

JURISDICTION

The Department of Health (the Department) acts as the single state agency to supervise the administration of the Medicaid Program in New York State. PHL 201(1)(v), 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 under the Medicaid Program to Dr. Laurence L. Rezkalla (the Appellant). The Appellant requested a hearing pursuant to Social Services Law 22 and the former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the determination.

SUMMARY OF FACTS

1. At all times relevant hereto, Appellant Laurence L. Rezkalla, M.D. was a physician and was enrolled as a provider in the New York State Medicaid Program.
2. The Appellant submitted claims to and was paid by the Medicaid Program for medical services provided during the period January 1, 2005 through December 31, 2008 to patients who were also eligible for coverage under the Medicare Program.
3. The OMIG conducted a review of the Medicaid payments along with a review of Medicare claim and payment records in order to determine whether the Medicaid payments were in compliance with Medicaid Program requirements.

4. By final audit report dated June 7, 2011, the OMIG notified the Appellant that it had identified and determined to seek restitution of Medicaid Program overpayments in the amount of \$70,132.15. (Exhibit 3.)

5. During the four year audit period, the Appellant submitted 527 claims to the Medicaid Program that included inaccurate information about the existence and extent of Medicare coverage for the services provided. The OMIG reevaluated the claims using actual Medicare payment records for the patients. (Exhibit 8; Transcript, pages 27, 45-46.) The \$70,132.15 overpayment represents the difference between what was paid by the Medicaid Program to the Appellant for these services, and the amount, based on Medicare payment records, that should have been paid by the Medicaid Program. (Exhibit 3, attachment I.)

ISSUE

Was the OMIG's determination to recover Medicaid Program overpayments in the amount of \$70,132.15 from Appellant Laurence L. Rezkalla correct?

APPLICABLE LAW

Medicaid "fee-for-service" providers are reimbursed by the Medicaid Program on the basis of the information they submit in support of their claims. The information provided in relation to any claim must be true, accurate and complete, and all claims for payment are subject to audit for six years. 18 NYCRR 504.3(a)&(h), 517.3(b), 540.7(a)(8).

If a Department 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 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).

DSS regulations most pertinent to this hearing decision are at 18 NYCRR Parts 360-7 (payment for services, in particular 360-7.2 – “MA program as payment source of last resort”), 505 (medical care), 517 (provider audits), 518 (recovery and withholding of payments or overpayments), 519 (provider hearings) and 540 (authorization of medical care, in particular 540.6 – “billing for medical assistance.”)

The New York State Medicaid Program issues Medicaid Management Information Systems (MMIS) provider manuals, which are available to all providers and include, among other things, billing policies, procedures, codes and instructions. www.emedny.org. The Medicaid Program also issues a monthly Medicaid Update with additional information, policy and instructions. www.emedny.org. Providers are obligated to comply with these official directives. 18 NYCRR 504.3(i); Lock v. NYS Department of Social Services, 220 A.D.2d 825, 632 N.Y.S.2d 300 (3d Dept. 1995); PSSNY v. Pataki, 58 A.D.3d 924, 870 N.Y.S.2d 633 (3d Dept. 2009).

DISCUSSION

The Medicaid Program is a payment source of last resort for health care services. Where a third party, such as a health insurer or responsible person, has a legal liability to

pay for Medicaid covered services on behalf of a recipient, the Department will pay only the amount by which the Medicaid reimbursement rate for the service exceeds the amount of the third party liability. The Department is entitled to reimbursement for any payments for care and services it makes for which a third party is legally responsible. 18 NYCRR 360-7.2. If a provider fails to make a claim to a liable third party, any reimbursement received by the provider from the Medicaid Program must be repaid. 18 NYCRR 540.6(e)(7). This case is about payments for which the responsible third party insurer was the Medicare Program.

The OMIG presented the audit file and summarized the case, as is required by 18 NYCRR 519.17. The OMIG presented documents (Exhibits 1-8) and the testimony of Katherine Rodgers, the OMIG management specialist who supervised this audit. (Transcript, pages 12-13.) The Appellant presented documents (Exhibits A-B) and he and his wife (and office manager) Evette Rezkalla also testified. (Transcript, pages 111, 137.)

The audit findings

The OMIG's final audit report summarized the findings and set forth the specific figures supporting the overpayment calculation for each claim. (Exhibit 3.) The final audit report incorporated the OMIG's conclusions after review of the Appellant's responses to a draft audit report. (Transcript, pages 16-21; Exhibits 1, 2.) These documents were exchanged between the parties in accordance with audit procedures set forth at 18 NYCRR 517.5 and 517.6(a).

It is uncontroverted that coverage was approved and payment was made by the Medicare Program in the amounts determined by the OMIG. (Exhibit 8.) The

Department's records of Medicaid payments to the Appellant were also not disputed, and are entitled to a presumption of accuracy. 18 NYCRR 519.18(f).

