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MEMORANDUM

TO: New York State Council for Community Behavioral Healthcare

FROM: Robert A. Hussar, Esq.

DATE: March 16, 2021

RE: Impact of David Poole Hearing Decision on OPRA Audits
RR File No.: 898022.00001

A recently issued DOH hearing decision related to OMIG Audits provides some insight on how an ALJ might view our OPRA audits, should OMIG refuse to allow providers to adjust claims or otherwise demonstrate there was a proper "referring" provider.

The audit at issue in the hearing, which is similar to the current OPRA audit and which the OMIG calls a "system match and recovery" audit, was a data-driven claims review as is authorized by 18 NYCRR 517.2(b). Although the audit focused on a different type of provider (transportation company), there were many similarities with the OMIG's current OPRA audits including:

- OMIG made disallowances solely because of missing information or discrepancies between the information on the claim forms

- Before issuing the draft audit report, the OMIG did not ask for or review any records prepared and maintained by the provider to support the claims.

- The OMIG was correct in provisionally disallowing payments in the draft audit report because information was missing on the claims.

The decision touched on many of the same points we have discussed and could potentially raise in response to a Draft Report including:

- Any claim returned to a provider due to data insufficiency or claiming errors may be resubmitted by the provider …. within 60 days of the date of the notification to the provider advising the provider of such insufficiency or invalidity. 18 NYCRR 540.6(a)(2).

- The Medicaid Program ignored the claiming requirements by paying claims for services that were submitted without complete information.

    - The Department could have identified and rejected these claims when they were originally submitted. 18 NYCRR 504.8(c).
    - There was evidence that it had the ability to do so, by means of an "edit" in its claim processing system.

- It is unreasonable to deny the provider an opportunity to correct claims since because they were paid, it had no reason to be aware that there were omissions or errors to be corrected.

Although generally favorable to our position, the decision undermines one argument we expected to advance by indicating:

> *the existence or functioning of "edits" is irrelevant to the provider's obligation to demonstrate its entitlement to payment. The Medicaid Program is not required to have them in place, or if it does, to use them consistently, nor is the Medicaid Program obligated to advise providers which edits are in place. Providers are not entitled to rely on edits to protect them from their own claiming errors and omissions, nor are they entitled to be advised of them so that they can devise their claims to circumvent them.*

While this cuts against our argument that OMH, OASAS and DOH are somehow accountable for depriving providers of the opportunity to correct claims, the ALJ went on to say:

> *But neither is an "edit," or a "data match" finding a substitute for a proper audit if it ignores issues that can be addressed by the provider's contemporaneous documentation of entitlement to payment. Had the Department denied the claims, the provider would have known there was a problem and could have corrected and resubmitted them. The provider had no reason to be aware of or correct the errors before the audit was conducted, because the Medicaid Program paid the claims. Because this was a "system match" audit, the first opportunity the Appellant had to submit its documentation in support of its claims was in the response to the draft audit report.*

The ALJ concluded that to the extent that the provider did maintain and was able to produce for audit appropriate contemporaneous documentation demonstrating its entitlement to payment as required by the relevant regulations, the OMIG's disallowances are not reasonable and are not upheld.

This decision is a great and timely precedent for providers in that it requires OMIG to look beyond just whether the information, as submitted, could support payment of the claim but also requires them, in response to a Draft Audit Report, to consider available contemporaneous documentation to support claims payment.