STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Request of **Vito Frank Taverna, M.D.** **Medicaid ID #** [redacted]	:	**Decision After Hearing**
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	:	#10-7805

Before: Christine C. Traskos
Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, New York 10007
February 7, 2012
Record closed April 6, 2012

Parties: New York State Office of the Medicaid Inspector General
217 Broadway, 8th floor
New York, New York 10007
By: Francis Ruddy, Esq.

Vito Frank Taverna, M.D.
[redacted]

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. Public Health Law Section (PHL) 201(1)(v), Social Services Law (SSL) Section363-a. Pursuant to PHL Sections 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. Vito Frank Taverna (the Appellant). The Appellant requested a hearing pursuant to SSL Section 22 and the former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the determination.

FINDING OF FACTS

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parenthesis refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Administrative Law Judge in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. At all times relevant hereto, Appellant Vito Frank Taverna, M.D. was a physician and was enrolled as a provider in the New York State Medicaid Program. (Exs. 1-3)

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. (T. 48-49)

3. Persons who are eligible for both Medicare and Medicaid are referred to as "dual eligibles." (T. 58)

4. The OMIG conducted a review of the Medicaid payments made to Appellant 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. (T. 50)

5. By final audit report dated June 1, 2011, the OMIG notified the Appellant that OMIG had identified and determined to seek restitution of Medicaid Program overpayments in the amount of $82,400.82. (Ex. 10.)

6. During the four year audit period, the Appellant in 1356 instances pertaining to 204 patients, submitted 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. (Exs.1-3, T., pages 50, 52-54.) The $82,400.82 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. (Ex. 10)

ISSUE

Was the OMIG's determination to recover Medicaid Program overpayments in the amount of $82,400.82 from Appellant Vito Frank Taverna correct?

APPLICABLE LAW

Medicaid 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).

Social Service regulations most pertinent to this hearing decision are at:

18 NYCRR Sections 360-7 (payment for services, in particular 360-7.2 – "MA program as payment source of last resort"), 18 NYCRR 505 (medical care), 18 NYCRR 517 (provider audits), 18 NYCRR 518 (recovery and withholding of payments or

overpayments), 18 NYCRR 519 (provider hearings) and 18 NYCRR 540 (authorization of medical care, in particular 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, 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. 18NYCRR 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 1-16) and the testimony

of Katherine Rodgers, the OMIG management specialist who supervised this audit. (T. 12-13.) The Appellant and his wife (office manager) Matilde Taverna also testified. (T. 105-128).

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.(Ex.10) The final audit report incorporated the OMIG's conclusions after review of the Appellant's responses to a draft audit report. As a result, the amount of the overpayment was reduced by $456.66. (T. 59-60) 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. (Ex.15) 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 this case, the Appellant billed Medicaid for larger amounts than the Medicare Program actually approved. In some instances Appellant prematurely billed Medicaid before he actually received a response from Medicare on what amount would actually be paid. (T. 59-73; Affidavit of Katherine Rodgers) In other instances, Appellant billed Medicaid before Medicare denied the full amount.(T. 78,80,91,94; Affidavit of Katherine Rodgers) Pursuant to 18 NYCRR 540.6(e)(7), the Appellant was not entitled to any payment from Medicaid for these services.

Medicaid claiming instructions 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 the 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.

Or as Ms. Rodgers testified: " During the period in question, if a Provider had provided a service to a dual eligible, someone under Medicare and Medicaid, it was the Provider's responsibility to first send the claim to Medicare, wait to hear what Medicare allowed or paid, before going to Medicaid for the difference, because Medicaid is the payor of last resort." (T. 94)

The Appellant did not follow these procedures and does not seem to appreciate the concept of payor of last resort. The Appellant testified that he at first sent his bills to many different insurance companies who denied the claim. He then sent the bill to Medicaid as the payor of last resort. He does not believe that this is an overpayment because he believes that Medicaid pays the bills when other parties deny the claim.(T. 106-107) Appellant's wife, who serves as his office manager, also believes that they were just following the Medicaid rules.(T. 108)

Appellant is mistaken about the Medicaid rules. The rules do not mean that Medicaid pays any remaining amounts when other insurance sources either deny or fail to completely pay Appellant's original bill. The rules required a Provider to wait to see what Medicare will actually pay before billing Medicaid. (T. 98) Medicaid would then

only pay the Provider 20 per cent of the Medicare Part B coinsurance for most Part B services. (T.97, DOH Medicaid Update August 2003 Vol. 18, No. 8)

The Appellant refused to wait for the information from Medicare. In his billing practices, Appellant repeatedly used a stamp with the following statement:

"**Claim filed but no response received (Administrative delay)**

The last alternative was to send claims to Medicaid for payment."

This practice demonstrates that Appellant was aware that claims were being submitted to Medicaid without the required response from Medicare on what Medicare actually paid on his claim for dual eligible patients. Appellant's practice of premature billing does not entitle him to keep whatever payment was generated.

At the hearing, Appellant was even given another opportunity to submit additional information for OMIG to review because Appellant failed to attend the pre-hearing conference. (Ex. 16) At the hearing, Appellant offered 43 pages from Ex. 7 and asked OMIG to examine them for errors. The record was held open so that the auditor, Ms. Rodgers could review the information. In an Affidavit dated March 2, 2012, Ms. Rodgers states the information was not "new" and can be cross-referenced to pages in the original OMIG final audit. Ms. Rodgers further stated that this information offers no references to Medicare reimbursement determinations and that "these pages in no way provide evidence to dispute the audit finding or address the audit issues." (Affidavit of Katherine Rodgers)

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." 18 NYCRR 518.4(b)&(e). It remains the case, however, that the Appellant submitted claims for and received over $82, 400.82 that was not properly payable by the Medicaid Program. Appellant has an obligation to return that overpayment to the Medicaid Program pursuant to 18 NYCRR 518.3(a).

DECISION: The OMIG's determination to recover Medicaid Program overpayments in the amount of $ 82,400.82 is affirmed.

This decision is made by Christine C. Traskos, who has been designated to make such decisions.

DATED:
April 2012
Troy, New York

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Christine C. Traskos
Administrative Law Judge