Tengeler, Robert

From:	Robert Tengeler
Date	November 1, 2019
To:	Bryan DeParma
Cc:	Colm Ryan
Subject:	RE: Hometown Taxi, Inc. Compliance Plan
Attachments:	Compliance Plan .DOC

CONFIDENTIAL ATTORNEY WORK PRODUCT

Colm Ryan requested that I draft a compliance plan for your organization. Prior to practicing law with Barclay Damon, I was a Deputy Medicaid Inspector General for New York and drafted many of the regulations relating to the State Medicaid Program. Attached please find a draft of the Compliance Plan that I prepared for Hometown Taxi, Inc. The Plan was drafted to meet the requirements of 18 NYCRR Part 521 (Medicaid Provider Compliance Requirements), a copy of which is included in your attachments. Key issues that you will need to decide upon are:

1- Designation of a Compliance Officer and Compliance Committee;
2- The manner in which the Plan is available to your staff; and
3-Training

The OMIG (Office of Medicaid Inspector General) does conduct reviews of Compliance Plans including the manner in which an organization utilizes the Plan. Given the experience I have had with other providers, I am sure you will have issues and/ or questions with the Plan's contents. After you have had an opportunity to review the Plan, feel free to e mail me to arrange a time for a conference call. There will be no charge for the call.

Hopefully after our discussion and any needed modification, your organization will then adopt the plan. I would reiterate the importance of having a plan and of certifying to OMIG of the existence of a plan. Failure to do either could result in the OMIG commencing an action against Hometown. I have enclosed a copy of a Legal Alert prepared by my colleagues that covers provider compliance responsibilities and which may address some of your questions. I look forward to speaking with you.

BARCLAY DAMON ALERT

OFFICE OF THE MEDICAID INSPECTOR GENERAL PUBLISHES NEW COMPLIANCE GUIDELINES/ANNUAL CERTIFICATION REMINDER

New Compliance Guidelines

On October 7, 2014, the New York State Office of the Medicaid Inspector General's ("OMIG") Bureau of Compliance published three Compliance Guidelines pertaining to adult rehabilitative mental health providers, transportation providers, and providers of comprehensive psychiatric emergency services. The Compliance Guidelines provide general guidance to assist those subject to the mandatory compliance program obligations in New York State Social Services Law § 363-d and 18 NYCRR Part 521. The Compliance Guidelines contain examples for providers to consider when assessing compliance risk areas during self-evaluations or audits to determine where compliance management or staff resources should be deployed to reduce, minimize, or eliminate compliance-related failures. Below are summaries of the Compliance Guidelines and examples contained therein. We recommend that applicable providers include the specific risk areas outlined in their compliance reviews.

1. Compliance Guideline 2014-05, Common Risk Areas for Mental Health Providers – *Comprehensive Psychiatric Emergency Programs*

When considering documentation risk areas, providers should consider whether a patient's medical record appropriately documents the Comprehensive Psychiatric Emergency Program ("CPEP") services provided; whether all brief emergency CPEP visits include a face-to-face interaction between the patient and staff physician; whether all full emergency CPEP visits include a face-to-face interaction between the patient and psychiatrist and other clinical staff as necessary; and whether the written records of a reimbursed unit of service include complete case records, discharge plans, and summaries, and conform to the requirements of 14 NYCRR Part 590.

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PRACTICE AREA

- Health Care & Human Services

RELATED ALERTS

- Will State Medicaid Fraud Control Units Be Allowed To Prosecute Abuse and Neglect In All Settings?
- NPs and PAs Can Now Officially Prescribe Buprenorphine for Opiate Dependency Treatment in New York
- Erie County Takes Action Against Nursing Homes

When considering quality of care risk areas, providers should consider whether all full emergency CPEP visits include a psychiatric or mental health diagnostic examination, psychosocial assessment, and medical examination; whether required physician examinations are initiated within six hours of admission to CPEP; whether services are performed beyond 24 hours in the CPEP without admission to an extended observation bed or psychiatric in-patient bed; and whether patients are in extended observation beds for less than 72 hours from the time a patient was received into the emergency room.

When considering billing and payment risk areas, providers should consider whether multiple visits are billed for emergency or crisis CPEP services for the same calendar day; whether billed interim crisis CPEP services are performed more than 5 days after discharge from CPEP; and whether there is a system in place to ensure that brief emergency CPEP visits are not billed as full emergency CPEP visits.

When considering credentialing and workforce risk areas, providers should consider whether psychiatrists or staff physicians providing services in the CPEP are properly licensed by New York State.

2. Compliance Guideline 2014-06, *Common Risk Areas for Mental Health Providers – Rehabilitation Adult Services*

When considering documentation risk areas, providers should consider whether the dates and duration of each rehabilitative service performed are documented in the case record; whether each rehabilitative service billed to Medicaid is of at least 15 minutes in duration; whether case records include appropriate service plans; and whether all provided services are identified in the recipient's current service plan.

When considering quality of care risk areas, providers should consider whether all initial service plans are developed within four weeks of admission to the program; whether each service plan is reviewed at least every three months; whether service plans are reviewed and signed by Qualified Mental Health Staff Persons; and whether all billed Medicaid services are covered by a physician's authorization or reauthorization.

When considering billing and payment risk areas, providers should consider whether there is a system in place to ensure billing does not occur for a month of rehabilitative services when a resident is not in residence for at least 21 days in a month or a half month of rehabilitative services when a resident is not in residence for at least 11 days in a month.

When considering credentialing and workforce risk areas, providers should consider whether the persons providing the service are being billed properly and are properly licensed or credentialed to provide the service; and whether the names of those providing the services are properly documented in the record.

3. Compliance Guideline 2014-07, *Common Risk Areas for Transportation Providers*

When considering documentation risk areas, providers should consider whether the transportation records contain all required information for each leg of the trip; whether electronic transportation records are time-stamped or whether another method is utilized to show that the records are contemporaneous with the services provided as required; and whether transportation services are provided to or from a location where Medicaid-covered services are provided.

When considering quality of care risk areas, providers should consider whether the vehicles used to provide transportation services are properly maintained, registered, licensed, inspected, and insured; whether personal assistance is provided by the driver to the enrollee when necessary as required; and whether the mode of transportation provided is designed and equipped to provide the non-emergency transport with the appropriate capacities, *i.e.*, wheelchair-carrying capacity, stretcher-carrying capacity, or the ability to carry individuals with disabilities.

When considering billing and payment risk areas, providers should consider whether prior authorization was obtained for all non-emergency transportation services; whether there is a process in place to determine if enrollees are covered by a managed care or managed long-term care plan that includes transportation; whether the correct driver license number of the driver and vehicle registration number of the vehicle used to provide the transportation service is indicated on claims; for group rides, whether claimed mileage and tolls are allowed under Medicaid rules; whether the required claim fields are completed; and whether claims are submitted in connection to actual services provided and not based on transportation rosters.

When considering credentialing and workforce risk areas, providers should consider whether all drivers who provide Medicaid transportation services have a valid driver's license in the appropriate license class; whether all ambulette drivers maintain appropriate driver license endorsements and 19A certification; and whether providers and drivers are appropriately licensed by local taxi and limousine commissions.

Providers should keep in mind that the Compliance Guidelines do not set out all points that OMIG will consider or use when assessing if compliance programs meet statutory and regulatory requirements. These new guidelines, however, do set forth specific areas that should be included in a provider's identified risk areas and as topics for internal auditing practices, along with any other risk areas that have been identified by the provider.

Compliance Certification

It is December and that means it is time to certify as to the effectiveness of your compliance plans. The process is generally the same as it has been in prior years but the forms have been updated as of December 1, 2014. OMIG reminds providers that they only need to submit the certification forms; they do not need to forward their plans or their assessment forms unless they are requested by OMIG at a later time.

Medicaid providers are subject to two sets of certification requirements, a federal requirement under the Deficit Reduction Act of 2005 ("DRA") and a New York State requirement under Social Services Law § 363-d(3). Under both

laws, providers must certify compliance for the year 2014 by December 31, 2014, which is accomplished by completing the forms located on OMIG's website. OMIG is tasked with administering both the federal and state certification process in New York. New York State requires completion of the forms in December of each year.

The DRA requires health care entities that *receive or make* $5 million or more in Medicaid payments during the federal fiscal year (October 1 to September 30) to certify annually that they are in compliance with the federal DRA. The DRA requires providers to establish written policies and procedures designed to inform employees, contractors, and agents about the federal and state false claims acts and whistleblower protections. Each year, the provider must certify that it maintains written policies, that its employee handbook includes the materials required by the DRA, that the materials have been properly adopted by the entity, and that the materials have been disseminated to employees, contractors, and agents. We note that OMIG has started to separately assess compliance plans for these requirements. The link to the DRA certification is https://www.omig.ny.gov/dra-certification.

NYS Social Services Law § 363-d(3) requires the following providers to certify that they have an effective compliance plan:

- Those providers subject to Article 28 and Article 36 of the Public Health Law (*e.g.*, hospitals, clinics);
- Those providers subject to Articles 16 and 31 of the Mental Hygiene Law (*e.g.*, OMH and OPWDD providers); and
- Those providers for which Medicaid is a "substantial portion of business operations." That has been interpreted to mean those that claim, order or receive payment for services or supplies directly or indirectly, or submit claims totaling at least $500,000 a year.

The link to the SSL certification can be found at https://www.omig.ny.gov/ssl-certification.

The eight elements of an effective compliance plan are set forth in Social Services Law § 363-d(2): 1) written compliance policies and procedures; 2) designation of an employee to be its compliance officer; 3) training for all employees, executives, and board members regarding its compliance program; 4) available communication lines to the compliance officer; 5) disciplinary procedures to encourage good faith participation; 6) identification of compliance risk areas; 7) institution of a system for responding to and investigating reports of non-compliance; and 8) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program. Having an effective compliance program is extremely important. OMIG has been reviewing the effectiveness of provider plans and will continue to do so in the coming year. OMIG has posted its Assessment of results as of March 31, 2014, which includes Best Practices, Opportunities for Enhancement, and Identified Insufficiencies with respect to compliance plan effectiveness reviews. These documents, which can be found at http://www.omig.ny.gov/compliance/compliance-library, detail each specific element and how providers have met or not met those elements.

Failure to certify is a violation of statutory and regulatory requirements. Providers' certification history is reviewed and OMIG has stated that certification history is the first metric it will use to identify providers who will become the subject of a compliance program effectiveness review. New Medicaid providers will not be able to complete the enrollment process without certifying. The certification is an official document. Therefore, you must ensure a reasonable level of diligence is taken to ensure that no false or incorrect statements are being made.

Should you need assistance with the certification process or a review of the effectiveness of any current plan, contact Margaret Surowka Rossi, Melissa M. Zambri or any member of our Firm's Health Care and Human Services Practice Area.

HOMETOWN TAXI, INC.

CORPORATE

COMPLIANCE PLAN

Prepared by Barclay Damon, LLP
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Disclaimer:

The following document is a Corporate Compliance Plan for Hometown Taxi, Inc., a provider of taxi transportation services licensed under the laws of New York State. Barclay Damon, LLP does not warrant that the implementation of the Compliance Plan will prevent an organization providing such services from being subject to an audit, investigation, sanction or other adverse action by a governmental or non-governmental agency.

The Compliance Plan represents an effort to comply with specific federal and state laws and regulations in existence as of October 31, 2019. The laws and regulations affecting the health care industry are subject to change. As part of an effective compliance plan, the Plan must be updated periodically to ensure compliance with the most recent laws and regulations.

This Compliance Plan was created for Hometown Taxi, Inc. based upon information provided to Barclay Damon, LLP.

October 31, 2019

Robert Tengeler
For Barclay Damon, LLP

MEMORANDUM

TO: Employees and Others Associated with Hometown Taxi, Inc.

