The State of New York Department of Health

IN THE MATTER OF THE REQUEST OF

COALO AMBULETTE SERVICE, INC. and AZAIRE PAUL (AKA PAUL AZAIRE)

Decision
Audit Number
11-F-1187

Provider ID # 01391946

For a hearing pursuant to Part 519 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18 NYCRR) to review the Determination of the Office of the Medicaid Inspector General to exclude the Appellants for a period of three (3) Years and to recover $152,275.20 in Medicaid Overpayments.

Before: James F. Horan, Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, NY 10007
July 10, 2014

Parties: Office of the Medicaid Inspector General
Office of Counsel
217 Broadway, 8th Floor
New York, NY 10007
BY: Tina Dolman, Esq.

Coalo Ambulette
[redacted]
BY: Azaire Paul, Owner, Pro Se

Summary and Jurisdiction

In this matter pursuant to Title 18 NYCRR §519.4, the Office of the Medicaid Inspector General (OMIG) seeks to exclude both the Coalo Ambulette Service (Provider) and Azaire Paul (Owner) from the Medicaid Program for three years each and seeks to recover overpayments, following an audit, totaling $152,275.20, with interest. The OMIG issued a Notice of Agency Action [Hearing Exhibit 1] alleging that the Owner and Provider engaged in unacceptable practices under the Medicaid Program and received Medicaid overpayments by:

1.) providing ambulette services within the City of New York, from January 1, 2008 until December 23, 2010, without a New York City Taxi and Limousine Commission (TLC) para transit license (TLC License),

2.) billing for services supposedly ordered by a physician who had no relationship to the Provider and who never ordered the services, and,

3.) operating without Worker's Compensation and Disability Insurance that the New York State Department of Transportation (DOT) and New York State Workers' Compensation Board (WCB) mandate.

After a hearing on the charges, the ALJ sustains the three charges, affirms the order that the Provider and Owner repay $152,275.20 in overpayments and sustains the determination to exclude the Owner and Provider from the Medicaid Program for three years each.

Background

Following the Notice of Agency Action, the Owner and Provider requested the hearing that took place on July 10, 2014. The ALJ conducted the hearing pursuant to New York Social Services Law Articles 1 and 5 (McKinney Supp. 2014), New York Public Health Law (PHL) Article 1 (McKinney Supp. 2014), New York Administrative Procedure Act (SAPA) Articles 3-5 (McKinney 2014) and Title 18 NYCRR Parts 504, 515, 518 & 519.

At hearing, the OMIG offered two exhibits which the ALJ received into evidence:

Exhibit 1 Notice of Agency Action (pages 1-7),
Exhibit 1A OMIG Coalo File (pages 8-1058).

The ALJ received Exhibit 1A on compact disc. The record from the hearing also included a transcript that a stenographic reporter prepared (pages 1-80). The OMIG presented a witness, Supervising Investigator Christopher Bedell. The Appellants marked a document as Exhibit A for identification, but the ALJ declined to receive the document into evidence. The Owner spoke for both Appellants, but did not testify. The Appellants called no witnesses.

Under SAPA § 306(2), all evidence, including records and documents in an agency's possession of which an agency wishes to avail itself, shall be offered and made a part of the record of a hearing. Under Title 18 NYCRR § 519.18(f), computer generated documents prepared by the Department or its fiscal agent to show the nature and amounts of payments made under the program will be presumed, in the absence of direct evidence to the contrary, to constitute an accurate itemization of the payments made to a provider.

In addition to testimony and documents in evidence, and pursuant to SAPA § 306(4), an ALJ may take Official Notice of any matter for which Judicial Notice may be taken.

Under SAPA § 306(1), the burden of proof in a hearing falls on the party which initiated the proceeding. Title 18 NYCRR § 519.18(d) provides that the Appellant bears the burden to show a determination of the Department was incorrect and that all claims submitted were due and payable and the Appellant bears the burden to provide mitigating factors with regard to any sanction. Title 18 NYCRR 519.18(h) and SAPA § 306(1) provide that a decision after hearing must be in accordance with substantial evidence. Substantial evidence means such relevant proof as a reasonable mind may accept as adequate to support conclusion or fact; less than preponderance of evidence, but more than mere surmise, conjecture or speculation and constituting a rational basis for decision, Stoker v. Tarantino, 101 A.D.2d 651, 475 N.Y.S.2d 562 (3rd Dept. 1984). Substantial evidence demands only that a given inference is reasonable and plausible, not necessarily the most probable, Ridge Road Fire Dept. v, Schiano, 16 N.Y.3d 494 (2011).

