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SAPA File



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

March 10, 2026

CERTIFIED MAIL/RETURN RECEIPT

Enoch Kun, Esq.
NYS Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Jean Debrard, Owner
V.I.P. Ambulette, Inc.
55 East Eckerson Road
Spring Valley, New York 10977

RE: In the Matter of V.I.P. Ambulette, Inc.

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 / cmg".

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

V.I.P. Ambulette, Inc.
Provider ID: 02110534

Appellant,

from a determination by the New York State Office of
the Medicaid Inspector General to recover Medicaid
Program overpayments

**DECISION
AFTER
HEARING**

Audit Number: 23-7382

Before: Shelby L. Foster
Administrative Law Judge

Held at: New York State Department of Health
150 Broadway, Suite 510
Menands, New York 12204

Hearing Date: September 23, 2025
Record closed: November 21, 2025

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

V.I.P. Ambulette, Inc.
55 East Eckerson Road
Spring Valley, New York 10977
By: Jean Debrard, Owner
Zuzana Debrard

JURISDICTION

The New York State Department of Health (Department) acts as the single state agency to supervise the administration of the Medical Assistance (Medicaid) Program in New York State. 42 USC 1396a; Public Health Law (PHL) § 201(1)(v); Social Services Law (SSL) § 363-a. The Office of the Medicaid Inspector General (OMIG), an independent office within the Department, is authorized to investigate and pursue civil and administrative enforcement actions to recover improperly expended Medicaid funds. PHL §§ 30-32.

The OMIG determined to recover Medicaid overpayments made to V.I.P. Ambulette, Inc. (Appellant). The Appellant requested a hearing pursuant to SSL § 145-a and former Department of Social Services (DSS) regulations at 18 New York Codes, Rules and Regulations (NYCRR) 519.4 to review the OMIG's determination.

HEARING RECORD

OMIG Witnesses:	Stacy Hammond, Medicaid Integrity Specialist 3
OMIG Exhibits:	1 – 13
Appellant Witnesses:	Jean Debrard, Owner Zuzana Debrard
Appellant Exhibits:	A

A transcript of the hearing was made. (Transcript [Tr.] 1 – 72.) The OMIG submitted a post-hearing brief; the Appellant made a closing statement at the hearing. The Appellant submitted a reply to the OMIG's post-hearing brief. The record closed on November 21, 2025, when the OMIG advised it would not be submitting a reply brief.

FINDINGS OF FACT

1. At all times relevant hereto, the Appellant, owned by Jean Debrard, was an ambulette services provider enrolled in the New York State Medicaid Program, provider ID 02110534. (Exhibit [Ex.] 1.)
2. By letter dated December 27, 2023, the OMIG advised the Appellant that it would be auditing the Appellant's records pertaining to ambulette services paid by the Medicaid Program during the period January 1, 2018, through December 31, 2020 (audit period). (Ex. 1.)
3. During the audit period, the Appellant was paid \$1,517,388.69 for 33,915 claims submitted to the Medicaid Program for ambulette services. The review consisted of a random sample of 100 claims with Medicaid payments totaling \$4,388.27. (Ex. 3.)
4. The OMIG shared its proposed findings with the Appellant at an exit conference held on October 18, 2024. (Ex. 3.)
5. On January 27, 2025, the OMIG issued a draft audit report (DAR) to the Appellant, which identified 63 claims with at least one error, amounting to a total sample overpayment of \$2,615.10. By using extrapolation, a statistical sampling methodology, the OMIG preliminarily determined that the Medicaid overpayment to the Appellant was \$886,911. (Ex. 5.)
6. On March 4, 2025, the Appellant submitted a response to the DAR that stated: "We provided all info needed. Drop off time is calculated 1 h[ou]r after pick up time." (Ex. 6.)

