State of New York
Supreme Court, Appellate Division
Third Judicial Department

Decided and Entered: July 2, 2026 CV-25-0551

In the Matter of NATIONAL SEATING & MOBILITY, INC.,

Petitioner,

v MEMORANDUM AND JUDGMENT

NEW YORK STATE OFFICE OF MEDICAID INSPECTOR GENERAL et al.,

Respondents.

Calendar Date: May 26, 2026

Before: Reynolds Fitzgerald, J.P., Ceresia, McShan, Mackey and Ryba, JJ.

Benesch Friedlander Coplan & Aronoff LLP, New York City (*Mark J. Silberman* of *Benesch Friedlander Coplan & Aronoff LLP*, Chicago, Illinois, of counsel, admitted pro hac vice), for petitioner.

Letitia James, Attorney General, Albany (*Kate H. Nepveu* of counsel), for respondents.

Ceresia, J.

Proceeding pursuant to CPLR article 78 (transferred to this Court by order of the Supreme Court, entered in Albany County) to review a determination of respondent Office of the Medicaid Inspector General to obtain reimbursement for certain Medicaid payments made to petitioner.

Petitioner provides customized wheelchairs and related durable medical equipment (hereinafter DME) to individuals, including Medicaid recipients. Respondent Office of the Medicaid Inspector General (hereinafter OMIG) is an independent office within respondent Department of Health (hereinafter DOH) responsible for "detecting and combating Medicaid fraud and abuse and maximiz[ing] the recoupment of improper Medicaid payments" (Public Health Law § 30). In December 2020, OMIG notified petitioner that it would be conducting an audit of a random sample of 160 Medicaid claims petitioner submitted in calendar years 2015 through 2017 (hereinafter the audit period). During the audit period, petitioner had filed 1,586 claims totaling $388,829. OMIG performed a review of the 160 sample claims and then issued a draft audit report identifying, as relevant here, 110 claims with inadequate supporting documentation. More particularly, OMIG found that for these claims, petitioner had failed to obtain original signed orders from Medicaid recipients' medical providers as required by New York's Medicaid Durable Medical Equipment Manual: Policy Guidelines (hereinafter the DME policy guidelines). Using statistical sampling methodology, OMIG extrapolated the sample findings to the total number of claims and determined that petitioner had received overpayments in the amount of $270,804. In response to the draft audit report, petitioner raised several objections and provided additional documents. OMIG thereafter issued a final audit report, adhering to its prior conclusions and offering a settlement amount of $251,393. After an administrative hearing held at petitioner's request, an Administrative Law Judge (hereinafter ALJ) upheld OMIG's disallowances and total overpayment calculation. Petitioner then commenced the instant proceeding, and Supreme Court transferred it to this Court (*see* CPLR 7804 [g]).

We confirm. First, as to petitioner's argument that OMIG improperly enforced the DME policy guidelines without promulgating them under the rulemaking requirements of the State Administrative Procedure Act (hereinafter SAPA), this contention is unpreserved for our review because it was not raised at the hearing (*see Matter of Woojin Cho v New York State Dept. of Health, Bd. of Professional Med. Conduct*, 243 AD3d 1049, 1050-1051 [3d Dept 2025]; *Matter of Rispoli v DiNapoli*, 180 AD3d 1127, 1128 [3d Dept 2020]). Instead, it was improperly presented for the first time in petitioner's reply brief (*see Matter of Maidenbaum & Sternberg, LLP v New York State Dept. of Taxation & Fin.*, 243 AD3d 1054, 1056 [3d Dept 2025]; *Uzamere v State of New York*, 240 AD3d 1020, 1021 [3d Dept 2025]). Even if this were not the case, we would find the claim to be lacking in merit. "[S]pecifically exempted from the definition of a rule under [SAPA] are 'forms and instructions, interpretive statements and statements of general policy which in themselves have no legal effect but are merely explanatory' " (*Matter of North Shore Hematology-Oncology Assoc., P.C. v New York State Dept. of Health*, 240

