State of New York : Department of Health

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In the Matter of the Request of

Eliot Silber, DDS (Appellant)

Audit # 14-F-1061
Provider #00403241

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 (18 NYCRR) to review a Determination under 18 NYCRR Parts 515 to 518 to impose the sanction of 3 years exclusion and to recover $46,521.00 in the Medicaid Overpayments.

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| Before: | James F. Horan, Administrative Law Judge |
| Held at: | New York State Department of Health<br>90 Church Street<br>New York, NY 10007<br>July 11, 2017 |
| Parties: | Office of the Medicaid Inspector General (OMIG)<br>Office of Counsel<br>217 Broadway, 8th Floor<br>New York, NY 10007<br>BY: Lisa Seeman, Esq. |
| | Jacobson, Goldberg & Kulb<br>Attorneys for Appellant<br>585 Stewart Avenue, Suite 720<br>Garden City, NY 11530<br>BY: Jeffrey Granat, Esq. |

The OMIG determined that the Appellant Medicaid Dental Provider engaged in unacceptable practices under six categories by submitting 395 claims for reimbursement for services between 2010 and 2013, which resulted in overpayments totaling $46,521.20. The OMIG determined to recoup the $46,521.20 overpayment (Recoupment) and to exclude the Appellant as a provider in the Medicaid Program for three years (Exclusion). After a hearing on this matter, the ALJ affirms the findings that the Appellant engaged in unacceptable practices, affirms the Recoupment and affirms the Exclusion.

## I. Background

Title 18 NYCRR §519.4 entitles a Medicaid provider to a hearing to review the Department's determination to impose sanctions or require repayment. After the OMIG issued the Notice of Agency Action (NOAA) seeking Recoupment and Exclusion, the Appellant requested the hearing, which took place on July 11, 2017 at the Department's Metropolitan Regional Office in New York City. The ALJ conducted the hearing in this matter pursuant to New York Social Services Law (SSL) Articles 1 and 5 (McKinney Supp. 2017), New York Public Health Law (PHL) Article 1 (McKinney Supp. 2017), New York State Administrative Procedure Act (SAPA) Articles 3-5 (McKinney 2017) and Title 18 NYCRR Parts 504, 515, 518, 519 & 540.

The OMIG presented as hearing witnesses: OMIG Investigative Specialist Kerry Quinn and OMIG Public Health Dentist Edmond Haven, DDS. The Appellant testified on his own behalf, but called no other witnesses. All witnesses testified under oath and subject to cross-examination. The OMIG offered 14 exhibits into evidence that the ALJ received into the record:

Exhibit 1 Notice of Hearing February 28, 2017,
Exhibit 2 Provider Request for Hearing January 23, 2017,
Exhibit 3 Notice of Pre-Hearing Conference March 21, 2017,
Exhibit 4 OMIG Record Request April 4, 2014,
Exhibit 5 Provider Response to Record Request,
Exhibit 6 NOAA Tab 1, Representative Samples Denoted,
Exhibit 7 Auditor's Notes Regarding Unacceptable Practices,
Exhibit 8 Provider Enrollment Papers and Certifications for Billing Medicaid,
Exhibit 9 Notice of Proposed Agency Action (NOPAA),
Exhibit 10 NOAA January 18, 2017,
Exhibit 11 Recipient Listing,
Exhibit 12 Patient Records,
Exhibit 13 Excerpts from the New York State Medicaid Dental Provider Manual,
Exhibit 14 Explanation of Medical Benefits.

The Appellant offered no exhibits into evidence. The record also contained the hearing transcript pages 1-169. Following the hearing, both parties submitted briefs [OMIG Brief November 13, 2017; Appellant's Brief November 15, 2017].

Under SAPA § 306(2), all evidence, including records and documents in an agency's possession of which an agency wishes to avail itself, shall be offered and made a part of the record of a hearing. Under Title 18 NYCRR § 519.18(f), computer generated documents prepared by the Department or its fiscal agent to show the nature and amounts of payments made under the 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. In addition to testimony and documents in evidence, and pursuant to SAPA § 306(4), an ALJ may take Official Notice of any matter for which Judicial Notice may be taken.

