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Ms. Marks by Scan  
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# Department of Health

KATHY HOCHUL  
Governor

JAMES V. McDONALD, MD, MPH  
Commissioner

JOHANNE E. MORNE, MS  
Executive Deputy Commissioner

July 18, 2025

**CERTIFIED MAIL/RETURN RECEIPT**

Dionne Wheatley, Esq.  
NYS OMIG  
800 North Pearl Street  
Albany, New York 12204

David R. Ross, Esq.  
O'Connell & Aronowitz, P.C.  
54 State Street  
Albany, New York 12207-2501

**RE: In the Matter of Schenectady ARC**

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter.

If the appellant did not win this hearing, the appellant may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the appellant wishes to appeal this decision, the appellant may wish to seek advice from the legal resources available (e.g. the appellant's attorney, the County Bar Association, Legal Aid, OEO groups, etc.). Such an appeal must be commenced within four (4) months after the determination to be reviewed becomes final and binding.

Sincerely,

A handwritten signature in cursive script that reads "Natalie J. Bordeaux".

Natalie J. Bordeaux  
Chief Administrative Law Judge  
Bureau of Adjudication

NJB: cmg  
Enclosure

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of

Schenectady ARC,

Provider No. 01557482,

Appellant,

from a determination by the NYS Office of the  
Medicaid Inspector General to recover Medicaid  
Program overpayments.

DECISION  
ON REMIT  
PURSUANT TO  
CPLR § 7806

Audit # 17-4015

Administrative Law Judge: Natalie J. Bordeaux

Parties:

New York State Office of the Medicaid Inspector General  
800 North Pearl Street  
Albany, New York 12204  
By: Dionne Wheatley, Esq.

Schenectady ARC  
214 State Street  
Schenectady, New York 12305  
By: David Ross, Esq.  
O'Connell & Aronowitz, P.C.  
54 State Street  
Albany, New York 12207-2501

## **BACKGROUND**

Schenectady ARC (Appellant) requested a hearing pursuant to Social Services Law (SSL) § 145-a and former Department of Social Services regulations at 18 NYCRR § 519.4 to appeal a determination by the Office of the Medicaid Inspector General (OMIG) to recover Medicaid Program overpayments, as set forth in a final audit report dated September 11, 2018, which contained six categories of disallowances identified by sampling 100 claims paid from January 1, 2012 through December 31, 2014 (audit period). The Appellant sought review of the first three disallowance categories, and a hearing was held on February 19, 2020, November 25, 2020, and May 19, 2021. The hearing record closed after the parties each submitted a post-hearing brief.

A decision was issued on February 16, 2023 by Administrative Law Judge (ALJ) Matthew Hall, which reversed the OMIG's determination to disallow samples in disallowance category 3 (failure to meet minimum duration requirements) but affirmed the OMIG's determination to disallow samples in categories 1 (no explanation of benefits/documentation for Medicare covered service) and 2 (no explanation of benefits for third-party health insurance).

On June 16, 2023, the Appellant filed a petition pursuant to Article 78 of New York Civil Practice Law & Rules (CPLR) seeking annulment of "so much of the ALJ Decision as affirmed the [final audit report] with respect to the first and second categories" of disallowances. By Decision and Order by the Honorable Stephan G. Schick dated May 9, 2025 and entered May 13, 2025, "the portion of the ALJ's decision affirming the OMIG's Final Audit Report on the basis that ARC failed to comply with 18 NYCRR § 540.6(e) is VACATED; and...the matter is REMITTED to the [New York State Department of Health] for further proceedings consistent with this decision and order."

### ISSUE

Was the OMIG's determination to recover Medicaid Program overpayments from the Appellant for disallowance categories 1 and 2 set forth in the September 11, 2018 final audit report correct?