AD3d 42, 45 [3d Dept 2025], *lv denied* 44 NY3d 904 [2025], quoting State Administrative Procedure Act § 102 [2] [b] [iv]; *see Mrijaj v Genting N.Y. LLC*, 235 AD3d 558, 559 [1st Dept 2025], *appeal dismissed* 43 NY3d 1001 [2025]). In this instance, the relevant section of the DME policy guidelines is an interpretive statement that serves to explain a regulation. That is, petitioner was obligated by regulation to retain each "written order" or "fiscal order" issued by a medical provider (18 NYCRR 505.5 [a] [8]), terms that are defined in the regulation, and the DME policy guidelines explain the various kinds of documents that are acceptable to meet this definition. Critically, a guideline or directive is not a rule subject to SAPA when it "merely address[es] the type of documentation needed to establish whether a predetermined test of eligibility for approval has been met" (*Matter of Brightonian Nursing Home, Inc. v Zucker*, 212 AD3d 162, 167 [3d Dept 2023] [internal quotation marks, brackets and citation omitted], *appeal dismissed* 39 NY3d 1144 [2023]), as is the case here.

Turning to the merits, "[i]n reviewing a Medicaid eligibility determination rendered after a hearing, this Court must review the record, as a whole, to determine if the agency's decisions are supported by substantial evidence and are not affected by an error of law" (*Matter of Krooks v Delaney*, 203 AD3d 1292, 1294 [3d Dept 2022] [internal quotation marks and citations omitted]; *see* CPLR 7803 [4]). "Substantial evidence is a minimal standard that requires less than the preponderance of the evidence and demands only the existence of a rational basis in the record as a whole to support the findings upon which the determination is based" (*Matter of Cooperstown Ctr. for Rehabilitation & Nursing v New York State Dept. of Health*, 225 AD3d 1045, 1047 [3d Dept 2024] [internal quotation marks and citations omitted]; *see Matter of Dunkez Private Home Care, Inc. v McDonald*, 243 AD3d 986, 988 [3d Dept 2025]). "If substantial evidence is present in the record, this Court cannot substitute its own judgment for that of the respondent, even if a contrary result is viable" (*Matter of Shanahan v Justice Ctr. for the Protection of People with Special Needs*, 198 AD3d 1157, 1158 [3d Dept 2021] [internal quotation marks and citations omitted]; *see Matter of P.C. v Stony Brook Univ.*, 43 NY3d 574, 581 [2025]).

Pertinent here, a provider "contesting the findings of an OMIG audit . . . has the burden of demonstrating 'that all claims submitted and denied were due and payable under the Medicaid program' " (*Matter of Wegman v New York State Dept. of Health*, 229 AD3d 862, 864 [3d Dept 2024] [brackets omitted], quoting 18 NYCRR 519.18 [d] [1]; *see Matter of Atlanticare Mgt., LLC v Ives*, 212 AD3d 132, 137 [3d Dept 2022], *lv denied* 40 NY3d 902 [2023]). In that regard, the provider must agree "to comply with the rules, regulations and official directives" of DOH (18 NYCRR 504.3 [i]) and "to prepare and

. . . maintain contemporaneous records demonstrating its right to receive payment under the" program (18 NYCRR 504.3 [a]). As mentioned above, petitioner was required to retain each "written order" or "fiscal order" issued by a medical provider, terms that are "used interchangeably" and defined to mean "any original, signed written order of a practitioner which requests [DME]" (18 NYCRR 505.5 [a] [8]; *see* 18 NYCRR 517.3 [b] [1]). Under the DME policy guidelines in place during the audit period, a "fiscal order" was acceptable if it was "a signed written order, or electronically transmitted fiscal order." Where a "signed written order" was not written on an official, serialized prescription form, but was instead telephoned or faxed, the DME provider was then responsible for "obtain[ing] the original signed fiscal order from the ordering practitioner within 30 calendar days." By contrast, an "electronically transmitted fiscal order" was one that "originate[d] from the practitioner's computer and [was] directly transmitted to the . . . DME provider's computer or fax."