FROM: Bryan DeParma, President/CEO

DATE: November 1, 2019

SUBJECT: Corporate Compliance Program

Our company, as a taxi transportation provider, is subject to complex federal and state laws and regulations. We are committed to full compliance with all applicable laws and regulations at all times. To help us attain this goal, and to continually maintain the highest ethical and legal standards of conduct, our company has adopted a Corporate Compliance Program ("the Plan"). The purpose of the Plan is to ensure that our organization and each individual associated with it fully comply at all times with these laws and regulations.

Our Plan defines the standards of conduct in a Code of Conduct that apply to all board members, employees, independent contractors and agents of our organization. These policies and procedures will aid you in understanding what conduct is acceptable and what conduct is unacceptable. All employees, contractors and other individuals that provide services on behalf of or in conjunction with our organization will receive access to the Code of Conduct, which defines the basic mission of the Plan and contains the fundamental principles that serve to guide all individuals associated with our company when providing services, and/or conducting any other business on behalf of our organization. This Plan operates in conjunction with other policies and procedures of the organization.

The Plan also serves as a mechanism to identify possible violations of the Plan or any applicable laws and regulations before they become a problem. Therefore, the Plan includes periodic review of our internal policies and procedures. Each individual should understand and appreciate his or her individual responsibility in this process. To manage the overall administration of the Plan, we have appointed a Compliance Officer and a Compliance Committee. The success of the Plan depends on the individual efforts of each person associated with our organization. Thus, individuals who have a good faith belief that someone in our organization or someone doing business with our organization is in violation of the Plan or any law or regulation are required to report such information to the Compliance Officer.

Inasmuch as laws and regulations change as the health care industry evolves, compliance with these rules must be viewed as an on-going effort. The Plan will be updated and modified as needed. Finally, each individual associated with our organization is invited to discuss the Plan with his or her supervisor and/or the Compliance Officer. In this way, our organization and those associated with it will work together to provide high quality services in accordance with the highest ethical and legal standards.

The management of the organization are firmly dedicated in this effort to implement a Compliance Plan that is effective. We require each individual associated with our organization to be similarly dedicated. Any issues or questions regarding compliance should be sent to our Compliance Officer. A full copy of the Plan is also available for review from our Compliance Officer.

The composition of our compliance committee and our compliance officer are as follows:

Compliance Officer: _____

Compliance Committee: _____

_____

_____

Introduction

Hometown Taxi, Inc. has established this compliance policy and plan (the "Plan") to ensure that it complies with various legal requirements applicable to health care providers, including, but not limited to, the Federal Medicare and Medicaid anti-kickback statute (the "Anti-Kickback Statute"), the Federal and New York State false claims laws (the "False Claims Acts") and certain regulations of the Medicaid program. Compliance with these complex legal requirements is extremely important because the failure to abide by these laws and regulations can lead to civil and/or criminal violations, serious financial consequences such as significant fines and penalties, and/or criminal sanctions for individuals and organizations.

The compliance efforts of Hometown Taxi, Inc. are designed to establish a culture within the organization that promotes prevention, detection and resolution of instances of conduct that do not conform to Federal and State laws, Federal, State and private payor health care program requirements, and our organization's ethical and business policies. We are committed to conducting our business in compliance with ethical standards and applicable laws, rules and regulations. The Standards of Conduct and the Compliance Plan do not represent any change from the organization's prior or current practices, but, rather, is a statement to guide all employees, contractors and other representatives of our organization.

The Compliance Plan is not intended to be a comprehensive explanation of all applicable legal and ethical principles applying to our organization, nor will it provide answers to every possible issue that may arise under these legal and ethical principles. It is intended to sensitize our organization and its representatives to potential problems that may arise under these legal and ethical principles so that advice can be sought should such an issue arise. We expect full compliance with the guidelines set forth in this Plan, and encourage our employees, contractors and other representatives to seek any further information or clarification necessary prior to engaging in any potentially risky or inappropriate actions or activities.

This Compliance Plan is intended to apply to all of the organization's activities. If any individual has any question about the application of this Compliance Plan, he or she should contact the Compliance Officer or any member of the Compliance Committee. This Compliance Policy and Plan is divided into three main sections:

1. An overview of certain applicable statutes, laws and regulations;
2. A Code of Conduct; and
3. The organization's Compliance Plan.

All persons associated with Hometown Taxi, Inc. will be advised to read this Compliance Plan which will be made available to them.

I. Summary of Certain Laws and Regulations Applicable to Hometown Taxi Inc.

The Anti-Kickback Statute

The Federal "Anti-Kickback" Statute makes it a crime, punishable by monetary fines and/or imprisonment, to knowingly and willfully offer, pay, solicit or receive a payment of any kind (i.e., cash, services, gifts, entertainment, favors, etc.) to anyone to induce patient referrals or in return for patient referrals of Medicare or Medicaid patients. These laws have been construed very broadly, and cover many "ordinary" business activities that are common practice in the non-health care arena. Examples of practices that could be covered by the "Anti-Kickback" Statute include: (i) routinely waiving patient deductibles or co-payments; (ii) offering or furnishing physicians or other providers with free equipment or services; and (iii) offering goods or services at below market value for the purpose of inducing patient referrals. Arrangements that satisfy all of the requirements of the regulatory "safe harbors" are immune from sanctions. Arrangements that do not meet the requirements of the regulatory safe harbors are not necessarily illegal but may be subject to heavy scrutiny. There are also New York State laws which correspond to these Federal laws. If you have any questions regarding the application of these laws, you should contact the Compliance Officer.

The False Claims Acts

The Federal criminal False Claims Act makes it illegal to submit or present a false, fictitious or fraudulent claim to the Federal government. Violations can result in imprisonment, exclusion from the Medicare program and/or a fine. The Federal civil False Claims Act authorizes the use of civil penalties of between $5,500 and $11,000, plus three times the amount of damages the government sustains, where a person knowingly presents, or causes to be presented, a false or fraudulent claim; knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid; or conspires to defraud the government in connection with the payment of a false or fraudulent claim. Penalties can be reduced where a person reports and cooperates with any government review that follows. Ignoring a potential violation of law can lead to liability. Under the False Claims Act, there are opportunities for the government and private persons to bring actions against health care providers for violation of these rules.

The New York State False Claims Act mirrors many of the provisions of the Federal False Claims Act. The State law authorizes the use of civil penalties of between $6,000 and $12,000, plus three times the amount of damages the State or local government sustains related to false claim violations. Similar to the Federal False Claims Act, penalties can be reduced where a person reports and cooperates with any government review that follows the reporting and there are opportunities for the government and private persons to bring actions against health care providers for violation of these rules.

Hometown Taxi, Inc. will pay particular attention to whether inappropriate activities are taking place that may violate the False Claims Act, including those items listed as risk areas later in this Plan. As this list is not exhaustive, Hometown Taxi, Inc. should be made aware of any activity in which an individual or entity may be filing claims that it knows to be false or fraudulent, regardless of the identity of the payor, governmental, private or otherwise.

This summary of the laws related to false or improper claims is not meant to be exhaustive. Included in the Attachments section are the requirements for a provider under the Medicaid program (18 NYCRR 504.3), a list of requirements for transportation providers (18 NYCRR 505.10) and a list of unacceptable practices in the Medicaid program (18 NYCRR 515.2) of which you should be familiar. This compliance plan was drafted and enacted pursuant to section 363-d of the SSL and 18 NYCRR Part 521. The New York State Medicaid Transportation Manual (April 1, 2016) can be accessed at http://www.emednyny.org/ProviderManuals.

II. Code of Conduct

Standards of Conduct for Employees and Others Associated with the Organization

All employees, contractors, board members, officers and other individuals associated with the organization shall perform their duties in good faith and to the best of their ability and refrain from any illegal conduct.

No employee, contractor, board member, officer or other person associated with the organization shall obtain any improper personal benefit by virtue of his or her relationship with the organization. No employee or other individual associated with the organization may engage in any conduct that conflicts—or is perceived to conflict—with the best interests of the organization. Further, individuals associated with the organization must actively avoid placing themselves in situations that could be viewed by others as compromising the individual's best judgment.

When the organization decides to enter into an agreement or arrangement with another healthcare entity or practitioner to provide services, that decision must be free of any improper influence. Thus, if you or any immediate family member is already an employee, consultant, owner, contractor or even a passive investor of an entity that: (i) engages in any business or maintains any relationship with the organization, (ii) provides to, or receives from, the organization any client referrals, or (iii) competes with the organization, you should advise the Compliance Officer. In this way, the organization can be assured that our business relationships are free from improper influences.

Employees may not accept gifts from clients, vendors or others associated with the organization without first receiving explicit authorization from the Compliance Officer. Further, you may not offer anything of value to an entity doing business with the organization or to someone who is a source of referrals for the organization without first receiving explicit authorization for such an offer from the Compliance Officer. This policy ensures that your activities will be at "arms' length" and free from outside influence. Contracts entered into by Hometown Taxi, Inc. shall be at fair market value. No agreement shall be entered into without the approval of the Chief Executive Officer.

Any waiver of deductibles or copayments must be reported to and approved by the organization's Compliance Officer. Routine waivers of deductibles and/or copayments will not be permitted as this practice could be a violation of federal and state law and regulations..

Employees and others involved in billing claims cannot bill for any amount other than in accord with the organization's usual and customary fee for the particular service being provided and according to the organization's policies and procedures or contracts with payors, as applicable. All communications with outside persons regarding services or billings and all information received related to billing should be clearly and comprehensively recorded in the appropriate files.

Claims are only to be submitted for services that are properly ordered as medically necessary. If an individual associated with the organization becomes aware of or discovers any claims that are false or are for services that are not properly ordered as medically necessary, this information must be reported to the Compliance Officer.

Employees, contractors, board members, officers and other individuals associated with the organization will not use confidential or proprietary information for their own personal benefit or for the benefit of any other person or entity, while working for or with the organization, or at any time thereafter.

Finally, it is our policy that no intimidation and no retaliation shall occur against any individual or entity for their good faith participation in our compliance program.

III. Compliance Program

A. The Compliance Officer and Compliance Committee

The Compliance Officer and Compliance Committee will oversee the Compliance Program. The Compliance Officer will be responsible for:

1. Developing compliance policies and procedures;
2. Overseeing and monitoring the organization's compliance activities;
3. Overseeing reviews of the organization's records which support claims to the Medicaid program;
4. Ensuring that policies and procedures are kept current and followed by all employees and other persons affiliated with the organization;
5. Distributing policies and procedures that are understandable to all those affected thereby;
6. Appointing employees and others associated with the organization to serve in various roles and to complete tasks as needed to promote the Compliance Program;
7. Ensuring that training is provided to employees, contractors, Board Members and others affiliated with the organization;
8. Reviewing agreements to ensure compliance with laws and regulations with consultation of counsel as needed;
9. Reviewing Incident Reports to determine any impact they might have on this Compliance Plan;
10. Working with senior management of the organization to ensure that appropriate discipline is taken in the event a person violates the Compliance Plan;
11. Investigating complaints related to the Compliance Plan and recommending a plan of action, which may include, but is not limited to, corrective action, new or revised policies and procedures, training or re-training, sanctioning/termination of individuals associated with the organization, repayment of payments for services, self-disclosure (after discussion with compliance counsel) and/or other appropriate actions; and
12. Providing reports to the President/CEO regarding the activities of the Compliance Program.

The Compliance Committee's functions shall include:

1. Analyzing the organization's ability to comply with all applicable laws, regulations and policies;
2. Assessing existing policies and procedures that address the stated risk areas set forth in this Compliance Plan;
3. Working with appropriate staff to develop standards of conduct and policies and procedures, as needed, to promote compliance with the organization's program;

4. Recommending and monitoring, in conjunction with relevant personnel, the development of internal systems and controls to carry out the organization's standards, policies and procedures as part of its daily operations;
5. Determining the appropriate strategy/approach to promote compliance with the Plan and detection of any potential violations; and
6. Developing a system to evaluate and respond to complaints and problems made under this Plan.