### APPLICABLE LAW

The Department of Health (Department) is the single state agency for the administration of the Medicaid Program in New York State. Public Health Law (PHL) § 201(1)(v); SSL § 363-a. The OMIG is an independent office within the Department with the authority to review and audit contracts, cost reports, claims, bills and all other expenditures of Medicaid Program funds to determine compliance with and take such actions as are authorized by federal or state laws and regulations. In addition, the OMIG is authorized to recover improperly expended Medicaid funds via civil and administrative enforcement actions against any individual or entity who engages in improper acts perpetrated within the Medicaid Program. PHL §§ 30-32.

When the Department has determined that any person has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, it may require repayment of the amount determined to have been overpaid. 18 NYCRR § 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 Department may require repayment for improper services from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished. 18 NYCRR § 518.3(b).

Medicaid is the payor of last resort. 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 or social services district will pay only the amount by which the Medicaid reimbursement rate for the services exceeds the amount of the third-party liability. 18 NYCRR § 360-7.2.

As a condition of payment, Medicaid providers must take reasonable measures to ascertain the legal liability of third parties to pay for medical care and services. 18 NYCRR § 540.6(e)(1). A provider shall not submit a claim for reimbursement from the Medicaid Program unless the provider has: (i) investigated to find third-party resources in the same manner and to the same extent as the provider would to ascertain the existence of third-party resources for individuals for whom reimbursement is not available under the Medicaid Program; and (ii) sought reimbursement from liable third parties. 18 NYCRR § 540.6(e)(2). Additionally, each Medicaid provider shall make claims against all resources available to pay for medical care and services. 18 NYCRR § 540.6(e)(3).

The provider must comply with all Medicare or other third-party billing requirements and must accept assignment of the recipient's right to receive payment or must acquire any other rights of the recipient necessary to ensure that no reimbursement is made by the Medicaid Program when the costs of medical care, services or supplies could be borne by a liable third party. The provider must repay any reimbursement received from the Medicaid Program if it has not complied with these conditions. 18 NYCRR § 540.6(e)(6).

The electronic Medicaid system of New York State (emedNY) Policy Guidelines entitled “Information for all Providers,” versions 2011-1 and 2, dated June 1, 2011<sup>1</sup> and October 20, 2011<sup>2</sup>, respectively, explicitly advised providers as follows:

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 the payer of last resort... Medicaid requires providers to exhaust all existing benefits prior to the billing of the Medicaid Program. If an enrollee has third-party insurance coverage, he/she must inform the LDSS [local district of social services] of that coverage and to use its benefits to the fullest extent before using Medicaid. Supplementary payments may be made by Medicaid when appropriate.

At a hearing contesting the OMIG’s determination to recover overpayments, the Appellant has the burden of showing that the OMIG’s determination was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR § 519.18(d)(1).

### **DISCUSSION**

The Appellant appealed ALJ Hall’s decision affirming disallowance categories 1 and 2 on the grounds that the ALJ’s affirmance

was made in violation of lawful procedure, was affected by an error of law, and was irrational, arbitrary, and capricious because, among other things, the ALJ failed to apply or even consider 18 NYCRR 540.6(e) which determines under what circumstances third party payors are required to be billed prior to billing Medicaid and because there was no requirement that the Appellant bill Medicare [and private insurers].

(Appellant’s verified Article 78 petition dated June 12, 2023, and filed June 16, 2023.)

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<sup>1</sup> [https://www.emedny.org/ProviderManuals/AllProviders/PDFS/archive/Information\\_for\\_All\\_Providers-General\\_Policy\\_2011-1.pdf](https://www.emedny.org/ProviderManuals/AllProviders/PDFS/archive/Information_for_All_Providers-General_Policy_2011-1.pdf)

<sup>2</sup> [https://www.emedny.org/ProviderManuals/AllProviders/PDFS/archive/Information\\_for\\_All\\_Providers-General\\_Policy\\_2011-2.pdf](https://www.emedny.org/ProviderManuals/AllProviders/PDFS/archive/Information_for_All_Providers-General_Policy_2011-2.pdf)

By Decision and Order dated May 9, 2025, and entered May 13, 2025, ALJ Hall's February 16, 2023 decision was vacated insofar as it affirmed the OMIG's determination to disallow specified claims in categories 1 and 2 on the grounds that the Appellant failed to comply with 18 NYCRR § 540.6(e), and the matter was remitted to the Department for "further proceedings consistent with" that decision and order. *Schenectady ARC v. New York State Department of Health*, Index No. 905229-23 (Sup. Ct. 2025).