7. On April 8, 2025, the OMIG issued its final audit report (FAR), in which the overpayment of \$886,911 identified in the DAR remained unchanged. (Ex. 7.)
8. The OMIG categorized its findings into the following disallowance categories:
 - a. In 62 instances, contemporaneous documentation supporting the time of drop off was missing or inaccurate for one or both legs. (Samples 2, 5, 6, 7, 9, 10, 11, 13, 15, 16, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 33, 34, 35, 36, 37, 41, 42, 43, 44, 45, 46, 48, 50, 52, 53, 54, 55, 56, 57, 60, 62, 63, 65, 67, 70, 71, 72, 75, 79, 80, 82, 84, 87, 88, 90, 92, 93, 95, 96, 97, and 99.)
 - b. In 2 instances, the provider did not comply with DMV certification requirements of Article 19A of the Vehicle and Traffic Law by not ensuring its drivers were connected to the provider's 19A Driver Roster on the date of service. (Samples 38 and 82.)

(Ex. 7.)

The payment for claim 82, disallowed in both categories, was only disallowed once.

9. By letter dated June 9, 2025, the Appellant requested a hearing to review the OMIG's determination. (Ex. 11.)

ISSUE

Was the OMIG's determination to recover Medicaid Program overpayments from the Appellant correct?

APPLICABLE LAW

By enrolling in the Medicaid Program, providers agree to prepare contemporaneous records demonstrating the right to receive payments under the Medicaid Program and to furnish such records and information, upon request, to the Department. The information submitted in relation to any claim for payment must be true, accurate, and complete. Medicaid

providers also agree to comply with the rules, regulations, and official directives of the Department. 18 NYCRR 504.3(a), (g)-(i), 540.7(a)(8).

Medicaid providers are subject to audit by the Department, and all information regarding claims for payment must be maintained for six years. Notification by the OMIG to a provider of its intent to audit shall toll the six-year period for record retention and audit. 18 NYCRR 504.3(a), 504.8(a), 517.3(b)-(c).

When a provider has submitted or caused to be submitted claims for medical care, services, or supplies for which payment should not have been made, the OMIG 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 Medicaid provider is entitled to a hearing to review the OMIG's final determination to require repayment of an overpayment. 18 NYCRR 519.4. 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); State Administrative Procedure Act § 306(1).

DISCUSSION

At the hearing, the OMIG presented the audit file and summarized the case, as required by 18 NYCRR 519.17.

Audit Findings

The OMIG identified 64 disallowances among 63 claims, for a total sample overpayment of \$2,615.10. Claim 82, with two disallowances, was only disallowed once. (Ex. 7.)

Disallowance Category 1: Missing/Incomplete Documentation.

The OMIG identified 60 instances of missing or incomplete contemporaneous documentation supporting the time of drop off for both legs, and 2 instances for one leg, of round-trip ambulette services.

Documentation of transportation services must include: (i) the recipient's name and MA identification number; (ii) the origination of the trip; (iii) the destination of the trip; (iv) the date and time of service; and (v) the name of the driver transporting the recipient. 18 NYCRR 505.10(e)(8).

An August 2010 Department of Health Medicaid Update (2010 Update) advised transportation providers of these documentation obligations and specified that date and time of service required to be contemporaneously documented means and must include both time of pick up and time of drop off:

Ambulette, Taxi, Livery, and Group Ride Providers: For each leg of the trip, trip verification should be completed at the time of the trip and must include, at a minimum:

- The Medicaid beneficiary's name and Medicaid identification number;
- The date of transport;
- Both the origination of the trip and time of pickup;
- Both the destination of the trip and time of drop off;
- The vehicle license plate number; and
- The full printed name of the driver providing the transportation.

The new documentation requirements include the *time of drop off* and the *vehicle license plate number*. Providers are expected to comply with these two new

requirements for dates of service on or after September 1, 2010. This documentation is required for every leg of the trip. A round trip is considered two separate services, with correlating documentation. Although the driver's signature is not required at this time, it is advised that providers include an attestation in the trip documentation that states, "*I provided the indicated transportation services,*" and request the driver's signature.

