STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Request of	:	
	:	**Decision After**
TATIANA GOUSKOVA, M.D.	:	**Hearing**
Medicaid Provider ID # 11418376	:	
	:	
for a hearing pursuant to Part 519 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) to review a determination to recover Medicaid overpayments	:	Audit # 14-2432

Before: Kimberly A. O'Brien
Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, New York 10007

Parties: New York State Office of the Medicaid Inspector General
217 Broadway, 8th Floor
New York, New York 10007
By: Robyn E. Henzel, Esq.

Tatiana Gouskova, M.D.
[redacted]
Pro Se

PROCEDURAL HISTORY

Date of Draft Audit Report	July 31, 2014
Date of the Final Audit Report	January 5, 2015
Appellant's Hearing Request	March 3, 2015
Date of Pre Hearing Conference	May 20, 2015
Date of Hearing	June 3, 2015
Post Hearing Submission	October 20, 2015[1]

JURISDICTION

The Department of Health (Department) acts as the single state agency to supervise the administration of the medical assistance program (Medicaid) in New York State, Public Health Law (PHL) § 201(1)(v), Social Services Law (SSL) § 363-a. Pursuant to PHL §§ 30, 31 and 32, the Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority to pursue administrative enforcement actions against any individual or entity that engages in fraud, abuse, or unacceptable practices in the Medicaid program, and to recover improperly expended Medicaid funds.

The OMIG determined to seek restitution of payments made by Medicaid to Tatiana Gouskova, M.D. ("Appellant"). The Appellant requested a hearing pursuant to SSL § 22 and the former Department of Social Services (DSS) regulations at 18 NYCRR § 519.4 to review the determination.

[1] At the conclusion of the hearing on June 3, 2015, the parties agreed to submit their brief to the ALJ on or before October 20, 2015, by e-mail and regular mail [Tr. 174-177]. The Appellant did not e-mail a copy of her brief. The ALJ's office received a hard copy of the Appellant's brief on Monday November 2, 2015, which the Appellant sent by "Priority Mail" on Friday October 30, 2015. The Appellant's brief did not

ISSUE

Was OMIG's determination to recover a Medicaid overpayment in the amount of $21,250.00 from Appellant correct?

FINDINGS OF FACT

The items appearing in brackets following the findings of fact ["FOF"] indicate exhibits in evidence [Ex.] and testimony from the transcript [Tr.], which support the finding of fact. In instances in which the cited testimony or exhibit contradicts other testimony or exhibits from the hearing, the ALJ considered that other testimony or exhibit and rejected it.

1. At all times relevant hereto, Appellant, Provider #1114186376, was a physician and enrolled as a provider in the New York State Medicaid program [Ex. 1].

2. *The New York State Electronic Health Records Incentive Program* pays Medicaid providers including individual physicians, group practices and hospitals to adopt, implement, or upgrade their electronic health record systems [Tr. 27, 72, 76, 93-94; Public Law 111-5 – The American Recovery and Investment Act of 2009, 42 CFR 495].

3. The Appellant signed and submitted an attestation for payment dated October 11, 2012 ("attestation") wherein she affirmed that the information she provided in the attestation was true and accurate [Ex. 1 – Attestation Form; Tr. 93]. In the attestation the Appellant "individually" agreed to participate in *The New York State Electronic Health Records Incentive Program* ("EHR Incentive Program") during the calendar year ending December 31, 2011, "to keep records necessary to demonstrate"

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appear to raise "new" issues and for the most part she reiterated her testimony at the hearing. Based on the foregoing, the ALJ considered the Appellant's brief in reaching a determination.

that she "met all EHR Incentive Program requirements", and on request "to furnish those records to the New York State Department of Health …or contractor acting on their behalf " [Ex. 1 at p. 3 & 5; Tr. 27-29, 72, 76, 93-94, 103].

4. In the attestation the Appellant supplied patient volume data wherein she represented that she had "7,406 Medicaid patient encounters" during the 90 day period "August 1, 2012 – October 29, 2010," which constituted "99.91" percent of her patients encounters [Ex. 1 at p. 3; Tr. 32, 64; 42 CFR §495.304(c) & (c)(1)].

5. The Appellant was paid $21,500 by the Medicaid program for her participation in the EHR Incentive Program [Tr. 94-95, 101].

6. On or about April 22, 2014, the Appellant was sent an Audit Notification Letter wherein the OMIG requested documentation to support her eligibility to participate in the EHR Incentive Program [Ex. 3; Tr. 94].

7. On or about July 31, 2014, the OMIG issued a draft audit report to Appellant providing notice of its preliminary findings [Ex. 6].

8. Auditors repeatedly requested documentation from the Appellant to substantiate the "90 day patient volume for the period August 1, 2010 – October 29, 2010" data she supplied in her attestation [Ex. 2, Ex. 3, Ex. 6, Ex. 10; See 18 NYCRR §504.3(a), §517.3(b)].

9. The OMIG granted the Appellant multiple extensions of the 30 day draft audit period in order to produce the documentation. The final deadline was December 29, 2014 [Ex. 2, Ex. 9, Ex. 10; Tr. 140-142, 148-149].

10. The OMIG issued the final audit report dated January 15, 2015 ("audit") to the Appellant [Ex.19].

11. The OMIG determined to disallow the EHR Incentive Payment made to the Appellant for her "Failure to Submit Documentation to Support Eligibility" [Ex. 19].

