

STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of

MERCY MEDICAL CENTER

Provider ID #: 02996725
Audit # 2014Z01-074T
Appellant,

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 the determination of the Department to recover \$9,553.96 in Medicaid overpayments.

Before: David A. Lenihan
Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, New York 10007

July 22, 2015
Record closed, November 13, 2015

Parties: New York State Department of Health
Office of the Medicaid Inspector General
217 Broadway, 8th Floor
New York, New York 10007

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JURISDICTION

The New York State Department of Health (the Department) acts as the single state agency to supervise the administration of the Medicaid Program in New York State pursuant to Social Services Law § 363-a. The New York State Office of the Medicaid Inspector General (OMIG) is an independent office within the New York State Department of Health, responsible for the Department's duties with respect to the recovery of improperly expended Medicaid funds pursuant to Public Health Law § 31.

The OMIG in this case issued a Final Audit Report on February 10, 2015 for Mercy Medical Center (the Appellant) in which the OMIG concluded that the Appellant had received Medicaid program overpayments. The Appellant requested this hearing pursuant to Social Services Law § 22 and Department of Social Services regulations at 18 NYCRR 519.4 to review the Department's determinations. Evidence was received. Testimony was taken under oath. A transcript of these proceedings was made.

The entire record was considered in reaching this decision.

ISSUE PRESENTED

Was the OMIG correct in finding that duplicate Medicaid payments which resulted from the treatment of Mercy Medical's in-patients by authorized members of Appellant's medical staff were overpayments which the OMIG was authorized by regulation to recoup from the Appellant?

FINDINGS OF FACT

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

1. This proceeding arises from an audit conducted by the New York State Office of the Medicaid Inspector General ("OMIG") of Mercy Medical Center, Medicaid Provider # 02996725, Audit Number 2014Z01-074T. (See Hearing Exhibits 1-4, 10-14)
2. The subject of the audit is Mercy Medical Center. Hearing Exhibits 1, 10.
3. Mercy Medical Center ("Mercy" or the "Medical Center") is, and at all times relevant to the audit has been, an acute care general hospital located in Rockville Centre, New York. (Tr. 194-195, 204; Hearing Ex. 10 at page 1)¹

¹ References to pages in the transcript of the administrative hearing held on July 22, 2015 are indicated by the prefix "Tr."

4. Mercy Medical Center’s patients currently are served by, and at all times relevant to the audit have been served by, a medical staff numbering between 750 and 800 members. (Tr. 222)

5. The Medical Staff of Mercy Medical Center (the “Medical Staff”) is an independent legal entity that is not, and was not at any time relevant to this audit, controlled by Mercy—it maintains its own tax identification number and its own bylaws that are separate and distinct from those of the Medical Center. (Tr. 223)

6. Medical Staff physicians make independent decisions with respect to the treatment of their patients, including whether to order tests and which tests to order. These tests are not dictated or controlled by Mercy. *Id.*

7. Most of the Medical Staff physician members are not employees of the Medical Center (the “non-employed physicians”). *Id.*

8. The non-employed physicians independently bill patients and payers for the services they provide. (Tr. 143)

9. Mercy does not submit claims for professional services provided to patients by non-employed physicians. Mercy does not review (or even have the ability to request for review) the claims submitted by non-employed physicians. Mercy does not receive any monies from payments made with respect to claims for reimbursement submitted by non-employed physicians. Finally, Mercy generally has no knowledge whatsoever with respect to non-employed physician claims that they independently submitted to Medicaid for payment. (Tr. 224-225)

10. Among the non-employed physicians who are members of the Medical Staff, and who were members of the Medical Staff at all times relevant to this audit, are Dr. [REDACTED], Dr. [REDACTED], Dr. [REDACTED], Dr. [REDACTED], Dr. [REDACTED] and Dr. [REDACTED] (the “six non-employed physicians”). (Tr. 275-276)

11. Each of those six non-employed physicians submits claims to Medicaid for services furnished to Medicaid beneficiaries separately and independently from Mercy Medical Center. (Tr. 224-225, 238, 240, 274-276)

12. Mercy has, and at all times relevant to the audit had, its own unique Medicaid provider number, #02996725. (Hearing Ex. 1 at page 1; Hearing Ex. 10 at page 1)

13. The non-employed physicians have independent provider numbers with Medicaid, and no non-employed Physician has been assigned or uses Medicaid provider ID number #02996725. (*Id.*; see also Tr. 94, 274-276)

14. The audit in this case resulted in the issuance by OMIG to Mercy of a Draft Audit Report dated September 9, 2014 (the “Draft Audit Report”). (Hearing Exhibits. 1-4)

15. The Draft Audit Report was addressed to Mercy and sent to the attention of its General Counsel, David DeCerbo. (Hearing Ex. 1 at page 1; Tr. 202-203)

16. The Draft Audit Report identified three issues that the OMIG claimed resulted in erroneous or unjustified payments from the Medicaid Program for care rendered to Medicaid beneficiaries at Mercy. (Hearing Ex. 1 at pages 2-5; see also Hearing Exhibits 2-4)

