**STATE OF NEW YORK**
**DEPARTMENT OF HEALTH**

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| In the Matter of the Request of | : | |
| **DEVENDRA KUMAR SHRIVASTAVA, M.D.,** Medicaid ID # 01506849, | : | **Decision After Hearing** |
| for a hearing pursuant to 18 NYCRR Part 519 to review a determination to recover Medicaid overpayments. | : | Audit #11-6828 |

Before: Denise Lepicier
Administrative Law Judge

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

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

Devendra Kumar Shrivastava, M.D.
[redacted]
By: *Pro Se*

Date of Hearing: June 19, 2014[1]

[1] Four adjournments of the first hearing date were granted to the Appellant prior to this case coming to hearing. (T. 20-24; Ex. 6)

## JURISDICTION

The Department of Health (Department) acts as the single state agency to supervise the administration of the Medicaid program (Medicaid) in New York State. Public Health Law (PHL) § 201(1)(v), Social Services Law (SSL) § 363-a. Pursuant to PHL §§ 30, 31 and 32, the Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority to pursue administrative enforcement actions against any individual who or entity which 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 Dr. Devendra Kumar Shrivastava (Appellant). The Appellant requested a hearing pursuant to SSL § 22 and the former Department of Social Services (DSS) regulations at 18 NYCRR § 519.4 to review the determination. (See Exhibit 4)

## APPLICABLE LAW

Medicaid fee for service providers are reimbursed by Medicaid 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. Providers must maintain records demonstrating the right to receive payment for six years, 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).

DSS regulations generally pertinent to this hearing decision are at: 18 NYCRR § 360-7 (payment for services, in particular 360-7.2 - "MA program as payment source of last resort"), 18 NYCRR § 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. (Ex. 9 & 10) 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).

## ISSUE

Was the OMIG's determination to recover Medicaid overpayments in the amount of $63,716 from Appellant Devendra Kumar Shrivastava, M.D., correct?

## FINDINGS OF FACT

1. At all times relevant hereto, Appellant Devendra Kumar Shrivastava, M.D., was a physician and was enrolled as a provider in the New York State Medicaid program. (Ex. 3)

2. The Appellant submitted claims to Medicaid for services provided to patients who were eligible for both Medicare and Medicaid coverage and was paid by Medicaid for the services in the period from January 1, 2005 through December 31, 2008. ( Ex. 1 & 3; T. 72-73)

3. The OMIG conducted a review of Medicaid payments made to the Appellant along with a review of Medicare claim and payment records. The purpose of the review was to determine whether the Medicaid claims submitted by the Appellant were in compliance with the Medicaid program. (T. 75-76; Ex. 1 & 3)

4. By final audit report dated April 26, 2012 the OMIG notified the Appellant that the OMIG had identified and determined to seek restitution of Medicaid overpayments in the amount of $63,716. (Ex. 3)

5. During the four year audit period, the Appellant submitted 467 claims to Medicaid that included inaccurate information about the existence and extent of Medicare coverage for the services provided. The OMIG evaluated the claims using actual Medicare claim and payment records for the patients. (Ex. 3 & 11; T. 75-79) The

$63,716 overpayment represents the difference between what was paid by Medicaid to the Appellant for these services, and the amount, based on Medicare payment records, that should have been paid by the Medicaid program. (Ex. 3; T.75-79; 83-91).

6. The OMIG provided a representative at the hearing to present the audit file and summarize the case. (T. 83-91) The representative's explanation of the findings included the following examples of payments to the Appellant that had been made inappropriately:

a. In some instances, the Appellant reported that Medicare had approved a claim but paid nothing on it, when in fact Medicare had denied the claim. Medicaid paid the claim in full in reliance on Appellant's report. As Medicare had disallowed the claim in its entirety, Medicaid should have paid only the amount it would pay on a Medicare denied claim. (T. 93-95) For example, for the first line item in the exhibit to the final audit report, the Appellant reported that Medicare had approved a payment of $139.27, but paid nothing. Medicare actually approved nothing on this claim. Medicaid would normally pay $5.00 on this claim. When Medicaid paid the full amount it believed Medicare had approved, it paid $134.27 more than it should have paid on this claim and the Appellant received an overpayment of $134.27. (Ex. 3, ex. 1, page 1) This scenario was found in 166 of the claims reviewed. (T. 100)

b. The Appellant reported in other instances that Medicare approved a claim, when in fact Medicare had never received a claim. Medicare had no record of the claim and had never approved or denied any payment on it. The Appellant was not entitled to any payment from Medicaid on claims that were not submitted to Medicare. (T. 98-100, 116) For example, for the fifth line item on the second page of the exhibit to the final audit report, the Appellant reported to Medicaid that Medicare had approved payment of $161.87, and had paid $129.50, leaving a difference of $32.37 coinsurance. Medicaid then paid the 20% of the coinsurance, in this case $6.47, when it should have paid nothing. (T. 101-110; Ex. 3, ex. 1, p. 2) This scenario was found in 241 of the claims reviewed. (T. 100-101)

c. In other instances, the Appellant reported that Medicare had paid a claim but reported that Medicare had paid more than Medicare had actually paid. For example, for the eleventh line item on the fifth page of the exhibit to the final audit report, the Appellant reported that Medicare approved $107.84 on a claim, and paid 80% of this amount, or $86.27. Medicaid then paid 20% of the difference between what was approved and what was