Findings of Fact

The ALJ made the following findings of fact (FF) after affording the parties an opportunity to be heard and after considering the evidence. The items in brackets that follow the findings represent documents in evidence [Ex], testimony from the record [T] and matters under Official Notice [ON] on which the ALJ relied in making the findings. In instances in which conflicting evidence appears in the record, the ALJ considered and rejected that other evidence.

1 The New York State Department of Health (Department) is the single state agency responsible for administering the Medicaid Program in New York State [ON SSL § 363-a, PHL § 201.1(v)].

2 The OMIG is an independent office within the Department with the responsibility for investigating, detecting and preventing Medicaid fraud, waste and abuse and for recouping improper Medicaid payments [ON PHL § 30].

3 The Appellant Owner Azaire Paul owns the Provider Coalo Ambulette Service, a para transit ambulette service provider for recipients under the New York State Medicaid system [Ex 1, page 2; T 5].

4 For services from January 1, 2008 to January 23, 2011, the Provider received $ 150,386.20 in Medicaid payments for para transit services, which occurred wholly within the City of New York, meaning pick up at one location within the City of New York and drop off at another location within the City of New York [T 31-32; Ex 1A, pages 547-572].

5 The New York City Taxi and Limousine Commission (TLC) requires that any para transit provider which operates wholly within the City of New York must hold a TLC para transit base license (TLC License) [ON New York City Administrative Code §§ 19-504(a)(1)and 19-528(a)].

6 The Provider held a TLC License that expired in 2007 [Ex 1A, pages 132-133; T 28].

7 For the period December 1, 2009 to December 30, 2009, the Provider submitted claims for services 61 times with Dr. Tanya Fatimi as the referring provider [Ex 1A, pages 160-262].

8 For the period January 4, 2010 to December 23, 2010, the Provider submitted claims for services 1,028 times with Dr. Tanya Fatimi as the referring provider [Ex 1A, pages 160-262].

9 Dr. Fatimi has no referring relationship with the provider [Ex 1A, pages 9, 47-48].

10 Dr. Fatimi practices at Mount Sinai Hospital Queens (MSQ) and Mount Sinai Hospital (MSH) [Ex. 1A, pages 47-48].

11 Neither Dr. Fatimi, MSQ nor MSH have any record or knowledge concerning ever issuing referrals to the Provider [Ex 1A, pages 47-48].

12 The Owner conceded in an October 6, 2013 response to OMIG that the Provider never provided any services for Dr. Fatimi and never transported any patients to MSQ or MSH [Ex 1A, page 9].

13 To operate lawfully in New York State, the Provider needed to maintain workers compensation and disability insurance [ON WCL § § 50, 211; TL § 139, 156(2)].

14 The Provider maintained no workers' compensation or disability policies for the audit period [T 45-46; Ex 1A, page 546a].

Controlling Regulations and Statutes

Title 18 NYCRR § 518.1(c) defines overpayment as any amount not authorized to be paid under the Medicaid Program, whether paid as a result of improper claiming, unacceptable practices, fraud, abuse or mistake. Title 18 NYCRR § 515.2(b)(1)(i) defines unacceptable practices to include submitting claims for not lawfully furnished services. Title 18 NYCRR § 504.3(h) states that a provider agrees to provide true, accurate and complete information in relation to any claim. Title 18 NYCRR §504.3(i) provides that by enrolling, a provider agrees to comply with the rules, regulations and official directives of the Department. Title 18 NYCRR § 515.3(c) provides that whenever the Department sanctions a person, the Department may also sanction any affiliate of that person. Title 18 NYCRR § 504.1(d)(1) defines an affiliate to include persons with ownership or control in the provider. Title 18 NYCRR § 519.4(a)(2) entitles a person to a hearing any time that an OMIG audit requires repayment or restitution of an overpayment.

The New York City Administrative Code § 19-504(a)(1) provides that a taxi-cab, coach, wheelchair accessible van, commuter van or for-hire vehicle shall operate in the City of New York only if the owner shall first have obtained from the TLC a license for such vehicle and only while such license remains in full force and effect. New York City Administrative Code § 19-528(a) provides that it shall be unlawful for persons required to be licensed pursuant to this chapter to engage in any trade, business or activity which requires a license without such license.