17. Upon review of the Draft Audit Report, Mercy submitted a response dated October 8, 2014. (Hearing Ex. 8)

18. In its response to the Draft Audit Report, Mercy did not contest the findings or the amounts of the alleged repayment obligations related to the first two audit issues OMIG had identified, and agreed to remit \$3,584.32 in full satisfaction of its obligations with respect to those two audit issues. (*Id.* at page 1)²

19. Mercy objected to the third audit issue reflected in the Draft Audit Report (“Audit Issue 3”), which related to alleged overpayments arising from ultrasound and diagnostic services rendered to Medicaid beneficiaries during the course of an in-patient stay at the Medical Center. (*Id.* at page 2)³

20. In its response to Audit Issue 3, Mercy contended that it did not submit an inappropriate claim for payment for in-patient services, and was not paid on the basis of an improperly submitted claim. (Tr. 244-245, 251-254)⁴

² At the hearing, [REDACTED], the Senior Vice President for Audit and Compliance at Mercy, explained the reasons why Mercy agreed not to contest the findings with respect to Audit Issues 1 and 2. (Tr. 213-218) With respect to Audit Issue 1, claims related to clinic or Emergency Room services provided to Medicaid in-patients were erroneous, and Mercy agreed to remit the \$1,603 with respect to this issue. (Tr. 213-215; Hearing Exhibits 2, 11) With respect to Audit Issue 2, certain independent laboratories billed Medicaid for services they furnished to Mercy’s in-patients during the course of the in-patient stay. (Tr. 215-218; Hearing Exhibits 3, 12) Unlike the situation at issue in this hearing related to Audit Issue 3—where physicians interpreting ultrasound or diagnostic tests performed on in-patients are permitted to bill for their professional services—laboratories providing tests on in-patients are expressly prohibited by Medicaid from billing the Program instead of the hospital. See Medicaid Laboratory Manual Policy Guidelines, Version 2015-2 at page 15. Neither Audit Issue 1 nor Audit Issue 2 is at issue in this proceeding. (Tr. 214)

³ Among the ambulatory services were such diagnostic tests as [REDACTED] and [REDACTED] tests and these were ordered by the physician. (Tr. 220)

⁴ Mercy was never informed by OMIG that Mercy erred in its billing for in-patient services rendered to the Medicaid beneficiaries identified in connection with Audit Issue

21. Rather, Mercy was reimbursed by Medicaid on a “per case” basis according to an assigned “Diagnosis-Related Group” (“DRG”) for in-patient services provided to Medicaid beneficiaries during the relevant period related to the audit. (Tr. 246-248)

22. Under the per case DRG reimbursement methodology for in-patient care, Medicaid pays an all-inclusive fixed amount, covering hospital services for the entire in-patient stay. The Medicaid DRG reimbursement paid to a hospital such as Mercy Medical Center for a particular in-patient admission does not vary based upon factors such as the number of diagnostic tests performed with respect to that particular in-patient. Thus, Mercy received the same DRG payment regardless of whether it provided the technical components that OMIG seeks to recover here; regardless of the number or type of ultrasounds or diagnostic tests that were provided to the patient, and regardless of the total resources consumed during the in-patient stay. (Tr. 247-248)

23. The per case DRG reimbursement paid to Mercy for in-patient care provided to Medicaid beneficiaries does not include a separate “line item” charge for each ultrasound and diagnostic test. (Tr. 248-249) Rather, the technical component of any services provided at Mercy during a beneficiary’s in-patient hospital stay would be included within the single DRG payment made to the Medical Center. (Id.)

3, or that the Medical Center was paid for its in-patient services due to any unacceptable practice or fraud on its part. (Tr. 244, 276-277) Rather, the erroneous billing amounts identified by OMIG with respect to Audit Issue 3 reflect the technical component paid to the six non-employed physicians, and were derived from the amounts billed by and paid to those physicians, not to Mercy, with respect to the technical component for those services. (Tr. 248-250, 272-273)

24 The DRG does not vary and does not correlate to whether or not a Medicaid beneficiary receives a particular test during an in-patient stay; it is a flat rate based upon a diagnosis that covers all services (including any diagnostic testing) provided by the hospital during a beneficiary's in-patient stay. (Tr. 248)

25. OMIG has not, as part of either its Draft Audit Report or its Final Audit Report, identified any error in the DRG amount claimed by Mercy for the in-patient services it rendered to the specified Medicaid beneficiaries listed on the exhibit corresponding to Audit Issue 3. (Tr. 142, 250; Hearing Exhibits. 4, 13)

26. It is the actions of the six non-employed physicians, not an error by Mercy, that form the basis for OMIG's repayment demands with respect to Audit Issue 3. (Tr. 161-163, 248-250, 272-273)

27. Thus, the Medical Center objected to Audit Issue 3 on the basis that the claims listed by OMIG as erroneous were billed by and paid to individual physicians, not by or to the Medical Center. (*Id.*; see also Hearing Ex. 8)

28. The six non-employed physicians listed by OMIG in the final audit exhibit related to Audit Issue 3 were entitled to bill for professional services they rendered to Medicaid beneficiaries during the in-patient hospital stays of those patients. (Tr. 141, 219-220; Hearing Ex. 13 at 1-7; see also Hearing Ex. 4 at pages 1-9)⁵ The OMIG does

