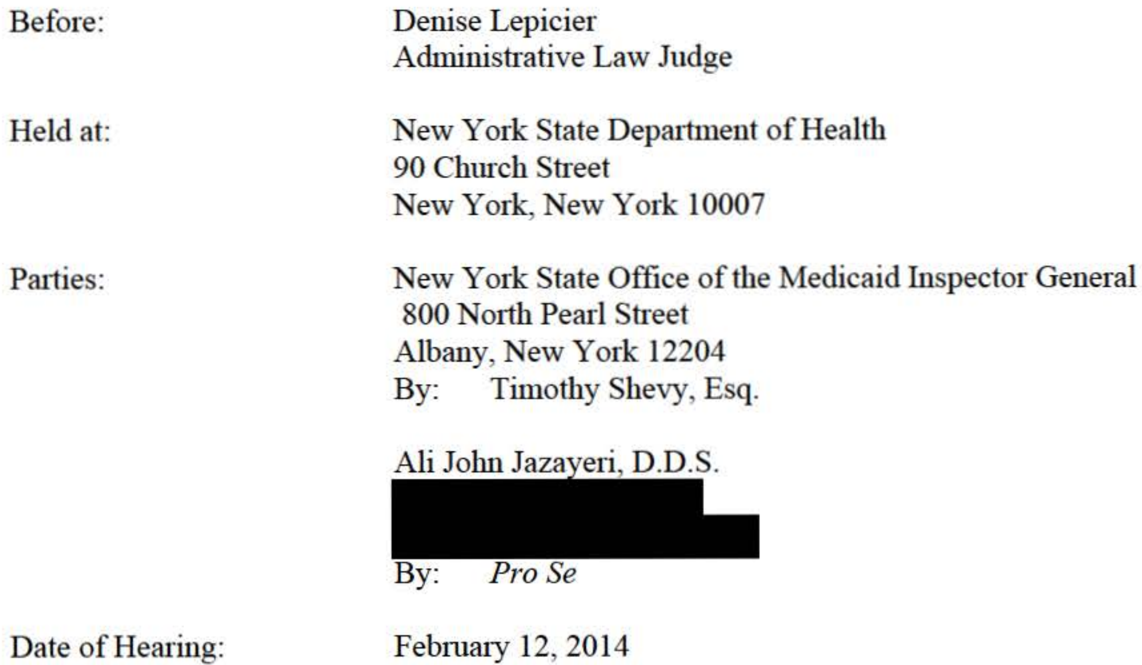
STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Request of **ALI JOHN JAZAYERI, D.D.S.** Medicaid Provider ID # 02838737 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	:	**Decision After Hearing** Audit # 13-2553



Before: Denise Lepicier
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
800 North Pearl Street
Albany, New York 12204
By: Timothy Shevy, Esq.

Ali John Jazayeri, D.D.S.

By: *Pro Se*

Date of Hearing: February 12, 2014

JURISDICTION

The Department of Health (Department) acts as the single state agency to supervise the administration of the Medicaid 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.

OMIG determined to seek restitution of payments made by Medicaid to Dr. Ali John Jazayeri (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. (See Exhibits 5 & 6)[1]

ISSUE

Was OMIG's determination to recover Medicaid overpayments in the amount of $1620 from Appellant Ali John Jazayeri correct?

FINDINGS OF FACT

1. At all times relevant hereto, Appellant Ali John Jazayeri, D.D.S., was a dentist and was enrolled as a provider in the New York State Medicaid program. (Ex. 5; T. 28)

2. Effective July 2, 2012, all Medicaid managed care plans were required by the Medicaid program to cover dental services for their beneficiaries. (Ex. 33, p.13; T. 32-34) Medicaid Update, Vol. 28, No. 2 (April 2012).