The Compliance Officer and Compliance Committee shall be appointed by the President/CEO and report to the President/CEO and to the Board of Directors.

B. Written Policies and Procedures

The Compliance Officer will ensure the development and distribution of written policies and procedures regarding the Compliance Program. The Compliance Officer will also provide a mechanism to address specific areas of potential violations, such as violations of billing regulations and standards, as set forth more fully below. The Compliance Officer will ensure that these written policies and procedures are updated when the law, regulations, or standards change or when events in our organization warrant a revision to the Compliance Plan and related policies and procedures. These policies will include a system for reporting any perceived issues regarding this plan, a system for responding to any compliance issues, a stated policy of non- retaliation for any person who in good faith reports an issue and a system for assessing risk areas and for self- reporting of issues where appropriate.

C. Education and Training Programs

There will be Compliance Program training provided to the organization designed to:

1. Teach individuals associated with the organization the policies and procedures in place to ensure compliance with legal and ethical principles;
2. Emphasize the organization's commitment to compliance with all laws, regulations and guidelines of Federal and State health care programs; and
3. Reinforce the fact that strict compliance with the law and the organization's policies and procedures is a condition of employment or other association with the organization.

The organization's Compliance Officer is responsible for organizing the training sessions which should include the following elements:

a) A review of program integrity and payor requirements of the Medicaid program;
b) Overview of our Compliance Program;
c) Education regarding proper documentation requirements especially the requirements related to billing; and
d) The responsibility to report compliance issues to the Compliance Officer and the mechanism for such reporting.

D. Monitoring/ Disciplinary Action

The Compliance Officer shall monitor the implementation of the Compliance Plan and report regularly to the President/CEO and to the Board of Directors. Monitoring will be designed to ensure compliance with Hometown Taxi, Inc.'s Compliance Plan and related policies and procedures, and all relevant Federal and New York State laws.

Compliance with these policies, procedures and requirements is a condition of employment or other association with the organization. The organization will take appropriate disciplinary action for misconduct, violating this Compliance Plan or violating the Federal or New York State laws and regulations that apply to the organization.

E. Investigation

The Compliance Officer will promptly investigate any potential violations or misconduct to determine whether a material violation of this Plan has occurred. When investigating a report of possible improper conduct, every effort will be made to keep the report confidential and maintain the anonymity of the reporting individual. When credible reports are received, the Compliance Officer, with assistance from legal counsel as needed, will conduct a fair and thorough investigation and will take appropriate corrective action. If a violation has occurred, the Compliance Officer in consultation with the President/CEO will determine what steps must be taken to rectify the problem.

F. Non-Employment or Non-Retention of Sanctioned Individuals/Credentialing

Individuals who have been convicted of a criminal offense related to health care or who are listed by a Federal agency as debarred, excluded or otherwise ineligible for participation in any federally funded health care program will not be employed or have another relationship with the organization. In addition, individuals who are excluded from participation in the New York State Medicaid program will not be employed or have another relationship with the organization. This is required under federal and state law and regulations.

Current employees or others currently associated with the organization who are charged with criminal offenses related to health care or proposed for exclusion or debarment from a federally or state funded health care program should be removed from direct responsibility for or involvement in any federally or state funded health care program until resolution of such criminal charges or proposed debarment or exclusion. If the resolution results in conviction, debarment or exclusion of the individual, the organization will terminate its employment of or other association with that individual.

It is the organization's policy to inquire into the background of applicants, or any health care entity that it learns has employed that applicant, with respect to matters relating to any current or prior disciplinary action, investigation, audit or review relating to the provision of health care goods or services, or any claim for reimbursement.

In the event an applicant or current/former employer has been or is being subjected to any governmental or third party payor review, the human resources employee or other appropriate individual will seek full disclosure of such review and, more particularly, the applicant's involvement in such activity. That inquiry will call for information on the following: (i) the nature of the review; (ii) the conduct that was under scrutiny; (iii) the applicant's job title/responsibilities at the prior/current employer; and (iv) the applicant's relationship, if any, to the conduct that was scrutinized. If an applicant or a current/former employer of the applicant is or was involved in any conduct that was challenged or questioned, the human resources employee or other appropriate individual will consult with the organization's Compliance Officer and/or legal counsel prior to making any offer of association. The Compliance Officer and/or legal counsel may suggest obtaining additional information from the applicant before the organization considers him/her for the position.

The following organizations can be queried with respect to potential employees, independent contractors, agents and Board Members:

a) General services administration: list of parties excluded from Federal programs. The URL address is https://www.epls.gov/epls/search.do.

b) HHS/OIG cumulative sanction report. The URL address is http://exclusions.oig.hhs.gov/.

c) NYS Medicaid Fraud Database. The URL address is http://www.omig.state.ny.us/data/component/option,com_physiciandirectory/.

G. Communication and Reporting of Compliance Plan Violations

Individuals associated with the organization must report all violations of the organization's Compliance Plan. Individuals associated with the organization may bring forth any information or questions without fear of retribution or retaliation and with anonymity. Individuals will not face any penalties or other forms of retribution, retaliation or intimidation when they make a good faith report to the Compliance Officer. Any matters reported to the Compliance Officer that suggest a violation of the Compliance Plan, the policies and procedures of the organization or other legal requirements will be investigated promptly. Any failure to report suspected illegal or improper conduct is a violation of the Compliance Plan and may subject the individual to discipline.

To report, employees and other individuals should contact their immediate supervisor or the Compliance Officer. No retaliation or adverse action will be taken against an individual as a result of submitting a good faith report of suspected irregular activities. However, an individual who submits a report that lacks a good faith basis for the sole purpose of hurting an associated individual may be subject to discipline.

H. Record Creation and Retention

One of the primary purposes of maintaining and retaining records is to demonstrate that the organization provides medically appropriate services to its clients. Further, appropriate and complete documentation provides the basis on which reimbursement is sought from third party payors. Maintaining appropriate documentation is vital to the continued success of the organization. Thus, all employees, contractors and agents of the organization have an obligation to maintain accurate and complete records.

It is the policy of the organization to comply with at least the minimum standard required by Federal and State laws and regulations. Employees, contractors and agents are also expected to maintain complete, accurate and contemporaneous records as required by the organization and payors. The term "records" includes all documents, both written and electronic, that relate to the provision of services or that provide support for billing services to all payors. Records must reflect the actual service provided.

All records required either by Federal or State law or by this Compliance Plan will be appropriately created and maintained. Records should never be altered without permission of the Compliance Officer. In the case of a necessary alteration, the alteration should be signed and dated by the staff member altering the document. Signatures should always be accompanied by the date that the signature was made. Dates in all cases should include the month, date and year. Documents must never be backdated or predated. Under no circumstances shall any person sign the name of another individual.

Because the organization provides services under State and Federal health care programs, State or Federal government agencies may from time to time seek access to the organization's records. If an employee, contractor or agent is requested to supply any records or documentation to individuals or entities outside of the organization, the employee, contractor or agent should immediately contact his or her supervisor and the Compliance Officer and/or President/CEO prior to taking any action.

The organization is dedicated to protecting the privacy and confidentiality of all records relating to the organization's clients and personnel. Employees and others associated with the organization should assume that all information relating to the provision of services and to billing is considered confidential. Should any question arises regarding the potential confidentiality of any information, individuals are instructed to seek guidance from the Compliance Officer. In particular, employees and others associated with the organization are directed to refrain from discussing any client names or details pertaining to services provided to any clients with any person outside of the organization, unless expressly authorized by the Compliance Officer.

I. Marketing

All marketing done on behalf of the organization should be honest, straightforward, fully informative and non-deceptive. Those associated with the organization should fully understand the services offered by the organization. No remuneration will be given in order to induce any person to refer business to the organization. All marketing and promotional practices must be pre-approved by the CEO, who will, with consultation with counsel as needed, ensure that they do not violate any Federal, State or other law or regulation. No discount shall be offered without approval of the CEO, who shall consult counsel as necessary. The structure of any marketing arrangement between the company and an individual or company will be reviewed by the CEO and counsel as necessary for compliance with state and federal law and regulations.

J. Billing

Hometown Taxi, Inc. is committed to prompt, complete and accurate billing of all services provided to clients. Billing shall be made for services provided, adhering to all terms and conditions specified by the government or private payor and consistent with industry practice. No false or misleading entries shall be made or submitted on any bills or claim forms, and no individual associated with the organization shall engage in any arrangement, or participate in such an arrangement at the direction of another individual associated with the organization (including any officer or supervisor of the organization) that results in such prohibited acts. Any false statement on any bill shall subject the individual to disciplinary action by the organization, including possible termination of the individual's relationship with the organization. The organization is committed to billings which are accurate, reliable, timely and valid.

False claims and billing fraud may take a variety of forms, including, but not limited to, false statements supporting claims for payments, misrepresentations of material facts, concealment of material facts, or theft of benefits or payments from the party who is entitled to receive it. Risk areas are described more thoroughly later in this Plan. If there is any question as to appropriate billing, the Compliance Officer should be consulted.

K. Government Inquiries

It is our organization's policy to cooperate with and properly respond to all government inquiries and investigations. Any individual who receives a search warrant, subpoena, or other demand or request for investigation or documentation, or is approached by a federal or state regulatory or prosecutorial agency, should attempt to identify the investigator, if any, and immediately notify their supervisor, the Compliance Officer and the CEO. The Compliance Officer, in consultation, as necessary, with legal counsel, will coordinate any response to warrants, subpoenas, inquiries and investigations by regulatory and prosecutorial agencies. The response to any warrant, subpoena, investigation or inquiry must be complete and accurate. No individual associated with the organization shall alter, delete or revise any material from any computer, word processor, disk or tape, nor shall any person revise, destroy or alter any written documentation once such inquiry has been commenced. If a document is required to be retained, it must be preserved in its original form.

L. Risk Areas- Risk areas of this provider include but are not limited to:

1. Provision of free or below fair market value services to referral sources.
2. The failure to comply with local, municipal and regulatory agency license plate requirements.
3. The failure of drivers to be qualified and licensed as required.
4. Compliance with requirements of all municipal and/or any other regulatory agency in the geographic area where the Provider furnishes services.
5. Compliance with requirements of the New York State Department of Motor Vehicles.
6. The failure to submit any requested information to the New York State Office of the Medicaid Inspector General or any other regulatory agency.
7. The failure to complete appropriate documentation including contemporaneous records to support billing.
8. The failure to maintain records required for Medicaid for six years following the date of payment or for the amount of time required by other payors.
9. For Medicaid recipients, the failure to accept Medicaid payment in full.
10. Providing services without a proper prior authorization where required.
11. Initiating a prior authorization request. Prior authorizations must be initiated by the ordering practitioner or other designated requestor.
12. The failure to maintain proper insurance.

13. Providing services while not in compliance with applicable licensure requirements.
14. Billing for services not provided.
15. Employing or contracting with those excluded from the Medicare and/or Medicaid programs.
16. The failure to disclose changes in ownership and control as required by the Medicaid regulations.
17. Submitting false claims or statements.
18. Illegally discriminating in the furnishing of services based upon the client's race, color, national origin, religion, sex, age or handicapping condition.
19. Submitting claims for payment to the Medicaid program that do not meet the requirements for billing under federal and New York State law, regulations and policy including but not limited to those applicable provisions set forth in the New York State Provider Manual for Transportation Providers.
20. Subcontracting for services as set forth in federal and New York State law, regulations and policy including but not limited to those applicable provisions set forth in the New York State Provider Manual for Transportation Providers.

O. Modification of this Compliance Plan

Hometown Taxi, Inc. shall modify this Compliance Plan as necessary to comply with changes in relevant laws and regulations or to enhance the Plan given changes in the operations or structure of the organization.

