cc: Ms. Daniels Rivera by Scan
Ms. Mailloux by Scan
Ms. Bordeaux by Scan
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NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

May 21, 2026

CERTIFIED MAIL/RETURN RECEIPT

Dionne Wheatley, Esq.
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Colm Ryan, Esq.
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80 State Street
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Aviva Neginsky, Owner
First Advanced Care Inc.
1411 Gravesend Neck Road – Floor 1
Brooklyn, New York 11229

RE: In the Matter of First Advanced Care, 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,

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB:nm
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Request of

FIRST ADVANCED CARE, INC.
Medicaid ID # 03059616

for a hearing pursuant to Part 519 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) to review a determination to recover Medicaid overpayments.

Decision After Hearing

Audit #2012Z31-031G

Before: Kimberly A. O'Brien
Administrative Law Judge (ALJ)

Parties:

New York State Office of the Medicaid Inspector General
800 North Pearl Street, 2nd floor
Albany, New York 12204
By: Dionne Wheatley, Esq.

Aviva Neginsky, Owner
First Advanced Care Inc.
1411 Gravesend Neck Road - Floor 1
Brooklyn, New York 11229
By: Colm Ryan, Esq.
Margaret Surowka, Esq.
Barclay Damon, LLP
80 State Street
Albany, New York 12207

INTRODUCTION

The Department of Health (Department) acts as the single state agency to supervise the administration of the medical assistance program (Medicaid Program) in New York State. Public Health Law (PHL) § 201(1)(v), Social Services Law (SSL) § 363-a. Pursuant to PHL §§ 30, 31 and 32, 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.

OMIG made a determination to seek restitution of payments made by Medicaid to First Advanced Care Inc. (Appellant). Aviva Neginsky, Appellant's owner requested a hearing pursuant to SSL 145-a and the former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the determination.

The hearing was scheduled to begin on August 13, 2014, but was adjourned on consent, and the parties engaged in settlement negotiations that extended over more than three years.[1] Transcript at page 6. Appellant requested a change of venue from Manhattan to Albany, New York, with leave to return to Manhattan on future dates, and without objection the request was granted.

The first day of hearing, September 28, 2017, was held in person in Albany and the subsequent hearing days were held via Webex. After the first day of hearing, the parties resumed settlement negotiations that extended another five years, and numerous adjournment requests were granted on consent. T. 7-8. Prior to the second day of hearing, June 14, 2023, Appellant requested a decision on the papers without hearing, the OMIG opposed the request. The ALJ

[1] The transcript of the first day of hearing (First Day T.) is numbered pages 1-172. The transcripts (T.) of the following eight hearing days are numbered pages 1-1013.

denied the request after Appellant's counsel requested a hearing to address the complexity of their request for a decision on the papers. T. 12-13.

The hearing was held on: September 28, 2017, and June 14, July 18, July 19, August 23, September 21, October 19, December 6, and December 14, 2023. Dionne Wheatley Esq.,[2] presented exhibits 1-3, 8, 12-15 and called Sandra Noonan, Manager of the Systems Match Unit; Christina Trimarchi, Supervisor Bureau of Business Intelligence Unit; and Emily Amiccuci, Medicaid Integrity Specialist 3. Colm Ryan, Esq. and Margaret Surowka, Esq.[3] represented Appellant, presented exhibits A, B, E Vol.1 & Vol.2, F, L, M, N, R and called Michael Fishman, Office Manager and Appellant Aviva Neginsky, who testified on her own behalf. A transcript of the hearing was made. The parties submitted briefs and reply briefs.

APPLICABLE LAW

DSS regulations generally pertinent to this hearing decision are: 18 NYCRR 504 (medical care-enrollment of providers, in particular 18 NYCRR 504.3 duties of the provider), 18 NYCRR 505 (medical care, in particular 18 NYCRR 505.10 transportation for medical care and services), 18 NYCRR 517 (provider audits), 18 NYCRR 518 (recovery and withholding of payments or overpayments), 18 NYCRR 519 (provider hearings), and 18 NYCRR 540 (authorization of medical care, in particular 18 NYCRR 540.6 billing for medical assistance).

