STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Request of

EDWARD R. MAYO, D.D.S., F.A.G.D.
Medicaid Provider ID # 01128596

for a hearing pursuant to Part 519 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) to review a determination to recover Medicaid overpayments

Decision After Hearing

Audit # 2011Z10-156D

Before:	Kimberly A. O'Brien Administrative Law Judge
Held at:	New York State Department of Health 90 Church Street New York, New York 10007
Parties:	New York State Office of the Medicaid Inspector General 217 Broadway, 8th Floor New York, New York 10007 By: Ferlande Milord, Esq. Edward R. Mayo, D.D.S., F.A.G.D. General Cosmetic & Reconstructive Dentistry 3350 National Boulevard Long Beach, New York 11561 By: *Pro Se*

PROCEDURAL HISTORY

Date of Draft Audit Report	February 10, 2011
Date of the Final Audit Report	May 13, 2013
Appellant's Hearing Request	May 21, 2013
Date of Pre Hearing Conference	January 16, 2014
Date of Hearing	February 27, 2014
Appellant's Post Hearing Submission to OMIG	March 14, 2014
OMIG Response to Appellant's Post Hearing Submission	April 8, 2014[1]
Post Hearing Telephone Conference	June 13, 2014
Submission OMIG's Brief	August 14, 2014
Appellant's Letter Brief	September 15, 2014

JURISDICTION

The Department of Health (Department) acts as the single state agency to supervise the administration of the medical assistance program (Medicaid) in New York State, Public Health Law (PHL) § 201(1)(v), Social Services Law (SSL) § 363-a. Pursuant to PHL §§ 30, 31 and 32, the Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority to pursue administrative enforcement actions against any individual or entity that engages in fraud, abuse, or unacceptable practices in the Medicaid program, and to recover improperly expended Medicaid funds.

[1] During the hearing, the Appellant indicated that he had additional patient records and information that he would like to provide to the OMIG for its review [Tr. 98, 107-118]. While the OMIG was not required to accept Appellant's post hearing submission ("submission"), in the interest of reaching a possible settlement it agreed to accept and review the submission, but the parties did not reach a settlement [Tr. 117-118; ALJ

The OMIG determined to seek restitution of payments made by Medicaid to Dr. Edward R. Mayo ("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.

ISSUE

Was OMIG's determination to recover Medicaid overpayments in the amount of $7,257.14, inclusive of interest, from Appellant correct?

FINDINGS OF FACT

The items appearing in brackets following the findings of fact ["FOF"] indicate exhibits in evidence [Ex.] and testimony from the transcript [Tr.], which support the finding of fact. In instances in which the cited testimony or exhibit contradicts other testimony or exhibits from the hearing, the ALJ considered that other testimony or exhibit and rejected it.

1. At all times relevant hereto, Appellant Edward R. Mayo D.D.S., F.A.G.D., Provider #01128596, was a dentist and enrolled as a provider in the New York State Medicaid program [Ex. 2, Ex. 3, Ex. 5; Tr. 28, 54].

2. The OMIG audited all the Medicaid payments made to the Appellant for dental services during the period from January 1, 2006, to December 31, 2009 [Ex. 1, Ex. 3].

3. On or about February 10, 2011, the OMIG issued a draft audit report and Appellant provided a response to the report [Ex. 1, Ex 2; Tr. 11-13].

Ex.2]. The Appellant's post hearing submission and the OMIG's response to the submission were not used by the ALJ in reaching a decision in this matter [ALJ Ex. 2].

4. The OMIG issued the final audit report dated May 13, 2013 ("audit") to the Appellant and the Appellant requested a hearing [Ex.3, Ex. 4; Tr. 13, 28, 40-42, 60-61, 83]. The OMIG determined to disallow multiple claims in each of three categories: *"Audit Finding #2- Inappropriate billing of upper and lower dentures; Audit Finding #4 - Inappropriate Billing of Dental Services for Recipients in a Skilled Nursing Facility; Audit Finding # 8- Multiple single surface restoration claims with surface codes I and O or F and B for the same patient, same tooth and same surface"* [Ex. 3, Ex. 8, Ex. 8A; Tr. 50, 64-66].

5. The total of the Medicaid overpayments to the Appellant for this period is $7,257.14 which includes $936.14 in accrued interest [Tr. 67-69, 82-83; Ex. 3].