New York Workers Compensation Law (WCL) § 50 (McKinney Supp. 2014) requires that an employer shall secure compensation for his employees. Under WCL § 211, a covered employer shall, with his own contributions and the contributions of his employees, provide disability benefits to his employees.

New York Transportation Law (TL) § 139 (McKinney Supp. 2014) provides that no certificate or permit shall be issued to a motor carrier or remain in force, unless such carrier complies with such rules and regulations as the Commissioner shall prescribe governing policies of insurance. Under TL § 156(2), any certificate or permit may be suspended by the Commissioner without hearing for the failure to comply with the insurance requirements under TL § 139. Further, the Commissioner may revoke any certificate so suspended, no less than thirty days after the suspension date, if the carrier still fails to comply with the insurance requirement.

Conclusions and Discussions

The OMIG Notice of Agency Action [Ex 1] sought overpayment recovery and exclusion in this case on the grounds that the Provider engaged in inacceptable practices by: 1.) billing for services within the City of New York during a time that the Provider lacked a TLC License, 2.) billing for services using Dr. Tanya Fatimi as the referring provider which Dr. Fatimi never ordered, and, 3.) billing for services during a time when the Provider lacked both Workers Compensation and Disability Insurance. In response to the TLC License Charge, the Owner responded that operating without a TLC License failed to amount to Medicaid Fraud [Ex 1A, page 9]. In response to the Charge on the

Fatimi Referrals, the Owner agreed that he never used Dr. Fatimi as a provider and that a mistake had been made, but indicated that the Provider had transported patients from Oxford Nursing Home. On the Insurance Charge, the Owner argued that he complied with requirements to maintain Workers Compensation and Disability Insurance. In response to the OMIG request for overpayment recovery and exclusions, the Owner indicated that he is currently paying a monetary penalty under a Stipulation with the New York State Attorney General's Medicaid Fraud Control Unit (MFCU Stipulation). The Owner argued that he will be unable to pay the penalty to "Medicaid" if he and the Provider receive an exclusion from the Medicaid Program and if the Owner must also return overpayments.

The ALJ finds that the OMIG proved by substantial evidence that the Provider engaged in unacceptable practices by submitting claims for services that the Provider failed to provide legally because the Provider lacked a TLC License to provide services wholly within the City of New York and because the Provider lacked Workers Compensation and Disability Insurance. The ALJ finds further that the Provider engaged in unacceptable practices by submitting false claims that listed as a referring provider Dr. Tanya Fatimi, who never ordered the services and who had no referral relationship with the Provider. The ALJ affirms the determination by the OMIG to recover $152,275.20 in overpayments from the Provider and to exclude the Provider and Owner from the Medicaid Program for three years each.

TLC License: For the period January 4, 2008 to December 23, 2010, the Provider submitted claims totaling $150,386.40 for services with a pick-up in the City of New York and a drop-off in the City of New York [Ex 1A, pages 134-147]. The New York

City Administrative Code § 19-504(a)(1) provides that a para transit provider may operate within the City of New York only if the provider first obtains a TLC License and only while such License is in full force and effect. Testimony at the hearing by Investigator Bedell indicated that OMIG contacted the TLC and learned that the Provider last held a valid TLC License in 2007 [T 37-38; Ex 1A, pages 544-545]. The ALJ concludes that the Provider submitted $150,386.40 in claims for services provided unlawfully in New York City in 2008-2010. Title 18 NYCRR § 515.2(b)(1)(i) defines unacceptable practices to include submitting claims for not lawfully furnished services.

The Owner's response to the TLC License allegations was that he thought TLC regulations had nothing to do with Medicaid fraud [Ex 1A, page 9]. The ALJ notes that the OMIG did not allege fraud in this instance, the OMIG alleged unacceptable practices and such unacceptable practices include submitting claims for unlawfully provided services.

Referrals: For the period December 1, 2009 to December 23, 2010, the Provider submitted 1089 claims for services that listed Dr. Tanya Fatimi as the referring provider [Ex 1A, pages 859-1051]. These claims were included in the $150,386.40 claims for services within the City of New York, during the time period in which the Provider lacked a TLC License. Testimony by Investigator Bedell indicated that OMIG contacted Dr. Fatima, as well as MSH and MSQ, the hospitals at which Dr. Fatima works [T 40]. Dr. Fatima indicated that she had no referring relationship with the Provider and MSQ indicated that it had no referring relationship with the Provider [T. 40; Ex 1A, page 546]. The Owner conceded in a reply to the OMIG that the Provider never supplied para transport services for Dr. Fatimi nor transported patients to MSH [Ex 1A, page 9]. The

ALJ concludes that the Provider submitted claims to the OMIG that contained false information. Under Title 18 NYCRR § 515.2(b)(2), submitting Medicaid claims containing false statements or misrepresentations of fact constitutes an unacceptable practice.

