STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Request of	:	
	:	**Decision After**
Michael Lance Klein, M.D.	:	**Hearing**
Medicaid ID # 00479589	:	
	:	
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	:	Audit #10-7131

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.

Michael Lance Klein, M.D.
35 East 35th Street, Room 200
New York, N.Y. 10016-3823
By: Ralph A. Erbaio, Jr., Esq.
94 Barrett Hill Road
Carmel, New York 10512

Date of Hearing: January 29, 2013

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 or entity that engages in fraud, abuse, or unacceptable practices in the Medicaid program, and to recover improperly expended Medicaid funds.

OMIG determined to seek restitution of payments made by Medicaid to Dr. Michael Lance Klein (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 6)

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. 12 & 13) 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 OMIG's determination to recover Medicaid overpayments in the amount of $443,429.67 from Appellant Michael Lance Klein correct?

FINDINGS OF FACT

1. At all times relevant hereto, Appellant Michael Lance Klein, M.D., was a physician and was enrolled as a provider in the New York State Medicaid program. (Ex. 1, 3, 4 & 5; Ex. A; T. 115-117)

2. The Appellant submitted claims to and was paid by Medicaid for medical services provided during the period January 1, 2005 through December 31, 2008 to patients who were also eligible for coverage under the Medicare program. (Ex. 1 & 5; T. 37-40)

3. OMIG conducted a review of the 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 payments were in compliance with the Medicaid program. (Ex. 1 & 5)

4. By final audit report dated June 7, 2011, OMIG notified the Appellant that OMIG had identified and determined to seek restitution of Medicaid overpayments in the amount of $443,429.67. (Ex. 5 & 5A)

5. During the four year audit period, the Appellant submitted 5718 claims to Medicaid that included inaccurate information about the existence and extent of Medicare coverage for the services provided. OMIG evaluated the claims using actual Medicare payment records for the patients. (Ex. 5 & 5a; T. 29, 31, 37-39) The

$443,429.67 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. 5A).

6. The OMIG provided a representative at the hearing to present the audit file and summarize the case. The representative's explanation of the findings included the following examples of payments to the Appellant that had been made inappropriately: (T. 42-66, 81, 84,105-106)

a. The Appellant reported in some instances that Medicare paid nothing on a claim on which it had actually paid. For example, for the first line item in the audit, the Appellant reported that Medicare had approved a payment of $0.56 but paid nothing. Medicare actually paid $0.45. When Medicaid paid $0.56 on this claim, the Appellant received an overpayment of $0.45 (Ex. 5A, page 1, line 1; T. 42-66, 81, 84, 105-106)

b. The Appellant reported in other instances that Medicare approved a claim but paid nothing, when in fact Medicare had never received a claim. For example, for the third line item in the audit, the Appellant reported that Medicare had approved payment of $157.79, but paid nothing on the claim. Medicaid then paid $157.79 on the claim. In fact, Medicare had no record of the claim and had never approved or denied any payment on it. (Ex. 5A, page 1, line 3; T. 46-50, 105-106) The Appellant was not entitled to any payment from Medicaid on claims that were not submitted to Medicare.

c. In other instances, the Appellant reported that Medicare had approved a claim but paid nothing on it, when in fact Medicare had denied the claim. Medicaid then paid the claim in full. As Medicare had disallowed the claim in its entirety, Medicaid should have paid nothing. (Ex. 5A, page 1, line 2; T. 53-66, 81, 84)

7. The Appellant did not contest OMIG's figures supporting the overpayment calculation or the specific reason given for disallowance of any of the 5718 claims under review, and never submitted any documentation from Medicare to contest either the draft audit or the final audit findings. (T. 52, 98, 104; Cf. Ex. 1, 1a & 5, 5a) The amount of the overpayment is $443.429.67.

DISCUSSION

Prior to 2008, 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. 42-44, 65-66, 97-98) OMIG accepted the provider's reported information as accurate and paid the claims on this basis. At the end of the year 2008, OMIG obtained access for the first time to Medicare payment records and began conducting audits such as this one. (T. 90-92)

Medicaid is a payment source of last resort for health care services. Medicaid claiming instructions state (Ex. 12, pp. 8-9):

> *The provider must bill Medicare or the other insurance first for **covered** services **prior** to submitting a claim to Medicaid.*
>
> The Medicaid program is designed to provide payment for medical care and services only after all other resources available for payments have been exhausted; **Medicaid is always payor of last resort**. Providers must maximize all applicable insurance sources before submitting claims to Medicaid. When coverage is available, payment from other insurance sources must be received before submitting a Medicaid claim. Medicaid Update December 2005 Vol. 20, No. 13.