At the hearing, OMIG presented evidence including the orders examined under the audit, as well as testimony pertaining to OMIG's evaluation and ultimate disqualification of 110 of said orders. According to hearing testimony by an auditor with OMIG, these 110 orders constituted "signed written orders" that bore practitioners' signatures. However, none were written on a serialized prescription pad. Instead, OMIG determined that in each instance, a proposed order was sent via fax from petitioner to a practitioner, who then physically signed the order before faxing it back to petitioner. Therefore, OMIG concluded, and the ALJ agreed, that petitioner was required to obtain the original order from the practitioner – containing a "wet signature," or one written in ink – within 30 days, but it failed to do so at any point. Petitioner did not argue that it had produced any original orders bearing wet signatures, but instead contended that this was not required because the orders in question constituted "electronically transmitted fiscal orders" in that they were sent from the practitioners to petitioner via an "email to fax" system, whereby the practitioner would send the signed order by email to petitioner's fax number. The ALJ rejected this contention, noting that even if petitioner had presented any evidence to support this assertion – which it did not – petitioner had failed to adequately explain how the orders could be said to have originated from the practitioner's computer, as required to constitute an "electronically transmitted fiscal order." Having reviewed the hearing proof including the orders at issue, it is plain that petitioner failed to comply with the DME policy guidelines and, resultingly, substantial evidence supports the ALJ's determination that the Medicaid payments pertaining to these orders were not authorized (*see Matter of Wegman v New York State Dept. of Health*, 229 AD3d at 864-865; *Matter of Fast Help Ambulette, Inc. v New York State Dept of Health*, 198 AD3d

756, 759-760 [2d Dept 2021]; *Matter of Gignac v Paterson*, 70 AD3d 1310, 1311-1312 [4th Dept 2010], *lv denied* 14 NY3d 714 [2010]).

Nevertheless, petitioner also challenges the determination based upon a change in the DME policy guidelines. Specifically, petitioner points out that, beginning with the 2021 version of the guidelines, DOH indicated that a "signed written order" could now include a legible, validated facsimile of an original signed order and that, in such case, the original order with the wet signature would no longer be required. While not disputing that this change occurred after the audit period and did not apply to the orders in this case, petitioner claims that the policy change reveals that reliance upon the previous version of the guidelines was arbitrary and capricious. We disagree. In keeping with the goal of Medicaid fraud prevention, both the earlier and the later versions of the guidelines implemented certain safeguards pertaining to the use of faxed orders. While the earlier guidelines achieved that goal by requiring the original order with wet signature, the later guidelines removed that condition but added requirements that the fax be legible and that the provider take certain steps to validate the order and the practitioner's identity. Neither version of the guidelines, in our view, is arbitrary or capricious, and the fact remains that petitioner did not meet the guidelines that were in place during the audit period.

Finally, we are unpersuaded by petitioner's assertion that it was unfairly subjected to a "penalty" of full reimbursement of the Medicaid overpayments despite the fact that all of the DME underlying the orders was actually provided to Medicaid recipients. "[P]etitioner's reimbursement of the unauthorized payments is not a sanction or penalty, but merely a remedy in the nature of recoupment" (*Matter of A.R.E.B.A. Casriel v Novello*, 298 AD2d 134, 135 [1st Dept 2002], *lv denied* 100 NY2d 506 [2003]; *accord Matter of Harry's Nurses Registry, Inc. v New York State Off. of Medicaid Inspector Gen. [OMIG]*, 236 AD3d 1338, 1340 [4th Dept 2025]; *see* 18 NYCRR 516.3 [a] [1]). This is because "[a] Medicaid provider is liable for reimbursement of any overpayment . . . and an overpayment 'includes any amount not authorized to be paid under the medical assistance program' " (*Matter of A.R.E.B.A. Casriel v Novello*, 298 AD2d at 135, quoting 18 NYCRR 518.1 [c]; *see Matter of Gignac v Paterson*, 70 AD3d at 1312). Where, as here, a provider engages in "unacceptable practices" (18 NYCRR 518.1 [c]), defined to include "[u]nacceptable recordkeeping" (18 NYCRR 515.2 [b] [6]), OMIG "may require repayment of the amount determined to have been overpaid" (18 NYCRR 518.1 [b]). Therefore, petitioner's argument that full recoupment is improper because it is shocking to one's sense of fairness is misplaced, as that standard applies in situations where the agency has imposed a penalty (*see e.g. Matter of Kelly v Safir*, 96 NY2d 32, 38 [2001];

Matter of Rensselaer County Dept. of Social Servs. v McDonald, 244 AD3d 1444, 1450 [3d Dept 2025]). Petitioner's remaining contention concerning a purported due process violation has been considered and found to be lacking in merit.

Reynolds Fitzgerald, J.P., McShan, Mackey and Ryba, JJ., concur.

ADJUDGED that the determination is confirmed, without costs, and petition dismissed.

ENTER:

Robert D. Mayberger
Clerk of the Court