



NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF DR. JOSE GORIS
MEDICARE PART B COINSURANCE/DEDUCTIBLES
FOR DUAL ELIGIBLES
JANUARY 1, 2005 – DECEMBER 31, 2008

FINAL AUDIT REPORT

James C. Cox
Medicaid Inspector General

September 13, 2012



STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, NY 12204

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

September 13, 2012

Jose Armando Goris, MD
436 Fort Washington Avenue
New York, NY 10033-3537

Re: Final Audit Report
Medicare Part B Coinsurance/Deductible
Audit #: 11-4358
NPI #: [REDACTED]
Provider ID #: [REDACTED]

Dear Dr. Goris:

Enclosed is the Office of the Medicaid Inspector General's ("OMIG") final audit report of the OMIG's review of Dr. Jose Goris (the "Provider") Medicare Part B coinsurance and/or deductible amounts for Medicaid reimbursable services to dual eligibles covering the period January 1, 2005 to December 31, 2008. Dual eligibles are defined to be recipients with both Medicare A and/or B and New York Medicaid coverage. In the attached final audit report, the OMIG has detailed its objectives and scope, laws, regulations, rules and policies, findings, and provider rights.

After reviewing and considering the Provider's March 8, 2012 response, submitted by Martin Clearwater & Bell on behalf of the Provider, to the September 21, 2011 Revised Draft Audit Report, the OMIG has decided to make no changes to the findings previously outlined in the Revised Draft Report. Attachments I, II, and III detail this decision.

In addition to recovering the overpayments set forth in this final audit report, the OMIG reserves the right to take additional actions, including the imposition of sanctions pursuant to 18 NYCRR 515.6, if such action is warranted. If the OMIG determines to take such action, the OMIG will notify the Provider in a separate notice.

If you have any questions, regarding the above, please contact [REDACTED] at [REDACTED] or by email at [REDACTED]. Please refer to audit number 11-4358 in all correspondence.

Sincerely,

[REDACTED]
Audit Manager
Bureau of Managed Care & Provider Review
Division of Medicaid Audit
Office of the Medicaid Inspector General

CC - [REDACTED]
CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.state.ny.us

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to ensure compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to ensure the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

DIVISION OF MEDICAID INVESTIGATIONS

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including capitation and supplemental payment claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

OBJECTIVE AND SCOPE

Objective

The objective of our audit was to ensure that the Provider was in compliance with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- appropriate rate or procedure codes were billed for services rendered based on the recipients county of fiscal responsibility;
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals;
- the Provider received the proper payment from the New York State Medicaid program.

Scope

A review of Medicare Part B claims submitted to Medicaid with incorrect claim amounts covering the period January 1, 2005 to December 31, 2008. Specifically, the amounts Medicare approved and paid were matched to Medicaid claims, as were the coinsurance and deductible amounts, identifying those instances where you either received Medicaid overpayments due to incorrectly reporting Medicare approved and paid amounts, or failed to pursue third party recoveries prior to billing Medicaid.

LAWS, REGULATIONS, RULES AND POLICIES

The following are applicable Laws, Regulations, Rules, and Policies of the Medicaid program referenced when conducting this audit:

- Department of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].
- Medicaid Management Information System ("MMIS") and eMedNY Provider Manual.
- Department of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)]. Specifically:

18 NYCRR Section 504.3:

(h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department.

18 NYCRR Section 517.3(b):

According to regulations, all providers must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. In addition, the provider must keep, for a period of six years, all records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply. This information is subject to audit for a period of six years and must be furnished, upon request.

18 NYCRR Section 518.1(c):

Regulations state, "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

18 NYCRR Section 540.7(a):

Regulations state: "All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing . . .; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment . . .; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided. . . ."

Social Services Law 367-a (d) (iii):

When payment under part B of title XVIII of the federal social security act for items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act... would exceed the amount that otherwise would be made under this title...the amount payable under this title shall be twenty percent of the amount of any co-insurance liability of such eligible persons pursuant to federal law were they not eligible for medical assistance...

18 NYCRR Section 360-7.2:

Regulations state, "MA program as payment source of last resort. Where a third party, such as a health insurer or responsible person, has a legal liability to pay for MA-covered services on behalf of a recipient, the department or social services district will pay only the amount by which the MA reimbursement rate for the services exceeds the amount of the third party liability".

Per DOH Medicaid Update (DOH Medicaid Update December 2005 Vol.20, No.13):

Medicaid law and regulations require that, when a recipient is eligible for both Medicare and Medicaid or has other insurance benefits: 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.

Per DOH Medicaid Update (DOH Medicaid Update August 2003 Vol.18, No.8):

Due to recent legislative change, Medicaid payment for Medicare coinsurance for most Part B services provided to recipients eligible under both the Medicare and Medicaid Programs - dual-eligibles and Qualified Medicare Beneficiaries - will be reduced effective July 1, 2003, the Medicaid program will no longer pay the full Medicare Part B coinsurance amount for dual-eligibles, but will instead pay 20% of the Medicare Part B coinsurance for most Part B services (except for ambulance, psychologist, and hospital-based/freestanding clinics).

DETAILED FINDINGS

The review has found instances where the Provider received Medicaid overpayments of \$95,458 (Attachment I) either because of incorrectly reported Medicare approved and paid amounts, or the failure to bill Medicaid only as a last resort; a violation of Social Services Law 367-a (d) (iii), 18 NYCRR Section 360-7.2, 18 NYCRR Section 518.1(c), and DOH Medicaid Updates December 2005 Vol.20, No.13 & August 2003 Vol.18, No.8. Please note Attachment 1 is a password protected CD and the password remains the same as that provided in previous correspondence.

Based on this determination, the total amount of overpayment as defined in 18 NYCRR §518.1 is \$95,458, and is due the New York State Department of Health.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below.

OPTION #1: Make full payment by check or money order within 20 days of the date of the final report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
Albany, New York 12237-0048

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final report, the OMIG will impose a 15% withhold after 20 days until the agreement is established.

Furthermore, the OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. The OMIG will notify you no later than 5 days after initiating such action. If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
[REDACTED]

If within 20 days, you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to recover payment, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.

If you choose not to settle this review through repayment, you have the right to challenge these findings by requesting an administrative hearing. Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. You may only request a hearing to challenge specific audit adjustments which you challenged in a response to the draft audit report. Your hearing request may not address issues regarding the methodology used to determine any rate of payment or fee.

At the hearing you have the right to:

- a) be represented by an attorney or other representative, or to represent yourself;
- b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
- c) cross examine witnesses of the Department of Health and/or the OMIG.

As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Questions regarding the request for a hearing should be directed to [REDACTED], Office of Counsel, at [REDACTED].

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including, but not limited to, the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

NAME AND ADDRESS OF AUDITEE

Jose Armando Goris, MD
436 Fort Washington Avenue
New York, NY 10033-3537

PROVIDER # [REDACTED]

AUDIT # 11-4358

PRINCIPAL AMOUNT: \$95,457.80

TOTAL AMOUNT DUE: \$95,457.80

**PROVIDER
TYPE**

- Fee For Service
- Rate - LTC
- Rate - NH
- Managed Care
- Other

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
Albany, New York 12237-0016

Thank you for your cooperation.