The New York State Medicaid Program (Medicaid Program) issues Medicaid Management Information Systems (MMIS) provider manuals, which are available to all providers and include, *inter alia*, billing policies, procedures, codes and instructions. The

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[2] Barry Mandel, Esq. represented the OMIG until on or about 2016 to early 2017. Ricja Rice, Esq. represented the OMIG at the first day of hearing but left the OMIG in or about December 2017. Ms. Wheatley represented the OMIG to the conclusion of the hearing. T. 11.

[3] Linda Clark, Esq. and Margaret Surowka, Esq. of Barclay Damon, LLP initially represented Appellant. Colm Ryan, Esq. and Ms. Surowka represented Appellant on the second day of hearing and going forward. T. 12-13.

Medicaid Program also issues a monthly Medicaid Update with additional information, policy and instructions. Providers are obligated to comply with these official directives. 18 NYCRR 504.3(i); Lock v. NYS Department of Social Services, 220 A.D.2d 825, 632 N.Y.S.2d 300 (3d Dept. 1995); PSSNY v. Pataki, 58 A.D.3d 924, 870 N.Y.S.2d 633 (3d Dept. 2009).

To receive payment for services to Medicaid recipients, a provider must be lawfully authorized to provide the services on the date the services are rendered. A transportation service and its drivers must comply with all requirements of the New York State Department of Transportation and Department of Motor Vehicles (DMV), and the transportation service must ensure that all ambulette drivers are qualified under Article 19-A of the Vehicle Traffic Law. 18 NYCRR 505.10(e)(6).

Medicaid fee-for-service providers (providers) are reimbursed by Medicaid based on the information they submit on their claims. By enrolling in the Medicaid Program providers agree to:

- "submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures on the claims submission." 10 NYCRR 504.3(f).

- "the information provided in relation to any claim must be true, accurate and complete." 18 NYCRR 504.3(h).

- "to comply with the rules, regulations and official directive of the department." 18 NYCRR 504.3(i).

- "any claim returned to a provider due to data insufficiency or claiming errors may be resubmitted by the provider upon proper completion of the claim in accordance with the claims processing requirements of the department within 60 days of the date of notification to the provider advising the provider of such insufficiency or invalidity." 18 NYCRR 540.6(a)(2).

- all claims for payment must be finally submitted within two years of the date of care, services or supplies were furnished. 18 NYCRR 540.6(a)(3)(i).

See also Transportation Policy Manual Guidelines 2004 Volume 19, Number 11 and Medicaid Updates.

Providers must prepare and maintain contemporaneous records demonstrating the right to receive payment and all claims for payment are subject to audit for six years. 18 NYCRR 504.3(a)&(h), 517.3(b), 540.7(a)(8).

The audit process includes the issuance of a draft audit report and final audit report. The draft audit report "must advise the provider of the basis for and the legal authority" for the proposed action; "contain a clear statement of the action to be taken;" and "afford the provider the opportunity to respond to the proposed action." 18 NYCRR 517.5(a)&(b). "In preparing the final audit report, the Department must consider the objections, any supporting documents and materials submitted therewith, the draft audit report, and any additional material which may become available." 18 NYCRR 517.6(a).

An overpayment is defined as "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). Interest may be collected upon any overpayments determined to have been made. 18 NYCRR 518.4(a). If an audit reveals overpayment, the Department may require repayment of the amount determined to have been overpaid. 18 NYCRR 504.8(a)(1), 518.1(b). "Computer-generated documents prepared by the department or its fiscal agent to show the nature and amount of payments made under the 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 519.18(f).

A provider 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 OMIG must present the audit file and summarize the case. 18 NYCRR 519.17. 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. SAPA 306(1); 18 NYCRR 519.18(d)(1).

FINDINGS OF FACT

1. At all times relevant hereto Appellant, First Advanced Care, Inc., owned by Aviva Neginsky was enrolled as a fee for service non-emergency ambulette transportation provider in the Medicaid Program. Ex. 1.

2. The OMIG conducted a "system match audit" of fee-for-service between January 1, 2008 and December 31, 2011 (audit period), by transportation providers across the state. The audit was based on specific "raw claims data" extracted from the Medicaid Data Warehouse, which is maintained by "CSRA," which is the data system that houses all the claims data processed by eMedNY. Ex. 1, Ex. 3, Ex. 9; First Day T. 65-69, 70-78, 85-86, 110-113, 122-123,127, 132-134; T. 23-28, 69, 191-194, 197, 325.