⁵ Mercy noted at the hearing that two of the claims identified as part of the Audit Issue 3 findings were billed by and paid to Mercy Medical Center. (See Hearing Ex. 13 at page 2, lines 7 and 8) It does not contest OMIG's disallowance of payment with respect to these two claims. (Tr. 219) There also is a difference between the claims identified in the schedule attached to the Draft Audit Report and the Final Audit Report. *Compare*

not contest this proposition. (Tr. 141). See *New York State Medicaid Physician-Procedure Codes*⁶ at page 9 (“Physicians can bill for services provided in Article 28 hospital in-patient and outpatient settings for Medicaid fee-for-service patients.” This policy became effective on February 1, 2010”)

29. In its October 8, 2014 response to OMIG, Mercy surmised that the claims listed in Audit Issue 3 appeared to lack a “modifier code” that would indicate a claim for only the physicians’ professional services.⁷ Without the appropriate modifier code, the physicians (including the six non-employed physicians referenced above) were reimbursed by Medicaid both for their professional services and for the facility services related to those tests. (Hearing Ex. 8 at page 2; see also Tr. 245-246, 251-252, and 254)

30. The overpayments listed as disallowed amounts on the exhibit corresponding to Audit Issue 3 were instead derived from the technical component amounts *paid to the physicians* (including the six non-employed physicians) by Medicaid. (Tr. 248, 250-251;

Hearing Ex. 4 and Hearing Ex. 13. Only the claims listed in Hearing Exhibit 13 (with the exception of Hearing Ex. 13, page 2 at lines 7 and 8) are at issue in this proceeding.

⁶ [https://www.emedny.org/Provider Manuals/Physician/PDFS/ %20 Procedure%20 Codes%20Sect1.pdf](https://www.emedny.org/Provider_Manuals/Physician/PDFS/%20Procedure%20Codes%20Sect1.pdf)).

⁷ Mercy was not privy to the physician claims at issue in this audit, because the Medical Center did not employ the subject physicians; did not submit claims for the professional services they rendered; did not review the claims submitted by these physicians; and was not privy to any of the physicians’ billing information with respect to the specified claims. (Hearing Ex. 8 at page 2; Tr. 224-225, 274-275)

Hearing Ex. 4 at pages 1-9, columns 11, 12 and 14 [“Amount Paid, Amount Disallowed, Overpayment”]; Hearing Ex. 13 at pages 1-7, columns 11, 12 and 14 [same titles])

31. In its October 8, 2014 response to the Draft Audit Report, Mercy noted that they were not the proper party from which OMIG should seek recoupment. Mercy instead recommended that “OMIG appropriately seek recovery of any potential overpayments related to claims listed on Hearing Exhibit 4 directly from the patient’s physician” (Hearing Ex. 8 at 2), because the physicians’ claims were the mechanism that triggered the repayment demand and formed the basis for OMIG’s assessment of the disallowed amounts. (Tr. 248, 250-251)

32. OMIG, however, declined to follow Mercy’s recommendation. Although it made certain modifications to the number of claims asserted as erroneous with respect to proposed Audit Issue 3, and revised the corresponding exhibit to remove the claimed amounts for the physicians’ professional services (for which they had properly billed Medicaid) from the disallowed amount in the February 10, 2015 Final Audit Report (the “Final Audit Report”), OMIG continued to assert that Mercy Medical Center was subject to audit liability with respect to the Audit Issue 3 findings. (See Hearing Ex. 10 at pages 4-5; Hearing Ex. 13 at pages 1-7)

33. In the Final Audit Report, OMIG cited five regulations and administrative guidelines in support of its position—18 NYCRR § 504.3(h), 18 NYCRR § 504(i); 18 NYCRR § 518.1(c), the July 2008 DOH *Medicaid Update* (Vol. 24, No. 8), and the *E-MedNY Provider Manual for In-patient Policy Guidelines* (Version 2007-1, page 15 of 26, Version 2011-1, page 18 of 30, and Version 2012-1, page 16 of 27). Hearing Ex.

10. The OMIG did not specifically identify 18 NYCRR § 518.3 as a ground for Mercy's potential audit liability in this Final Audit Report. (Tr. 155)

34. The content of the Final Audit Report narrative with respect to Audit Issue 3 was identical to the narrative contained in the Draft Audit Report issued by OMIG in September 2014. *Compare* Hearing Ex. 1 at pages 4-5 *with* Hearing Ex. 10 at page 4.

35. Thus, neither the Draft Audit Report nor the Final Audit Report identified, cited or relied upon 18 NYCRR § 518.3 as a basis for Mercy's purported audit liability.

