STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of	:	
	:	**Decision**
Volga Transportation Corporation	:	**After**
Medicaid ID # 01915975,	:	**Hearing**
Appellant,	:	
	:	
appealing a determination to recover	:	Audit # 10-5738
Medicaid program overpayments.	:	
	:	

Before: David A. Lenihan
Ann H. Gayle
Administrative Law Judges

Held at: New York State Department of Health
Metropolitan Area Regional Office
90 Church Street
New York, New York 10007

Hearing Dates: July 6, 2016 (Lenihan)
October 21, 2016 (Lenihan)
March 8, 2017 (Gayle)
Record closed May 31, 2017

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Jurisdiction and Relevant Statutes and Regulations

The New York State Department of Health (Department) acts as the single state agency to supervise the administration of the Medicaid program in New York State. Public Health Law (PHL) §201(1)(v); Social Services Law (SSL) §363-a. The New York State Office of the Medicaid Inspector General (OMIG), an independent office within the Department, is responsible for the Department's duties with respect to the recovery of improperly expended Medicaid funds. PHL §§30, 31, 32. Regulations of the former Department of Social Services (DSS) most pertinent to this hearing are found at Title 18 of the New York Code of Rules and Regulations (NYCRR) Parts 504 (enrollment of providers), 505 (medical care, in particular section 505.10, regarding transportation for medical care), 517 (audit and record retention) 518 (overpayments), and 519 (provider hearings). A transportation service must comply with all requirements of the Departments of Transportation and Motor Vehicles, including that its drivers must be qualified under Article 19-A of the Vehicle Traffic Law (VTL). 18 NYCRR 505.10(e)(6).

Medicaid program participation is a voluntary, contractual relationship between the provider of service and the State. SSL §365(a); 18 NYCRR 504.1; *Schaubman v. Blum*, 49 NY2d 375 (1980); *Lang v. Berger*, 427 F.Supp. 2d 204 (S.D.N.Y. 1977). A Medicaid provider agrees to comply with all program requirements as a prerequisite to payment and continued participation in the program. 18 NYCRR 504, 515, 517, 518. The provider certifies at both the time of enrollment and when submitting claims that the provider will comply or has complied with all its contractual responsibilities. 18 NYCRR 504.3, 540.7(a)(8). Based on these contractual obligations, the Medicaid program

employs a pay-first-and-audit-later system to insure compliance. This process helps ensure that providers are paid promptly. 18 NYCRR 504.3, 540.7(a)(8).

An extrapolation based upon an audit utilizing a statistical sampling method certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made. The Appellant, however, may submit expert testimony and evidence to the contrary, or an accounting of all claims paid in rebuttal to the Department's proof. 18 NYCRR 519.18(g).

The Department may require the repayment of any amounts not authorized to be paid under the Medicaid program, whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake. 18 NYCRR 518.1. Interest may be collected upon any overpayments determined to have been made; interest may also be waived in whole or in part when the department determines the imposition of interest would effect an unjust result, or would unduly burden the provider. 18 NYCRR 518.4(a) and (e).

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 by substantial evidence that the determination of the Department was incorrect and that all claims submitted and denied were due and payable under the program. 18 NYCRR 519.18(d)(1) and (2) and (h).

This case stemmed from the Department's determination to recover Medicaid program overpayments from Volga Transportation Corporation (Appellant). Appellant requested a hearing pursuant to SSL §22 and 18 NYCRR 519.4 to review this overpayment determination, and a hearing was held. Witnesses testified, a transcript [T]

of the hearing was made [pages 1-299], and exhibits [Ex] were admitted into evidence as OMIG's 1-9.