The parties were afforded a full and fair opportunity to present their positions to ALJ Hall at the original hearing, and then again to the New York State Supreme Court. As such, the present review, at the direction of the Supreme Court, constitutes the full implementation of the Honorable Stephan J. Schick's order.

The OMIG disallowed samples specified in category 1 (no explanation of benefits (EOB)/documentation for Medicare covered service) and in category 2 (no EOB for third-party health insurance (TPHI) covered service (excluding Medicare), citing 18 NYCRR § 360-7.2; 18 NYCRR § 540.6(e)(2); and the emedNY Information for all Providers, Policy Guidelines, Version 2011-1 & 2.

For category 1, the Final Audit Report explained that the OMIG determined to disallow samples # 3, 5, 10, 13, 14, 18, 21, 31, 33-36, 39-41, 48-50, 52, 56, 63, 71, 73, 77, 78, 87, 88, 93, 99, and 100 because no EOB was found for a Medicare eligible recipient who received services covered by Medicare. Samples #18, 21<sup>3</sup>, 44, and 69 were disallowed under category 2 because the Appellant failed to seek payment from patient's third-party health insurance coverage before submitting claims for payment for those services to the Medicaid Program. (OMIG Exhibit 7.)

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<sup>3</sup> Samples # 18 and 21 were thus disallowed in both categories that remain at issue - the Appellant failed to seek reimbursement from both Medicare and the patient's third-party health insurance before seeking payment from Medicaid for the services claimed.



At the hearing, OMIG Auditor Rosalyn Renas confirmed that she verified that Medicaid recipients receiving services claimed in the samples were Medicare-eligible and whether claimed services were eligible for reimbursement by Medicare. (T 66.) Services not eligible for Medicare reimbursement were removed from the findings, as were any claims involving providers who were not eligible for participation as Medicare providers. (T 80, 140, 144.) The Appellant did not dispute the OMIG's audit findings regarding Medicare and/or third-party health insurance eligibility of recipients identified in the disallowed samples.

The remitting court's finding of error was that the ALJ erroneously held that obtaining an EOB was required by 18 NYCRR § 540.6(e). It remains the case, however, that the regulation still requires the provider to investigate and determine whether there is Medicare or third-party coverage, and the burden is on the provider to demonstrate that it took reasonable measures to do so. 18 NYCRR §§ 540.6(e)(1)&(2). The Appellant has not met that burden.

#### The Appellant's Arguments

The Appellant contended broadly that the OMIG's audit protocol<sup>4</sup> was improper and constituted proposed rulemaking or an interpretation of applicable regulations which did not exist during the audit period. (Appellant's post-hearing brief, pp. 24-30.)

The Appellant was repeatedly advised that the purpose of the audit was to:

assess Schenectady County ARC's (Provider) adherence to applicable laws, regulations, rules and policies governing the New York State Medicaid [P]rogram and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate procedure codes were billed for services rendered;
- recipient related records contained the documentation required by the regulations; and
- claims for payment were submitted in accordance with applicable rules and requirements.

(Exhibits 2, 3, 5 and 7.)

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<sup>4</sup> Available at <https://omig.ny.gov/audit/audit-protocols>.

The audit protocol for New York State Office for People With Developmental Disabilities (OPWDD) Article 16 clinics used in the audit explains that protocols are used as a guide during an audit:

to evaluate a provider's compliance with Medicaid requirements and to determine the propriety of Medicaid expended funds. In this effort, OMIG will review and consider any relevant contemporaneous documentation maintained and available in the provider's records to substantiate a claim.