36. At the time the Draft and Final Audit Reports were released there was, and currently there is, no legal impediment to OMIG's ability to audit the relevant beneficiaries' physicians, or to seek recovery from those physicians for the technical components that were not provided the listed physicians.⁸

38. Mercy, one of the constituent entities within the Catholic Health Services of Long Island ("CHS") health system, has at all times (including the period relevant to the audit at issue) maintained a robust compliance program. (Tr. 196-201)

39. The network of which Mercy is a member directly expends in excess of \$3,000,000 annually to support its compliance efforts, and maintains a compliance staff of more than 20 full-time employees. (Tr. 196-198)

⁸ Mercy notes that such an audit and such recovery efforts are actually unnecessary in this instance. Mercy forwarded information related to the overpayment issues to the six non-employed physicians who actually submitted these erroneous claims. Mercy subsequently obtained acknowledgements from those Physicians that the claims they had submitted for the technical components of the services rendered to Mercy's in-patients indeed were erroneous, and thus the Physicians forwarded checks to repay OMIG for the specified errors. OMIG has refused to accept these checks. (Tr. 252-254, 257, 262, 263)

40. Among the compliance efforts relevant to this proceeding, the CHS and Mercy compliance staff provide training on the proper manner for billing governmental payers like Medicaid, perform internal reviews and “data mining” processes in an effort to identify any errors or unwarranted billings to patients and payers, and, when errors are discovered, take appropriate steps to correct them and return any overpayment. (Tr. 198-201)

41. In assuming such oversight responsibility, the Catholic Health Services compliance program draws a distinction between the acts of an entity’s employed staff and non-employees such as the non-employed physicians in this case. This distinction is driven by the reality that Mercy and the CHS revenue cycle and compliance teams are involved in the submission of claims for, and have access to the billing records and related records of employed medical staff. They do not have access, or a legal right to access, the billing records of non-employees or the patient records maintained in the offices of non-employed medical staff members. (Tr. 223-225)

42. The CHS Board of Trustees, in recognition of this distinction, developed a formal policy in 2002, applicable to all constituent entities, including Mercy, entitled *Review of Physician Compliance Matters*. (Tr. 225-237; Hearing Ex. A)

43 In relevant part, this policy provides that if the alleged transgressor is an independent physician, such as the six non-employed physicians who submitted the erroneous claims at issue here, then the CHS entity’s compliance officer is not required to investigate the activities of the independent physicians *unless* the conduct concerns (a) the appropriateness of the care rendered to a patient; (b) the documentation of that

care in the hospital medical record, or (c) the quality of care rendered to the patient.
(See Hearing Ex. A)

44. Specifically, the CHS compliance officers have no obligation to investigate “how or how much the [independent] physician bills for his or her services,” even if those services are furnished to patients at the hospital. (Tr. 238; Hearing Ex. A)

45. Among the reasons for this policy is the fact that the compliance officers have no ability or authority to review the claims for reimbursement submitted by independent, non-employed physicians. Further, the compliance officers also could potentially become implicated in a HIPAA violation if they attempted to inspect certain confidential patient records maintained by independent physicians who may have medical staff privileges at more than one facility (including facilities that are not affiliated with CHS). (Tr. 241)

46. An independent compliance concern triggered by the OMIG position in this case relates to the federal Stark Laws.⁹ Those laws, among other things, prohibit an institutional provider such as Mercy from assuming responsibility for the acts or omissions of non-employed physicians who are in a position to admit patients to the institution, and/or from repaying any obligation owed by such physicians. (Tr. 260)¹⁰

⁹ See 42 U.S.C. § 1395nn.

¹⁰ While admitting she was “not an expert in the Stark Laws,” (Tr. 265), counsel for OMIG expressed her view that the Stark laws were “not really relevant here. We are here for a Medicaid hearing.” (Tr. 264-265) Of course, as a State agency charged with ensuring the integrity of provider actions related to the federally sponsored and supported Medicaid program, OMIG assuredly *should be* focused on ensuring that its audit and oversight efforts comply with federal law (including the Stark Law), and should

47. To avoid that potential violation, and in an effort to accommodate OMIG and secure repayment from the providers who actually erred in this case, Mercy approached Drs. [REDACTED], and inquired as to: (i) whether their billing records indicated that they submitted claims to the Medicaid program without excluding the “technical component” from the claims for reimbursement; and (ii) if so, whether they would agree to remit such overpayment amounts to the Medicaid Program. (Tr. 255-56, 258-260, and 263-264)

48. The six non-employed physicians agreed to remit the payments in question, and Mercy thereafter collected checks that reflected the contested amounts identified in Audit Issue 3 in the Final Audit Report. (Tr. 256, 258, 263-264; Hearing Ex. B)¹¹

49. OMIG has refused to accept the proffered checks that Mercy had collected from the non-employed physicians. (Tr. 257, 262, 263)

50. If OMIG had accepted the proffered checks, the providers responsible for submitting the erroneous claims would have remitted, in full, the overpayments identified in Audit Issue 3 in the Final Audit Report, and the need for this hearing would have been obviated. (See Tr. 263-264)

be zealous in ensuring that New York providers such as Mercy do not violate federal law. If Mercy were to do what OMIG demands and pay OMIG directly for the errors committed by the six non-employed physicians, however, OMIG would be complicit in just such a Stark violation, with Mercy enjoying no protection from enforcement action by either the Centers for Medicare and Medicaid Services (“CMS”) or the Office of Inspector General of the Department of Health and Human Services (“OIGHHS”).