APPLICABLE LAW

In order to participate as a Medicaid provider ("provider"), the provider shall agree to "comply with the rules regulations and official directives of the department," 18NYCRR §504.3. "All providers… must prepare and maintain contemporaneous records demonstrating their right to receive payment for a period of six years from the date services were furnished or billed, whichever is later, and must be furnished, upon request, to the department … for audit and review" 18 NYCRR §517.3(b).

Providers who elect to participate in the EHR Incentive Program "must have a minimum 30 percent patient volume attributable to individuals receiving Medicaid," 42 CFR §495.304(c). The methodology for calculating patient volume requires total patient encounters be divided by the Medicaid patient encounters that occur in the same 90 day period, 42 CFR §495.304(c)(1).

If an audit reveals an overpayment, the Department may require repayment of the amount determined to have been overpaid, 18 NYCRR §§ 504.8(a)(1), 518.1(b). An overpayment includes any amount not authorized to be paid under the Medicaid program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake, 18 NYCRR § 518.1(c).

A provider is entitled to a hearing to have the Department's determination reviewed if the Department requires repayment of an overpayment, 18 NYCRR § 519.4. At the hearing, the provider 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 §§ 518.1(c), 519.18 (d).

DISCUSSION

OMIG presented the audit file and summarized the case and presented documents, exhibits 1-33. One witness, Tyler Corcoran, New York State Technology Enterprise Corporation ("NYSTEC") testified on behalf of OMIG. The Appellant appeared in person and testified on her own behalf.

The EHR Incentive Program was established to "provide incentive payments to hospitals and eligible providers for the adoption, implementation and upgrade and subsequent meaningful use of an electronic health record or EHR system" [Tr. 20-21]. The Medicaid program contracts with NYSTEC to act as OMIG's agent to perform post payment audits of the EHR incentive payments made to providers [Tr.19-20]. A post payment audit of Appellant's EHR Incentive Program claim was made to determine whether the claim had been inappropriately paid by the Medicaid program. OMIG is seeking restitution of Appellant's EHR Incentive Payment because she has failed to produce the records for the "90 day patient volume for the period August 1, 2010 – October 29, 2010" that were required to substantiate her claim.

During the audit period the Appellant was working for a group practice, but it is undisputed that she was "individually" participating in the EHR Incentive Program. In order to be eligible to participate in the EHR Incentive Program, the Appellant was required to have at least 30 percent of her individual patient volume for a continuous 90 day period constitute Medicaid patients [27-28]. The Medicaid program paid the EHR Incentive Claim to the Appellant not the practice. The Appellant requested and was

granted an extension of the draft audit period to December 29, 2014, in order to obtain patient volume documentation from her former practice. Mr. Corcoran testified that the Appellant is under audit not the practice, and the OMIG cannot force the practice to provide the documentation to the Appellant [Tr. 66]. Mr. Corcoran said that while NYSTEC was willing to communicate with the practice on behalf of the Appellant, it was her responsibility to arrange the communications, and ultimately to obtain and submit the required documentation to substantiate her claim [Tr. 150-153]. The Appellant did not request an additional extension of the draft audit period and did not furnish the documentation by the December 29, 2015 deadline [Tr. 157- 158]. Once the deadline passed the final audit report was prepared and issued to the Appellant.

The Appellant testified on her own behalf and did not offer any exhibits. She argued that she did not have access to her individual patient volume records because she was no longer at the practice where she provided the EHR Incentive Program services [Tr. 94]. While she does not deny that she signed an attestation wherein she agreed to keep records to substantiate her claim, she professed that she did not know how long she was supposed to keep the records [Tr.72-73]. She claimed that if she had taken the patient volume information with her when she left the practice it would be a "HIPPA violation" [Tr. 102-104].

The Appellant contended that if her former practice had provided the records it would verify the patient volume data she supplied in her application, but the practice refused to provide the information to her [Tr. 102]. The Appellant argued that during the pertinent 90 day period she provided methadone treatments to approximately 600 patients or more a week and her individual patient volume for the 90 day period was

approximately 7,000 patients [Tr. 106 -108]. While she said she could not produce the patient volume records, she is entitled to the payment because "99 percent" of her patients were Medicaid patients far exceeding the "30 percent" EHR Incentive Program eligibility requirement [Tr. 105].

CONCLUSIONS

The Appellant supplied data in an EHR Incentive Program attestation, signed, and submitted it for payment. She affirmed that the information she supplied in the attestation was true and correct and that upon audit she would produce the records to substantiate the data. The Appellant was approved to participate in the EHR Incentive Program as an individual provider and was found eligible to participate in the program based on among other things data she supplied about her individual 90 day patient volume for the period August 1, 2012 – October 29, 2011. The Appellant's EHR Incentive Claim in the amount of $21,250.00 was paid to her. It was the Appellant's obligation as a provider to compile, maintain and produce on audit the pertinent patient volume records to substantiate her claim. The Appellant did not provide the required documentation to substantiate the disallowed claim. It was the Appellant's burden to prove that the audit is in error. Based on the foregoing, the Appellant has failed to carry her burden of proof.

DECISION

OMIG's determination to recover Medicaid overpayments in the amount of $21, 250.00 is **affirmed**. This decision is made by Kimberly A. O'Brien, who has been designated to make such decisions.

Dated: December 9, 2015
Albany, New York

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Kimberly A. O'Brien
Administrative Law Judge