In every one of these 527 instances, the Appellant's Medicaid claim failed to report that he received Medicare payment for the service he provided. In most instances, however, a Medicare payment was made to him. As a result, the Appellant received duplicate payment for the service. In many instances, the Appellant also billed Medicaid for larger amounts than the Medicare Program actually approved. This practice led to Medicaid approval for greater reimbursement than he was entitled. (Transcript, pages 25-28.) In 69 instances no claim was ever submitted to Medicare for an eligible patient. Pursuant to 18 NYCRR 540.6(e)(7), the Appellant was not entitled to any payment from Medicaid for these services. (Transcript, pages 36, 38, 44-45.)

Medicaid claiming instructions applicable to these claims include:

*The provider must bill Medicare or the other insurance first for **covered** services **prior** to submitting a claim to Medicaid.*

The Medicaid program is designed to provide payment for medical care and services only after all other resources available for payments have been exhausted; **Medicaid is always payor of last resort**. Providers must maximize all applicable insurance sources before submitting claims to Medicaid. When coverage is available, payment from other insurance sources must be received before submitting a Medicaid claim. Medicaid Update December 2005 Vol. 20, No. 13. (Exhibit 7.)

The Appellant did not follow these procedures. Had he done so, he would have been able to submit accurate information about his Medicare reimbursement with his Medicaid claims. (Transcript, page 50.) Instead, he simply submitted claims to the Medicaid Program in the same amounts that he billed to the Medicare Program without regard to what Medicare actually approved or paid. (Transcript, pages 127, 150-51.)

The Appellant claims “[a]ll of Dr. Rezkalla’s claims were submitted pursuant to Medicaid’s instructions.” (Appellant brief, page 54.) That is obviously not true as he did not bill Medicare and obtain payment information before billing Medicaid as the Medicaid claiming process specifically required him to do. He claims the information he provided was accurate. (Transcript, page 153.) That is also not true as by his own account his claims did not accurately report the amounts paid by Medicare for these services.

The Appellant’s main argument in justification of his billings is that “Medicaid provided instructions that Dr. Rezkalla could leave blank the amount that Medicare paid.” (Appellant brief, page 52.) No such instructions exist. The alleged “instructions” turn out to be advice he claims to have been given after attending a training session about Medicaid issues arranged by the New York Medical Society. (Transcript, pages 115-16, 129-30, 136, 140.) The Appellant had been experiencing difficulties with the Medicaid electronic claiming system. A lecturer at the session referred him to “somebody” (Transcript, page 139) who, he says, told him not to include any figure for the amount paid by Medicare in his Medicaid claims, but rather to leave blank the claim field that specifically asked for such information. (Transcript, pages 120-21.) The Appellant found that he was able to obtain approval of a Medicaid claim by submitting it in this manner, and so made it his practice always to do it this way. (Transcript, pages 139-41.)

The Appellant claims this advice was given to him by someone in the Medicaid Program. (Transcript, pages 138-39.) It does not matter who gave it to him: It simply does not follow, from his ability to get a claim through the electronic system and get paid, that the Appellant did nothing wrong and is entitled to keep whatever payment was

generated. If an overpayment was made as a result of his claiming procedure, the OMIG is entitled to recover it from him.

The Appellant said that he believed the Medicare and Medicaid Programs would reconcile everything for him and make the correct payments. (Transcript, page 121.) He was not entitled to rely on any such assumption. His argument that the Department's obligation was to investigate and correct rather than process his claims on the basis of the information he submitted is rejected. (Transcript, pages 83-86.) Investigation and correction by means of a reconciliation of the Appellant's Medicare and Medicaid claims is what this audit is about. (Transcript, page 48.)

The Appellant now says that had he known how little Medicaid would pay on these claims he never would have bothered to submit them. (Transcript, page 114; Appellant brief, page 56.) This is not a persuasive reason to allow him to retain overpayments on claims he did submit. His efforts to suggest some kind of estoppel against the Department amount to little more than an argument that he assumed he was entitled to the money and so should now be allowed to keep it. (Transcript, page 153; Appellant brief, pages 54, 56.) Estoppel is hardly applicable to these payments from a government entity made on the express condition that they were subject to correction on audit. 18 NYCRR 504.8(a)(1), 517.3(b).

The OMIG "is not arguing that Appellant is engaged in any wrongdoing." (OMIG brief, page 9.) Although the OMIG is authorized to collect interest on an overpayment from the date it was made, it waived that interest after reviewing the Appellant's response to the draft audit report because it concluded that "these overpayments resulted in part from factors beyond the provider's reporting control."

(Exhibit 3, page 3.) 18 NYCRR 518.4(b)&(e). It remains the case, however, that the Appellant submitted claims for and received over \$70 thousand that was not properly payable by the Medicaid Program. He has an obligation to return that overpayment to the Medicaid Program. 18 NYCRR 518.1(b), 518.3(a).

DECISION: The OMIG's determination to recover Medicaid Program overpayments in the amount of \$70,132.15 is affirmed.

This decision is made by John Harris Terepka, who has been designated to make such decisions.

DATED: Rochester, New York
April 23, 2012

_____/s/_____
John Harris Terepka
Bureau of Adjudication