Every page of this protocol states:

This document is intended solely for guidance. No statutory or regulatory requirement(s) are in any way altered by any statement(s) contained herein. This guidance does not constitute rulemaking by OMIG and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person.

The Appellant failed to identify any provision in the audit protocol that was inconsistent with applicable regulations in effect during the audit period, or any instance in which the OMIG applied an audit protocol inconsistently with the regulations. The remitting court did not hold that the protocols required providers to obtain an EOB. It held that the ALJ erred in saying so.

The Appellant also contended that it complied with regulations applicable to OPWDD clinics. (T 229-32, 322-23.) The Appellant's submission of claims to the Medicaid Program required its compliance with all rules, regulations, and directives of the Department. 18 NYCRR § 504.3(i).

The Appellant contended that the disallowed claims involved services not payable by Medicare but offered no documentation supporting this contention. The Appellant itself acknowledges uncertainty about whether these claims were payable by Medicare, asserting that, during the audit period, "substantial uncertainty" existed as to whether therapy services it provided to patients were covered by Medicare. (Exhibit 6.) Kirk Lewis, the Appellant's

Executive Director, acknowledged his own inability to ascertain whether disallowed claims were reimbursable by Medicare based upon the Appellant's supporting documentation. (T 287-88.)

The Appellant also contended that "[t]here is no proof that the maintenance/long term therapy services at issue were covered by Medicare during the audit period." (Appellant's post-hearing brief, p. 15; *see also* p 48.) The burden of proving entitlement to payment is on the Appellant, not the OMIG. 18 NYCRR § 519.18(d). The Appellant could have attempted to verify coverage by Medicare for rendered services by billing Medicare for those services. However, it did not do so before seeking payment from the Medicaid Program, nor did it otherwise prove the claims were not payable by Medicare. Had the Appellant provided documentation establishing that claimed services were not eligible for reimbursement, the samples would not have been disallowed. However, the Appellant came forward with no evidence to support its claim that these services were not covered and so has failed to prove it made reasonable efforts to ascertain whether they were covered.

Although the Appellant submitted a plenitude of documents, none demonstrated the accuracy of any of its arguments. Information the Appellant submitted regarding a settlement agreement involving the Medicare Program (*Jimmo v. Sebelius*) did not establish that Medicare would not cover and pay for therapy services rendered to patients when such therapy was provided for maintenance rather than improvement. Instead, the documentation provided by the Appellant from the Centers for Medicare and Medicaid Services (CMS) explicitly states that Medicare "has long recognized that even in situations where no improvement is possible, skilled care may nevertheless be needed for maintenance purposes." (Exhibit E.)

The Appellant's description of a "general understanding" by service providers that services claimed in the disallowed samples were not payable by Medicare is not credible.

(Appellant's post-hearing brief, pp. 20, 34-35.) Its own documentation belies that assertion. Before determining to audit Article 16 clinics such as the Appellant for claims submitted and paid by the Medicaid Program, the OMIG verified that Article 16 clinics were eligible to bill Medicare. (T 79.)

While the Appellant's presentation and post-hearing brief repeatedly suggested that the services billed in the disallowed claims would not have been eligible for reimbursement<sup>5</sup> by Medicare, its position was not supported by evidence that it made reasonable efforts to investigate and attempt to secure such reimbursement, an omission that directly contravenes conditions by which it is eligible for Medicaid payments. The Appellant tacitly acknowledged this omission by asserting in its response to the draft audit report that there was no requirement for servicing providers to be enrolled in Medicare, which it described as "an obvious prerequisite to billing Medicare," and argued that no express requirement existed for them to enroll in Medicare. (Exhibit 6; Appellant's post-hearing brief, pp. 36-37.)

The Appellant's attempt to justify its failure to enroll providers in Medicare because a response from the Department, not CMS, to its December 29, 2017 Freedom of Information Law (FOIL) request failed to indicate that clinicians at providers servicing dual eligible recipients (the bulk of its serviced population) were required to enroll in the Medicare program does not disprove the Appellant's existing obligations of which it is clearly aware but has chosen to ignore. (Exhibit N; Appellant's post-hearing brief, p. 38.) It only highlights the illogic of the Appellant's contradictory positions in this case.