Under SAPA § 306(1), the burden of proof in a hearing falls on the party which initiated the proceeding. Title 18 NYCRR § 519.18(d) provides that the Appellant bears the burden to show a determination of the Department was incorrect and that all claims submitted were due and payable. Title 18 NYCRR 519.18(h) and SAPA § 306(1) provide that a decision after hearing must be in accordance with substantial evidence. Substantial evidence means such

relevant proof as a reasonable mind may accept as adequate to support a conclusion or fact; less than a preponderance of evidence, but more than mere surmise, conjecture or speculation and constituting a rational basis for decision, Stoker v. Tarantino, 101 A.D.2d 651, 475 N.Y.S.2d 562 (3rd Dept. 1984), appeal dismissed 63 N.Y.2d 649. The substantial evidence standard demands only that a given inference is reasonable and plausible, not necessarily the most probable, Ridge Road Fire District v. Schiano, 16 N.Y.3d 494 (2011).

## II. Findings of Fact

The ALJ made the following findings of fact (FF) after affording the parties an opportunity to be heard and after considering the evidence. The items in brackets that follow the findings represent documents in evidence [Ex], testimony from the record [T] and matters under Official Notice [ON] on which the ALJ relied in making the findings. In instances in which conflicting evidence appears in the record, the ALJ considered and rejected that other evidence.

1. The New York State Department of Health (Department) is the single state agency responsible for administering the Medicaid Program in New York State [ON SSL § 363-a, PHL § 201.1(v)].

2. The OMIG is an independent office within the Department with the responsibility for investigating, detecting and preventing Medicaid fraud, waste and abuse and for recouping improper Medicaid payments [ON PHL § 30].

3. The Appellant is licensed to practice Dentistry in the State of New York [Ex 8].

4. The practice of Dentistry in the State of New York entails the diagnosing, treating, operating or prescribing for any disease, pain, injury, deformity or physical condition of the oral and maxillofacial area relating to restoring and maintaining dental health, including the prescribing and fabrication of dental prostheses and appliances [ON New York Education Law § 6601(McKinney's 2016)].

5. The Appellant enrolled as a dental provider in the Medicaid Program in 1979 [Ex 8].

6. The Appellant was excluded by the Medicaid Program from 1986-1990, due to disciplinary action against the Appellant's dental license, rather than for conduct concerning services or billings under the Medicaid Program [T 33; Ex 8].

7. The Appellant enrolled as a Medicaid provider again in 1990 and has been a provider ever since [Ex 8].

8. The Appellant entered into a Stipulation and Settlement with Medicaid in 2007 to pay $3,098.00 (2007Z10-13C), following allegations that the Appellant violated the Medicaid Provider Manual by billing for rebase, reline or repair of prosthetic appliance within twelve months prior to placement of a new prothesis [Ex 7; T 32].

9. The OMIG recovered $1,459.00 from the Appellant in 2009 (2009Z12-219R) for billing improperly to the Medicaid Program for services to Medicaid recipients after the recipients' date of death [Ex 7, T 32-33].

10. By letter dated April 1, 2014, the OMIG requested the Appellant's complete dental records for thirty specific Medicaid recipient patients for the purposes of a provider audit [Ex 4].

11. Investigative Specialist Kerry Quinn and Public Health Dentist Edmond Haven, DDS participated in the audit on the thirty records [T 15, 103].

12. The OMIG issued a NOPAA on April 22, 2016, which determined that the Appellant committed unacceptable practices by submitting 395 inappropriate claims for $46,521.20 in Medicaid reimbursement for dental services the Appellant rendered between May 1, 2010 and December 31, 2013 [Ex 9].

13. The NOPAA determined that the dental services rendered or the dental records associated with the review: failed to comply with the Medicaid Dental Manual requirements, failed to meet professionally recognized standards of dental care, failed to document adequately that the services were rendered, lacked documentation to substantiate the necessity for the services and included inappropriate billings and claims for unfurnished services [Ex 9].

14. The OMIG issued a January 18, 2017 NOAA, which found that the Appellant failed to respond to the NOPAA, despite four extensions to respond, so the OMIG made no changes from the NOPAA [Ex 10].

15. The NOAA indicated that the OMIG would seek restitution amounting to $46,521.20 for overpayments for the period May 1, 2010 to December 31, 2013

and the Appellant's exclusion from the Medicaid Program for three years [Ex 10].

## III Issue

Has the Appellant established that the OMIG erred in finding that the Appellant engaged in unacceptable practices, in seeking $46,521.20 in restitution for payments to the Appellant and in excluding the Appellant from the Medicaid Program for three years.