Providers are urged to maintain a record with all information listed above in case of a Medicaid audit. If any of the information above is lacking, illegible, or false, a claim may be denied...

(Ex. 7.)

These record-keeping requirements, including the requirement to document times for both legs of each trip, were also set forth in Section II of the NYS Medicaid Program Transportation Manual, Policy Guidelines, Versions 2016-1 through 2019-1 (Provider Manual). (Ex. 7.)

Stacy Hammond, Medicaid Integrity Specialist III, who reviewed the findings for this audit, explained how the Appellant's trip tickets showed missing or incomplete drop off times for one or both legs of the trip, in violation of specific requirements in the 2010 Update, and the Provider Manual, that providers document "both the destination of the trip and time of drop off." (Tr. 27-28.)

Representative examples included sample 23, where the driver picked up two recipients at different locations and times and dropped them off at the same destination with different appointment times. The second leg of the trip for one of those recipients documented a pick-up, but no drop off time. (Ex. 8; Tr. 28-30.) In sample 33, the driver picked up two recipients that lived in close proximity at the same time, however the drop off times for that leg of the trip for each recipient were the same, despite being in very different locations. The second leg of the trip for one of those recipients documented a pick-up time, but no drop off

time. (Ex. 8; Tr. 30-31.) In sample 52 the electronic trip ticket did not include a drop off time. (Ex. 9; Tr. 32.)

The Appellant argued that it relied on computer software from MedTrans Pro to ensure compliance, and it does not include a field for drop-off time, only appointment time. (Tr. 46-47.) Ms. Debrard has tried to contact the software developer but has not been able to reach them. (Tr. 14, 45.) A review of the MedTrans Pro Software Proposal offered by the Appellant shows that MedTrans purports to “assure[s] accuracy from the initiation of a trip right through posting a payment,” and includes the following information regarding Medicaid billing:

Billing Module

Daily billing for insurance companies, Medicaid and private pay clients is completed using the Dispatch module. The Billing Module is designed to allow managers to quickly update or change an invoice, to review a particular day, finalize trips, view the payment status of a single client, and create agency bills.

- *Electronic Billing—X12N V5010 837: Health Care Claim: Professional Computer Science Corporation-New York State Medicaid Billing.*
 - *Import the New York State—Computer Science Corporation weekly roster for medical billing.*
 - *Import and verify the roster, relate the roster to trips completed*
 - *Create electronic files of completed trips and submit thru the emedny exchange mailbox.*
 - *Multiple levels of verification are included in the process including, but not limited to, prior authorization methodology, trip verification, roster reconciliation, NPI information, billing codes, and the regulations governing electronic billing for the specified organizations.*

(Ex. A.)

While the language contained in the MedTrans proposal was relied on by the Appellant, it does not contain a “guarantee” of compliance as Ms. Debrard has asserted. (Tr. 13, 46.) Nor does it excuse the Appellant of its responsibility to maintain, and produce for audit, documentation establishing entitlement to payment in order to ensure the information

submitted for its claims is true, accurate, and complete pursuant to regulation 18 NYCRR 504.3(h).

The Appellant failed to offer any contemporaneous documentation to meet its burden of establishing that the times of pick up and drop off for these, or any of the 62 disallowances in this category, were documented as required. The Appellant's statement in response to the DAR that "Drop off time is calculated 1 h[ou]r after pick up time" (Ex. 6) is an admission that it did not accurately document times of service. The Appellant's argument that the drop off time equals the appointment time is also rejected. As the OMIG pointed out, an appointment time is a scheduled time, not necessarily equal to the drop off time. (Tr. 26-27.)

Disallowance Category 2: Driver Not Connected to Provider's NYS DMV 19-A Carrier Driver History Report on Date of Service.