3. On December 27, 2012, the OMIG issued a draft audit report (DAR) to the Appellant. The DAR included Audit Finding 3, notifying Appellant that the OMIG was disallowing all "Transportation Claims with Incorrect Driver's License for Date of Service" within the audit period. All the subject claims, approximately 31,000, contained nine zeros in the driver license field. The OMIG determined to seek restitution in the amount of $1,956,332.86. Only Audit Finding 3 is at issue in this hearing. Ex. 1, Ex. 3.

4. The OMIG does not dispute that Appellant provided the services for which the subject claims were paid. First Day T. 70, 73-75, 81-83, 109-113; T. 24, 140, 193-194, 208-210; Ex. 1, Ex. 3.

5. Throughout the audit period Appellant used the Soft Pro software program/billing system to electronically process and submit its claims to eMedNY. T. 778, 796, 829, 835, 865, 999-1000.

6. OMIG auditor Marianne Geleta (Auditor) kept an audit file including notes about the OMIG's "back and forth" with Appellant. The file also contains the final audit report, mailing receipts, auditor worksheets, auditor notes and internal communications, emails pertaining to the audit, documentation Appellant provided in response to the draft audit report, and the OMIG "summary" created "just prior" to the final audit being issued. Ex. 8; First Day T. 83-84, 89-91, 93-94, 151.

7. A Medicaid provider can submit claims adjustments "up to two years in order to correct anything that they realize is---needs fixing on the original claim they billed" (two-year rule). 18 NYCRR 540.6(a)(3); First Day T. 84-85; T. 69, 342-345; Ex. 8 at 100.

8. On January 25, 2013, Appellant office manager Michael Fishman notified the Auditor that Appellant intended to adjust 7,956 claims within the two-year rule by providing a valid driver's license number for a qualified driver (adjusted claims). Mr. Fishman further advised that he had an "adjustment file" with the driver's license number for the remaining claims within the audit period. Ex. 8 at 100, 102.

9. On February 1, 2013, Appellant requested a 30-day extension to respond to the draft audit report. Ex. 8 at 90-91

10. On February 20, 2013, Appellant emailed the Auditor and provided batch numbers for the adjusted claims that fell within the two-year rule. Ex. 1, Ex. 8 at page 2, 87-89, 20-40, Ex. 12, Ex. 14, Ex. B; First Day T. 73-76, 84-85, 100-101, 110-113: T. 56-57, 67-71, 76-109, 299-301, 342-344, 347-349, 374.

11. Appellant adjusted all claims within the two-year rule, providing a driver license number for each claim. The OMIG then verified the driver/driver's license number on each claim with the DMV "Driver History Report" which showed the driver was connected to Appellant and 19-A qualified on the date of service. Ex. 8 at 43, 49 -51; T. 378 -386.

12. On March 4, 2023, the Auditor spoke with Mr. Fishman, who requested a conference call with Sandra Noonan, Manager of the System Match Unit, and said he wanted to send the Auditor "adjustments for all claims." The Auditor forwarded the request to Ms. Noonan. Ex. 8 at page 2, 87; First Day T. 64.

13. On March 7, 2013, the Auditor and Ms. Noonan had a conference call with Mr. Fishman about the processing of the adjustments for the remaining claims. They asked Mr. Fishman to provide "10-20 examples of his documentation for these claims. We will review those & then determine next steps." Ex. 8 at page 2, 85-86; T. 343-346, 762-763.

14. On March 11, 2013, Mr. Fishman requested another 30-day extension. Mr. Fishman confirmed that Appellant has "all necessary information for the rest of the claims." Ex. 8 at page 2-3, 43-44, 48, 86-88, 100; First Day T. 89 - 91, 151; T. 72-86, 344-346, 999-1000.

15. On March 13, 2013, Mr. Fishman submitted the requested sample documentation including trip tickets; driver schedules/rosters; driver's licenses with driver's license number, paratransit driver licenses; and DMV "Article 19-A Bus Driver Add/Drop Acknowledgement Reports" for 20 claims. Ex. 8 at page 109-174; First Day T. 83-84, 93-110; T. 346.

16. On October 18, 2013, the Auditor was notified that all of the 7,956 claims corrected by Appellant within two years of submission were "voided" by eMedNY and removed from the audit reducing the number of disallowed claims from 31,000 to approximately 23,000

claims. The overpayment amount was reduced by $501,814.73, to $1,454,453.63, which includes Medicaid overpayments in the amount of $1,386,449.50 and accrued interest in the amount of $67,959.13. Ex. 1, Ex. 3, Ex. 8 at page 3, 20-22, 38.