In a FOIL request dated August 19, 2019 to the OPWDD, the Appellant sought coding guidelines for clinic treatment facilities dated January 2004, January 2013, a revision of an

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<sup>5</sup> In one instance, going so far as to assert that submitting such claims to the Medicare Program would not only have been wasteful, but a violation of the federal False Claims Act. (Appellant's post-hearing brief, pp. 19-20.)

unknown date, and guidelines dated January 2017. The OPWDD's response, dated August 27, 2019, produced the requested guidelines as available (January 2013 and January 2017). The January 2013 revision (the only FOIL-produced revision in effect during the audit period) emphasized the importance of billing Medicare and third-party health insurance (Exhibit V.)

Independent of the FOIL request, the Appellant produced coding guidelines issued in January 2004 by the Office of Mental Retardation and Developmental Disabilities (OMRDD) for clinic treatment facilities such as the Appellant, which also emphasized the importance of billing Medicare and other third-party health insurance, even though its list of Medicare eligible clinicians was not exhaustive. (Exhibit P.)

The Appellant also provided an email from OPWDD dated November 20, 2012, in which Article 16 clinics were explicitly advised to immediately enroll the following providers in Medicare: licensed psychologist; licensed occupational therapist; licensed physical therapist; licensed speech language pathologist; licensed clinical social worker; registered nurse; certified dietician/certified nutritionist; and licensed audiologist. (Exhibit E.) Yet, the Appellant made little to no effort to enroll any of its providers in Medicare. Instead, the Appellant challenged its own exhibit by claiming that the email did not constitute guidance. (T 216.) If the Appellant deemed irrelevant this clarification from the OPWDD, under whose purview the Appellant operates, the Appellant did so in contradiction of its other argument that it complied with all OPWDD requirements and thus was entitled to Medicaid payments.

Ms. Renas testified that sampled claims for services rendered by individuals who were not eligible for enrollment as Medicare providers were removed from all disallowances. (T 70, 134, 140, 143-44.) The Appellant did not disprove Ms. Renas' explanation or offer any evidence to meet its burden of proving that any service provider ineligible for Medicare enrollment was

included in any of the sampled claims. Instead, it produced documentation showing that four providers who rendered services claimed in disallowed samples were not only eligible, but were actually enrolled in the Medicare Program before the dates of service on disallowed claims even though the Appellant deemed it unnecessary to attempt Medicare reimbursement before billing the Medicaid Program; three servicing providers never applied for Medicare enrollment; and one provider's application was rejected by Medicare solely because she failed to provide additional information requested by CMS. (Exhibit R.) No information was offered by the Appellant regarding the Medicare enrollment status of the other servicing providers.

An express requirement for enrollment of providers in Medicare before billing Medicare existed before, during and after the audit period. Providers have been required to comply with all Medicare or other third-party billing requirements to ensure that no reimbursement is made by the Medicaid Program when the costs of medical care, services or supplies could be borne by a liable third party. 18 NYCRR § 540.6(e)(6). The conclusive way for the Appellant to know if Medicare did not cover services rendered would be for the Appellant to comply with Medicare billing requirements and then submit claims to Medicare. However, as Kirk Lewis, the Appellant's Executive Director, explained, the Appellant's practice was not to bill Medicare, a determination to which he credited the Appellant's billing office. (T 283-84.)

Interestingly, several email inquiries and responses that did not involve the Appellant directly but occurred before the audit period, and which the Appellant now suggests it may have relied upon in its billing operations, only bolster the OMIG's position that the Appellant lacked basic documentation to establish that it had ever attempted to obtain reimbursement from Medicare for claimed services, even at other points in time. Those communications, combined with the Appellant's introduction of Medicaid billing guidelines and Medicaid updates at the

hearing, also disprove the Appellant's claim that it "had no notice or guidance to indicate that these claims should have been submitted to Medicare to obtain a Medicare EOB before billing Medicaid." (Appellant's post-hearing brief, pp. 4-5, 38-39.)