Ambulette services must be authorized by the Department of Transportation (DOT) and ambulette drivers must be qualified under Article 19-A of the New York State Vehicle and Traffic Law (VTL). Ambulette services and their drivers must comply with all requirements of the DOT and the DMV. 18 NYCRR 505.10(e)(6)(ii); Section I of the NYS Medicaid Program Transportation Manual, Policy Guidelines, Versions 2012-1 through 2019-1. Motor carriers are required to report all drivers who are transporting for them. NYS DMV Article 19-A Guide for Motor Carriers, version CDL-15, January 2015. In addition, motor carriers are required to notify the DMV of the date of hire, re-hire, and termination of any driver, within ten days. VTL § 509-d(4).

The OMIG identified two instances where the provider failed to document drivers were connected to the provider's 19-A Driver Roster on the date of service. (Samples 38 and 82.)

Ms. Hammond testified regarding sample 82 that the DMV 19-A system roster showed the driver, M.L., was hired on October 20, 2018, however the date of service for sample 82 was October 12, 2018. The driver was not on the provider's 19-A roster at the time of service. A review of the 19-A roster for sample 38 shows that the driver, I.S., was terminated by the Appellant on March 15, 2020, and re-hired on October 9, 2020, however the date of service for sample 38 was August 27, 2020. The driver was not on the provider's 19-A roster at the time of service. (Ex. 10; Tr. 33)

The Appellant testified that he has an inspector that handles the paperwork for the DMV and Department of Transportation. He could not explain why these two samples were not handled properly and admitted to the disallowances. (Tr. 45-46, 50.)

The Medicaid Program Overpayment.

The 100-claim audit sample was randomly selected from an audit frame of all 33,915 claims that the Department's billing and payment records show were paid by the Medicaid Program to the Appellant during the three-year audit period. Computer generated documents prepared by the Department or its fiscal agent to show the nature and amount of payments made under the Medicaid Program will be presumed, in the absence of direct evidence to the contrary, to constitute an accurate itemization of the payments made to a provider. 18 NYCRR 519.19(f). The Appellant did not challenge or offer any evidence to rebut this presumption.

The draft audit report (Exhibit 5) and the final audit report (Exhibit 7) explained and set forth the manner in which the extrapolation was made. An extrapolation based upon an

audit utilizing a statistical sampling method certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made. 18 NYCRR 519.18(g). The OMIG submitted certifications in compliance with this regulation. (Exs. 12, 13.) The Appellant failed to object to or offer any evidence to overcome the presumption of accuracy.

CONCLUSION

Appellant witness Zuzana Debrard testified that she and her husband admit the OMIG's findings are correct. (Tr. 56.) Owner Jean Debrard testified that he cannot afford to pay the OMIG back and does not want to close the business. (Tr. 57.) The OMIG provided the Appellant and Ms. Debrard with information about its Hardship Program. (Tr. 52-53, 57.)

The Medicaid Program employs a pay first and audit later process which ensures providers receive prompt payment of their claims. In return, providers are required to produce proof of their entitlement to payment when requested on a subsequent audit. The provider's obligation to fully and properly document entitlement to payment and to produce that documentation for audit goes to the heart of the Department's ability to oversee expenditures in this government funded program. It is reasonable and appropriate to hold providers to that obligation, and Department regulations specifically authorize the recovery of payments not supported by adequate documentation.

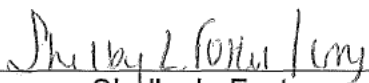
The Appellant has failed to meet its burden of proving that the OMIG's determination to recover Medicaid Program overpayments was incorrect. The OMIG is entitled to recover the identified overpayments.

DECISION

1. With respect to Disallowance Category 1, the OMIG's determination to recover Medicaid Program overpayments from the Appellant is affirmed.
2. With respect to Disallowance Category 2, the OMIG's determination to recover Medicaid Program overpayments from the Appellant is affirmed.
3. The OMIG is entitled to recover restitution in the amount of \$886,911.

This decision is made by Shelby L. Foster, Bureau of Adjudication, who has been designated to make such decisions.

Dated: Menands, New York
March 10, 2026



Shelby L. Foster
Administrative Law Judge

To: Enoch Kun, Esq.
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