¹¹ After lengthy colloquy, the checks were admitted into evidence, with the ruling, “I am going to allow this into evidence over the objection of the OMIG as relevant and germane to the issues.” (Tr. 272)

DISCUSSION

It is noted at the outset that, by agreement of the parties, the only finding at issue in this case is finding # 3 of the final audit report. This final audit identified an overpayment of \$9,533.96. (Tr. 28) It is also noted that there is no contention by the OMIG that any improper billing was done by the Appellant. (Tr. 38)

The OMIG has based its case against the Appellant on the theory of joint and several liability. It is noted that this is a form of tort liability that is used in civil cases where two or more people are found liable for damages. In such a case the creditor may collect the entire judgment from any one of the parties, or from any and all of the parties in various amounts until the judgment is paid in full.¹² In other words, if any of the parties to be charged do not have enough money or assets to pay an equal share of the award, the other defendants must make up the difference, without regard to their individual culpability,

Another example of joint and several liability can be found in cases where multiple parties, who are joined together by partnership or corporate ties, may owe the government income taxes. In such cases, the Internal Revenue Service may collect on

¹² See Black's Law Dictionary, Fifth Edition, p, 433.

the debt from any and all of the debtors. In this particular case there is no such bond as the doctors who did the billing are all independent contractors.

This case is about physicians' billing for services rendered to patients in the Appellant's hospital. (Tr. 38). The pivotal point in this case is the fact that the physicians who actually submitted the bills in question were not employed by the Appellant. It was conceded by the Appellant that an error was made by the six non-employed physicians in billing for services to which they were not entitled, as the hospital had already submitted the bill for these services. (Tr. 252) It should also be noted the six individual physicians acknowledged their mistake in billing and gave the Appellant their checks to reimburse Medicaid. The OMIG, however, refused to accept these checks as a settlement of this case. (Tr. 263-264)

In its *Brief of Legal Argument*, submitted after the hearing, at page 30, the OMIG sought legal authority for its theory of joint and several liability in a 2010 case brought before the Appellate Division, Third Department, the *Matter of Bilow v. Daines*. The Court found that the Department of Health was entitled to recover payments made to Petitioner Jefferson County Public Health Services pursuant to a contract for administration and coordination of the Medicaid-funded program. The *Bilow* decision found that Petitioner county was required under contract to ensure that no duplicate billing occurred but failed to do so, and spoke thus to the issue of joint and several liability for overpayments.¹³

¹³ *Matter of Bilow v Daines*, 77 A.D.3d 1249, 1251 (N.Y. App. Div.,3d Dept., 2010).

The *Bilow* case, however, is to be distinguished from the case at bar for several reasons. While it is true that, in *Bilow*, the court found that Jefferson County had failed to prevent double billing and was thus jointly and severally liable, there is a glaring difference between *Bilow* and the case of Mercy Hospital. It is noted, especially, that Jefferson County had been warned twice before, in 1995 and again in the year 2000, about double billing by outside vendors. Furthermore, as a consequence of these prior warnings there was a specific provision in the 1996 and 1998 contracts that the fetal nonstress tests were not to be separately billed.¹⁴

In the *Bilow* case, Jefferson County was found to have explicitly violated the terms of its contract to prevent double billing and that was the reason it was found liable for the actions of the providers. This explicit inclusion of the obligation to oversee and prevent double billing by their providers makes *Bilow* distinguishable from the case at bar. I note that in the present case, there was no such contractual obligation put forward by the OMIG to justify joint liability.

Similarly, the OMIG has attempted to use, as legal authority for joint and several liability, *Louis v. Dowling*, a 1994 case heard before the Appellate Division, Third Department. That case was an Article 78 proceeding in which the Petitioner Medicaid provider appealed a determination of OMIG's predecessor, the New York State Department of Social Services, DSS. DSS had censured the provider in connection

¹⁴ *Id* at 1250.

with his participation in the Medicaid program and required restitution for overpayments. In that case, which (unlike the present case) did involve unacceptable practices under 18 NYCRR Part 515, the Department of Social Services had charged the provider with submitting false claims, unacceptable recordkeeping, and furnishing or ordering medical services in excess of patients' needs. The department censured the provider in connection with his participation in the Medicaid program and required restitution for overpayments. The provider commenced an Article 78 proceeding to challenge the determination. The court confirmed the department's determination and dismissed the provider's petition, finding that the record below contained substantial evidence to support the findings.¹⁵ In the *Louis v. Dowling* case, the court recognized that the provider was jointly and severally liable under 18 NYCRR 518.3(c) for any overpayments:

As to the restitution ordered by respondents, the regulations recognize that providers are jointly and severally liable for any overpayments, but the amount of the recovery from any one provider cannot include any amount actually recovered from another provider (18 NYCRR 518.3 [c]) (Emphasis added).¹⁶

I find that the *Louis v. Dowling* case is not dispositive. To begin with, the reference to joint and severable liability is an *obiter dicta* and not at all central to that

¹⁵ *Louis v. Dowling*, 203 A.D.2d 742, 743 (N.Y. App. Div. 3d Dept. 1994).