ACKNOWLEDGEMENT

I/ we hereby acknowledge receipt of Hometown Taxi, Inc., Inc. Compliance Plan. I/we have read the Plan and understand its contents. I/we promise to abide by the principles and directives contained within.

_____ _____

For, Hometown Taxi, Inc./ Bryan DeParma Date

ATTACHMENTS- RELEVANT NEW YORK STATE MEDICAID REGULATIONS

1-18 NYCRR Part 504- Enrollment of Medicaid Providers

2-18 NYCRR 505.10-Transportation

3-18 NYCRR 515.1, 515.2-Sanctions

4-18 NYCRR Part 521-Compliance

5- NYS Transportation Provider Manual (Hard copy not supplied- The Manual can be accessed on-line at https://www.emednyny.org/ProviderManuals/Transportation.)

Part 504 - MEDICAL CARE - ENROLLMENT OF PROVIDERS

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Complete
Effective Date:
Wednesday, April 13, 2016
Statutory Authority:
Social Services Law, Sections 20, 34, 131, 363, 363-a, 364, 365-a, 365-b, 367, 367-a, 367-b, 368-a

Section 504.1 - Policy and scope.

Section 504.1 Policy and scope. (a) The policy of this State is to make available to everyone, regardless of race, age, national origin or economic standing, uniform high quality medical care. In pursuit of this goal the department will contract with only those persons who can demonstrate that they are qualified to provide medical care, services or supplies and who can provide reasonable assurance that public funds will be properly utilized. Only qualified and responsible persons may be enrolled as providers of care, services and supplies.

(b) (1) Any person who furnishes medical care, services or supplies for which payments under the medical assistance program are to be claimed; or who arranges the furnishing of such care, services or supplies; or who submits claims for or on behalf of any person furnishing or arranging for the furnishing of such care, services or supplies must enroll as a provider of services prior to being eligible to receive such payments, to arrange for such care, services or supplies or to submit claims for such care, services or supplies.

(2) Those persons who are required to enroll as providers of services under paragraph (1) of this subdivision include, but are not limited to, laboratory directors, supervising pharmacists, nurse practitioners and physician's assistants.

(c) If a license, registration or certification is required to render the medical care, services or supplies to be furnished, an applicant must hold a proper and currently valid license, registration and/or certification to be eligible to furnish the care, services or supplies under the medical assistance program.

(d) The following definitions shall apply to this Part unless the context requires otherwise:

(1) Affiliate or affiliated person means any person having an overt, covert or conspiratorial relationship with another such that either of them may directly or indirectly control the other or such that they are under common control or ownership. For example, persons with an ownership or control interest in a provider; agents and managing employees of a provider; subcontractors; and wholly-owned suppliers of a provider with whom the provider has significant business transactions are considered affiliated with each other. Similarly, providers sharing a common owner or managing employee are affiliated with each other.

(2) Agent means a person who has actual or apparent authority to obligate or to act for another.

(3) Applicant is any person who has submitted an application for enrollment.

(4) Application for enrollment or application means any document submitted by a person for the purpose of enrolling in the medical assistance program.

(5) Conviction or convicted means that a plea of guilty or no contest or a verdict of guilty has been entered in a Federal, State or local court, regardless of whether an appeal from the judgment is pending or whether a certificate of relief from civil disability has been granted.

(6) Department means the State Department of Social Services, or a local social services department where enrollment of specified provider types has been delegated to or retained by such local district (e.g., in the case of certain transportation providers).

(7) Enrollment or enrolling is the process by which an applicant contracts with the department to participate in the medical assistance program as a provider of medical care, services or supplies.

(8) Furnishes means the provision of medical care, services or supplies, either directly or indirectly by supervising the provision of medical care, services or supplies or by prescribing or ordering care, services or supplies.

(9) Indirect ownership interest means an ownership interest in an entity that has an ownership interest in a provider. This term includes an ownership interest in any entity that has an indirect ownership interest in a provider.

(10) Indictment means an indictment has been handed down by a grand jury, or an accusatory instrument charging a crime which would be a felony under New York State law has been filed.

(11) Managing employee means a general manager, business manager, administrator, director, or other person who exercises operational or managerial control of a provider, or who directly or indirectly conducts the day-to-day operation of a provider.

(12) Medicaid is the program of State-administered medical assistance established by title XIX of the Social Security Act.

(13) Medical assistance program or program means the program of medical assistance for needy persons provided for in title 11 of article 5 of the Social Services Law.

(14) Medicare is the program of hospital and medical insurance established under title XVIII of the Social Security Act.

(15) Ownership interest means possession of equity in the capital, the stock or the profits of a provider.

(16) Participation is the ability and authority to furnish care, services or supplies to eligible recipients and to receive payment from the medical assistance program for such care, services or supplies.

(17) Person includes natural persons, corporations, partnerships, associations, clinics, groups and other entities.

(18) Person with an ownership or control interest means a person who:

(i) has an ownership interest totaling five percent or more in a provider;

(ii) has an indirect ownership interest equal to five percent or more in a provider;

(iii) has a combined direct and indirect ownership interest equal to five percent or more in a provider;

(iv) owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the provider if that interest equals at least five percent of the value of the property or assets of the provider;

(v) is an officer or director of a provider that is organized as a corporation;

(vi) is a partner in a provider that is organized as a partnership.

(19) Provider is any person who has enrolled under the medical assistance program to furnish medical care, services or supplies; or to arrange for the furnishing of such care, services or supplies; or to submit claims for such care, services or supplies for or on behalf of another person. Only a provider may order or prescribe care, services or supplies, exclusive of in-patient hospital care, if such ordering or prescribing results in payment of more than 4,500 claims totaling $75,000 or more per year. The failure or refusal of a person who orders or prescribes such amounts to enroll as a provider in the medical assistance program will result in the denial of payment by the department for care, services or supplies ordered or prescribed by such person following such failure or refusal. For the purposes of this paragraph, "claim" has the same meaning as set forth in section 515.1(b)(3) of this Title.

(20) Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 or five percent of a provider's total operating expenses.

(21) Subcontractor means any person to which a provider has contracted or delegated some of its management functions, or its responsibilities for providing medical care, services or supplies; or its claiming or claims preparation or processing functions or responsibilities.

(22) Supplier means a person from whom a provider purchases goods and services used in carrying out its responsibilities under the medical assistance program (e.g., a service bureau, or billing service, a commercial laundry, a manufacturer, or a pharmaceutical firm).

(23) Wholly owned supplier means a supplier whose total ownership interest is held by a provider or a person with an ownership or control interest in a provider.

(24) Service bureau means any person who provides claims processing or claims submission services for or on behalf of a provider, including a business agent, billing service or accounting firm.

(25) Laboratory director means an individual who has met the quali fications of a laboratory director as set forth in 10 NYCRR 19.2 and who has those responsibilities set forth in 10 NYCRR 58-1.2.

(26) Supervising pharmacist means the individual designated by a pharmacy on the pharmacy's State registration form as the licensed pharmacist having personal supervision of the pharmacy.

(27) Nurse practitioner means an individual who is licensed and currently registered as a professional nurse in the State and who is certified under section 6910 of the Education Law as a nurse practitioner.

(28) Physician's assistant means a person who is registered as a physician's assistant pursuant to section 6541 of the Education Law.

Doc Status:
Complete

Section 504.2 - Application for participation.

504.2 Application for participation. (a) Information regarding application for enrollment may be obtained by writing to the Provider Enrollment Unit of the department.

(b) To apply for enrollment as a provider of services, an applicant must submit a complete, original, signed and sworn application in the form and manner as may be required by the department. The ownership and disclosure form required by Part 502 of this Title is part of the application.

(c) The department may require the provision of information relative to the applicant's ability to provide high-quality care, services and supplies and to be financially responsible. The department may use different applications for each provider type, for certain types of providers only, or for different geographic areas.

Doc Status:
Complete

Section 504.3 - Duties of the provider.

504.3 Duties of the provider. By enrolling the provider agrees:

(a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health;

(b) to comply with the disclosure requirements of Part 502 of this Title with respect to ownership and control interests, significant business transactions and involvement with convicted persons;

(c) to accept payment from the medical assistance program as payment in full for all care, services and supplies billed under the program, except where specifically provided in law to the contrary;

(d) not to illegally discriminate on the basis of handicap, race, color, religion, national origin, sex or age;

(e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons;

(f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission;

(g) to permit audits, by the persons and agencies denominated in subdivision (a) of this section, of all books and records or, in the discretion of the auditing agency, a sample thereof, relating to services furnished and payments received under the medical assistance program, including patient histories, case files and patient-specific data;

(h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and

(i) to comply with the rules, regulations and official directives of the department.

Doc Status:
Complete

Section 504.4 - Duties of the department.

504.4 Duties of the department. (a) Upon receipt of a complete, original and signed application, an investigation will be conducted to verify or supplement the information contained in the application. The background and qualifications of the applicant shall also be reviewed.

(b) The department may request further information from an applicant. In such a case, it shall make a clear and precise request to the applicant for the information and inform the applicant whether or not action on the application will be postponed pending receipt of the requested information. Delay occasioned by the applicant's failure to timely reply shall not be counted in calculating the time within which the department shall make its determination on the application.

(c) The department shall complete its investigation and determine whether or not to enroll the applicant within 90 calendar days after receipt of an application.

(d) If an applicant cannot be fully investigated within 90 days, the department may extend the time for acting on an application for up to 120 calendar days from the date of receipt of the application. Written notice of this extension will be mailed to the applicant within 60 calendar days from the time the application was received.

(e) Upon completion of its consideration of an application, the department shall either:

(1) enroll the applicant as a provider; or

(2) deny the application, if it is in the best interest of the medical assistance program to do so, specifying the reasons for denial.

Doc Status:
Complete

Section 504.5 - Denial of an application.

504.5 Denial of an application. (a) In determining whether to enter into a contract with an applicant, the department shall consider the following factors with respect to the applicant and any affiliated person:

(1) any false representation or omission of any material fact in making the application;

(2) any previous or current suspension, exclusion or involuntary withdrawal from participation in the medical assistance program or the Medicaid program of any other state of the United States or from participation in any other governmental or private medical insurance program including, but not limited to, Medicare, Workers' Compensation, Physically Handicapped Children's Program and Rehabilitation Services;

(3) the receipt of, but not having made restitution for, a Medicaid or Medicare overpayment, as determined to have been made pursuant to a final decision or determination of an agency having the powers to conduct the proceeding and after an adjudicatory proceeding in which no appeal is pending or after resolution of the proceeding by stipulation or agreement; however, if an applicant has entered into a plan of restitution of such overpayments, an application may not be denied based solely on this factor unless the applicant has defaulted in repayment;

(4) any false representation or omission of a material fact in making application in any state of the United States for any license, permit, certificate or registration related to a profession or business;

(5) any previous failure to correct deficiencies in the operation of a business or enterprise after having received written notice of the deficiencies from a State or Federal licensing or auditing agency;

(6) any failure to supply further information concerning the application after receiving a written request for such further information;

(7) the submission of an application which conceals an ownership or control interest of any person who would otherwise be ineligible to participate;

(8) a pending indictment for, or prior conviction of, any crime relating to the furnishing of, or billing for, medical care, services or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals;

(9) a prior finding of having engaged in an unacceptable practice in the medical assistance program, another state's Medicaid program, the Medicare program or any other publicly funded program;

(10) a pending indictment for, or prior conviction of, any crime relating to the furnishing of or billing for medical care, services or supplies, or a determination of having engaged in an unacceptable practice in the medical assistance program;

(11) a prior finding by a licensing, certifying or professional standards board or agency of the violation of the standards or conditions relating to licensure or certification or as to the quality of services provided;

(12) any prior pattern or practices in furnishing medical care, services or supplies and any prior conduct under any private or publicly funded program or policy of insurance;

(13) any other factor having a direct bearing on the applicant's ability to provide high-quality medical care, services or supplies to recipients of medical assistance benefits, or to be fiscally responsible to the program for care, services or supplies to be furnished under the program including actions by persons affiliated with the applicant;

(14) any other factor which may affect the effective and efficient administration of the program, including, but not limited to, the current availability of medical care, services or supplies to recipients

(taking into account geographic location and reasonable travel time).

