STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Request of **David S. Gavlin, D.D.S.** Medicaid Provider ID # 01981608 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 # 16-4611

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
800 North Pearl Street
Albany, New York 12204
By: Kathleen Dix, Esq.

David S. Gavlin, D.D.S.
9438 59th Avenue
Elmhurst, New York 11373
Pro Se

PROCEDURAL HISTORY

Date of Draft Audit Report	January 19, 2017
Date of the Final Audit Report	March 30, 2017
Appellant's Hearing Request	May 16, 2017
Date of Hearing	October 8, 2019[1]
Post Hearing Submission	November 19, 2019

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 David S. Gavlin, D.D.S. ("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] James Horan, ALJ, was originally scheduled to hear this matter on June 13, 2019. Upon mutual consent, ALJ Horan adjourned the matter. Close in time to the October 8, 2019 hearing the matter was reassigned to Kimberly A. O'Brien, ALJ [Ex.7, Ex. 25].

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 #01981608, was a dentist and enrolled as a provider in the New York State Medicaid program [Ex. 1, Ex. 20; Tr. 46-47].

2. *The New York State Electronic Health Records Incentive Program* ("EHR Incentive Program") pays Medicaid providers including individual physicians, group practices and hospitals to adopt, implement, or upgrade electronic health record ("EHR") systems [Tr. 19-25; 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 February 13, 2013 ("attestation") wherein he affirmed that the information he provided in the attestation was true and accurate. In the attestation the Appellant agreed to individually participate in the EHR Incentive Program, during the calendar year ending December 31, 2012, "to keep records necessary to demonstrate" that he "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, Ex. 2 ; Tr. 21-25, 31-38].

4. In his attestation Appellant represented that his Medicaid patient volume during the self-selected 90-day period "September 1, 2011– November 29, 2011" ("90-day period" or "period"), was 2,880 Medicaid encounters or "88.10" percent or all patient encounters during the period [Ex. 1].

5. The Appellant was paid $21,500 by the Medicaid program for his participation in the EHR Incentive Program [Tr. 24-25, 34-38, 55; Ex.2].

6. On October 20, 2016, the Appellant was sent an Audit Notification Letter wherein the OMIG requested documentation to support his eligibility to participate in the EHR Incentive Program [Ex. 3].

7. On or about January 19, 2017, the OMIG issued a draft audit report to Appellant providing notice of its preliminary findings [Ex. 4; Tr. 57-59].

8. The OMIG issued the final audit report dated March 30, 2017 ("audit") to the Appellant [Ex. 6; Tr 64-67].

9. The OMIG determined to disallow the EHR Incentive Payment made to the Appellant for three identified "errors" including that he failed to: "Support the Adoption, Implementation, or Upgrade to a Certified EHR System; Support Medicaid Patient Volume; and Submit Documentation to Support Eligibility" [Ex. 6 at p. 4-5].

10. The OMIG issued the original Notice of Prehearing Conference for June 7, 2018, and subsequently issued a Statement of Prehearing Conference [Ex.7, Ex. 8 Ex. 27].

11. Appellant failed to produce documentation to support self-described patient volume for the 90-day period he selected in his attestation. The Appellant also failed to document that he upgraded, adopted or implemented a certified EHR system during the calendar year ending December 31, 2012 [Tr. 31- 57, 65, 72; *See* Ex.1, Ex. 2, Ex. 3, Ex. 4, Ex.5, Ex. 6, Ex. 18, Ex.19, Ex. 20, Ex. 21, Ex. 22, Ex. 23, Ex. 24, Ex. 25].

APPLICABLE LAW

To participate as a Medicaid provider ("provider"), the provider shall agree to "comply with the rules regulations and official directives of the department," 18 NYCRR §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). In the "first payment year" the provider must be able to demonstrate that it has adopted, implemented, or upgraded certified EHR technology, 42 CFR §§495.302, §§495.314(a)(1)(i).

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 1-25, all of which were admitted into evidence. One witness, Kelly McCarville-Ryan, New York State Technology Enterprise Corporation ("NYSTEC") testified on behalf of OMIG. The Appellant appeared and testified on his 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. 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. A post payment audit of Appellant's EHR incentive 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 Program payment alleging that he has failed to substantiate his claim including self-selected and reported 90-day patient volume for the period September 1, 2011–November 29, 2011, and that he has failed to document that he adopted implemented, or upgraded a certified EHR system during the calendar year ending December 31, 2012.

