

No Deficiencies Cited in Care Rendered

The Appellant also argues that the OMIG has not cited deficiencies in the care rendered to patients in the disallowed samples, and no patients have been harmed. (OMIG Exhibit 5; Appellant Exhibit 1; T 93, 188-89, 194.) The audit objective was to verify the accuracy of submitted claims, not to review quality of care. The disallowed claims were incorrect and therefore subject to recovery as overpayments. 18 NYCRR § 518.3(a). Outside of a formal

audit, the Appellant's inaccurate claiming practices precluded oversight and verification that billed services complied with applicable legal requirements. As previously noted, the Medicaid Program repeatedly advised providers that procedure codes must accurately reflect actual services rendered and must also be consistent with the servicing provider's scope of practice. By failing to correctly identify a servicing provider on its claims, the Appellant violated the Department's reasonable and consistent policies.

Collaborative Agreements and Peer Collaboration

By means of explaining identified discrepancies, namely, the absence of documentation showing that individual providers named on disallowed claims had any involvement in patient care on billed dates of service, the Appellant argues that its physicians, nurse practitioners, and physician assistants "work in a truly collaborative professional environment...and that there is ongoing, regular communication between and among the clinicians." (OMIG Exhibit 5.) For disallowed claims in which nurse practitioners rendered the billed services, the Appellant correctly notes that such practitioners are required to have collaborative practice agreements with supervising physicians pursuant to New York Education Law § 6902. (OMIG Exhibit 5.) The Appellant asserts that, given this requirement, either the nurse practitioner or the supervising physician could have been identified on the 837I claim form as the servicing provider. (T 18.)

Nurse practitioners are able to enroll as Medicaid providers and must therefore be identified on the claim as the servicing provider. A supervising provider is only required on a Medicaid claim if the servicing provider cannot enroll as a Medicaid provider. New York State Department of Health, Medicaid Update – December 2013, Volume 29- Number 13; eMedNY, *Ordering Referring Prescribing Attending Provider Enrollment Frequently Asked Questions*,

revised February 28, 2020, available at:

https://www.emedny.org/info/providerenrollment/ProviderMaintForms/Core_OPRA_FAQs.pdf.

The Appellant is aware that nurse practitioners are authorized to submit claims as Medicaid providers. During the audit period, the Appellant was reimbursed for submitted Medicaid claims which accurately identified a nurse practitioner who rendered services to the patient. (OMIG Exhibit 8; T 68-69, 97-98, 103-04.)

The Appellant's collaborative practice agreements do not constitute supporting medical or fiscal records. Moreover, the Appellant's collaborative practice agreement specific to nurse practitioners (NPs) indicates that only NPs with less than two years' experience are required to have a collaborative agreement, and that NPs with greater experience have the option of having such an agreement. While the agreement provides for reviews of patient records seen by the NP "on a regular basis" and a formal chart review on a quarterly basis, such agreement fails to establish that the "physician/designee" reviewer was at all involved in the care and treatment of a particular patient for the encounters billed on a given claim.

In addition to file reviews, [REDACTED] explained that a physician was available every day to NPs for "clinical consultation and supervision on every patient they saw, should that be needed." (T 167.) Availability and involvement in patient care are not synonymous.

As evidence of the Appellant's collaborative practice, [REDACTED] described collegial discussions in the hallway, over lunch, by phone, periodic chart visits, or "some quality improvement activities or educational activities." (T 162-63.) Despite the described elasticity of professional collaboration, [REDACTED] was able to confirm that the hallway and phone conversations occurred at least weekly. (T 164-65.) However, she also confirmed that such "informal collaboration" would only result in the collaborating or supervising physician logging

into a patient's EHR on an extremely rare occasion. [REDACTED] opined that such a physician, even without any documented involvement in patient care, would be considered responsible for the patient's care. (T 165.) If the Appellant's claims submissions practices (according to this description) were permissible, neither the Department nor the OMIG would ever be able to ensure that a provider who actually rendered services to a patient was legally and professionally authorized to do so. The Appellant's argument does not comport with Medicaid requirements.