(b) If any application is denied, the applicant shall be given a written notice of the denial, stating the reason or reasons for the denial. The written notice of denial will be effective upon the date it is mailed to the applicant.

(c) Denial of an application shall preclude the applicant from submitting claims for payment under the medical assistance program either directly, or indirectly through any other person. Any claims submitted by such applicant or such other person and paid by the department shall constitute overpayments.

(d) If an application has been denied, the applicant may reapply only upon correction of the factors leading to its denial, or after two years if the factors relate to prior conduct of the applicant or an affiliated person.

(e)(1) If an application is denied, the applicant may appeal the denial by filing a written request for reconsideration with the department within 45 days of the date of the notice of denial. A timely request stays any action to terminate a provider currently participating in the medical assistance program pending the decision on reconsideration.

(2) The request for reconsideration must include all information which the applicant wishes to be considered in the reconsideration, including any documentation or arguments which would controvert the reason for the denial or disclose that the denial was based upon a mistake of fact.

(3) The department will review its determination to deny enrollment and issue a written determination after reconsideration within 60 days of receipt of the request. The determination after reconsideration may affirm, revoke or modify the denial and will be the final decision of the department.

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Section 504.6 - Acceptance of an application.

504.6 Acceptance of an application. (a) Upon acceptance of an application, the department shall issue to the provider instructions on participation in the medical assistance program and filing of claims for payment. In addition, the provider shall be given an identifying number to be used exclusively by the provider for billing and identification purposes.

(b) Enrollment, including the use of the identifying number, is not assignable or transferrable but is strictly limited to the provider to which it was issued unless authorized in writing by the department prior to the assignment or transfer.

(c) A provider's participation may begin only on or after the date specified in the notification of acceptance. A provider may participate in the program for the period specified in the notice of acceptance, unless participation has been otherwise terminated or suspended under this Title.

(d) A provider may submit claims only for services provided by the provider or another person under his supervision and in compliance with this Title; the name of the person actually furnishing the care, services or supplies shall be indicated on the claim form in the space provided.

Doc Status:
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Section 504.7 - Continued enrollment termination.

504.7 Continued enrollment termination. (a) A provider's participation in the program may be terminated by either the provider or the department upon 30 days' written notice to the other without cause.

(b) A provider's participation in the program may be terminated, suspended or restricted for a reasonable period of time if the department finds that the provider has engaged in an unacceptable practice as set forth in Part 515 of this Title. A provider whose participation is so terminated, suspended or restricted is entitled to notice and an opportunity to be heard in accordance with Part 515 of this Title.

(c) A provider's participation is automatically terminated or suspended as of the date of the provider's suspension or termination from Medicare. A notice confirming the termination or suspension will be sent to the provider.

(d) (1) A provider's participation in the medical assistance program is automatically terminated as of the date of any termination, revocation or suspension of a license to practice a medical profession, or the termination, revocation or suspension of any registration, certification, license or other approval required to provide medical care, services or supplies under the medical assistance program. However, a provider of intermediate care facility services for the developmentally disabled, licensed or operated by the Office of Mental Retardation and Developmental Disabilities, whose participation in the medical assistance program is terminated by the department because the provider no longer meets the requirements for participation or whose participation in such program is not renewed upon expiration of its provider agreement with the department, remains eligible to participate in the program if the Department of Health certifies that the provider's continuation in the medical assistance program will not jeopardize a medical assistance recipient's health and safety and the provider has requested an administrative evidentiary hearing which is held after the effective date of termination or nonrenewal or is held before such date but not completed until after such date.

(2) A provider who is permitted to remain in the medical assistance program as a result of meeting the conditions of continuation, as set forth in paragraph (1) of this subdivision, may remain in the program until the earlier of:

(i) the date that an administrative hearing decision is issued in the evidentiary hearing which upholds the department's termination or nonrenewal action; or

(ii) the 120th day after the effective date of termination of the facility's provider agreement or, if the agreement is not terminated, the 120th day after the effective date of expiration.

(e) A provider must maintain an up-to-date "Disclosure of Ownership and Control Interest Statement" on file with the department, as required by Part 502 of this Title, amending it annually and from time to time, as necessary, to assure that the information contained in the statement is true, accurate and complete. Failure to maintain an up-to-date disclosure form on file or to submit one within 35 days of a request by the department or to disclose any information as required by section 502.6 of this Title will result in the automatic termination of the provider's participation in the medical assistance program. A notice confirming the termination will be sent to the provider.

(f) A provider's participation may be terminated and a new application for enrollment required where the ownership or control of the provider has substantially changed since acceptance of its enrollment application, whether by the sale or exchange of the capital stock in a provider organized as a corporation, the addition or elimination of one or more partners in a provider organized as a partnership, or the sale of the business or assets of any provider entity. A notice advising of the termination and of the requirement to submit a new application for enrollment will be sent to the provider prior to its termination from the program.

(g) A provider's participation will be terminated where the provider furnished incorrect, inaccurate or incomplete information in connection with an application and where provision of correct, accurate and complete information would have resulted in the denial of the application based upon one or more of the factors set forth in subdivision (a) of section 504.5 of this Part. A notice, as provided for in subdivision

(b) of section 504.5, shall be sent to the provider confirming the termination and stating the reason or reasons for which a denial would have been made.

(h) A provider's participation will be terminated where the provider fails or refuses to pay the full amount of any penalty imposed, including any interest thereon, pursuant to Part 516 of this Title on or before the 90th day after the date of the department's notice or, where a hearing has been requested pursuant to Part 519 of this Title, on or before the 90th day after the date of a decision after hearing which affirms the penalty.

Doc Status:
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Section 504.8 - Audit and claim review.

504.8 Audit and claim review. (a) Providers shall be subject to audit by the department and with respect to such audits will be required:

(1) to reimburse the department for overpayments discovered by audits in accordance with Parts 516 and 517 of this Title;

(2) to pay restitution for any direct or indirect monetary damage to the program resulting from their improperly or inappropriately furnishing services or arranging for, ordering, or prescribing care, services or supplies, in accordance with Parts 515 and 516 of this Title;

(3) to reimburse the auditing agency for the costs incurred by the department in performing the audit where records are not maintained in a readily reviewable form; and

(4) to pay any statutorily authorized fine or penalty.

(b) The department may conduct or have conducted audits and claims reviews which may be limited to reviews of costs of operation or which may involve reviews of the quality, appropriateness, and necessity of care provided and adherence to established department policy and procedures or conduct investigations as to the provider's conduct relative to unacceptable practices.

(c) The department, its fiscal agent, or the Department of Health upon prepayment review, may deny claims, adjust claims to eliminate noncompensable items or to reflect established rates or fees, correct obvious or mathematical errors, pend claims for further audit or review, or approve the claim for payment, subject to post-payment audit and verification.

(d) Where the department's routine utilization review procedures, an analysis of claims, or initial onsite audit findings indicate that a provider has claimed or is claiming for care, services or supplies which may be inconsistent with regulations governing the program or with established standards for quality of care, or which are inappropriate to the client's needs, not medically necessary or in excess of the client's medical needs, payment of all claims submitted and of all future claims may be delayed or suspended pending completion of an investigation. A notice of the withholding of payment shall be sent to the provider contemporaneous with withholding of payments.

Doc Status:
Complete

Section 504.9 - Service bureaus, billing services and electronic media billers.

504.9 Service bureaus, billing services and electronic media billers.

(a)(1) Persons submitting claims, verifying client eligibility or obtaining service authorizations for or on behalf of providers, except those individuals employed by providers enrolled in the medical assistance program, must enroll in the medical assistance program in accordance with this Part and must meet the appropriate additional requirements set forth in this section. However, payment may be made only to the provider of the medical care, services or supplies; or in accordance with a reassignment from a provider to a government agency or reassignment by court order; or to an employer of a practitioner, if the practitioner is required as a condition of his/her employment to turn over his/her fees to the employer; or to a facility or a foundation, plan or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the facility or organization submits the claims; or to a business agent, including a service bureau, billing service, or accounting firm, if the payment is made in the name of the provider and the agent's compensation for the services is related to the cost of processing the claim, is not related on a percentage or other basis to the amount billed or collected, and is not dependent upon collection of the payment.

(2) Providers submitting their claims by means of electronic/magnetic media (computer tape, disks, etc.) must also meet the requirements of this section in order to be eligible to submit their claims by such media.

(b) Service bureaus must maintain a system approved by the department for notifying providers of the claims to be submitted on their behalf. Prior to submission to the department, claim submissions must be reviewed by the provider of the care, services or supplies in order that the provider may correct any inaccurate claims, delete improper claims or otherwise revise the intended submission to ensure that only claims for services actually provided, due and owing are submitted.

(c) Service bureaus must submit systems documentation to the department for the systems configuration which they will be using to process claims prior to acceptance of their enrollment application. Such documentation must be revised as necessary to assure its accuracy. The department will not disclose any proprietary software, firmware or other systems component of a proprietary nature to any person other than another governmental agency as may be required for the efficient administration of the program.

(d) Service bureaus must meet the processing standards established by the department and its fiscal intermediary and satisfactorily perform claims submissions based upon a test claim provided by the department or its fiscal intermediary prior to acceptance of their enrollment applications.

(e) Service bureaus must enter into an electronic/magnetic billing agreement with the department or its fiscal intermediary, establishing the rights and obligations of the service bureau, the provider

and the department, prior to acceptance of any claims from the service bureau. Such agreements will include provisions for liability in case of errors, submission criteria, record retention requirements, data integrity, confidentiality of client data, and audit requirements.

(f) Client identifying data may not be used by any service bureau, provider, or any person verifying eligibility or obtaining service authorizations on behalf of a provider for any purpose other than claiming for medical care, services or supplies actually furnished to the client, or verifying client eligibility or obtaining service authorizations or another valid purpose directly related to the administration of the medical assistance program, and may not be released or disclosed to any person or entity other than the department, the State Medicaid Fraud Control Unit or the Federal Department of Health and Human Services without express written authorization of the department.

(g) Any provider desiring to submit claims, verify client eligibility, or obtain service authorizations for or on behalf of any other provider must enroll as a service bureau in addition to enrolling as a provider of medical care, services or supplies.

(h)(1) A Qualified Health Information Technology Entity, as defined in paragraph (2) of this subdivision, seeking access to medical assistance information must enroll in the medical assistance program in accordance with this Part and must meet the appropriate additional requirements set forth in this section.

(2) Qualified Health Information Technology Entities, which may include but are not limited to regional health information organizations (RHIOs), are entities to whom recipient-specific medical assistance information is released, with the consent of the medical assistance recipient, for the purpose of sharing such information with one or more of its members that are providing medical care, services, or supplies to such recipient. The release of such information is intended to improve the quality of care delivered to medical assistance recipients, reduce the occurrence of medically adverse events, and reduce costs through better coordination of care.

(3) As a condition of enrollment and of receipt of medical assistance information pursuant to this subdivision, Qualified Health Information Technology Entities must develop and maintain policies and procedures:

(a) to ensure that informed consent is obtained from medical assistance recipients for the release of confidential information;

(b) to handle and safeguard confidential information in compliance with all applicable federal and state laws and regulations; and

(c) to ensure that their members comply with all applicable federal and state laws and regulations regarding confidential information.

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Section 504.10 - New enrollments; previously enrolled providers.