¹⁶ *Louis v. Dowling*, at 743. See the OMIG brief at page 31.

case. The “Louis” of *Louis v. Dowling* was physician charged with submitting false claims and furnishing medical services in excess of patient’s needs. Unlike the case at bar, Doctor Louis was personally charged with these offenses and had a hearing on his personal involvement. The Hearing Officer and the Appellant Division both found him personally liable for the Medicaid fraud in question. The joint and several liability issue cited above came into play because there was some question about overpayments being sought from one petitioner which had already been recovered from another.

In the present case there is no nexus between the Appellant and the six non-employed physicians which would justify making the Appellant responsible for their acknowledged billing error. It is also noted that the Appellant attempted to rectify this mistake in billing by collecting the monies in question owed by each doctor and offering them to OMIG to settle this matter. However, the OMIG refused to accept this repayment from the Appellant in the form of checks made out to the doctors who actually submitted the erroneous billings. The logic of this refusal was that, pursuant to 18 NYCRR § 518.3, Mercy should be deemed jointly and severally liable for the inappropriate claims submitted, not by the Medical Center, but by the non-employed physicians. However, as we will see below, § 518.3 was never cited by the OMIG as legal authority.

The OMIG also attempted to establish that the Appellant, Mercy Medical, by the application of the plain meaning of 18 NYCRR § 518.3(c), was jointly and severally liable with its physicians ministering to its in-patients while they were under their umbrella of responsibility as “persons furnishing, or supervising the furnishing of,

medical care, services or supplies.” 18 NYCRR § 518.3(c). The OMIG attempted to do this by the admission of the Appellant’s witness, [REDACTED].¹⁷ I do not accept this contention by the OMIG and find that the doctors in question were independent of the Appellant. I find this attempt to base joint and several liability on [REDACTED] testimony unavailing. It should be noted that [REDACTED] is not a lawyer and in response to this quite technical question first said: “I can’t answer that..”

For the foregoing reasons I find that the Appellant Mercy Medical Center should not be held jointly liable under the facts of this case. There is also a technical procedural reason for this finding. State Regulations specifically state that both the Draft Audit Report and the Final Audit Report must contain a statement of the basis for the proposed action and the legal authority therefor.

It would be helpful, at this time, to look to the full text of the Regulation on Final Audit Reports:

¹⁷ [REDACTED], Senior Vice President Internal Audit and Compliance, Catholic Health Services of Long Island, Appellant’s own (and only) witness at the hearing of this matter conceded on cross examination that Appellant and Appellant’s physicians were “probably jointly responsible” for the care of the in-patients at Appellant’s facility during their in-patient stay: (Tr. 283:13-287:8)

Q. [MS. HENZELI: Does Mercy Medical have primary responsibility for the care of in-patients at your facility?

A. [REDACTED]: I can’t answer that. I don’t know. It is probably jointly responsible. The physician is the one that orders the test, admits the patient, performs procedures, so the physician is probably primarily responsible for the care of their patient and the hospital assists the physician with that care.

Q. [MS. HENZELI: And you have previously testified that you are the head of compliance?

A. [REDACTED]: Yes.

18 NYCRR § 517.6 Final audit report. (a) After receipt of the provider's objections to the draft audit report, or at any time after the expiration of 40 days after mailing of the draft audit report without objections having been received, a final report may be issued. In preparing the final audit report, the department must consider the objections, any supporting documents and materials submitted therewith, the draft audit report, and any additional material which may become available.

(b) The final audit report and/or the cover letter accompanying it must clearly advise the provider:

- (1) of the nature and amount of the audit findings, the basis for the action and the legal authority therefor;
- (2) of the action which will be taken;
- (3) of the effective date of the intended action which will be not less than 20 days from the date of the final audit report;
- (4) of the right to appeal the audit findings set forth in the final audit report and of the requirements and procedures for requesting an administrative hearing;
- (5) that the request may not address issues regarding the methodology used to determine the rate or any issue that was raised or could have been raised at a proceeding to appeal a rate determination but shall be limited to those issues relating to determinations contained in the final audit report. ¹⁸

The OMIG has attempted to hold Mercy Hospital jointly liable for the actions of six of its doctors. On review of this record, I find that OMIG's reliance on 18 NYCRR § 518.3 must be rejected because it fails to specify or cite 18 NYCRR § 518.3 in the discussion of Audit Issue 3 in either its Draft or its Final Audit Reports. (See Hearing Ex. 1 at pages 4-5; Hearing Ex. 4; Hearing Ex. 10 at page 4; Hearing Ex. 13; see *also* Tr. 155)

At no point was 18 NYCRR § 518.3 ever presented to the Appellant as the basis for the attempted recovery. This is a critical oversight by the OMIG and this alone would compel one to find for the Appellant. The operative regulation provides that when overpayments have been identified, "a draft audit report may be issued identifying the

¹⁸ 18 NYCRR § 516.6

items which are being disallowed *and advising the provider of the basis for the proposed action and the legal authority therefor.*” (See 18 NYCRR § 517.5(a)(emphasis supplied).

The same language is found in the regulation governing final audit reports: 18 NYCRR § 517.6(b)(1). The final audit report must advise the provider of “the nature and amount of the audit findings, the basis for the action and the legal authority therefor.”

