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NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Acting Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

February 16, 2023

CERTIFIED MAIL/RETURN RECEIPT

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RE: In the Matter of Schenectady ARC

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter.

If the appellant did not win this hearing, the appellant may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the appellant wishes to appeal this decision, the appellant may wish to seek advice from the legal resources available (e.g. the appellant's attorney, the County Bar Association, Legal Aid, OEO groups, etc.). Such an appeal must be commenced within four (4) months after the determination to be reviewed becomes final and binding.

Sincerely,

Natalie J. Bordeaux

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB:nm
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of **Schenectady ARC** **Provider No. 01557482** Appellant, from determinations by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.	**Decision After Hearing** Audit # 17-4015

Before: Matthew C. Hall
Administrative Law Judge

Held at: New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway, Suite 510
Albany, New York 12204

Dates: February 19, 2020
November 25, 2020
May 19, 2021

Parties: NYS Office of the Medicaid Inspector General
40 N. Pearl Street
Albany, New York 12243
By: Kathleen Dix, Esq.

Schenectady ARC
214 State Street
Schenectady, New York 12305
By: David Ross, Esq.
Andrew Ko, Esq.

JURISDICTION

The New York State Department of Health (the Department) acts as a single state agency to supervise the administration of the Medicaid Program in New York. 42 USC 1396a, Public Health Law (PHL) 201(1)(v), Social Services Law (SSL) 363-a. The Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority to pursue administrative enforcement actions to recover improperly expended Medicaid funds. PHL 30, 31 and 32.

The OMIG determined to seek restitution of overpayments by the Medicaid Program to the Schenectady County ARC (Appellant). The Appellant requested a hearing pursuant to Social Services Law § 22 and former Department of Social Services (DSS) regulations at 18 NYCRR § 519.4 to review the determination.

HEARING RECORD

OMIG witness:	Roselyn Renas, Auditor One, OMIG
OMIG exhibits:	1-16
Appellant witnesses:	Kirk Lewis, Executive Director of Schenectady ARC [redacted] Community Support Professional Lisa Serotta, Director of Corporate Compliance Erik Geizer, C.E.O., ARC of New York Deborah Williams, VP Reimbursement, CPA of New York
Appellant exhibits:	A - J

A transcript of the hearing was made. (Transcript, pages 1-379.)

SUMMARY OF FACTS

1. At all times relevant hereto, Appellant Schenectady ARC was a private, not-for-profit organization enrolled as a provider in the New York State Medicaid Program, operating under the Office for People with Developmental Disabilities (OPWDD), pursuant to Article 16 of the Mental Hygiene Law.

2. By draft audit report dated February 15, 2018, the OMIG notified the Appellant that it had determined to seek restitution of Medicaid overpayments in the amount of $1,239,242. (Ex. 5.)

3. Pursuant to 18 NYCRR 517.5(b)&(c), the draft audit report advised the Appellant that it was entitled to object to the proposed determinations and to submit documents in response to them. The Appellant submitted a response to the draft audit report by letter dated April 6, 2018. (Ex. 6.)

4. By final audit report, dated September 11, 2018, the OMIG notified the Appellant that it had now determined to recover Medicaid Program overpayments in the amount of $1,020,319. (Ex. 7.)

5. OMIG's determination was based upon a review of the Appellant's Medicaid reimbursement of Article 16 claims paid to the Appellant from January 1, 2012, through December 31, 2014. The review was undertaken to determine whether the Appellant's records reflected compliance with Medicaid Program requirements. (Ex. 7.)

6. The audit universe consisted of 44,089 claims totaling $4,312,085.25. The audit consisted of a random sample of 100 claims with Medicaid payments totaling $8,737.31. (Ex. 7.)

7. OMIG identified one or more violations of Medicaid Program requirements and laws and regulations in the submission of several of these claims, and after consideration of the Appellant's response to the draft audit report, disallowed payment for those claims in the total amount of $1,020,319. (Ex. 7.)