17. The Auditor and Ms. Noonan determined, with regard to the documentation submitted for the 20-claim sample, that Appellant's "documentation relating to the drivers cannot be tied back to an individual Medicaid claim date of service. The trip tickets and schedules of the patient pickups and drop-offs do not identify the driver's license number for the individual driving the ambulette." Ex. 1, Ex.3, Ex. 8 at page 6-19, 20-21; First Day T. 64, 93-95, 105, 147.

18. On October 23, 2013, the OMIG issued the Final Audit Report (FAR) in which the number of claims, 23,000, and the overpayment amount, $1,454,453.63, remained unchanged. Ex. 1, Ex. 3.

ISSUE

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

DISCUSSION

The OMIG presented the audit file and summarized the case. 18 NYCRR 519.17. Ms. Noonan was the Manager of the System Match Unit at the time of the audit and provided direct testimony on the first day of hearing.[4] Ms. Amiccuci succeeded Ms. Noonan as Manager of the System Match Unit, and she "inherited" this audit when Ms. Noonan and the Auditor retired in

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[4] Ms. Noonan testified on the first day of hearing but retired from the OMIG in October of 2019. Upon information and belief, the parties were aware of Ms. Noonan's impending retirement which occurred within the five-year period between the first and second hearing day. Neither party was able to secure a return appearance for a future hearing date. Mr. Ryan requested that Ms. Noonan's testimony not be considered because she was not subject to cross examination. The ALJ denied the request, without prejudice. Mr. Ryan was given leave to renew his

October of 2019. T. 328. At the time of the audit, Ms. Trimarchi was a data analyst and supervisor in the Business Intelligence Unit which analyzes raw claims data extracted from the Medicaid Data Warehouse.

Aviva Neginsky is the owner of First Advanced Care. At the time of the audit Michael Fishman was the Appellant's business manager and communicated with the OMIG about the audit by phone and email. Ex. 8. Ms. Neginsky conferred with Mr. Fishman throughout the audit and was aware of all of his communications with the OMIG and assisted with preparing the responses to the OMIG. T. 752-754.

System Match Audit

OMIG witness Noonan testified that the Medicaid Program does not verify the validity of the information provided in a claim before it pays a claim, the claim system only verifies that there is information in each required field. The transportation providers original claim submissions, claim adjustments and void transactions are processed by eMedNY, a third-party contractor. First Day T. 65-69. In system match audits claims data is extracted from the Medicaid Data Warehouse based on the audit "criteria" *e.g.* driver license number on each claim, not by individual provider. First Day T. 111. The OMIG issued the DAR notifying Appellant that it had disallowed claims that did not contain a valid driver's license number for the date of service, Audit Finding 3. There is no valid New York State driver's license number that contains all zeros. First Day T. 112. Audit Finding 3 contains approximately 31,000 disallowed claims that contain a driver's license number with "nine zeros." . First Day 111.

OMIG witness Trimarchi testified that while she was not directly involved in this audit, she is very familiar with the analysis of the claims data for system match audits and has worked

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request if the OMIG's witnesses could not answer questions about the sum and substance of the audit. He did not renew his request. T. 7-8, 326-328.

closely with the System Match Unit. She testified that "system match audits use data submitted on the claims to determine whether they are appropriate based on the rules, regulations and policy of the Medicaid Program," and that if the data is "inappropriate" a "draft audit report is issued." T. 173. Each claim is required to have an accurate driver's license number for a qualified driver in the driver's license number field. T. 28, 105-06.

Ms. Trimarchi explained that providers electronically submit to eMedNY large batches of claims that are processed by CSRA. T. 21. The raw batch claims data is archived upon a provider's submission of batch claims to eMedNY and before the claims are processed for payment. T. 99-102. The claims data extracted from the Medicaid Data Warehouse (raw claims data) revealed that Appellant had "incorrect" driver's license numbers, "all zeros," on the subject claims resulting in an overpayment. T. 23-28, 77.

The OMIG is aware that Appellant and "multiple" providers subject to the audit used the same "third party billing software," "Soft Pro," and that this software program/billing system inserted nine zeros for a driver license number in some of the providers' claims. T. 389. Ms. Trimarchi was aware that Appellant and other providers subject to this audit had "similar findings," where the "software that they used to submit their billing" populated the driver's license field on a claim with zeros. T. 42-43. Without a driver's license number there "is no way for us to identify who that driver was" or verify that the driver was 19-A qualified on the date of service. T. 168.