Findings of Fact

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. At all times relevant hereto Appellant, Volga Transportation Corporation (Volga), located in Brooklyn, New York, was an ambulette and transportation service enrolled as a provider in the New York State Medicaid program. [Ex 1; Ex 3; T 274]

2. In 2013, OMIG conducted an audit of Appellant. OMIG's audit was conducted by New York City Human Resources Administration (NYC HRA) pursuant to the County Demonstration Project and a Memorandum of Understanding between OMIG and NYC HRA. The audit period was January 1, 2006 through December 31, 2009, during which time Appellant was paid $6,714,372 by the Medicaid program for 114,020 claims for ambulette transportation services it provided to Medicaid recipients. The audit was based on a random sample of 150 paid claims (sample claims). [Ex 1; Ex 3; T 9, 27]

3. OMIG's October 30, 2013 draft audit report notified Appellant that the Department had disallowed 84 claims in the 150 sample claims and determined to seek restitution of Medicaid overpayments in the amount of $3,729,836. On December 13, 2013, Appellant submitted a reply to the draft audit report. OMIG's April 1, 2014 final audit report notified Appellant that the Department had disallowed 66 claims in the 150 sample claims and determined to seek restitution of Medicaid overpayments in the amount of $2,943,236.00. [Ex 1; Ex 2; Ex 3].

4. OMIG's restitution claim was an extrapolation using a statistical sampling method in which the value of the disallowed claims found among the sample of 150 claims was projected to the total of 114,020 claims paid by the Medicaid program during the audit period. [Ex 1; Ex 3]

5. By letter dated April 3, 2014, Appellant requested an administrative hearing to challenge the Department's determination, and a hearing was scheduled for June 10, 2014. After several adjournments, the hearing was held on July 6, 2016, October 21, 2016, and March 8, 2017. On the first day of hearing, OMIG removed 46 of the final audit report's 66 disallowed claims, which brought the amount OMIG was seeking to recover to $1,182,767.47. The 19 claims remaining for hearing in the Missing/Inaccurate Information of Medicaid Claims category were for Incorrect Plate Number (8 claims) and Incorrect Driver License Number (11 claims), and there was one claim remaining for hearing in the Driver is Not NYS DMV 19A Certified category. [Ex 4; T 4-5]

Issue

Has Appellant established that OMIG's determination to recover Medicaid program overpayments in the amount of $1,182,767.47 was not correct?

Discussion

OMIG presented the audit file and summarized the case at hearing. OMIG presented Exhibits 1-9 and two witnesses, Tricia Smith, an OMIG Management Specialist, and Ping Tran, a NYC HRA Management Auditor. Appellant presented two witnesses, Nana Hana, a biller with Volga, and Shiman Miller, Vice President and part owner of Volga during the audit period, now President of Volga. Appellant did not offer any exhibits into evidence. OMIG and Appellant each submitted a post-hearing brief, and a reply brief.

At issue at this hearing is OMIG's determination to disallow 20 claims totaling an overpayment amount of $1,182,767.47. The Department is now seeking to recoup that $1,182,767.47, plus interest.

Finding #1 - Missing/Inaccurate Information on Medicaid Claim (total: 19 claims)

Incorrect Plate Number (8 claims); Incorrect Driver License Number (11 claims)

OMIG determined to disallow eight claims (Samples 4, 22, 73, 80, 131, 138, 145, 148) based on the subcategory, Incorrect Plate Number, in Finding #1. Appellant failed in all eight instances to put accurate information in the vehicle plate number field of the claim forms. In each of these claims, the license plate number identified on the claim differed from the vehicle's actual license plate number. [Ex 3; T 97-112]

OMIG further determined to disallow eleven claims (Samples 7, 12, 46, 64, 84, 94, 96, 113, 119, 121, 149) based on the subcategory, Incorrect Driver License Number, in Finding #1. Appellant failed in all eleven instances to put accurate information in the driver license field of the claim forms. In each of these claims, the driver identified on the claim was not the driver who actually transported the Medicaid patient. [Ex 3; T 112-121, 150-155]

OMIG disallowed the 19 claims in Finding #1 because Appellant's contemporaneous documentation did not substantiate the claims. OMIG's witnesses provided ample proof to justify the disallowances at issue at this hearing due to Appellant's violation of New York Rules and Regulations, the eMedNY Transportation Policy Guidelines and the DOH Medicaid Update[1]. [Ex 3; T 40-45]

[1] *Medicaid Management Information Systems (MMIS) provider manuals, available to all providers, provide information on billing policies, procedures, codes and instructions, and Medicaid Updates contain additional information, policy and instructions.*

Appellant has failed to meet its burden of showing that it complied with the contemporaneous documentation requirement.