> paid, or $4.31. In fact, Medicare had approved $105.12 on this claim and had paid $84.10. . (Ex. 3, ex. 1, page 5) Medicaid should have paid 20% of the difference between these two figures or $4.20, eleven cents less than it actually paid. (T. 111-114) By inflating the amount approved by Medicare, the Medicaid payment was inflated. This scenario was found in 60 of the claims reviewed. (T. 101)

7. The Appellant did not contest the OMIG's figures supporting the overpayment calculation and never submitted any documentation from Medicare to contest either the draft audit or the final audit findings.[2] (T. 77-81) The amount of the overpayment is $63,716. (T. 81-82, 118)

## DISCUSSION

During the period of this audit, the Medicaid provider was responsible for reporting what Medicare approved and paid on claims and for attesting to the truth of what was reported. (T. 75-76) The OMIG accepted the provider's reported information as accurate and paid the claims on this basis. (T. 170-172) For this audit, the OMIG obtained access to actual Medicare payment records from National Government Services, the electronic warehouse which stores Medicare data. (T. 75-76)

Medicaid is a payment source of last resort for health care services. Medicaid regulations state that "As a condition of payment, all providers of medical assistance must take reasonable measures to ascertain the legal liability of third parties to pay for medical care and services" and "[n]o claim for reimbursement shall be submitted unless the provider has . . . sought reimbursement from liable third parties." 18 NYCRR § 540.6 (e)(1) & (e)(2)(ii). Medicaid claiming instructions reiterate the regulations:

> *The provider must bill Medicare or the other insurance first for **covered** services **prior** to submitting a claim to Medicaid.*

[2] Appellant made no formal response to the draft audit report. Appellant did send some e-mails to OMIG auditors which were admitted as OMIG Exhibit 2, but never provided any proof to contest any OMIG findings.

> 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 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.
>
> - If the service is covered, **or** the provider does not know if the service is covered by Medicare . . . the provider must first submit a claim to Medicare . . . .
> - **Only when you are certain that Medicare . . . does not cover the service, can you bill Medicaid solely, and not bill [the] other insurer first.**

Medicaid Update December 2005 Vol. 20, No. 13. (Ex. 9)

Where a third party, such as Medicare, has a legal liability to pay for Medicaid covered services on behalf of a recipient, the Department will authorize payment only on the amount by which the Medicaid reimbursement rate for the service exceeds the amount of the third party liability. 18 NYCRR § 360-7.2. If Medicare does not approve payment of a claim, Medicaid will only pay what it would normally pay on the claim. If a provider fails to make a claim to Medicare when Medicare is the primary insurer, any reimbursement received by the provider from the Medicaid program must be repaid. 18 NYCRR § 540.6(e)(7). If a provider does not accurately report what is approved or paid by Medicare, Medicaid payments will be adjusted accordingly. 18 NYCRR §§ 504.3(h) & 518.1(c).

The OMIG presented documents (Exhibits 1-11) and the testimony of Catherine McCulskey, the Director of the Syracuse regional office of the Office of the Medicaid Inspector General, who supervised this audit. The Appellant testified in his own behalf.

The OMIG explained how it obtained the records of Medicare payments. The Appellant offered no reason to question the accuracy of these figures and has not

identified even one line item that he claims contains any erroneous information. Appellant variously claimed that he had never received payment from Medicaid for the claims in issue, or could not tell whether he was paid because he did not have the Explanation of Benefits. However, Appellant was required to maintain his records with respect to his Medicaid claims for six years and the Medicare Explanation of Benefits (EOB) would be part of the information he should have maintained to justify his claims to Medicaid. Moreover, when the OMIG assisted the Appellant in acquiring new copies of the EOBs for many of the claims, the Appellant failed to produce any of them to justify the claims in issue. (T. 77-78)

It is Appellant's burden to prove that the audit is in error. 18 NYCRR § 518.1(c) The Appellant has failed to carry his burden of proof.

**DECISION:**

The OMIG's determination to recover Medicaid overpayments in the amount of $63,716 is affirmed. This decision is made by Denise Lepicier, who has been designated to make such decisions.

DATED:
November 10, 2014
New York, New York

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Denise Lepicier
Administrative Law Judge