After commencement of the hearing, Appellant produced batch claims for "batch 1763," which contains a driver license number on each claim. T. 87-89, The OMIG then asked the Department to extract all the claims relating to batch 1763, OMIG Exhibit 13. T. 88. The OMIG's Exhibit 13 contains all the claims in batch 1763, and each claim contains nine zeros

in the driver's license field. T. 99-102. When compared to OMIG Exhibit 13, Appellant's batch claims documentation, among other inconsistencies, contains a driver's license number in the driver's license field. T. 232-237, 254-259. There is no way to know how and when the documentation was created and it is only a subset of claims within batch 1763. T. 80-81, 102, 119-120.

Appellant witness Neginsky testified that on a weekly basis Appellant electronically submits a batch of claims to eMedNY for processing and payment; at the time of the audit they were using the Soft Pro software program/billing system. T. 725-726. After each batch of claims is submitted, eMedNY sends written notification to Appellant identifying which claims in the batch are approved/paid and which are denied; if a claim is denied a reason for the denial is provided, and the Appellant corrects the claim. T. 734-736. As none of the claims were denied the DAR was the first notice that Appellant received that the claims contained nine zeros for the driver's license number. T. 736- 738, 750, 822. If Appellant had been made aware of this error, they would have corrected the claims. T. 781. While the attachment to the DAR shows that the driver's license number on each of the subject claims contain nine zeros, the Appellant's computer system shows the "correct" driver's license number on each claim. T. 751-752. After the hearing commenced, Ms. Neginsky asked the "programmer from Soft Pro" to print a sample batch of claims maintained on Appellant's server (batch claims), which all contain a driver's license number in the driver license field. T. 778, 829-831.

The OMIG is authorized to conduct in-house post payment claims reviews, as it did here. 18 NYCRR 517.2(b). It is uncontroverted that Appellant first became aware of the errors on the subject claims when they received the DAR. Because the claims were paid, Appellant was not given notice of any reason or need to correct and resubmit the claims. Appellant suggests that

there should be edits in place to deny claims with blatant errors, *e.g.* driver's license numbers with nine zeros, and a provider should be notified of the errors. Appellant's Brief at page 6, 13. The Medicaid Program may use edits to identify claim errors prepayment, and Appellant's suggestion obviously makes good sense, but providers are not entitled to rely on edits to protect them from claims being disallowed on audit. It is Appellant's responsibility to provide a driver's license number on all claims and submit claims with information that is "true, accurate and complete." 18 NYCRR 504.3(h)&(i).

Appellant contends that the batch claims they produced at this hearing "remained undisturbed on its server from the date of submission to Medicaid through the conclusion of the audit period" and constitutes direct evidence that the OMIG's raw claims data is incorrect. Appellant's Reply Brief at page 1. It is uncontroverted that the OMIG's raw claims data reflects that the subject claims contain nine zeros for the driver's license number and Appellant's batch claims contain driver's license numbers, and that when compared there are other inconsistencies.

Appellant maintains that the batch claims gleaned from its internal system constitute what Appellant had in its system when it originally submitted the claims. There is little evidence to support that driver's license numbers were on Appellant's original batch claim submissions to eMedNY. The OMIG is not alleging, as Appellant suggests, that it intentionally submitted the subject claims with incorrect driver license numbers. Appellant's Brief at page 18. It was known that before the batch claims were submitted to eMedNY, the Soft Pro software program/billing system that Appellant and other transportation providers used populated the driver's license number field on the claims with nine zeros. Thus, the Soft Pro software program/ billing system created the claim errors, not the eMedNY system.

Appellant argues that the OMIG must "verify the accuracy" of the raw claims data it relied on, and at hearing produce an expert to testify to the accuracy of the data. Appellant's Brief at page 12. Pursuant to 18 NYCRR 519.18(f), the OMIG's claims records are presumed to be accurate. The OMIG explained how the raw claims data it relied on for the audit is maintained, and Appellant offered nothing to rebut the presumption of the accuracy of the data.