8. OMIG organized its audit findings into seven categories. Disallowances were made for the following reasons:

(1) No Explanation of Benefits (EOB)/Documentation for Medicare Covered Service (30 instances.)

(2) No EOB for Third Party Health Insurance (TPHI) Covered Service (Excluding Medicare) (4 instances.)

(3) Failure to Meet Minimum Duration Requirements (4 instances.)

(4) Missing Elements of Clinical Service Documentation (2 instances.)

(5) Missing Elements of Annual Physician (Re)Assessment (1 instance.)

(6) Missing Elements of Treatment Plan (1 instance.)

9. Findings 4, 5 and 6 were not challenged. (T. 8.)

ISSUE

Is the OMIG entitled to recover Medicaid Program overpayments from the Appellant?

APPLICABLE LAW

By enrolling in the Medicaid Program, Medicaid providers agree to prepare contemporaneous records demonstrating the right to receive payment under the Medicaid

Program and to furnish such records and information, upon request, to the Department of Health (Department). Providers agree to submit claims for payment only for services that were actually furnished and were medically necessary when rendered to Medicaid-eligible patients. The information submitted in relation to any claim for payment must be true, accurate and complete. Medicaid providers also agree to comply with the rules, regulations, and official directives of the Department. 18 NYCRR §§ 504.3(e), (h)-(i), § 517.3(b), § 540.7(a)(8).

When the Department has determined that claims for medical services or supplies have been submitted for which payment should not have been made, it may require repayment of the amount determined to have been overpaid. 18 NYCRR § 518.1(b). A person is entitled to a hearing to have the Department's determination reviewed if the Department requires repayment of an overpayment. 18 NYCRR § 519.4. At the hearing, the Appellant has the burden of showing that the determination of the Department was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR § 519.18(d), SAPA § 306(1).

DISCUSSION

At the hearing, the OMIG presented the audit files and summarized the case as required by 18 NYCRR § 519.17. In addition, the OMIG presented documents and one witness as described above. The Appellant also presented documents and the testimony of five witness, also described above. Both parties submitted "post hearing briefs" which were given full consideration.

General Challenges

In response the draft audit report, the Appellant argued that, to the extent that this audit relied on "the OMIG's OPWDD Article 16 Clinic Services audit protocol available on the OMIG's website," the Appellant objects to the protocol "as it was not adopted in accordance with the requirements of the State Administrative Procedure Act (SAPA) and therefor constitutes illegal and retroactive rulemaking." (Ex. 6.) However, the Appellant was repeatedly advised of the purpose of the audit and failed to identify any provision in the audit protocol that was inconsistent with the applicable regulations, or any instance in which the OMIG applied an audit protocol inconsistently with the regulations. The extent of the Appellant's objection was limited to witness Erik Geizer stating that he "really disagreed" with this component of the audit protocol and that he "certainly does(n't) think it's fair." (T. 342.)

The Appellant also contended in its response to the draft audit report that the proposed disallowances are unreasonable, contrary to the law, are highly technical and "improperly impose sanction." (Ex. 6.) However, as a condition of their enrollment, Medicaid providers agree to submit claims on officially authorized claim forms in a manner specified by the Department [18 NYCRR 504.3(f)] and to ensure that the information provided in relation to any claim is true, accurate and complete. If an audit reveals an overpayment, the Department may require repayment of the amount determined to have been overpaid. 18 NYCRR Part 518. What OMIG seeks to recover from the Appellant is not a penalty, 18 NYCRR Part 516 or a sanction 18 NYCRR Part 515. The result of the audit is a determination that an "overpayment" of Medicaid funds was made to the Appellant. The amount of overpayment found upon audit is directly

related to the claims made by the Appellant, claims which did not comply with Medicaid billing requirements.

Extrapolated Overpayments

The Appellant challenged the methods used to determine "extrapolated payments." The Appellant argued that the "sampling and extrapolation methodology was fatally flawed," and that the Appellant is therefore entitled to a "missing witness inference." (Appellant's brief.)