3. The Medicaid program advised all providers of the policy for managed care billing in the Dental Policy and Procedure Manual version 2011-1 (5-15-2011) as follows: "if a beneficiary is enrolled in a managed care or other capitated program which

[1] Numbers in parentheses refer to transcript page numbers or exhibits. Transcript references will be cited as a "T." followed by the appropriate page number(s); exhibits will be cited by an "Ex." followed by the appropriate exhibit number(s) or letter(s).

covers the specific care or services being provided, it is inappropriate to bill such services to the Medicaid program on a fee-for-service basis whether or not prior approval has been obtained." (Ex. 29, p. 12 and 29A)

4. Appellant was aware of the change in managed care coverage when it occurred. (T. 105, 115-116, 119)

5. Appellant also was aware that all of the patients in issue in this case were covered by managed care plans. (T. 84, 98-99, 104, 113)

6. The Appellant submitted claims to and was paid by Medicaid on a fee-for-service basis for dental services provided during the period July 2, 2012, through February 15, 2013, to patients who were eligible for coverage under a Medicaid managed care plan. (Ex. 1)

7. The audit identified twenty-eight claims for eight patients during the period from July 2, 2012, to February 15, 2013, who were covered by Medicaid managed care plans, but who were inappropriately billed to the Medicaid program as fee-for-service claims. (T. 50, 64-66; Ex. 1) The total of the overpayments to the Appellant for this period was $1620. (T. 67-68, 82-83; Ex. 1)

8. On or about October 9, 2013, OMIG issued a Final Audit Report notifying the Appellant that OMIG was seeking restitution of the overpayment of $1620. (Ex. 3; T. 81-83)

9. The Appellant did not contest OMIG's figures supporting the overpayment calculation or provide any documentation to prove that any of the eight patients were not covered by a Medicaid managed care plan. (T. 106-112)

APPLICABLE LAW

Medicaid fee-for-service providers are reimbursed by Medicaid in accord with Department claiming procedures and fee schedules set forth in Department regulations and the Medicaid Management Information Systems (MMIS) provider manuals. (Ex. 29) See e.g., 18 NYCRR Parts 506, 513 and 514. Medicaid is a payment source of last resort for health care services. (Ex. 32) 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). In this case, the liable third party is the Medicaid managed care plan.

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). (See also, Ex. 21, 22, 23, 24, 25 and 25A)

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 generally pertinent to this hearing decision are at: 18 NYCRR § 360-7 (payment for services, in particular 360-7.2 - "MA program as payment source of last resort"), 18 NYCRR § 506.2 (dental care), 18 NYCRR § 517 (provider audits), 18

NYCRR § 518 (recovery and withholding of payments or overpayments), 18 NYCRR § 519 (provider hearings), 18 NYCRR § 506.3 (authorization of dental care) and 18 NYCRR § 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, *inter alia*, billing policies, procedures, codes and instructions. (Ex. 26, 27, 28, 29 and 29A) The Medicaid program also issues a monthly Medicaid Update with additional information, policy and instructions. (Ex. 31, 32 and 33) 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

OMIG presented the audit file and summarized the case, as is required by 18 NYCRR § 519.17. OMIG presented documents (Exhibits 1-33), the testimony of Paula Pugliese, the OMIG management specialist who managed the audit in this case, and the testimony of John McCrea, the OMIG management specialist who conducted the audit in this case. The Appellant testified in his own behalf.

On July 2, 2012, a change occurred in the manner in which beneficiaries covered by Medicaid managed care programs would be covered for dental services.[2] (Ex. 33) Medicaid Update, Vol. 28, No. 5 (April 2012). Prior to this date, if a Medicaid managed care organization did not cover dental services, a beneficiary's dental service claims were sent directly to Medicaid and were paid by Medicaid on a fee-for-service basis. (Ex. 32)

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[2] Although not relevant to this case, some managed care plans already had provided dental services prior to this date. In those cases billing was always to the managed care plan. (T. 35, 117-118)