Claims Adjustments within the Two-Year Rule

Appellant witness Fishman contacted the Auditor after Appellant received the DAR. Mr. Fishman told the Auditor that Appellant was adjusting claims within the two-year rule. He provided an adjustment file containing driver's license numbers for these claims and told the Auditor he also had an adjustment file and contemporaneous documentation to support the remaining claims. The driver license numbers contained in the adjustment files came from batch claims maintained on Appellant's server, not from their contemporaneous documentation. T. 983-984. The Auditor told Mr. Fishman that the "adjustment file" containing the driver's license numbers for the remaining claims would not be considered because the adjustments "can only go back two years." T. 997-1000.

OMIG witness Amiccuci testified that there "are multiple auditing units within OMIG that perform different types of audits." T. 441-442. A system match audit also known as a "billing audit or claims audit." is based on "specific criteria dependent on the audit, for a certain time period, and pulls all of the claims that hit that criteria." T. 324. Unlike a "service audit, where the auditor is looking to see that the service was performed and determining there is appropriate documentation" to support a claim; here the auditor is "looking to see that the claim was submitted appropriately by the provider." T. 325. Ms. Amiccuci opined that to have claims removed from system match audit a provider is "required by policy" to show that they originally

submitted a valid driver's license number on each claim. T. 388, 540. She noted that the DAR states "not to submit claim voids or adjustments in response to this draft audit report," because it constitutes "altering the audit record." T. 342. The Appellant provided an adjustment file with driver's license numbers for all 7,956 of the "zero claims" within the two-year rule. T. 343. Ms. Amiccuci conceded that after the OMIG reviewed the adjusted claims and verified the driver/ driver's license numbers against "DMV data," which confirmed a valid driver's license number for the driver on each claim who was "19A qualified" and connected to Appellant on the date of service, all the adjusted claims were voided/removed from the audit. T. 373-376, 443

Pursuant to 18 NYCRR 540.6(a)(3) a provider may correct/adjust claims within two years of submission. Prior to submitting documentation in response to the DAR, Appellant corrected the claims within the two-year rule and provided an adjustment file with valid driver license numbers for qualified drivers. It is uncontroverted that the adjusted claims were then voided/removed from the audit, reducing the number of disallowed claims to 23,000.

Upon audit, the OMIG's raw claims data showed that the claims as submitted contained nine zeros in the driver's license number field. The OMIG's provisional rejection/disallowance of these claims on audit was justified because there are no driver's license numbers that contain nine zeros. Thus, by definition the information on the claims as submitted was incorrect/inaccurate. However, Appellant's adjustment file with driver's license numbers for qualified drivers was accepted by the OMIG as sufficient to remove the claims within the two-year rule from the audit, even though those claims as submitted were incorrect.

The OMIG's contention that the remaining claims containing this error must be disallowed without affording Appellant any opportunity to establish its entitlement to payment by contemporaneous documentation has been repeatedly rejected in prior administrative hearing

decisions. OMIG's Brief at page 9-11, 15; *See* David M. Poole #2017Z31-038W, March 8, 2021 at page 20-22. It was the Department that erroneously approved and paid these claims with nine zeros in the driver's license field. Appellant having been paid and having had no notice of the error should not be foreclosed from an opportunity to prove right to payment through contemporaneous documentation.

Appellant's adjustment file with driver license numbers for qualified drivers was deemed sufficient to have the claims within the two-year rule removed from the audit, and the OMIG's raw claims data with nine zeros for the driver's license numbers was sufficient to provisionally disallow the claims on audit. Neither Appellant's adjustment file nor the OMIG's raw claims data constitute a reason to support or deny payment for the 23,000 remaining claims under review in this hearing. Appellant is entitled to a review of its contemporaneous documentation for each remaining claim to determine whether it identifies the driver who provided the transportation service to an individual Medicaid recipient on the date of service; and to show that the driver has a valid driver's license/driver's license number and is a qualified driver on the date of service. 18 NYCRR 505.10(e)(8).

Contemporaneous Documentation

Appellant witness Neginsky testified that the documentation Appellant uses to support their electronic claims includes paper copies of daily trip tickets/trip rosters. A copy of the trip tickets/trip rosters is provided to each driver, the driver documents the trips provided to Medicaid recipients, and at the end of the day the completed trip tickets/trip rosters are returned to the office. T. 669-670, 685. In addition, Appellant keeps a file for each driver which includes a copy of their driver's license and driver qualifications. Appellant also keeps scheduling paperwork from physician's offices, dialysis centers etc. (appointment documentation). T. 695-696, 762-

763. Appellant then uses this "paperwork" to complete the electronic claims submitted to eMedNY. T. 685. The documentation is filed by day, week, month and year and is maintained in Appellant's offices. Appellant has 7 banker boxes of contemporaneous documentation covering the audit period, which the OMIG has not reviewed. T. 695-696, 762-763.