Appellant's explanation for the inconsistencies between the license plate numbers and/or driver's license number on the claim and in its contemporaneous documentation related to the claim was that its billers made recordkeeping errors such as using the old license plate number of a vehicle that had been replaced after it was stolen, and putting the wrong driver's name on trip tickets[2]. Appellant's witnesses did not address the specific disallowances, and the testimony they did give did not rise to the level of meeting Appellant's burden of proving that the disallowances should be overturned and the claims should stand.

The audit period is January 1, 2006 to December 31, 2009. Appellant's first witness, [redacted], was hired as Appellant's biller in July 2009[3]. Appellant did not call any witness to testify about the billing practices for the first three-and-a-half years of the audit period, and neither [redacted] testimony nor [redacted] testimony refuted or even addressed the specific disallowed samples in the audit.

[redacted] testified that [redacted] taught her how to bill, and she further testified that the driver and license plate numbers were already inputted into the claim before she received it. [redacted] testified:

> Q: Who would be responsible for dealing with issues that arise with regard to the change of vehicles, change of plates?
> A: That's Shiman.
> Q: Shiman Miller. And what is your understanding of the problem that's associated with when that occurs? What is the issue that's involved?

[2] *This position was iterated in Appellant's then attorney's reply to the draft audit report and in its current attorney's post hearing brief.*
[3] *Ms. Hana's testimony was in regard to the last six months of the four-year audit period. Twelve of the twenty disallowances had dates of service prior to Ms. Hana's employment.*

A: Nothing with billing.
Q: Nothing with billing?
A: No. I don't know. Since I'm working there, I had not this problem. [T 235]

According to Appellant's reply to the draft audit report, this "problem" did occur during [redacted] employment. For example, 7/18/07, the date of service for Sample 4 in the Incorrect Plate Number subcategory, and 9/29/09, the date of service for Sample 7 in the Incorrect Driver License Number subcategory, are during Ms. Hana's employment.

Regardless of whether the disallowance was for a date of service before or during [redacted] employment, what the explanation in the reply was, or what documentation was given to HRA/OMIG from the time of the Entrance Conference to the Pre-hearing conference, [redacted] did not testify about Appellant's billing practices at all. [redacted] testimony was a summary of Appellant's business ownership from inception, its profits and costs, and the hardship of OMIG's withholding. [redacted] did not address any of these nineteen disallowances and he did not provide any testimony to contradict the findings in the final audit report or in [redacted] or [redacted] testimony; neither did [redacted]

The disallowances in Finding #1 are sustained.

Finding #2 - Driver is Not NYS DMV 19-A Certified

OMIG determined to disallow one claim (Sample 100) based on non 19-A certification for driver "Vladimir Prokofiev" (driver). All drivers that provide ambulette transportation services must be qualified under 19-A of the VTL at the time services billed to Medicaid are provided. 18 NYCRR 505.10(e)(6). Sample 100's date of service is December 16, 2005. Appellant argues that OMIG should allow this claim because this

driver was 19-A qualified before the date of service and again after the date of service[4]. This argument actually supports OMIG's disallowance of this claim. Being 19-A qualified until late October/early November 2005, when his 19-A certification was dropped, and then regaining 19-A qualification again in April 2006 proves that the driver was not qualified under 19-A of the VTL at the time service was provided, and that is what is required. Appellant failed to meet its burden to show that the driver was 19-A qualified at the time the service was provided and so Appellant did not demonstrate its right to payment on this claim. [Ex 2; Ex 6; T 72-77, 201-209]

The disallowance in Finding #2 is sustained.

The overpayment claim

Pursuant to 18 NYCRR §519.18(g), an extrapolation based upon an audit utilizing a statistical sampling method certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made or penalty imposed. Appellant did not challenge the statistical sampling methodology in its reply, and there was no expert testimony to challenge the validity of the statistical sampling methodology. The extrapolation will stand. The extrapolated amount of overpayment is $1,182,767.47.