The Appellant submitted two emails dated April 4, 2008 (well before the audit period) between Debra Williams (a witness at the hearing)<sup>6</sup>, Vice President of Reimbursement and Regulatory Compliance at Cerebral Palsy Associations of New York State (whose organization is not related to the Appellant) and Bruce Gembala, an individual from the OMIG with an unverified title. These emails, presented and relied on by the Appellant, confirmed that in order to indicate on a Medicaid claim that Medicare as the primary payor provided zero reimbursement (referred to as "zero-fill"), a service should be billed to Medicare once for each patient and the provider should keep the denial from Medicare on file. (Exhibit I; T 358-59, 367.)

Ms. Williams subsequently submitted another inquiry, this time to the Department, on January 23, 2014, in which she asked Ronald Bass, Director of the Bureau of Medical, Dental and Pharmacy Policy, to confirm that "agencies can continue to obtain a denial for Medicare, zero fill, and roll the claim to Medicaid until we receive further guidance from DOH. This entails using the GY modifier to obtain one denial per year per service per consumer." (Exhibit J.) Even though Ms. Williams was offered as a witness at the hearing to support the Appellant's lack of documentation in this audit, her own understanding reflects a far more balanced approach to ensuring that Medicaid continued to be treated as the payor of last resort for rendered services, as opposed to the Appellant's failure to do anything. The Appellant's argument that the emails do not have the force of law (Appellant's post-hearing brief, p. 39), however voluminously

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<sup>6</sup> Described by Erik Geizer, CEO of ARC New York, as "an expert in article sixteen clinic billing." (T 338.)

communicated, is incoherent because it attempts to ignore the real issue, which is what if anything the Appellant did to comply with the law, specifically 18 NYCRR § 540.6(e).

The Appellant did not provide documentation to the OMIG showing that it made at least one attempt (ever) to bill Medicare for the services claimed in the disallowed samples per patient, let alone once per patient per year. The Appellant never even suggested that it possessed those documents or made such attempts, arguing instead that this was “arbitrary,” all the while insisting that it had no idea how to proceed even though it had made no independent inquiries. (Appellant’s post-hearing brief, pp. 33-34.) Without any documentation to justify the Appellant’s election not to pursue Medicare and other third-party resources, the OMIG reasonably concluded that the Appellant failed to establish that it made reasonable attempts to exhaust all other payor sources before seeking payment from the Medicaid Program.

The Appellant’s failure to treat Medicaid as a payor of last resort is also manifest in its failure to seek payment from third-party health insurance for the samples disallowed in category 2. Kirk Lewis, the Appellant’s Executive Director, acknowledged that the Appellant was unable to bill third-party health insurance because the Appellant’s providers were not enrolled in Medicare, a process which the Appellant described as tedious, time-consuming, and arduous. (Exhibit 6; Appellant’s post-hearing brief, pp. 5-6, 41, 46; T 220-23, 251, 279, 286.) This again amounts to an admission that the Appellant did not make reasonable efforts to obtain payment elsewhere before billing Medicaid, and offers the excuse that it was simply too much trouble to do so.

In addition to applicable law in, among other places, 18 NYCRR § 360-7.2, § 504.3, and § 540.6(e), the Appellant was expected to abide by other guidance promulgated by the Department. This guidance, disseminated well before the audit period, was in the Appellant’s



possession, despite the Appellant's confused assertion that "there was never any direction that all claims had to be billed to obtain an EOB before billing Medicaid." (Appellant's post-hearing brief, p. 22.) The Appellant itself introduced two Medicaid Updates issued by the Department. The December 1995 Medicaid Update reminded OMRDD (now the OPWDD) day treatment and clinic providers such as the Appellant that "Medicaid is the payor of last resort. It is the responsibility of the provider to make every effort to obtain reimbursement from [t]hird [p]arty [i]nsurance prior to billing Medicaid." (Exhibit D.)