It cannot be overemphasized that the action OMIG proposes to take is to hold Mercy jointly and severally liable for the erroneous claims submitted by the six non-employed physicians. The vehicle it seeks to use to effect this action is Section 518.3 of 18 NYCRR. The authority cited with respect to Audit Issue 3 in both the Draft Audit Report and the Final Audit Report, however, does not include or cite to the Section 518.3 provision upon which OMIG now seeks to employ. Furthermore, in both the Draft Audit Report and the Final Audit Report, the concept of potential joint and several liability is never discussed, or even mentioned.

The cited authority offered by OMIG in those documents is limited to 18 NYCRR §§ 504.3(h), 504.3(i), 518.1(c), the June 2008 *DOH Medicaid Update* (Vol. 24, No. 8) and excerpts from the *EMedNY Provider Manual for In-patient Policy Guidelines* (Versions 2007-1, 2011-1 and 2012-1). (See Hearing Ex. 1 at pages 4-5; Hearing Ex. 10 at page 4) The OMIG quotes what it believes is the pertinent language from each of these five sources of authority. Again, nowhere is the concept of any potential joint and several liability raised.

Specifically, 18 NYCRR §§ 504.3(h) states that providers must, in claims for payment, include information that is “true, accurate and complete.” OMIG has not contended that the in-patient claims *submitted* by Mercy were untrue, incomplete or inaccurate in any way. The proof elicited at the hearing establishes that Mercy’s claims were in fact “true, accurate and complete.”

18 NYCRR § 504.3(i) mandates that providers must “comply with the rules, regulations and official directives of the department.” Again, OMIG has not demonstrated that Mercy failed to comply in any way with departmental rules, regulations or directives with respect to its DRG claims, or that the claims *Mercy* made for reimbursement for the in-patient services it provided to Medicaid beneficiaries were not compliant with any rule, regulation or directive.¹⁹

18 NYCRR § 518.1(c) defines an overpayment as an amount “not authorized to be paid” under the Medicaid program. But the DRG amounts paid *to* Mercy were not audited or challenged, and were not shown to have been unauthorized or an overpayment. This regulation therefore does not afford OMIG any ground upon which to recover from the Medical Center for the independent physician provider claims identified in the exhibits accompanying Audit Issue 3. (See Hearing Ex. 4, 13)

¹⁹ There is no merit to the suggestion OMIG appeared to make during the hearing that this broad provision, requiring compliance with regulation, would put Mercy on notice of OMIG’s intended use of 18 NYCRR § 518.3 to impose joint and several liability on it for the erroneous acts of others. Indeed, Section 518.3 happens to be one of literally *thousands* of departmental rules, regulations and/or directives. As Mercy noted, if that were accepted then OMIG would not have needed to cite any of the specific authority it did in the draft and final audit reports here. (Tr. 92-95) This effort to excuse OMIG’s omission is unavailing.

The June 2008 DOH *Medicaid Update* states that “[a]ncillary services that are already included in a facility’s all-inclusive DRG payment . . . should not be billed on a fee for service basis” and services rendered to in-patients “should not be billed on an ordered ambulatory basis.” When that occurs (i.e., when a provider bills for services already included in a facility’s in-patient DRG payment), the provider’s claim for such ancillary services “will be considered a duplicate payment and therefore subject to recoupment.”

In its *Brief of Legal Argument*, the OMIG asserted that the Appellant has attempted to raise issues objections at hearing for the first time and so should be precluded from raising issues which were not offered in response to the draft audit report.²⁰

I find that the issue of joint and several liability has been raised in the Responses of Mercy Medical Center to both the Draft Audit report and the Final Audit Report. In his October 8, 2014 letter to OMIG, Dr. Aaron Glatt, the Executive Vice President of Mercy Medical Center, acknowledged the error of the Appellant with regard to Exhibits 1 and 2. However, as to Exhibit 3, Dr. Glatt clearly stated that these were physician claims and were not the result of any error on the part of the Appellant. He suggested that the OMIG seek recovery of the overpayments directly from the patient’s physician.²¹

²⁰ See the OMIG’s Brief of Legal Argument, page 31.

²¹ See OMIG Exhibit 8, page 3.

Similarly, in its response to the Final Audit Report the Appellant again broached the issue of joint and several liability. In his letter of April 29, 2015, David DeCerbo, Esq., the Appellant's general counsel, stated that the OMIG has recouped money from Mercy Medical Center based upon improper billings that were submitted by private voluntary physician members of its medical staff— not physicians employed by the hospital. Mr. Decerbo accurately stated that Mercy Medical Center did not have any role in the submission of the billing that resulted in Medicaid payments to these independent physicians. Mr. DeCerbo went on to state that it was simply bad public policy — and is contrary to the stated mission of OMIG and applicable law governing provider compliance in New York — for the OMIG to seek to recoup these overpayments from the hospital rather than the physicians who submitted the improper billings and received the Medicaid overpayments in question. It is especially troubling that OMIG is seeking recoupment of Medicaid overpayments made to independent physicians from Mercy Medical Center, one of only three DSRIP Program “Safety Net Hospitals” located in Nassau County.