Appellant is asking this Tribunal to dismiss or set aside all of OMIG's claims, and if anything, to impose a small fine. Appellant argues:

> The law permits this Tribunal to overturn OMIG's claims if it deems them "arbitrary and capricious[5]", and this includes consideration of the punishment that it has inflicted. As the Court of Appeals has stated, "where the finding of guilt is confirmed and punishment has been imposed, the test is whether such punishment

[4] *This argument was made in Appellant's reply to the draft audit report, in its post-hearing submission, and on cross examination of Ms. Tran; neither Ms. Hana nor Mr. Miller testified about it.*

[5] *This argument was not made in Appellant's reply to the draft audit report.*

> is "'so disproportionate to the offense, in the light of all the circumstances, as to be shocking to one's sense of fairness'."[6] (cites omitted). Pell v. Bd. of Educ., 34 N.Y.2d 222, 233, 356 N.Y.S.2d 833, 841 (1974). Volga submits that penalizing it more than one million dollars – a full year of its gross receipts – is grossly disproportional and must shock one's sense of fairness. Accordingly, Volga asks that this Tribunal dismiss all of OMIG's claims. [Appellant's Reply Brief, page 11]

Appellant further submits that this tribunal must utilize the same standard that will be applied by the Courts to its ruling, pursuant to CPLR §7803, arguing that

> There is no doubt that the reason for the enactment of the statute (CPLR 7803) was to make it possible, where warranted, to ameliorate harsh impositions of sanctions by administrative agencies. That purpose should be fulfilled by the courts not only as a matter of legislative intention, but also in order to accomplish what a sense of justice would dictate. *Pell v. Bd. of Educ.*, *id* at 235(emphasis supplied).[Appellant's Reply Brief, page 4]

Appellant misconstrues the nature of the overpayment claim. This is not a sanction or penalty under Part 515 or 516. It is a recovery of an overpayment revealed in a Part 517 audit. All claims are subject to audit for six years, and the Department is entitled to recover any amounts paid as the result of improper claiming. 18 NYCRR 517.3(b)(2) and 518.1(c).

There is no evidence to support Appellant's "arbitrary and capricious" argument or its argument that "OMIG has taken this audit as an opportunity to take back payment for services that were rendered to serve no purpose other than to unjustly enrich Medicaid at the expense of an honest business" [Appellant's Reply Brief, page 3]. State and federal regulations are designed to ensure Medicaid recipient's safety and proper expenditure of the limited Medicaid fund. OMIG is mandated to "maximize the recoupment of improper

[6] *This argument was not made in Appellant's reply to the draft audit report).*

Medicaid payments" and refund the federal share[7]. Appellant's assertion that "bookkeeping errors" resulting in an overpayment of $1,182,767.47 should result in what would amount to a slap on the wrist, at tax payers' expense, flies in the face of these mandates. OMIG conducted this audit pursuant to its mandate to ensure that Appellant was in compliance with Medicaid regulations. An improper Medicaid payment/ 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). The twenty disallowances under review are overpayments within the meaning of this regulation.

The Department seeks to recoup the overpayment of $1,182,767.47, plus interest. Interest may be collected upon any overpayments determined to have been made. 18 NYCRR 518.4(a) (emphasis added). However, interest may be waived in whole or in part when the department determines the imposition of interest would effect an unjust result, or would unduly burden the provider. 18 NYCRR 518.4(e).

According to Mr. Miller's testimony, the amount owed is just shy of Appellant's approximate annual gross receipts. Mr. Miller testified that repaying this amount through OMIG's withhold is causing Appellant to amass significant loan and credit card debt in order to meet the costs of running its business. Under these circumstances, I find that interest should not be collected on the amount due.

Appellant failed to meet its burden to establish that OMIG's findings are incorrect. The final determination to recover $1,182,767.47 in Medicaid overpayments is affirmed.

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[7] *Social Security Act 1903(d)(2)(C)(D); 42 CFR §§ 433.300, 433.304; PHL §30. See also, Matter of Community Related Services, Inc., v. NY Dept. of Health, 2010 N.Y. Misc. LEXIS 5057, 3-4 (N.Y. Sup. Ct. Sept. 29, 2010)*

Decision

The Department's determination to recover Medicaid program overpayments from Appellant, Volga Transportation Corporation, for the twenty claims at issue in this hearing is affirmed.

The Department's determination to recover interest on the Medicaid program overpayments from Appellant, Volga Transportation Corporation, is overturned.

This decision is made by Ann H. Gayle, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Albany, New York
October 20, 2017

Ann H. Gayle
Administrative Law Judge

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