The December 2005 Medicaid Update also explicitly requires providers to bill Medicare or other insurance first for covered services before submitting a claim to Medicaid and provides the following explicit instructions:

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

(Exhibit L.)

The Department has the authority to make such rules, regulations and official directives (including manuals, Medicaid Updates, administrative directives) as are necessary to implement the regulations, and providers are required to abide by them. 18 NYCRR § 504.3(i); *PSSNY v. Pataki*, 870 N.Y.S.2d 633 (App. Div. 3d Dep't 2009); *Lock v. NYS Department of Social Services*, 632 N.Y.S.2d 300 (App. Div. 3d Dep't 1995.)

The Appellant made no effort to ascertain whether Medicare or other insurance would cover the services for which it sought reimbursement from Medicaid, and did not present documentation to establish that services rendered in the disallowed claims were not payable by Medicare and/or third-party health insurance. Such documentation would generally be in the

form of an EOB, as evidenced by Ms. Williams' initiated communications with various individuals at the OMIG and the Department. Nevertheless, the Appellant insisted that it complied with the spirit and purpose of 18 NYCRR § 540.6(e) when reviewing the requirements set forth therein within context and regulatory history.

The Appellant did not provide the supposedly overlooked context and history, not even in the form of citations to available resources, but instead pivoted to a definition of "reasonable" in Black's Law Dictionary. (Appellant's post-hearing brief, p. 16.)

A review of legislative history is appropriate when a law is unclear. *Shannon v. Westchester County Department of Social Services*, 34 N.E.3d 600 (N.Y. 2015); *White v. Metropolitan Opera Association, Inc.*, 44 N.Y.S.3d 412 (App. Div. 1st Dep't 2017). Requirements set forth in 18 NYCRR § 540.6(e) are not unclear. As such, neither a review of legislative history nor a review of the definition of "reasonable" are necessary.

At a minimum, the Appellant was required to seek reimbursement from liable third parties by making claims against all resources available to a patient and comply with billing requirements of Medicare and other third-party insurers to ensure that no reimbursement is made by the Medicaid Program when the costs could be borne by a liable third party. 18 NYCRR §§ 540.6(e)(2),(3)&(6). The Appellant failed to establish that it made reasonable efforts to fully investigate all resources available and, by its own admission, did not comply with billing guidelines of Medicare and third-party insurers. (Exhibit 6; Appellant's post-hearing brief, pp. 41, 46; T 220-23, 251, 279, 286.)

As support for the Appellant having made no effort to verify coverage by Medicare and/or third-party insurance for services billed to the Medicaid Program in claims now disallowed, the Appellant asserted that a prior Department-led audit in the year 2004 and/or year

2005 originally included findings regarding the Appellant's failure to show auditors EOBs for patients possessing Medicare and/or third-party insurance, but that those disallowances were removed. (Appellant's post-hearing brief, pp. 13-14.) However, according to Mr. Lewis, that disallowance category was removed from audit findings during settlement negotiations. (T 202-07, 209-10.) Audit findings in a different audit, particularly one that was ultimately settled and for which neither an administrative nor a judicial determination was made, offers no support for the Appellant's standard practice of billing only Medicaid without first verifying the availability of other payor sources. While the standard way of establishing such verification requires the presentation of an EOB, something the Appellant's own witness has acknowledged, the Appellant simply offered no documentation demonstrating its attempt to verify in any other manner the availability of a primary payor source for services rendered to each patient identified in the disallowed samples.

The Appellant argued that 18 NYCRR § 540.6(e) does not, "on its face", "require billing Medicare in each and every instance". (T 93-95.) The remitting court, and this hearing decision, agree with that self-evident assertion. It remains the case, however, that the regulation still requires the provider to investigate and determine whether there is Medicare or third-party coverage, and the burden is on the provider to demonstrate that it took reasonable measures to do so. 18 NYCRR §§ 540.6(e)(1)-(3)&(6). The Appellant has not met that burden.