Where a third party, such as a health insurer or responsible person, has a legal liability to pay for Medicaid covered services on behalf of a recipient, the Department will 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 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). If a provider receives payment from a third party, the claim to Medicaid will be reduced accordingly. 18 NYCRR § 540.6(e)(4). If Medicare will not approve payment of a

claim, Medicaid will not pay. 18 NYCRR § 540.6(e)(6). This case is about payments for which the responsible third party insurer was Medicare.

OMIG presented the audit file and summarized the case, as is required by 18 NYCRR § 519.17. OMIG presented documents (Exhibits 1-14) and the testimony of Beth Perue, the OMIG management specialist who compiled the audit; Catherine McCluskey, the Director of Audit; and Maguerite Montysk, a former OMIG employee who worked on the billing codes with respect to the audit. The Appellant testified in his own behalf.

The Appellant testified that his wife did most of his billing for him. (T. 116) He testified that billing information would be sent to a third party processor, which he believes was known as "WebMD," which would submit the claims to Medicare and Medicaid for him. (T. 117-118, 130-135) The Appellant admitted that he could not produce a contract with WebMD to document the services this corporation was allegedly providing at the times in issue in this matter, nor did the Appellant produce a witness from this service. (T. 135)

The Appellant argued both in response to the draft audit and at hearing, that OMIG is estopped from seeking recovery of the overpayments because Appellant relied on Medicaid's promise to pay and spent the money he was wrongly paid thereby suffering harm. As a general rule, estoppel "cannot be invoked against a governmental agency to prevent it from discharging its statutory duties or from rectifying an administrative error." Matter of New York State Medical Transporter Assoc., Inc., v. Perales, 77 N.Y. 2d 126, 130, 564 N.Y.S.2d 1007, 1010 (N.Y. 1990)(agency corrected its prior practice of approving medical transportation services after the fact to comply with

its statutory duties; those that deal with the government are expected to know the law and could not rely on the erroneous conduct of agents of the government to claim injustice or estoppel). See also, Matter of Parkview Associates v. City of New York, 71 N.Y.2d 274, 525 N.Y.S.2d 176 (N.Y. 1988)(error in building permit did not justify estoppel); Matter of Sunset Nursing Home v. DeBuono, 24 A.D.3d 927, 805 N.Y.S.2d 471 (App. Div. 3d Dept. 2005), leave to appeal denied 7 N.Y.3d 701 (N.Y. 2006)(change in consideration of factors involved in rate increases to conform with statute not grounds for estoppel).

The Court of Appeals case cited by Appellant to support its argument for estoppel involved motions by two claimants against the New York City Health and Hospitals Corporation (HHC) who had erroneously filed their notices of claim with the City of New York instead of the new HHC. The City took steps to defend the actions prior to moving to dismiss. Bender v. New York City Health and Hospitals Corporation, 38 N.Y.2d 662, 382 N.Y.S.2d 18 (N.Y. 1976). The Court of Appeals stated: "We believe that where a governmental subdivision acts or comports itself wrongfully or negligently, inducing reliance by a party who is entitled to rely and who changes his position to his detriment or prejudice, that subdivision should be estopped from asserting a right or defense which it otherwise could have raised." Id. at 563.

In Appellant's case the Department did not "comport itself wrongfully or negligently" nor did it "[induce] reliance by a party who is entitled to rely." It was the Appellant's obligation to comply with all Medicaid rules and regulations. 18 NYCRR § 504.3. Among these regulations was an obligation to report accurately. 18 NYCRR §§ 504.3(h). It was the Appellant's inaccurate claim reporting that led to the overpayments. Also among these regulations was an express provision that all payments were subject to

audit. 18 NYCRR §§ 504.3(g), 517.3(b). The Appellant was not entitled to rely on his receipt of these payments until the time within which an audit could be conducted had expired. 18 NYCRR 517.3. Moreover, Appellant has really not been harmed. At most he has had an interest free loan from the government with which he expanded his practice. (T. 119-121, 126-127)

The Appellant also argued for the first time in his post-hearing brief, that OMIG's audit process was flawed because the OMIG employee who compiled the audit could not testify from personal knowledge that the Medicare information provided by a Medicare subcontractor was accurate. It is initially noted that the Appellant should have raised this issue at the time of the draft audit. 18 NYCRR §§ 517.5(b) & 519.18(a); Lock v. New York Department of Social Services, 220 A.D.2d 825, 632 N.Y.S.2d 300 (App. Div. 3rd Dept. 1995). This is particularly true in light of the fact that the Appellant produced no information to challenge the audit findings. OMIG explained how it obtained the records of Medicare payments. The Appellant offered no reason to question the accuracy of those figures and has not identified even one line item that he claims contains any erroneous information. 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:

OMIG's determination to recover Medicaid overpayments in the amount of $443,429.67 is affirmed. This decision is made by Denise Lepicier, who has been designated to make such decisions.

DATED:
May 24, 2013
New York, New York

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Denise Lepicier
Administrative Law Judge