The statistical sampling methodology employed by the Department in this audit allows for extrapolation of the sample findings to the universe of claims. (Department's brief.) As stated above, the audit universe consisted of 44,089 claims totaling $4,312,085.25 in Medicaid reimbursement. The audit sample consisted of 100 claims totaling $8,737.31. The audit findings consisted of 42 errors over six categories of findings resulting in a sample overpayment of $2,668.07, and an adjusted point estimate overpayment of $1,020,319. The Department's Exit Conference Summary and Draft Audit each included a section entitled "Sampling Methodology – Service Sample." (Ex 3, 5.) Each document included a description of the sampling methodology used. These descriptions included an explanation of how the universe of claims was extracted from payment records, how it was refined to create the audit frame, the computer program used to obtain the random samples, and an explanation that a series of statistical tests was done to verify the random characteristics of the sample. These documents, plus the Final Audit Report each identified the sample design, the method of extrapolation, and the confidence level utilized to calculate the lower confidence limit. (Ex. 7.) All of the records needed to

verify the extrapolation methodology, including the universe of claims, the audit frame, the sample and the computer programs used were available to the Appellant prior to the hearing. (Ex. 3, 13, 14.)

Pursuant to 18 NYCRR 519.18(g), an extrapolation based on a statistical sample audit, certified as valid, will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made. To rebut this presumption, the Appellant may submit expert testimony challenging the extrapolation or an actual accounting of all claims paid. The OMIG presented the required certification at the hearing and so is entitled to the presumption. (Ex. 13, 14.)

The Appellant challenged the extrapolation in this audit and offered the report of Dr. [redacted]. (E. 6.) This report provided the doctor's "expert opinion that the statistical study and extrapolation performed...are both invalid and fatally flawed rendering any projected overpayment meaningless and of no value to estimation of true overpayment." (Ex. 67.) The Appellant, however, offered no evidence at the hearing, neither expert testimony nor an accounting of the claims, to rebut the presumption. The Appellant sought a "missing witness inference," suggesting that an expert witness must testify at the hearing to justify the Department's methods, and be subject to cross-examination by the Appellant. However, this is not provided for by 18 NYCRR 519.18(g). Given that the Appellant provided no expert testimony at the hearing, nor an accounting of the audited claims to challenge the validity of the statistical sampling methodology used, the Department's methodology and overpayment calculation is presumed to be valid. 18 NYCRR 519.18(g).

Findings No. 1 and No.2 – No Explanation of Benefits (EOB) / Documentation for Medicare and Third-Party Health Insurance (TPHI) Covered Service

The Final Audit Report stated that in 30 instances pertaining to 22 Medicaid recipients, the audit found that no EOB was found for a Medicare eligible recipient who received services covered by Medicare. (Ex. 6.) Medicaid is the payor of last resort and prior to submitting a claim for Medicaid reimbursement, a provider is required to investigate and bill available third-party resources for the services provided to Medicaid recipients before billing Medicaid, and maintain appropriate records supporting its receipt of Medicaid funds. The Final Audit Report also stated that in four instances, pertaining to four recipients, the audit found that no EOB was found for a Medicaid recipient who received services covered by a TPHI. (Ex. 7.), 18 NYCRR 360-7.2, 18 NYCRR 540.6(e)(2).

The Appellant admitted in its response to the Draft Audit Report that "it is true that there are no EOBs for each of the samples identified" in Finding #1. (Ex. 6.) The Appellant contended that "there was no requirement that the clinicians providing the service be enrolled in Medicare, an obvious prerequisite to billing Medicare," and "that there is no regulation that requires that Article 16 clinic providers enroll in Medicare." (Ex. 6.) The Appellant raises the same argument regarding Finding #2 as it did for Finding #1 and contends that "according to [the Appellant's] billing service, third party insurers only get billed after Medicare has been billed. If the provider cannot bill Medicare, then it cannot bill the third-party insurer." (Ex. 6.)