6. Each Medicaid eligible patient that Appellant provided services to and submitted claims for he was required to create a detailed contemporaneous record of the treatment he provided and be able to produce the record to substantiate each claim [18 NYCRR §504.3(a); Tr. 33, 54, 64].

7. The Appellant submitted claims to the Medicaid program for dental services provided on [redacted] 2008 [Ex. 3 - *Audit Finding #2*]. The claims related to the [redacted] however, the patient [redacted] resulting in an overpayment in the amount of $180.00 [Ex. 3 - *Audit Finding #2*; Tr.38-39, 41- 44, 87].

8. The Appellant submitted thirteen claims regarding seven patients where he billed the Medicaid program for " multiple single surface restoration claims with surface codes I and O or F and B for the same patient, same tooth and same surface"

resulting in overpayments to the Appellant in the amount of $724.00 [Ex. 3 - *Audit Finding #8*; Tr. 38-39, 60-69].

9. New York State Residential Health Care Facilities/ skilled nursing facilities (“nursing homes”) “are responsible for the provision of and reimbursement of all dental services” for their Medicaid eligible beneficiaries [18 NYCRR 415.17; Ex.7- “State of New York Department of Health Memorandum-Health Facilities Series 87-67, NH-26, HRF-26”; Tr. 46-48, 51-52, 54, 57-60;].

10. “Dental providers should seek reimbursement for services provided to Medicaid–eligible residents of all New York State Residential Health Care Facilities (RHCF) directly from such facilities.”[Ex. 9*“Dental Manual Policy Guidelines Version 2006-1”*; Tr. 57-59]

11. Each of the patients identified in *Audit Finding #4* is a Medicaid eligible nursing home resident” [Ex. 7- “eMedNY: Client Summary”]. If the patient has an NH designation, the provider is required to bill the patient’s nursing home not the Medicaid program [Ex. 7 “eMedNY MEVS Provider Manual –January 2006”; Tr. 46-49].

12. The Appellant submitted fifty claims that were paid by the Medicaid program for dental services provided to three patients who were Medicaid eligible nursing home residents resulting in overpayments to the Appellant in the amount of $5,417.00 [Ex. 3 - *Audit Finding #4* ; Tr. 44-46, 58-60; Ex. 3, Ex. 7, Ex. 9].

APPLICABLE LAW

In order to participate as a Medicaid provider (“provider”), the provider shall agree to “comply with the rules regulations and official directives of the department” including the claiming procedures set forth in the Medicaid Management Information

Systems ("MMIS") provider manuals,18NYCRR §504.3. The provider has an obligation to create and maintain detailed contemporaneous records for each patient and comply with the claiming procedures set forth in the provider manuals, 18 NYCRR §504.3.

The New York State Office of Health Insurance Programs, formerly Medicaid Management Information Systems Program (MMIS), issues provider manuals, which are available to all providers and include, *inter alia*, billing policies, procedures, codes and instructions. 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).

If an audit reveals an overpayment, the Department may require repayment of the amount determined to have been overpaid, 18 NYCRR §§ 504.8(a)(1), 518.1(b). An overpayment includes any amount not authorized to be paid under the Medicaid program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake, 18 NYCRR § 518.1(c).

The Provider is reimbursed by Medicaid for furnishing services to Medicaid recipients in accord with Department claiming procedures and fee schedules set forth in Department regulations and MMIS provider manuals, 18 NYCRR Parts 506, 513 and 514. A provider submitting claims for dental services to a Medicaid eligible resident of a skilled nursing / residential health care facility ("nursing home"), the liable third party is the nursing home, 18 NYCRR §415.17. 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, 18 NYCRR § 540.6(e)(7).

A provider is entitled to a hearing to have the Department's determination reviewed if the Department requires repayment of an overpayment, 18 NYCRR § 519.4. At the hearing, the provider has the burden of showing that the determination of the Department was incorrect and that all claims submitted and denied were due and payable under the Medicaid program, 18 NYCRR §519.18 (d).

DISCUSSION

OMIG presented the audit file and summarized the case and presented documents, exhibits 1-9. Two witnesses, Nancy delPrado, OMIG Management Specialist and Jean Hanson, OMIG Management Specialist, testified on behalf of OMIG. The Appellant appeared in person and testified on his own behalf.