## IV. Controlling Regulations and Directives

Title 18 NYCRR § 518.1(c) defines overpayment as any amount not authorized to be paid under the medical assistance program, whether paid as a result of improper claiming, unacceptable practices, fraud, abuse or mistake. Title 18 NYCRR § 515.2 defines unacceptable practices to include conduct contrary to rules, rates or fees, fraud or abuse, false claims, false statements, failure to disclose, unacceptable record keeping, client deception and failure to meet recognized standards. Conduct which constitutes fraud or abuse also constitutes unacceptable practices under Title 18 NYCRR § 515.2(b). Further, Title 18 NYCRR § 515.2(b)(6) defines unacceptable practices as failing to maintain or to make available for purposes of audit or investigation records necessary to fully disclose the medical necessity for and the nature and extent of the medical care, services or supplies furnished, or to comply with other requirements of this Title. Under Title 18 NYCRR §504.3(e), by enrolling in the Medicaid Program, a provider agrees to submit claims for payment only for services actually furnished and which are

medically necessary or otherwise authorized. Title 18 NYCRR § 504.3(h) states that a provider agrees to provide true, accurate and complete information in relation to any claim.

Title 18 NYCRR §504.3(i) provides that by enrolling, a provider agrees to comply with the rules, regulations and official directives of the Department. In this case, the Medicaid Program Dental Provider Manual constituted the specific directives to dental providers about what is appropriate treatment and what would be required for billing [T 40]. The Appellant as a Medicaid dental provider was obligated to comply with the directives under the Dental Provider Manual, Lock v. New York State Department of Social Services, 220 A.D.2d 300, 632 N.Y.S.2d 300 (3rd Dept. 1995); Pharmacy Society of the State of New York v. Pataki, 58 A.D.3d 924, 870 N.Y.S.2d 633 (3rd Dept. 2009).

Upon a determination that a provider has engaged in an unacceptable practice, Title 18 NYCRR §515.3(a)(1) provides that the Department may impose sanctions, including exclusion for a reasonable time. Title 18 NYCRR §515.3(b) provides that the Department may also require the repayment of overpayments determined to have been made as a result of an unacceptable practice. Title 18 NYCRR §515.4(b) provides that the Department will consider the following factors in determining a sanction:

1) the number and nature of the program violation or other related offenses,
2) the nature and extent of any adverse impact the violations have had on recipients,
3) the amount of damages to the Medicaid Program,
4) mitigating circumstances,
5) other factors related to the nature and seriousness of the violations, and
6) the previous record of the provider under the Medicaid, Medicare and social services programs.

Title 18 NYCRR §518.1(b) provides that when the Department determines that a provider has submitted claims for services that should not have been made, the Department may require repayment of the amount determined to have been overpaid.

## V. Discussion and Conclusions

The evidence from the hearing demonstrated that the Appellant committed unacceptable practices by submitting 395 inappropriate claims for $46,521.20 in Medicaid reimbursement that the Appellant accepted for dental services the Appellant rendered between May 1, 2010 and December 31, 2013. The unacceptable practices fell into six categories under the definitions for unacceptable practices at 18 NYCRR § 515.2: failing to comply with the Medicaid Dental Manual requirements [515.2(a)], failing to meet professionally recognized standards of dental care [515.2(b)(12)], failing to document adequately that the services were rendered [515.2(b)(6)], lacking documentation to substantiate the necessity for the services [515.2(b)(1)(i)(2) & (b)(11)], submitting inappropriate billings [515.2(b)(12)] and filing claims for unfurnished services [515.2(b)(1)(i)(a)]. The ALJ concludes that the OMIG determined an appropriate sanction in this matter by ordering Recoupment of the $46,521.20 the Appellant collected for the services at issue and by the Appellant's Exclusion from the Medicaid Program for three years.

**Manual Noncompliance:** Dr. Haven determined that the Appellant failed to comply with the Manual for 48 billed services because the Appellant failed to follow the prescribed recommendations and the protocol set down for the Program [T 106]. In this category, Dr. Haven gave an example of a case in this category that involved placing a [redacted] on Tooth [redacted] of Patient 10. This decision refers to patients by number to protect patient privacy. Dr. Haven found

unacceptable practices because the Appellant billed for the services prior to completion/insertion of the [redacted] The Appellant had received prior approval to place a cast [redacted]. Rather than placing a cast [redacted], the Appellant placed a [redacted] to [redacted], which is not covered as a service under the Medicaid Program [T 108; Ex 10, page 000035]. In another case in this category involving Patient 3, the Appellant billed for two services on the same date for [redacted] Dr. Haven testified that the procedures require prior approval and the Appellant took impressions prior to receiving approval, which violates policy. Dr. Haven also found there was no laboratory prescription documenting the appliance design and materials used, no specific instructions for the laboratory technician and no invoice documenting the type of appliance the laboratory constructed [T 109]. In addition, the Appellant applied for the repair of a [redacted] for Patient 3 and performed the repair [redacted] years later at a cost that exceeded 50% of the cost of a new [redacted] Dr. Haven testified that the Manual requires that, in cases in which a repair exceeds 50% of the cost of a new [redacted] the new [redacted] is the procedure to follow [T 110]. In the case of Patient 14, the Appellant billed for a [redacted] prior to insertion and completion and also placed a [redacted] on the Patient's tooth [redacted] Dr. Haven found the service unacceptable because the Appellant billed before completion on the partial and because the Appellant should have completed the [redacted] before taking the impression on the [redacted] so he would have the contour for tooth [redacted] prior to creating the [redacted] [T 110-111].