Sample Contemporaneous Documentation for 20 Claims

On March 7, 2013, Ms. Noonan and the Auditor had a conference call with Mr. Fishman (conference). During the conference Mr. Fishman told the Auditor and Ms. Noonan that Appellant had contemporaneous documentation to support the remaining claims and he offered to produce it. Mr. Fishman was told to produce only a sample to support 10-20 claims of the 23,000 claims remaining at issue. T. 989.

As requested by the OMIG, Mr. Fishman randomly selected 20 claims and provided the documentation that Appellant had to support the claims (sample documentation). Ms. Neginsky testified that they did not provide all their contemporaneous documentation because the OMIG told them to provide only a sample, and that the OMIG would let them know if anything else was needed. T. 762-763. The OMIG did not, however, communicate with Appellant until after it issued the FAR.

Both Ms. Noonan and the Auditor reviewed the sample documentation and determined that "the documentation relating to the drivers cannot be tied back to an individual Medicaid claim date of service." First Day T. 105.

OMIG witness Amiccuci testified that the Auditor and Ms. Noonan correctly determined that the sample documentation failed to tie a driver to a claim date of service. Ms. Amiccuci agrees with the OMIG's determination to issue the FAR and disallow the remaining claims. However, because the Auditor and Ms. Noonan said they would get in touch with Appellant

after they reviewed the sample documentation, Ms. Amiccuci said they should have contacted Appellant before the FAR was issued. T. 343-346; *See* Ex. 8 at page 2, 85-86. She noted that there is no driver's license number on any of the sample trip tickets/trip rosters and that there is other missing information on some of the sample claims including driver's name/signature and the year the service was provided. Ms. Amiccuci conceded, however, that a driver could be tied to some of the claims where the date and driver name was listed on the trip ticket/trip roster, and the driver file contained a valid driver's license/driver's license number and showed the driver was qualified on the date of service.

It is uncontroverted that the OMIG asked for and Appellant provided sample contemporaneous documentation for 20 claims. While Appellant offered additional contemporaneous documentation at this hearing, which included among other things appointment documentation, the OMIG's determination to issue the FAR and disallow the 23,000 remaining claims was based entirely on Appellant's sample documentation.

The sample documentation Appellant provided included trip tickets and trip rosters with handwritten and typewritten trip information on preprinted forms (trip tickets/trip rosters), driver files containing a driver's license /driver's license number, paratransit driver's license, and 19A add/drop reports showing when the driver was 19-A qualified and connected to Appellant (driver file). The sample documentation relates to 16 trips that occurred in June 2010 and September - December of 2010, and 4 trips[5] with a month and day, but no year of service was provided. Ex. 8 at page 109-174.

On audit, the OMIG determined that the sample documentation provided does not tie a qualified driver to any of the 20 trips/claims, presumably because there was no driver's license

[5] Appellant's sample documentation does not include any appointment documentation or any other documentation to substantiate the year the service was provided.

number on the trip ticket/trip roster. OMIG's Reply Brief at page 1-3. While a driver's license number on a dated trip ticket/trip roster would tie the driver to the claim, it is not required if there is other information identifying the driver who provided the service on the dated trip ticket/trip roster. At hearing, Appellant's counsel brought Ms. Amiccuci through some of the sample documentation. She demonstrated how the trip tickets/trip rosters that contain the date of service and the driver name tie the driver to the claim, and how the driver file for the driver shows that the driver was a qualified driver on the date of service.

Sample Documentation – 14 Substantiated Claims

A review of the sample documentation demonstrates that 14 of the 20 claims include a dated trip ticket/trip roster with the name of the driver who provided the transportation service to the named Medicaid recipient, and the driver file shows that the driver had a valid driver's license/driver's license number and was a qualified driver on the date of service. Ex. 8 at page 118-128, 134-136, 142-173. Accordingly, Appellant has substantiated their right to payment for these 14 claims.