After nursing homes began to cover dental services for Medicaid eligible residents, it came to the attention of OMIG that the Medicaid program continued to pay dental claims for Medicaid eligible nursing home residents ("NH claims") [Tr. 83-84]. OMIG initiated a project to determine whether any claims had been inappropriately paid by the Medicaid program. Audit procedures were also developed to determine whether claims were paid for treatment of teeth that had previously been removed, and whether multiple claims were paid for treating the same tooth and or surface for the same patient within a three year window [Tr. 60-64]. The claims at issue here were identified by OMIG as over payments during a post payment review

The Medicaid program did not charge the Appellant with fraud or wrongdoing. At the hearing, Ms. del Prado made it very clear that the OMIG did not disallow

Appellant's [redacted] 2008 claim for [redacted] patient with [redacted] because there was sufficient documentation to support the claim [Tr. 44]. OMIG is seeking restitution for claims paid for treating the patient's [redacted] (*Audit Finding #2).* Similarly the OMIG is not seeking restitution for any claim relating to the first treatment or "occurrence" for each of seven patients, but is seeking restitution for paid claims where there were multiple treatments on the same tooth and same surface within a relatively short period of time *(Audit Finding #8)* [Tr. 66]. While the Medicaid program may have allowed the additional treatment claims for the [redacted] patient and for the treatment claims involving multiple treatments on the same tooth and surface for each of the seven patients, the Appellant did not offer any treatment records [Tr. 39, 70, 76].

The bulk of the overpayments in this case involve *Audit Finding #4*. Fifty claims were paid by the Medicaid program to the Appellant for dental services he provided to three Medicaid eligible nursing home residents. Ms. delPrado testified that these claims should have been submitted to and been paid by the nursing home not the Medicaid program [Tr. 86]. Medicaid has a system for providers to check each patient's eligibility and when the Appellant sought to determine the eligibility of these three patients he would have been informed that each of these patients is a "Medicaid eligible nursing home resident 'NH' " [Tr. 46-49]. If the patient has an NH designation, the provider is required to bill the patient's nursing home Medicaid managed care plan not Medicaid [Tr. 47-48]. While the Medicaid program paid the claims, the Appellant was required to submit the claims for each of the three Medicaid eligible nursing home residents to their individual nursing home.

The Appellant testified on his own behalf and did not offer any exhibits. He argued that transcription errors could have been made when the claims were processed, and he expressed frustration with the fact that he was expected to keep up with all the program changes and eligibility requirements when he was paid very little to treat Medicaid patients [Tr. 24, 80, 104-107].

The Appellant testified that he never billed for services he did not provide. He recalled that the patient identified in *Audit Finding #2* [Tr. 106]. For each of the seven patients identified in *Audit Finding #8*, the Appellant said that there were legitimate reasons for why he may have treated the same tooth and surface within a short period of time. He lamented that he sees so many patients and because so much time had passed between the audit period and when he treated these seven patients, he had difficulty remembering each patient's circumstances and needs [Tr. 108]. It is undisputed that the Appellant provided dental services to eligible nursing home residents and that long ago the Medicaid program paid these claims identified in *Audit Finding #4*. The Appellant said that at the time he submitted these claims, he did not know he should have submitted them to each patient's nursing home. He believes that because so much time has passed OMIG should seek restitution from the nursing homes not from him.

CONCLUSIONS

It was the Appellant's obligation as a provider to comply with all Medicaid program rules, regulations and official directives. Specifically, the Appellant had an obligation to create and maintain detailed contemporaneous records for each patient, and submit claims related to each Medicaid eligible nursing home resident to their nursing home. The Appellant did not provide the required documentation to substantiate the disallowed claims contained in *Audit Finding 2 & Audit Finding #8.* The claims contained in *Audit Finding #4* were paid by the Medicaid program, however, these claims should have been submitted to and paid by each patient's nursing home. The Appellant offered nothing to challenge the validity of the findings and disallowances in the audit. It was the Appellant's burden to prove that the audit is in error. Based on the foregoing, the Appellant has failed to carry his burden of proof.

DECISION

OMIG's determination to recover Medicaid overpayments in the amount of $7,257.14 is **affirmed**. This decision is made by Kimberly A. O'Brien, who has been designated to make such decisions.

Dated: November 16, 2015
Albany, New York

Kimberly A. O'Brien
Administrative Law Judge