Medicaid providers are required to comply with the rules, regulations and directives of the Medicaid Program. 18 NYCRR 504.3(i). The Medicaid program is a

payor of last resort. 18 NYCRR 360-7.2. A provider is required to take reasonable steps to ascertain whether a Medicaid recipient has a third party who is liable to pay for his or her medical care and services. 18 NYCRR 540.6(e)(1). The provider must seek reimbursement from any third-party resources prior to submitting a Medicaid claim. 18 NYCRR 540.6(2). Therefore, prior to billing Medicaid, a provider must first look to Medicare or other health insurance providers for payment for services provided to Medicaid recipients. It is incumbent upon Medicaid providers, then, to take the necessary actions to meet this requirement, including obtaining any necessary prerequisites to bill Medicare and other third-party health insurers when necessary, including enrolling in Medicare where necessary. It is not a defense that there wasn't a specific regulation that required Article 16 clinics to enroll in Medicare. The burden is on the provider to follow all rules, regulations and policies of the Medicaid Program. 18 NYCRR 504.3(i). The Appellant is required to bill Medicare and third-party insurers before billing Medicaid and thus the Appellant is tasked with taking any and all steps necessary to comply with these regulations. 18 NYCRR 540.6(2). OMIG Auditor in Charge Rosalyn Renas testified that for people who have Medicare, she would expect to see an explanation of benefits showing that Medicare was billed first and whether Medicare paid or not, because Medicaid is the payor of last resort. The EOB is a necessary document to show that Medicare was billed first. (T. 37.) Similarly, for third-party insurers other than Medicare, the provider is "supposed to bill third-party insurance carriers first, to see if they do pay on the claim because Medicaid is the payor of last resort." (T. 37.) She further testified that she would not have taken a disallowance if there was documentation to prove that the provider tried to bill Medicare and the service was not covered. (T. 70.)

She also stated that she determined that the occupational-therapy and physical-therapy assistants could not bill Medicare because they were not eligible to do so. Therefore, no EOB could be obtained for those services and the findings related to those claims were removed from the audit. (T. 133-134.)

It is clear from the exhibits and testimony provided, that the Medicaid program is the payor of last resort and is designed to provide payment for medical care and services only after all other resources for payment have been exhausted. Medicaid providers like the Appellant may not submit a claim for medical reimbursement unless it has investigated to find third-party resources for payment and sought reimbursement from liable third parties including Medicare. 18 NYCRR 540.6(e). The Appellant did not seek reimbursement from third parties prior to submitting claims for its services to Medicaid. The Appellant admits that it did not seek such reimbursement. The Appellant's reason for not submitting claims to Medicare or other third-party sources was because its providers were not enrolled in Medicare, which is necessary to bill Medicare. (Ex. 6.) The Appellant asserts that the reason providers were not enrolled in Medicare was because there was no requirement of regulation that told them to do so. However, regulations did require the Appellant to submit claims to Medicare and the Appellant was well aware that in order to do so, it had to be enrolled in Medicare. (T. Lewis.) It is irrelevant to its obligation to bill Medicare of a third-party source first, whether it knew or believed that Medicare would pay for the services provided. The Appellant was required to bill Medicare or a third-party first for every claim, regardless of their belief that it would not be a covered service. Mr. Lewis testified that "it's been our experience that it can be a time consuming and challenging task to get somebody enrolled in

Medicare." Nevertheless, the Appellant was obligated to follow the regulations and bill Medicare or a third-party insurer prior to billing Medicaid, and to provide an EOB to show that they did so. By not doing so, the Appellant created an overpayment of Medicaid reimbursement.