Sample Documentation Without a Year - 4 Unsubstantiated Claims

The sample documentation includes two trip tickets pertaining to roundtrip transportation (4 trips) provided to two different Medicaid recipients and two driver files for two different drivers, who were both qualified drivers for a period of time within the audit. Ex. 8 at page 110-117. One trip ticket contains the "DATE 8/04" with no year and no driver's name/identification. There is no way to tell when the service was provided, and without a driver's name the driver named in the driver file cannot be tied to the claim. Ex. 8 at page 110. The other trip ticket contains a driver's signature/name and a "DATE 9/06" without a year that the service was provided. Ex. 8 at page 114. While the trip ticket contains a driver's name, without a year there

is no established date of service and no way to tell whether the driver was a qualified driver when the service was provided. Accordingly, Appellant has failed to substantiate their right to payment for these 4 claims.

Sample Documentation Without Driver Identification - 2 Unsubstantiated Claims

Two trip rosters show that on "[redacted]2010" transportation services were provided to Medicaid recipient "[redacted] who was presumably transported from their residence to a dialysis center and later brought home, but there is no driver name on either trip ticket. Ex. 8 at page 129 & 137. While Appellant provided two different driver files that show both drivers were 19A qualified on the date of service, neither trip roster contains a driver's name, driver's license number or any other information identifying the driver. Without any information identifying the driver on either trip roster there is nothing tying either driver named in the driver files to either leg of the trip. Accordingly, Appellant has failed to substantiate their right to payment for these 2 claims.

Statistical Sampling

The OMIG may utilize statistical sampling in a claims audit. Statistical sampling involves an established methodology where the sample is extrapolated from across the entire universe of claims within the audit (statistical sample). 18 NYCRR 519.18(g).

The OMIG has made it abundantly clear that this is a claims audit, and while the OMIG routinely uses statistical sampling in claims audits it did not obtain a statistical sample in this audit. Instead, the OMIG asked Appellant to select 20 claims and provide contemporaneous documentation to support each claim in the sample. Even assuming the accuracy of the OMIG's contention that the Appellant's documentation did not tie a qualified driver to a specific date of service for any of the 20 sample claims, which is not supported by the evidence, it does not

follow that the OMIG may use the sample as the basis to deny/disallow all the remaining claims. *See* OMIG Reply Brief at page 1-3. Nor does it follow that Appellant's substantiation of right to payment for any of the sample claims demonstrate that Appellant is entitled to a reversal of the disallowances for all 23,000 remaining claims. *See* Appellant's Reply Brief at 5-7. Because the 20 sample claims do not constitute a statistical sample certified as valid in accordance with 18 NYCRR 519.18(g), there is no presumption of accuracy in projecting the sample findings to all 23,000 claims.

The OMIG does not dispute that Appellant provided the services and, therefore, it must give Appellant the opportunity to substantiate through their contemporaneous documentation its entitlement to payment. Appellant is entitled to establish through its contemporaneous documentation: date of service, the identity of the driver who provided the service to the specific Medicaid recipient, and that the driver had a valid driver's license/driver's license number and was a qualified driver on the date of service.

CONCLUSIONS

The OMIG only requested that Appellant produce contemporaneous documentation relating to 20 sample claims. Appellant complied with that request. The OMIG incorrectly determined that Appellant's sample documentation did not tie a qualified driver to any of the 20 sample claims and then, without requesting any further documentation, incorrectly based its determination to disallow all 23,000 claims on a statistically invalid sample.

Neither Appellant nor the OMIG can use any of the 20 sample claims as a basis to substantiate or deny payment for the remaining claims. Appellant has 7 banker boxes of contemporaneous documentation relating to the remaining claims. Once Appellant provides the OMIG with their documentation, the OMIG will review Appellant's documentation for each of

the 23,0000 remaining claims. In the alternative, the parties may agree to have the OMIG obtain a statistical sample of the remaining claims pursuant to 18 NYCRR 519.18(g), and the OMIG will review Appellant's documentation for the statistical sample.

DECISION

The OMIG's determination to disallow and recover Medicaid overpayments for the 23,000 remaining claims is *REMANDED* to the OMIG.

The OMIG will expeditiously review Appellant's contemporaneous documentation and in consideration of and consistent with the foregoing issue a *REVISED DETERMINATION.*

This decision is made by Kimberly A. O'Brien, who has been designated to make such decisions.

DATED:
May 20, 2026
Albany, New York

Kimberly A. O'Brien, Administrative Law Judge