504.10 New enrollments; previously enrolled providers. (a) Any person wishing to participate as a provider on or after the effective date of this Part (January 5, 1987) will be required to submit an application for enrollment in accordance with the requirements of this Part.

(b) All providers enrolled prior to the effective date of this Part

(January 5, 1987) shall be required to submit an application for enrollment upon notice from the department. A provider so notified will have 60 days to submit a completed, signed enrollment application to the department. The failure to do so will result in the provider's automatic termination from the medical assistance program. Written notice of the termination will be sent to the provider. Submission of the application within 60 days will continue the provider's enrollment until a determination with respect to the application for enrollment has been made and notice thereof mailed to the provider.

(c) For the convenience of the department and the provider community, providers enrolled prior to the effective date of this Part (January 5, 1987) shall be notified of the requirement to reenroll pursuant to subdivision (b) of this section in accordance with a reenrollment schedule developed by the department. Such schedule may require reenrollment on the basis of provider type, geographic location or a combination of provider type and location.

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Section 504.11 - Financial security.

504.11 Financial security. (a) General. (1) Purpose. The furnishing of financial security will indemnify the department against overpayments which may be made to the provider.

(2) This section applies only to providers of ordered services or supplies and applicants for enrollment as providers of such services or supplies. For the purposes of this section, ordered services or supplies are:

(i) pharmacy services and supplies;

(ii) durable medical equipment;

(iii) clinical laboratory services;

(iv) nonemergency transportation.

(3) The department may require a provider to provide financial security to the department if the department has estimated that the total claims for payment for ordered services or supplies to be

submitted to the department by that provider exceed either $500,000 per year or $42,000 in any month. The computation of these estimates must exclude the amount, if any, of the estimate of the provider's claims for payment for services that are not ordered services. When the department has determined that a provider must furnish financial security, that provider must provide such security as a condition of the provider's participation or continued participation in the medical assistance program.

(b) Exemptions. The department will not require a provider established under the authority of Article 28 of the Public Health Law to supply financial security.

(c) Form of financial security. (1) Financial security may take the following forms:

(i) a bond;

(ii) an irrevocable letter of credit;

(iii) a certificate of deposit inclusive of any interest earned thereon; or

(iv) a combination of the above.

(2) Financial security must be issued by an issuing entity. An issuing entity is:

(i) a corporate surety authorized to do business in this State where the financial security to be supplied is in the form of a bond;

(ii) a bank, trust company, savings bank or savings and loan association which is:

(a) chartered by either this State or the United States of America; and

(b) authorized to do business in this State; and

(c) insured by either the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation where the financial security to be supplied is in the form of a letter of credit or certificate of deposit.

(3) The bond, letter of credit or certificate of deposit must be payable to the State of New York.

(d) Means of estimation. Providers determined to be solvent, stable, and fiscally responsible will not be required to provide financial security. in determining whether to require a provider to supply financial security, and in determining whether such security should be increased or decreased, the department will consider the following:

(1) whether the provider is solvent as shown by a review of certified financial statements, credit checks, other sources of income or other indicia of financial status;

(2) the stability of the provider as shown by the length of time the provider has been in business and the length of time the provider has been enrolled in the medical assistance program; and

(3) the fiscal responsibility of the provider as shown by the results of any prior audits or investigations of the provider by the department, a health insurance program or another government agency.

(e) Amount of financial security. (1) If financial security is required by the department, it must be in the amount of a provider's estimated claims for payment for the year for ordered services as determined by the department in accordance with the provisions of this section. In determining the estimated claims for payment for the year, the department may consider:

(i) the provider's actual billings during the previous year;

(ii) the billings of providers of similar services, taking into consideration the comparative sizes of the businesses of such other providers;

(iii) the location of the provider; and

(iv) the provider's estimate of yearly billings.

(2) A provider may request a decrease in the amount of financial security required if its actual claims for payment for ordered services are 10 percent or more below the estimated claims for payment. A provider may request such a decrease at the end of the first six months after initially providing financial security and every six months thereafter. If a provider's actual claims for payment for ordered services are below the estimated amount by more than 10 percent, the department may reduce the amount of security. The department must make its determination on the basis of at least six consecutive months of submitted claims.

(3) The department may assess a provider's billings as often as the department deems appropriate to determine whether the amount of financial security should be increased. If a provider's actual claims for payment for ordered services exceeds the amount of estimated claims for payment for ordered services by more than 10 percent, the department may require that the amount of security be increased. The department will make its determination on the basis of at least six consecutive months of submitted claims. The department will notify the provider in writing that the provider must increase the amount of financial security. such notice will set forth the basis for the department's conclusion that the amount of security shall be increased. A provider's enrollment in the medical assistance program may be terminated upon the failure to increase the amount of such security within 90 days of the date of the department's request to increase the amount of such security.

(4) A provider which was not previously required to supply financial security because its estimated claims were less than $500,000 per year or $42,000 per month may later be required to supply such security if that provider's actual claims exceed either such amount. The department may require such security if the provider submits at least $42,000 in claims for payment during any given month or if the provider submits claims for payment amounting to at least $500,000 during any one-year period. The department will notify the provider in writing of the requirement that the provider supply financial security. A provider's enrollment in the medical assistance program may be terminated upon the failure to supply such security within 90 days of the date of the department's request to supply such security.

(5) A provider which was previously required to supply financial security may request to be relieved of the obligation to continue to supply such security on the basis that the provider has not submitted billings of $500,000 in a year or $42,000 during any given month. In determining whether a provider should be relieved of the obligation to supply financial security, the department will consider the provider's billings for the 12 month period beginning with the first full month after the provider supplied the financial security.

(f) Effect of not supplying financial security. A provider's enrollment in the medical assistance program will be terminated upon the failure to supply or to increase the amount of financial security within 90 days of the date of the department's request to supply or increase the amount of such security. A provider's enrollment will not be terminated if the provider can demonstrate in writing within 90 days of the department's request that the failure to supply or increase such security is solely attributable to delays on the part of the issuing entity. Except as provided in paragraph (g) (1) of this section, if any financial security supplied pursuant to this section is canceled, revoked, allowed to expire or otherwise terminated or changed by the issuing entity, the participation of the provider in the medical assistance program will be immediately terminated. The department will send the provider a notice confirming any such termination.

(g) Financial security agreements. (1) Any bond, letter of credit or certificate of deposit supplied pursuant to this section may not by its terms be canceled, revoked, modified or allowed to expire or be otherwise terminated without at least 45 days prior written notice to the department and the express written consent of the department. The department will grant consent only when it has previously approved a request made pursuant to either paragraph (e) (2) or paragraph (e) (5) of this section. However, the consent of the department is not required before a financial security agreement is terminated or changed by the issuing entity by reason of non-payment of a premium or other default by the provider or when the amount of security is increased pursuant to paragraph (e) (3) of this section. The agreement between the provider and the issuing entity concerning the financial security of the provider must contain a provision which requires the issuing entity to provide written notification to the department 45 days in advance of any proposed cancellation, revocation, modification, expiration or other termination or change, including instances where the agreement is terminated or otherwise affected by a default by the provider.

(2) The department may demand that the issuing entity pay to the department the proceeds of the financial security only when the department has determined as a result of an audit report issued pursuant to Part 517 of this Title or a notice issued pursuant to Part 515 of this Title, that a provider was overpaid for services claimed to have been provided to one or more recipients of medical assistance and the provider has not complied with a request from the department for repayment of such overpayments, plus interest if any.

Doc Status:
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Section 505.10 - Transportation for medical care and services.

505.10 Transportation for medical care and services. (a) Scope and purpose. This section describes the department's policy concerning payment for transportation services provided to Medical Assistance (MA) recipients, the standards to be used in determining when the MA program will pay for transportation, and the prior authorization process required for obtaining such payment. Generally, payment will be made only upon prior authorization for transportation services provided to an eligible MA recipient. Prior authorization will be granted by the prior authorization official only when payment for transportation expenses is essential in order for an eligible MA recipient to obtain necessary medical care and services which may be paid for under the MA program.

(b) Definitions. (1) Ambulance means a motor vehicle, aircraft, boat or other form of transportation designed and equipped to provide emergency medical services during transit.

(2) Ambulance service means any entity, as defined in section 3001 of the Public Health Law, which is engaged in the provision of emergency medical services and the transportation of sick, disabled or injured persons by motor vehicle, aircraft, boat or other form of transportation to or from facilities providing hospital services and which is currently certified or registered by the Department of Health as an ambulance service.

(3) Ambulette or invalid coach means a special-purpose vehicle, designed and equipped to provide nonemergency transport, that has wheelchair-carrying capacity, stretcher-carrying capacity, or the ability to carry disabled individuals.

(4) Ambulette service means an individual, partnership, association, corporation, or any other legal entity which transports the invalid, infirm or disabled by ambulette to or from facilities which provide medical care. An ambulette service provides the invalid, infirm or disabled with personal assistance as defined in this subdivision.

(5) Common medical marketing area means the geographic area from which a community customarily obtains its medical care and services.

(6) Community means either the State, a portion of the State, a city or a particular classification of the population, such as all persons 65 years of age and older.

(7) Conditional liability means that the prior authorization official is responsible for making payment only for transportation services which are provided to MA-eligible individuals in accordance with the requirements of this Title.

(8) Day treatment program or continuing treatment program means a planned combination of diagnostic, treatment and rehabilitative services certified by the Office of Mental Retardation and Developmental Disabilities or the Office of Mental Health.

(9) Department established rate means the rate for any given mode of transportation which the department has determined will ensure the efficient provision of appropriate transportation to MA recipients in order for the recipients to obtain necessary medical care or services.

(10) Emergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining hospital services for an MA recipient who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency medical services while the recipient is being transported.

(11) Emergency medical services means the provision of initial urgent medical care including, but not limited to, the treatment of trauma, burns, and respiratory, circulatory and obstetrical emergencies.

(12) Locally prevailing rate means a rate for a given mode of transportation which is established by a transit or transportation authority or commission empowered to establish rates for public transportation, a municipality, or a third-party payor, and which is charged to all persons using that mode of transportation in a given community.

(13) Locally established rate means the rate for any given mode of transportation which the social services official has determined will ensure the efficient provision of appropriate transportation for MA recipients in order for the recipients to obtain necessary medical care or services.

(14) Nonemergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining necessary medical care or services to an MA recipient whose medical condition requires transportation by an ambulance service.

(15) Ordering practitioner means the MA recipient's attending physician or other medical practitioner who has not been excluded from enrollment in the MA program and who is requesting transportation on behalf of the MA recipient in order that the MA recipient may obtain medical care or services which are covered under the MA program. The ordering practitioner is responsible for initially determining when a specific mode of transportation to a particular medical care or service is medically necessary.

(16) Personal assistance means the provision of physical assistance by a provider of ambulette services or the provider's employee to an MA recipient for the purpose of assuring safe access to and from the recipient's place of residence, ambulette vehicle and MA covered health service provider's place of business. Personal assistance is the rendering of physical assistance to the recipient in walking, climbing or descending stairs, ramps, curbs or other obstacles; opening or closing doors; accessing an ambulette vehicle; and the moving of wheelchairs or other items of medical equipment and the removal of obstacles as necessary to assure the safe movement of the recipient. In providing personal assistance, the provider or the provider's employee will physically assist the recipient which shall include touching, or, if the recipient prefers not to be touched, guiding the recipient in such close proximity that the provider of services will be able to prevent any potential injury due to a sudden loss of steadiness or balance. A recipient who can walk to and from a vehicle, his or her home, and a place of medical services without such assistance is deemed not to require personal assistance.

(17) Prior authorization means a prior authorization official's determination that payment for a specific mode of transportation is essential in order for an MA recipient to obtain necessary medical care and services and that the prior authorization official accepts conditional liability for payment of the recipient's transportation costs.

(18) Prior authorization official means the department, a social services district, or their designated agents.