The Owner's response to OMIG described the billings referencing Dr. Fatimi as a mistake that had been done somewhere and that the owner would like to get to the "bottom of this". The Owner provided no explanation at hearing concerning how the billing mistakes occurred. The Owner and Provider bore the responsibility to submit truthful and accurate claims to the Medicaid Program and the OMIG may recover overpayments that resulted from claims containing false information.

Insurance: The testimony by Investigator Bedell indicated the Provider needed to hold Workers Compensation and Disability Insurance [T 43-44]. The OMIG viewed the WCB website and found no workers compensation or disability coverage for the Provider for the years 2008-2010 [T 44-45]. An exception to the requirement for Workers Compensation coverage applies when a business has no employees [T 44]. The OMIG determined that the Provider did have employees during the period at issue. The Department of Motor Vehicles listed at least one driver as an employee at the Provider for that time period [T 46-47]. The Provider also submitted billing records to the OMIG that listed several drivers' license numbers for drivers who performed services for which the Provider submitted claims [T 46; Ex 1A, pages 547-572]. The ALJ concludes that the Provider lacked legal authority to operate, because the Provider failed to obtain the Workers Compensation and Disability Insurance. Title 18 NYCRR §515.2(b)(1)(i)

defines unacceptable practices to include submitting claims for not lawfully furnished services.

During the period at issue in this case, the Provider submitted claims for services wholly within the City of New York that totaled $150,386.40. The OMIG already determined that the Provider received overpayments in that amount due to the findings relating to the TLC License. In addition, during the years 2008 to the end of 2010, the Provider submitted claims totaling $1,888.80 for services not wholly within the City of New York. During the time at issue in those claims, the Provider lacked Workers Compensation or Disability Insurance [T 48].

The Owner argued that he complied with the insurance requirements. The Provider's response to the OMIG included two documents that the Owner submitted claiming exemption from workers' compensation insurance requirements. Those documents, however, bore the dates 11/30/12 and 1/28/13. The Owner submitted nothing to indicate either compliance with or exemption from the insurance requirements for the years at issue in this proceeding: 2008, 2009 and 2010.

Sanctions: Under Title 18 NYCRR § 515.3, the sanctions for Medicaid providers and affiliates who engage in unacceptable practices include exclusion from the Program for a reasonable time and repayments of any overpayments that resulted from unacceptable practices. The OMIG seeks to recover $152,275.20 from the Owner and Provider for overpayments and to exclude both the Owner and Provider from the Medicaid Program for three years. The Owner asked to remain a Medicaid Provider because he needs to support himself. The Owner also indicated that he would be unable to make repayment, because he is paying another amount under the MFCU Stipulation.

The ALJ has concluded that the Owner and Provider received Medicaid overpayments amounting to $152,275.20. The ALJ affirms the determination by the OMIG to recover the overpayments from the Owner and the Provider. The ALJ also affirms the determination to exclude both the Owner and the Provider from the Medicaid Program for three years each. The ALJ finds that the false billings that listed Dr. Fatimi as referring physician would, standing alone, warrant the three year exclusions. The Provider and Owner also provided services unlawfully over a three year period. The Owner controlled the Provider and received the proceeds from the Medicaid billings, so the Owner shared in responsibility for the unacceptable practices by the Provider. Further, the testimony by Investigator Bedell indicated that the exclusions would cause no disruption in services to Medicaid recipients in the area that the Provider covered, because there are other providers in the area that can provide para transit services to Medicaid recipients [T 55].

Administrative Law Judge James F. Horan renders this decision pursuant to the designation by the Commissioner of Health of the State of New York to render final decisions in hearings involving Medicaid provider audits.

Dated: November 10, 2014
Menands, New York

_____

James F. Horan
Administrative Law Judge

To:

Tina Dolman, Esq.
Office of the Medicaid Inspector General
Office of Counsel
217 Broadway, 8th Floor
New York, NY 10007

Azaire Paul, Owner
Coalo Ambulette Service
[redacted]