Escobar Materiality Standard

Finally, citing the United States Supreme Court's decision in *Universal Health Services, Inc., v. U.S. ex rel. Escobar*, 579 U.S. 176 (2016) the Appellant argues that the audit findings "do not rise to the level of materiality required to disallow payment." (OMIG Exhibit 5, Bates pp. 142-44; T.17-18, 195.) The cited case is inapplicable to the disallowances at issue.

Escobar involved a Medicaid provider's liability under the False Claims Act. The False Claims Act (31 U.S.C. §§ 3729-3733) provides for penalties to be imposed against anyone who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval. 31 U.S.C. § 3729(a)(1). The audit at issue in this hearing seeks to disallow and recover payments previously made pursuant to New York State law. The disallowances are not being sought independently of an audit and pursued in federal court under the False Claims Act. The OMIG is acting squarely within its legal mandate to audit claims paid by the New York State Medicaid Program pursuant to the Public Health Law. The Appellant has failed to establish that the OMIG's determination, as set forth in its final audit report, was incorrect.

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

The OMIG extrapolated its sample findings of 42 disallowed claims totaling \$8,061.65 to the Appellant's total 24,082 claims for which it received a total payment of \$4,324,251.90 from the Medicaid Program during the audit period. (OMIG Exhibit 6.)

The OMIG's use of statistical sampling methodology for extrapolation of the sample findings was explained to the Appellant in the exit conference summary (OMIG Exhibit 2), the draft audit report (OMIG Exhibit 4), and the final audit report (OMIG Exhibit 6). During the exit conference, the Appellant was also given a compact disk (CD) containing information about the universe of claims in the audit period and sample information about the claims selected for audit. (OMIG 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. The Appellant may 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 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 Krista Bryk, the OMIG employee who applied the methodology to establish the audit frame and select the random sample. (OMIG Exhibits 10, 11.)

The Appellant has offered neither expert testimony nor an actual accounting of all claims to establish error in the extrapolation. Instead, the Appellant merely argues that the OMIG's failure to disclose details underlying the sampling methodology should invalidate attempted recovery of an extrapolated overpayment. (OMIG Exhibit 5.) The OMIG disclosed sufficient

information concerning the universe of claims and extrapolation methodology. While the Appellant asserts that “there is no reason to believe OMIG performed a probe sample in this case,” which it deems significant because the sampling frame is large, the Appellant points only to the Medicare Program Integrity Manual as support for this claim. (OMIG Exhibit 5.)

The Medicare Program Integrity Manual is not binding authority in an audit of claims paid by the Medicaid Program. In fact, the Medicare Manual itself 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>.

There is also a Medicaid Program Integrity Manual, which pertains to Medicaid audits and defers to state Medicaid policies regarding extrapolation. Medicaid Program Integrity Manual § 1.7.3, effective 4-3-18, 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 extrapolation based upon audit findings 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, 590 N.E.2d 13 (N.Y. 1992); Enrico v. Bane, 623 N.Y.S.2d 25 (App. Div. 3d Dep't 1995); 615 N.Y.S.2d 771 (App. Div. 3d Dep't 1994); Clin Path, Inc. v. New York State Dep't of Social Servs., 598 N.Y.S.2d 583 (3d Dep't 1993). The OMIG's selection of 100 claims from 24,082 paid claims afforded both the OMIG and the Appellant an efficient means by which to establish whether the

Appellant had created and maintained the requisite documentation to justify its right to the Medicaid payments received for DTC services in the period reviewed.

The fact that the audit resulted in a disallowance rate of 42% (42 samples disallowed out of 100 reviewed samples) for the same error shows the Appellant's significant need for improvement in its claim submissions. The Appellant failed to demonstrate that a smaller percentage of errors would be identified in an audit of the entire universe.

The Appellant also failed to submit any expert testimony to challenge the presumption of accuracy established by the certifications of the extrapolation methodology. Bare assertions of unfairness fail to overcome that presumption. 18 NYCRR § 519.18(g). For all of these reasons, the OMIG's determination is sustained.

DECISION

The OMIG's determination to recover Medicaid Program overpayments from the Appellant was correct and is affirmed. The overpayment amount is \$1,941,407.

Dated: February 11, 2025
Menands, New York



Natalie J. Bordeaux
Administrative Law Judge

To:

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