(19) Transportation attendant means any individual authorized by the prior authorization official to assist the MA recipient in receiving safe transportation.

(20) Transportation expenses means:

(i) the costs of transportation services; and

(ii) the costs of outside meals and lodging incurred when going to and returning from a provider of medical care and services when distance and travel time require these costs.

(21) Transportation services means:

(i) transportation by ambulance, ambulette or invalid coach, taxicab, common carrier or other means appropriate to the recipient's medical condition; and

(ii) a transportation attendant to accompany the MA recipient, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the MA recipient's family.

(22) Undue financial hardship means transportation expenses which the MA recipient cannot be expected to meet from monthly income or from available resources. Such transportation expenses may include those of a recurring nature or major one-time costs.

(23) Vendor means a lawfully authorized provider of transportation services who is either enrolled in the MA program pursuant to Part 504 of this Title or authorized to receive payment for transportation services directly from a social services district or other agent designated by the department. The term vendor does not mean an MA recipient or other individual who transports an MA recipient by means of a private vehicle.
(c) Ambulette and nonemergency ambulance transportation. (1) Who may order. Only those practitioners, facilities or programs listed in paragraph (d)(4) of this section may order or submit an order on behalf of a practitioner for ambulette or nonemergency ambulance transportation services.

(2) Criteria for ordering ambulette transportation. Ambulette transportation may be ordered if any one of the following conditions exist:

(i) The recipient needs to be transported in a recumbent position and the ambulette service ordered has stretcher-carrying capacity;

(ii) The recipient is wheelchair bound and is unable to use a taxi, livery service, bus or private vehicle;

(iii) The recipient has a disabling physical condition which requires the use of a walker or crutches and is unable to use a taxi, livery service, bus or private vehicle;

(iv) The recipient has a disabling physical condition other than one described in subparagraph (iii) of this paragraph or a disabling mental condition, either of which requires the personal assistance provided by an ambulette service, and the ordering practitioner certifies, in a manner designated by the department, that the recipient cannot be transported by a taxi, livery service, bus or private vehicle and requires transportation by ambulette service; or

(v) An otherwise ambulatory recipient requires radiation therapy, chemotherapy, or dialysis treatment which results in a disabling physical condition after treatment and renders the recipient unable to access transportation without the personal assistance provided by an ambulette service.

(3) Criteria for ordering nonemergency ambulance transportation. Nonemergency ambulance transportation may be ordered when the recipient is in need of services while being transported to a provider of medical services which can only be administered by an ambulance service.

(4) Recordkeeping. The ordering practitioner must note in the recipient's patient record the condition which justifies the practitioner's ordering ambulette or nonemergency ambulance services.

(5) Audit and claim review. An ordering practitioner, or a facility or program submitting an order on the practitioner's behalf, which does not comply with this subdivision may be subjected to monetary claims and/or program sanctions as provided in section 504.8(a) of this Title.

(d) Prior authorization. (1) Generally, prior authorization must be obtained before transportation expenses are incurred. Prior authorization is not required for emergency ambulance transportation or Medicare approved transportation by an ambulance service provided to an MA-eligible person who is also eligible for Medicare Part B payments. If transportation services are provided in accordance with paragraph (e)(7) of this section, the individualized education program or interim or final individualized family services plan of an MA eligible person will qualify as the prior authorization required by this subdivision.

(2) Requests for prior authorization may be made by the MA recipient, his or her representative, or an ordering practitioner.

(3) The recipient, his or her representative, or ordering practitioner must make the request in the manner required by the prior authorization official.

(4) A request for prior authorization for nonemergency ambulance transportation must be supported by the order of an ordering practitioner who is the MA recipient's attending physician, physician's assistant or nurse practitioner. A request for prior authorization for transportation by ambulette or invalid coach must be supported by the order of an ordering practitioner who is the MA recipient's attending physician, physician's assistant, nurse practitioner, dentist, optometrist, podiatrist or other type of medical practitioner designated by the district and approved by the department. A diagnostic and treatment center, hospital, nursing home, intermediate care facility, long-term home health care program, home and community-based services waiver program, or managed care program may submit an order for ambulette or nonemergency ambulance transportation services on behalf of the ordering practitioner.

(5) Each social services district must inform applicants for and recipients of MA of the need for prior authorization in order for transportation expenses to be paid under the MA program and of the procedures for obtaining such prior authorization.

(6) The prior authorization official may approve or deny a request for prior authorization, or require the ordering practitioner to submit additional information before the request is approved or denied.

(7) The prior authorization official must use the following criteria in determining whether to authorize payment of transportation expenses in accordance with subdivision (d) of this section:

(i) when the MA recipient can be transported to necessary medical care or services by use of private vehicle or by means of mass transportation which are use by the MA recipient for the usual activities of daily living, prior authorization for payment for such transportation expenses may be denied;

(ii) when the MA recipient needs multiple visits or treatments within a short period of time and the MA recipient would suffer undue financial hardship if required to make payment for the transportation to such visits or treatments, prior authorization for payment for such transportation expenses may be granted for a means of transportation ordinarily used by the MA recipient for the usual activities of daily living;

(iii) when the nature and severity of the MA recipient's illness necessitates a mode of transportation other than that ordinarily used by the MA recipient, prior authorization for such a mode of transportation may be granted;

(iv) when the geographic locations of the MA recipient and the provider of medical care and services are such that the usual mode of transportation is inappropriate, prior authorization for another mode of transportation may be granted;

(v) when the distance to be traveled necessitates a large transportation expense and undue financial hardship to the MA recipient, prior authorization for payment for the MA recipient's usual mode of transportation may be granted;

(vi) when the medical care and services needed are available within the common medical marketing area of the MA recipient's community, prior authorization for payment of transportation expenses to such medical care and services outside the common medical marketing area may be denied;

(vii) when the need to continue a regimen of medical care or service with a specific provider necessitates travel which is outside the MA recipient's common medical marketing area, notwithstanding the fact that the medical care or service is available within the common medical marketing area, prior authorization for payment of transportation expenses to such medical care and services outside the common medical marketing area may be granted; and

(viii) when there are any other circumstances which are unique to the MA recipient and which the prior authorization official determines have an effect on the need for payment of transportation expenses, prior authorization for payment for such transportation expenses may be granted.

(e) Payment. (1) Payment for transportation expenses will be made only when transportation expenses have been prior authorized except for emergency ambulance transportation or Medicare approved transportation by an ambulance service provided to an MA-eligible person who is also eligible for Medicare Part B payments.

(2) Payment for transportation expenses will be made only to the vendor of transportation services, to the MA recipient or to an individual providing transportation services on behalf of the MA recipient.

(3) Payment will be made only for the least expensive available mode of transportation suitable to the MA recipient's needs, as determined by the prior authorization official.

(4) Payment to vendors for transportation services must not exceed the lower of the department established rate, the locally established rate, the locally prevailing rate, or the rate charged to the

public, by the most direct route for the mode of transportation used. However, payment may be made in excess of the locally prevailing rate or the rate charged to the public when federal financial participation in the MA payment for transportation services is available and such payment is necessary to assure the transportation service.

(5) Payment to vendors will made only where an MA recipient is actually being transported in the vehicle.

(6) In order to receive payment for services provided to an MA recipient, a vendor must be lawfully authorized to provide transportation services on the date the services are rendered. A vendor of transportation services is lawfully authorized to provide such services if it meets the following standards:

(i) Ambulance services must be certified or registered by the Department of Health and comply with all requirements of that department;

(ii) Ambulette services must be authorized by the Department of Transportation. Ambulette drivers must be qualified under Article 19-A of the Vehicle and Traffic Law. Ambulette services and their drivers must comply with all requirements of the Department of Transportation and the Department of Motor Vehicles or have a statement in writing from the appropriate department or departments verifying that the ambulette services or their drivers are exempt from such requirements. In addition, ambulette services operating in New York City must be licensed by the New York City Taxi and Limousine Commission;

(iii) taxicab or livery services must comply with all requirements of the local municipality concerning the operation of taxicab or livery service in that municipality and with all requirements of the Department of Motor Vehicles; and

(iv) Vendors which provide transportation to day treatment or continuing treatment programs must be authorized by the Department of Transportation. Drivers for such vendors must be qualified under Article 19-A of the Vehicle and Traffic Law. Such vendors and their drivers must comply with all requirements of the Department of Transportation and the Department of Motor Vehicles or have a statement in writing from the appropriate department or departments verifying that the vendors or their drivers are exempt from such requirements.

(7) Payment is available for transportation services provided in order for the recipient to receive an MA covered service is the recipient receives such service (other than transportation services) at school or off of the school premises and both the covered service and transportation service are included in the recipient's individualized education plan. Payment is available for transportation services provided in order for the recipient, or the recipient's family member or significant other to receive an MA covered service if both the covered service and transportation service are included in the recipient's interim or final individualized family services plan. For purposes of this section, a significant other is a person who substitutes for the recipient's family, interacts regularly with the recipient, and affects directly the recipient's developmental status. Reimbursement for such services must be made in accordance with the provider agreement.

(8) Payment to a provider of ambulette services will only be made for services documented in contemporaneous records in accordance with section 504.3 of this Title. Documentation must include:

(i) the recipient's name and MA identification number;

(ii) the origination of the trip;

(iii) the destination of the trip;

(iv) the date and time of service; and

(v) the name of the driver transporting the recipient.

(9) Payment will not be made for transportation services when:

(i) the transportation services are ordinarily made available to other persons in the community without charge; however, payment may be made under such circumstances when federal financial participation in the MA payment for transportation services is available;

(ii) the transportation services are provided by a medical facility and the costs are included in the facility's MA rate;

(iii) a vendor is not actually transporting an MA recipient;

(iv) the MA recipient has access to and can make use of transportation, such as a private vehicle or mass transportation, which the recipient ordinarily uses for the usual activities of daily living unless prior authorization has been granted by the prior authorization official.

(f) Medical transportation plans and rate schedules.

(1) The department may either establish rate schedules at which transportation services can be assured or delegate such authority to the social services districts.

(2) As directed by the department, each social services district must prepare and submit for department approval a medical transportation plan which provides for essential transportation of MA recipients to and from medical care and services which may be paid for under the MA program and the rate schedules to be used by the district. The department will approve a transportation plan if it finds that the plan satisfactorily demonstrates that appropriate modes of transportation are available to MA recipients in the social services district and that the rates of payment for transportation are adequate to ensure the availability of transportation to and from medically necessary care and services which can be paid for under the MA program.

(i) Amendments to transportation plans or changes to rate schedules must be submitted at least 60 days prior to the effective date of the amendment. The department may permit a shorter notification period in circumstances where the department has adequate time to review the proposed amendment prior to its effective date. Factors which will be considered in determining whether to shorten the notification period include, but are not limited to, the complexity of the proposed amendment and the number and complexity of any other proposed amendments which the department is reviewing when the request is made. The department may also waive the notification period at the request of the social services district where a waiver would permit more efficient and effective administration of the MA program.

(ii) Plans, rate schedules or amendments may not be implemented without departmental approval.

(iii) The transportation rate schedules submitted for approval must be complete and contain the current department established rates, the locally established rates, or the locally prevailing rates for each transportation service for which the district is required to pay.

(3) Failure to obtain the approval required by this subdivision may result in the social services district being denied federal and State reimbursement for the expenses related to transporting MA recipients to providers of medical care or services.

(4) On request, a vendor of transportation services must submit pertinent cost data, which is available to the vendor, to the department or the social services district. The department or the social services district may not require a certified cost document if providing such certification will result in additional expense to the vendor. Failure to comply with the requirements of this paragraph may result in the vendor's termination from participation in the MA program.