During the audit period the Appellant was a Medicaid provider working in a group dental practice, Elite Dental. However, he chose to participate in the EHR Incentive Program as an individual provider, and upon enrolling he was given his own unique individual provider number (IPN). The OMIG searched the Medicaid Data Warehouse using his IPN and obtained the actual number of Medicaid claims that were billed to Appellant during his self-selected 90-day period. The search revealed that Appellant individually billed for 1,056 Medicaid encounters and the practice billed for 437, but the number of Medicaid encounters Appellant attested to for the period is 2,880, "about a little over 1,000 as a discrepancy" [Tr. 51]. The Appellant did not provide any patient volume documentation to support whether the 1,056 Medicaid encounters during the period met the minimum 30 percent patient volume [Tr. 53-56].

Regarding the Appellant's adoption of certified EHR technology in 2012, Ms. McCarville-Ryan spoke with Appellant and also reached out to certified vendors on his behalf, but there "wasn't anyone who would generate documentation to help him pass the audit" [Tr. 44]. Easy Dental, EHR vendor, was the vendor name provided in Appellant's attestation. Easy Dental provided a letter confirming that the Appellant registered for their system, but not until July 8, 2013 [Tr. 65]. Even after the final audit was issued, Ms. McCarville-Ryan attempted to verify that Appellant had a certified EHR system in 2012, but the documentation she received did not verify his claim [Tr. 65-68].

The EHR Incentive Program audit is a "holistic audit" meaning that all the criteria must be met [Tr.57]. The Appellant was required to provide documentation to substantiate his patient volume for the period and "proof of a certified system in 2012"

[Tr. 57]. The Appellant did not provide documentation to substantiate his claim and he failed the audit [Tr. 56-57].

The Appellant testified on his own behalf, but he did not offer any documentation to demonstrate adoption of a certified EHR system in 2012, the year for which he attested. With regard to his Medicaid patient volume, he contended that approximately "80 percent" of his patient volume is Medicaid, and that the patient data OMIG obtained "didn't include the vast majority of Medicaid HMOs that we used, so that was skewed" [Tr. 94]. In the absence of direct evidence to the contrary, the OMIG's record of the Medicaid payments made to Appellant are presumed to be an accurate itemization of the Medicaid payments made, 18 NYCRR 519.18(f). The Appellant offered no evidence to refute this presumption and presented no documentation to demonstrate his Medicaid patient volume was higher than OMIG records reflect or documentation to substantiate that he met the minimum 30 percent patient volume for the period.

The Appellant explained that in about December 2012 he realized that he and his practice had fallen victim to identity theft, and he had to change emails and passwords, and close accounts [Tr. 97]. The Appellant said he "called" to get the 2012 documentation and he was told his "old email appears, but it's blocked," and that when he called back and gave an email for "when they started again," the 2013 records were found [Tr. 99-100]. Upon cross-examination, Appellant conceded that in his attestation he stated Easy Dental was his EHR vendor, but said that he had to switch to "Practice Fusion because they were not updated yet," and it was Practice Fusion that lost the 2012 records [Tr. 116-117]. None of these explanations excuse his failure to maintain records demonstrating his entitlement to the EHR incentive payment he applied for and received.

CONCLUSIONS

The Appellant individually enrolled in the EHR Incentive Program, signed an attestation, and submitted it for payment. He affirmed that the information he supplied in the attestation was true and correct and that upon audit he would produce the records to substantiate his eligibility to receive payment. 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 he supplied about his individual 90-day patient volume for the period September 1, 2011– November 29, 2011 and stated EHR vendor. The Appellant's EHR incentive claim in the amount of $21,250.00 was paid to him to adopt, implement, or upgrade a certified EHR system during the calendar year ending December 31, 2012. It was the Appellant's obligation to compile, maintain and produce on audit the required records to substantiate his 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 his 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: April 20, 2020
Albany, New York

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Kimberly A. O'Brien
Administrative Law Judge