Finding No. 3 – Failure to Meet Minimum Duration Requirements

The Final Audit Report stated that in four instances related to four Medicaid recipients, the audit found that the clinical documentation of the duration of services was less than the required minimum as specified in the descriptive terms and guidelines of Current Protocol Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS). Relying on the OPWDD policy and Medicaid Billing Guidance Manual, the clinical file documentation must support descriptive terms and guidelines associated with the CPT and/or HCPCS codes used for billing Article claims to Medicaid and that Medicaid reimbursement for approved services is based on face-to-face service.

Ms. Renas testified that this finding was "particular to the VOC-rehab service that was given. VOC-rehab services have to be a full fifteen minutes per unit and the person was signed out of their other service, exactly at the times that the VOC-rehab service was given. There was no way that the full fifteen minute per unit could be given. So, we just disallowed one unit on those." (T. 38.)

There are only four samples out of 100 with disallowances in this category, Sample Nos. 18, 53, 84 and 96. Sample 18 was not challenged at this hearing. (T. 152.) Sample Nos. 53 and 96 involve counseling by witness [redacted] Sample No. 84 involved counseling by [redacted]

Mr. Lewis testified that on the "attendance sheet for Sample No. 53, it showed that he arrived at 7:41." He went out at 11:39... and he was out from 8:00 to 8:30 for clinic service. Services for Sample No. 53 refer to services provided at the Appellant's work center and were site-based pre-vocational services." The site where Sample No. 53's services were performed has a work floor where work is done and the service provided to Sample No. 53 was done by a clinician whose office is located in the hallway which is next to the work floor. The office is "literally seconds away from the work floor...in very close proximity." (T. 259.)

Mr. [redacted] testified that during the audit period he was a vocational rehabilitation counselor and confirmed that Mr. Lewis's explanation regarding the way clients would come to him for service. (T. 297-305.) Mr. [redacted] testified that he performed vocational rehabilitation services for Sample No. 53 and Sample No. 96. (T. 299-308.) From reviewing his notes, he confirmed that he met with both people in his office at the times indicated in his notes. He met Sample No. 53 from 8:00 a.m.to 8:30 a.m. He met with Sample No. 96 from 8:30 a.m. to 9:00 a.m. Ms. Renas explained that these samples were signed out of their other service, exactly at the times that the VOC-rehab service was given.

The Department assumes that there must have been travel time involved in travelling to the location of the Vocational Rehabilitation services. Therefore, a 30-minute session could not have occurred because the service recipient was receiving other services that ended exactly when the start time of the subsequent service began. Mr. [redacted] testified however, that he met the residents at issue and accurately noted the time

when the session started and finished. During the audit period, recipients could receive service either by coming to Mr. [redacted] office, or by Mr. [redacted] going out to the "floor" and staying there between sessions. Either way, Mr. [redacted] could have transferred seamlessly from one patient to the next without having to travel at all. The daily attendance logs support that one individual received services from 8:00 a.m. to 8:30 a.m. and the next patient received services from 8:30 a.m. to 9:00 a.m.

Conclusion

The Appellant provided convincing evidence to refute the three claims challenged in the Failure to Meet Minimum Duration Requirements category while convincing evidence was not provided by the Department to dispute this claim.

The other claims disallowed in this audit were not authorized to be paid under the Medicaid Program because they were not supported by evidence demonstrating the Appellant's entitlement to payment.

The claims in Category 1 (No Explanation of Benefits (EOB)/Documentation for Medicare Covered Service (30)) and Category 2 (No EOB for Third Party Health Insurance (TPHI) Covered Service (4)), are affirmed. In Category 3 (Failure to Meet Minimum Duration Requirements), Sample 18 is affirmed as it was not challenged. The other three samples; 53, 84 and 96 are reversed.

DECISION: The OMIG's determination to recover Medicaid Program overpayments from Schenectady ARC for Categories 1 and 2, is affirmed. The OMIG's determination to recover Medicaid Program overpayments from Schenectady ARC in Category 3 (samples 53, 84 and 96) is reversed.

This decision is made by Matthew C. Hall, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Albany, New York
February 16, 2023

Matthew C. Hall
Administrative Law Judge

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