The May 13, 2025 Decision and Order concluded that ALJ Hall's decision affirming the OMIG's determination to disallow samples identified in categories 1 and 2 contained an "unreasonable interpretation of" 18 NYCRR § 540.6(e) inasmuch as ALJ Hall determined that this regulatory provision required Medicaid providers to "always bill Medicare and potential third-party insurer before seeking Medicaid reimbursement, regardless of the actual liability of

those parties.” The issue then remains what, if any, documentation did the Appellant supply to the OMIG auditors to demonstrate reasonable attempts to verify that neither Medicare nor a patient’s third-party insurer was liable for the services documented in the disallowed claims.

The Appellant’s conflated presentation at the hearing and in its post-hearing brief regarding whether attempts to bill Medicare and/or third-party health insurance once per year per Medicaid recipient for the services claimed in the disallowed samples would suffice, as opposed to submitting new EOBs for every date of service before billing Medicaid, is irrelevant because the evidence fails to prove that the Appellant did even that. The hearing record establishes that the Appellant made no attempt to ascertain the liability of Medicare or third-party health insurance for rendered services whatsoever. In short, and to address Judge Schick’s concerns regarding ALJ Hall’s decision, the Appellant did not make reasonable efforts to ascertain the legal liability of Medicare and other third-party insurers because, for the period audited, it did not make any efforts at all.

The Appellant argued that, since Medicare frequently pays more than Medicaid for the same service, it had “every incentive to bill Medicare and it does bill Medicare,” as “[i]t would be irrational not to.” (Appellant’s post-hearing brief, p. 17.) This review does not necessitate analysis of the Appellant’s own business motives and whether or not they are rational. The requested supposition, in addition to being inappropriate for consideration in this review, does not disprove the OMIG’s audit findings.

Regarding disallowance category 2, failure to provide EOBs for recipients covered by non-Medicare, third-party insurers, the Appellant argued that it “experienced similar issues with private insurance” as it “similarly does not cover maintenance/long term therapy services.” (Appellant’s post-hearing brief, p. 23.) The Appellant provided no documentation of any

“experience” at all with billing third-party insurers, likely because, as it concedes, the Appellant was unable to bill private insurance “until a Medicare EOB is obtained.” (Appellant’s post-hearing brief, p. 23; T 279.) This renews the Appellant’s circular and self-made dilemma: the Appellant had no Medicare EOBs because it did not bill Medicare.

What is clear, however, is that the Appellant viewed attempts to bill third-party sources, including Medicare, as a “waste.” (Appellant’s post-hearing brief, pp. 19, 20, 35, 66.) This characterization, even though a majority of its patients possess such coverage (T 166, 349), is not reasonable.

The Appellant offered no information to show that disallowed claims were not eligible for payment by Medicare or third-party health insurance. Despite Ms. Renas’ best efforts to eliminate any disallowances involving claims in which a provider could not enroll in Medicare (because they were not qualified to do so) and verify that services rendered were eligible for payment by the Medicare Program, she could not substantiate that, for remaining disallowed samples, all amounts claimed were due and payable from the Medicaid Program because the Appellant did not have any documentation to demonstrate its compliance with all requirements. The Appellant did not provide that documentation because the Appellant failed to treat the Medicaid Program as a payor of last resort, opting instead to utilize the Medicaid Program’s funds as its primary, if not sole, source of reimbursement. References to 18 NYCRR § 540.6(e), while relevant, are not needed to explain the Appellant’s failure to establish that the OMIG’s determination to disallow samples identified in categories 1 and 2 was incorrect. The Appellant failed to document that it exhausted other benefits available to Medicaid recipients identified on the disallowed claims before seeking reimbursement from the Medicaid Program.

**DECISION**

The OMIG's determination to recover Medicaid Program overpayments from the Appellant for disallowance categories 1 and 2 set forth in the September 11, 2018 final audit report was correct and is affirmed.

Dated: July 18, 2025  
Menands, New York



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Natalie J. Bordeaux  
Administrative Law Judge