Medicaid Update, Vol. 20, No. 12 (December 2005). Effective July 2, 2012, all Medicaid managed care plans were required by the Medicaid program to cover dental services for their beneficiaries. Medicaid would pay a capitation rate per enrollee to the managed care plans to cover both dental and medical services. (T. 32-34)

After July 2, 2012, if a client was enrolled in a managed care plan which covered the specific dental services provided, providers could no longer bill Medicaid on a fee-for-service basis.[3] (See Ex. 31) The provider would obtain payment from the managed care plan instead. (Ex. 33, p. 13; T. 35-36)

Medicaid has a program for providers to check each patient's eligibility. (T. 43-44) It is the provider's responsibility to check a patient's eligibility at each visit. (T. 100) If the patient is eligible for services through a managed care plan, the verification program notifies the provider that the patient is "PCP" eligible.

The Appellant was aware, by his own admission, of the change in dental coverage. Further, an eligibility verification report for Appellant's provider identification number reveals that when Appellant checked each of the eight clients' eligibility for services, he was informed that each was "PCP" covered. (T. 44-49; Ex. 17) Yet Appellant submitted the claims to Medicaid and not to the managed care plan.

After all managed care plans began to cover dental services, it came to the attention of OMIG that a Medicaid program computer edit intended to automatically reject dental claims that came into the Medicaid program for those in managed care plans was not working with respect to three managed care plans. OMIG initiated a project to determine whether any claims had been inappropriately paid as fee-for-service

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[3] There were a few exceptions to billing the managed care plan for certain services, but they are not relevant to this case. (T. 35-36)

claims where there was actually managed care coverage. (T. 38-40) An audit procedure was developed to identify overpayments. (T. 40-42, 60-61; Ex. 15) The claims at issue in this case were identified.

Appellant received the draft audit report for his practice on or about June 5, 2013. (Ex. 1) OMIG had arranged with the three managed care providers who were in issue with respect to the overpayments to accept late submissions for claims for payment until October 1, 2013, even accepting claims from non-participating providers. (T. 42-43, 53-54, 70-71; Ex. 1, letters from providers) The draft audit report included letters from the three managed care organizations in issue concerning how a provider could resubmit a claim to them which had been wrongly submitted to Medicaid for fee-for-service payment. (Ex. 1)

Appellant responded to the draft audit report essentially arguing that he was not a provider who participated with Medicaid managed care plans and that since it was the state's error in paying the claims, he could not issue repayment of what he had collected from Medicaid. (Ex. 2; T. 78-80) At the hearing, Appellant testified that he did not pursue payment from the Medicaid managed care organizations, who had agreed to pay even the non-participating providers for the claims in issue, because he did not want to accept the managed care organizations' low fee schedules. (T. 121-122)

It was the Appellant's obligation to comply with all Medicaid rules and regulations. 18 NYCRR § 504.3. Among these regulations was an obligation to report accurately. 18 NYCRR §§ 504.3(h). Appellant was aware that coverage was changing under managed care plans and that these plans would be providing dental coverage. He also claimed that he was unsure whether he would receive payment from Medicaid with

respect to some of his patients and that he submitted claims to Medicaid to see if he would be paid. (T. 103-108) While Medicaid did have an error in its computer program leading to payment of the inappropriate claims, it was the Appellant's inappropriate claiming of Medicaid that led to the overpayments in this case. Overpayments include payments made by mistake. 18 NYCRR § 518.1(c).

The Appellant offered no reason to question the accuracy of the figures in the OMIG audit. It is Appellant's burden to prove that the audit is in error. 18 NYCRR § 518.1(c) The Appellant has failed to carry his burden of proof.

DECISION:

OMIG's determination to recover Medicaid overpayments in the amount of $1620.00 is affirmed. This decision is made by Denise Lepicier, who has been designated to make such decisions.

Dated: April 3, 2014
New York, New York

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Denise Lepicier
Administrative Law Judge