(5) The department or each social services district for which payment of transportation services is made through the Medicaid Management Information System (MMIS) must adhere to the following requirements in establishing payment rates with vendors of transportation services:

(i) The department or the social services district must select at least one of the following:

(a) a flat-rate for all transportation services provided;

(b) a base rate for all transportation services provided, plus a mileage charge;

(c) a flat-rate for transportation services within specified areas; or

(d) a mileage rate based on distance.

(ii) The department or the social services district may establish with vendors a reduced rate for any of the following:

(a) transportation of additional persons;

(b) transportation of persons traveling to and from day treatment or continuing treatment programs; and

(c) transportation of persons for purposes of obtaining regularly recurring medical care and services.

(iii) The department or the social services district may establish an additional rate for any of the following:

(a) other transportation costs, limited to the costs of meals, lodging and transportation attendants. Such costs must be approved by the department before the social services district may establish the additional rate; and

(b) bridge and road tolls.

(6) Rates established by the department will be deemed part of all applicable social services district medical transportation plans.

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Section 515.1 - Scope and definitions.

Section 515.1 Scope and definitions. (a) Scope. This Part sets forth the requirements and procedures for:

(1) sanctioning persons under the medical assistance program;

(2) recovering overpayments resulting from unacceptable practices;

(3) obtaining restitution;

(4) administrative appeals of sanctions and overpayments; and

(5) reinstatement into the medical assistance program.

(b) Definitions. The terms defined in Part 504 of this Title have the same meanings for purposes of this Part. In addition, for purposes of this Part, the following terms have the following meanings:

(1) Abuse means practices that are inconsistent with sound fiscal, business, medical or professional practices and which result in unnecessary costs to the medical assistance program, payments for services which were not medically necessary, or payments for services which fail to meet recognized standards for health care.

(2) Censure means a warning that continued conduct of the type or nature cited may result in a more severe sanction. A censure may serve as a basis for imposition of a more severe sanction against the same person or an affiliate on a subsequent matter, whether or not the subsequent matter is related to the matter for which a censure was issued.

(3) Claim means any request for payment under the medical assistance program. Where a claim form, voucher or invoice contains more than one item of care, services or supplies, each item will be considered a separate claim.

(4) Commissioner means the State Commissioner of Social Services, or any person designated to represent the commissioner.

(5) Department means the State Department of Social Services.

(6) Exclusion means that items of medical care, services or supplies furnished by the provider or ordered or prescribed by the provider will not be reimbursed under the medical assistance program.

(7) Fraud means an intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit to the provider or another person and includes the acts prohibited by section 366-b of the Social Services Law.

(8) Furnish means that medical care, services or supplies are provided directly by, or under the supervision of, or ordered or prescribed by the person.

(9) Program means the medical assistance program.

(10) Sanction means any final administrative action taken by the department under this Part which limits a person's participation in the medical assistance program. Sanctions which may be imposed are set forth in section 515.3 of this Part.

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Section 515.2 - Unacceptable practices under the medical assistance program.

515.2 Unacceptable practices under the medical assistance program. (a) General. An unacceptable practice is conduct by a person which is contrary to:

(1) the official rules and regulations of the department;

(2) the published fees, rates, claiming instructions or procedures of the department;

(3) the official rules and regulations of the Departments of Health, Education and Mental Hygiene, including the latter department's offices and divisions, relating to standards for medical care and services under the program; or

(4) the regulations of the Federal Department of Health and Human Services promulgated under title XIX of the Federal Social Security Act.

(b) Conduct included. An unacceptable practice is conduct which constitutes fraud or abuse and includes the practices specifically enumerated in this subdivision.

(1) False claims. (i) Submitting, or causing to be submitted, a claim or claims for:

(a) unfurnished medical care, services or supplies;

(b) an amount in excess of established rates or fees;

(c) medical care, services or supplies provided at a frequency or in an amount not medically necessary; or

(d) amounts substantially in excess of the customary charges or costs to the general public.

(ii) Inducing, or seeking to induce, any person to submit a false claim under this subdivision.

(2) False statements. (i) Making, or causing to be made any false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a medical assistance payment, or for use in determining the right to payment.

(ii) Inducing or seeking to induce the making of any false, fictitious or fraudulent statement or a misrepresentation of material fact.

(3) Failure to disclose. Having knowledge of any event affecting the right to payment of any person and concealing or failing to disclose the event with the intention that a payment be made when not authorized or in a greater amount than due.

(4) Conversion. Converting a medical assistance payment, or any part of such payment, to a use or benefit other than for the use and benefit intended by the medical assistance program.

(5) Bribes and kickbacks. Unless the discount or reduction in price is disclosed to the client and the department and reflected in a claim, or a payment is made pursuant to a valid employer-employee relationship, the following activities are unacceptable practices:

(i) soliciting or receiving either directly or indirectly any payment

(including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for referring a client to a person for any medical care, services or supplies for which payment is claimed under the program;

(ii) soliciting or receiving either directly or indirectly any payment

(including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for purchasing, leasing, ordering or recommending any medical care, services or supplies for which payment is claimed under the program;

(iii) offering or paying either directly or indirectly any payment

(including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for referring a client to a person for any medical care, services or supplies for which payment is claimed under the program; or

(iv) offering or paying either directly or indirectly any payment

(including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for purchasing, leasing, ordering or recommending any medical care, services or supplies for which payment is claimed under the program.

(6) Unacceptable recordkeeping. Failing to maintain or to make available for purposes of audit or investigation records necessary to fully disclose the medical necessity for and the nature and extent of the medical care, services or supplies furnished, or to comply with other requirements of this Title.

(7) Employment of sanctioned persons. Submitting claims or accepting payment for medical care, services or supplies furnished by a person suspended, disqualified or otherwise terminated from participation in the program or furnished in violation of any condition of participation in the program.

(8) Receiving additional payments. Seeking or accepting any gift, money, donation or other consideration in addition to the amount paid or payable under the program for any medical care, services or supplies for which a claim is made.

(9) Client deception. Deceiving, misleading or threatening a client, or charging or agreeing to charge or collect any fee in excess of the maximum fee, rate or schedule amount from a client.

(10) Conspiracy. Making any agreement, combination or conspiracy to defraud the program by obtaining, or aiding anyone to obtain, payment of any false, fictitious or fraudulent claim.

(11) Excessive services. Furnishing or ordering medical care, services or supplies that are substantially in excess of the client's needs.

(12) Failure to meet recognized standards. Furnishing medical care, services or supplies that fail to meet professionally recognized standards for health care or which are beyond the scope of the person's professional qualifications or licensure.

(13) Unlawful discrimination. Illegally discriminating in the furnishing of medical care, services or supplies based upon the client's race, color, national origin, religion, sex, age or handicapping condition.

(14) Factoring. Assigning payments under the program to a factor, either directly or by power of attorney; or receiving payment through any person whose compensation is not related to the cost of processing the claim, is related to the amount collected or is dependent upon collection of the payment.

(15) Solicitation of clients. Offering or providing any premium or inducement to a client in return for the client's patronage of the provider or other person to receive care, services or supplies under the program.

(16) Verification of MA eligibility:

(i) failing to use the Medicaid Eligibility Terminal (MET) verification procedure, as required by Part 514 of this Title, in a significant number of cases and such failure is unjustified;

(ii) failing to use the card swipe capability of the MET, as required by Part 514 of this Title, in a significant number of cases and such failure is unjustified;

(iii) failing to post orders for medical care, services or supplies in the electronic Medicaid eligibility verification system (EMEVS), as required by part 514 of this Title, in a significant number of cases and such failure is unjustified; or

(iv) failing to clear prescription or fiscal orders which are required to be posted to EMEVS, as required by Part 514 of this Title, in a significant number of cases and such failure is unjustified.

(17) Denial of services. Denying services to a recipient based in whole or in part upon the recipient's inability to pay a co-payment for medical care, services or supplies.

(18) Other prohibited acts. With respect to any person not a provider, committing any act which would result in the termination of a provider's enrollment in the program pursuant to section 504.7 of this Title.

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Part 521 - Provider Compliance Programs

This part is not updated by the Regulatory Affairs Unit in the Department of Health. The following may not be current. For information and/or copies please contact:

Office of the Medicaid Inspector General
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Section 521.1 - General requirements and scope

521.1 General requirements and scope.

To be eligible to receive medical assistance payments for care, services, or supplies, or to be eligible to submit claims for care, services, or supplies for or on behalf of another person, the following persons shall adopt and implement effective compliance programs:

(a) persons subject to the provisions of articles twenty-eight or thirty-six of the public health law;

(b) persons subject to the provisions of articles sixteen or thirty-one of the mental hygiene law; or

(c) other persons, providers or affiliates who provide care, services or supplies under the medical assistance program or persons who submit claims for care, services, or supplies for or on behalf of another person for which the medical assistance program is or should be reasonably expected by a provider to be a substantial portion of their business operations.

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Section 521.2 - Definitions

521.2 Definitions.

For purposes of this Part, the definitions contained in Parts 504 and 515 of this Title shall apply. In addition, the following terms, as used in this Part, shall have the following meanings:

(a) "Required provider" means a provider meeting any of the criteria listed in subpart 521.1 of this Part.

(b) "Substantial portion" of business operations means any of the following:

(1) when a person, provider or affiliate claims or orders, or has claimed or has ordered, or should be reasonably expected to claim or order at least five hundred thousand dollars ($500,000) in any consecutive twelve-month period from the medical assistance program;

(2) when a person, provider or affiliate receives or has received, or should be reasonably expected to receive at least five hundred thousand dollars ($500,000) in any consecutive twelve-month period directly or indirectly from the medical assistance program; or

(3) when a person, provider or affiliate who submits or has submitted claims for care, services, or supplies to the medical assistance program on behalf of another person or persons in the aggregate of at least five hundred thousand dollars ($500,000) in any consecutive twelve-month period.

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Section 521.3 - Compliance Program Required Provider Duties

521.3 Compliance Program Required Provider Duties.

(a) Every required provider shall adopt and implement an effective compliance program. The compliance program may be a component of more comprehensive compliance activities by the required provider so long as the requirements of this Part are met. Required providers' compliance programs shall be applicable to:

(1) billings;

(2) payments;

(3) medical necessity and quality of care;

(4) governance;

(5) mandatory reporting;

(6) credentialing; and

(7) other risk areas that are or should with due diligence be identified by the provider.

(b) Upon applying for enrollment in the medical assistance program, and during the month of December each year thereafter, a required provider shall certify to the department, using a form provided by the Office of the Medicaid Inspector General on its website, that a compliance program

meeting the requirements of this Part is in place. The Office of the Medicaid Inspector General will make available on its website compliance program guidelines for certain types of required providers.

(c) A required provider's compliance program shall include the following elements:

(1) written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;

(2) designate an employee vested with responsibility for the day-to-day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator designated by the chief executive and shall periodically report directly to the governing body on the activities of the compliance program;

(3) training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member;

(4) communication lines to the responsible compliance position, as described in paragraph (2) of this subdivision, that are accessible to all employees, persons associated with the provider, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;

(5) disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for:

(i) failing to report suspected problems;

(ii) participating in non-compliant behavior; or

(iii) encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;
such disciplinary policies shall be fairly and firmly enforced;

(6) a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care of medical assistance program beneficiaries;

(7) a system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing

procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments;

(8) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty and seven hundred forty-one of the labor law.

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Section 521.4 - Determination of Adequacy of Compliance Program

521.4 Determination of Adequacy of Compliance Program.

(a) The commissioner of health and the Medicaid inspector general shall have the authority to determine at any time if a provider has a compliance program that is effective and appropriate to its characteristics and satisfactorily meets the requirements of this Part.

(b) A provider whose compliance program that is accepted by the federal department of health and human services office of inspector general and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provisions of this Part, so long as such plans adequately address medical assistance program risk areas and compliance issues.

(c) In the event that the commissioner of health or the Medicaid inspector general finds that the required provider does not have a satisfactory program, the provider may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program.

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