Mr. Decerbo was clear in his letter about joint and several liability and stated that the OMIG has departed from well-reasoned and longstanding Medicaid audit and compliance principles and has exceeded its regulatory authority in this attempt to recover from one provider (i.e., a hospital) an overpayment that was improperly billed by and paid to another provider (i.e., non-employed independent physicians).²²

²² See OMIG Exhibit 31. Pages 2 and 3.

It should be noted, however, that the parties were in agreement on some aspects of this case. The claims submitted by the six non-employed physicians for the specified ultrasound and diagnostic procedures listed on the exhibit correlating to Audit Issue 3 were not proper, and they resulted in unwarranted, duplicative Medicaid payments, because Mercy had appropriately billed and received the DRG payment for these in-patients.

Another point of agreement was that Doctors [REDACTED], [REDACTED] submitted claims for the specified ultrasound and diagnostic procedures that included claims for reimbursement of both the professional and technical components of the services listed on the exhibits related to Audit Issue 3 that accompanied OMIG's Audit Reports. (See Hearing Exhibits 4, 13) Indeed, these six non-employed physician providers have acknowledged responsibility for the erroneous and duplicative payments, by writing checks to reimburse the Medicaid Program for the erroneous claims. (Hearing Ex. B)

On review of the entire record, I find that the OMIG has failed to specify in its Audit Reports, both draft and final, any regulatory authority that would justify recovering from one provider (*i.e.*, Mercy) funds erroneously paid to another independent provider (*i.e.*, the six non-employed physicians). The OMIG thus runs afoul of both 18 NYCRR § 517.5(a) and § 517.6(b)(1). I find that this is not a mere technicality. It goes to the heart of fairness and due process. State Regulations require the auditor—in this case OMIG—to be specific in terms of the theory of recovery, and the authority permitting any such recovery by the agency. Indeed, after reviewing the Draft Audit Report, it is plain

that Mercy did not perceive that these were issues for which it could be responsible. Mercy's October 8, 2014 response suggests quite logically that the OMIG should seek recovery from the physicians who apparently submitted the erroneous claims. (Hearing Ex. 8). OMIG declined to do so and while that certainly is the OMIG's prerogative, it cannot visit on Mercy the consequence of its choice, or its omission, of requisite authority in contravention of 18 NYCRR § 51.

Assuming, *arguendo*, that the OMIG did give proper notice of its intention to rely on 18 NYCRR § 518.3, it still would not establish a case for joint and several liability under that regulation for the following reasons:

Section 518.3 actually has three subsections, and each will be dealt with separately:

18 NYCRR § 518.3(a) provides that “[t]he department may require repayment from *the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim.*” It is clear from the hearing record that the Appellant did *not* submit the claims for the ancillary ultrasound and diagnostic services that OMIG asserts were incorrect or improper—rather, the six non-employed physicians did. Furthermore, the Appellant did not cause those incorrect or improper claims to be submitted—the six non-employed physicians did. Finally, the Appellant never received payment for those claims submitted by the six non-employed physicians.

18 NYCRR § 518.3(b), in relevant part, states that where services are provided under the supervision of another, or at the direction of another, the department may recover payment for “inappropriate, improper, unnecessary or excessive care, services

or supplies” from either the person furnishing such care, or the person supervising such care or causing it to be furnished.

The hearing testimony and the record in this case did not establish, nor does it appear that the OMIG ever even claimed that the care or services in any of the subject cases was “inappropriate, improper, unnecessary or excessive.” The key issue, instead, is which provider properly billed for the service, and which did not. With respect to the “duplicative” claims for the ultrasound and diagnostic care furnished to the subject beneficiaries identified in connection with Audit Issue 3, the only erroneous, “duplicative” claims are those that emanated from the six non-employed physicians who submitted those claims in their capacities as independently practicing clinical professionals. Accordingly, I find that the provisions of Subsection (b) were not met.

Finally, 18 NYCRR § 518.3(c) authorizes joint and several liability for “overpayments resulting from the care, services or supplies.” The care provided by the Appellant in this case—for which it billed an in-patient DRG—has not been shown to have resulted in an overpayment. There is no showing that Mercy erred in billing the in-patient DRG, misclassified the patient services in an improper DRG, or was otherwise overpaid by Medicaid for the in-patient care provided. The additional claims submitted by and paid to the six non-employed physicians, which failed to limit the claim to the physicians’ professional component only, constitute the overpayments identified in the exhibit to Audit Issue 3.

It is understandable why the OMIG would seek recovery from the Appellant, Mercy Hospital, in this case. It would be quicker and more economical to do it that way.

However, our system of law, however, is not based on speed or efficiency. Due process of law requires that the party to be charged be given notice of the basis of the suit. That was not done in this case and so I find for the Appellant.

CONCLUSION

For the foregoing reasons, Appellant Mercy Medical Center is entitled to an award vacating the audit liability assessed with respect to Audit Issue 3, and a return of monies improperly withheld from it as a result of the findings set forth in Audit Issue 3 of the Final Audit Report that are vacated by this Decision.

DECISION

The Department's determination to recover on Audit Issue 3 is reversed. This decision is made by David A Lenihan, Administrative Law Judge, Bureau of Adjudication, who has been designated to make such decisions.

DATED:

Albany, New York

December 11, 2015

David Lenihan
Administrative Law Judge
Bureau of Adjudication

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