The Appellant conceded that he inserted a [redacted] as opposed to a [redacted] [redacted] on Patient 10's Tooth [redacted] [T 155], but the Appellant claimed that he probably misread the prior approval. The Appellant also addressed billing for [redacted] prior to insertion. The Appellant indicated that he called Medicaid on three separate occasions, dating back to 1990, and was told verbally that he could bill for [redacted] after impression and before completion. The

Appellant presented nothing in writing to support that testimony and he admitted that the Manual held otherwise [T 143]. The Appellant stated further that he did what he thought was proper and that when you make [redacted] you have to pay the laboratory for the [redacted] and then wait to bill [T 143].

In rebuttal to the Appellant's testimony, Dr. Haven testified that the Manual requires providers to complete all [redacted] treatment before an impression for [redacted] is made [T 164].

**Documentation:** The OMIG determined that there were no records for 231 services or that the records were missing, incomplete, inaccurate or illegible. As an example, Dr. Haven testified that the Appellant billed twice for an [redacted] restoration for Tooth [redacted] on Patient 28, but there were no records for the date of service [redacted], 2013, so there was no current review to indicate updated changes and no way to determine the need for [redacted] replacement [T 114]. For Patient 5, the Appellant billed for a therapeutic procedure on [redacted] 2010 called [redacted] scale and a [redacted] planning. Dr. Haven testified that there was no progress note for the procedure date and a note for six days previously contained no [redacted] charting, no [redacted] diagnosis and no description of the condition of the tissue, as required for billing [T 114-115].

The Appellant conceded that he omitted information from his records [T 152-155]. The Appellant indicated he might omit to list a material used for a filling in a [redacted] tooth, because he almost always uses [redacted] for filling [redacted] teeth. He stated that these were his records, not public records, and he had to make sure that he knew what the records said [T 152-153]. The Appellant indicated that he did all medical histories orally because he practices in Harlem, where the Appellant claims a certain percentage of the population is illiterate and unable to respond to a

medical history [T 153]. The Appellant testified that his patients often didn't know the names of the medications they took, but only knew the medication was for [redacted] or [redacted] The Appellant also indicated that he doesn't list medications in his records, because they don't affect dental treatment [T 155].

In rebuttal to the Appellant's testimony, Dr. Haven testified that it is important to track a patient's medications in a dental chart, especially when you are giving the patient [redacted] that could affect [redacted] [T 162]. Dr. Haven also indicated that he would want to know if a patient is on [redacted] or any [redacted] Dr. Haven testified that if a patient had a procedure that required follow-up medication and the patient didn't have the names of the medications the patient took, Dr. Haven would call the patient's physician, ask about the patient's medications and request the physician's recommendation [T 162-163]. Dr. Haven testified that he knows such contact occurs in overall dental practice, because he sees letters going back and forth over these questions in patient records.

**Need For Services:** The NOAA determined that records for 55 services contained no evidence to show a need for the services the Appellant billed. In the case of Patient 25, the Appellant billed for adding a tooth to an existing [redacted]. Dr. Haven testified that you would add a tooth to an existing [redacted] to replace a recently [redacted]. In this case, however, the history showed that tooth number [redacted] had been replaced on a [redacted] previously and there was no documentation to indicate there was a recent [redacted] [T 116]. In the case of Patient 9, the Appellant billed for a [redacted] on tooth [redacted] Dr. Haven testified that x-rays, progress notes and dental notes showed no presence of [redacted] and that there was no documentation of a diagnosis using any method that showed a defect requiring [redacted] [T 117-118]. In the case of Patient 27, the Appellant billed for placing [redacted]

[redacted] on tooth [redacted] Dr. Haven testified that there were no x-rays or documentation of a diagnosis to show the necessity for the service [T 119-120].

In discussing Need for Services, the Appellant made no reply to Dr. Haven's testimony concerning the services to Patients 9, 25 and 27, but instead addressed a written finding by Dr. Haven in the record at Exhibit 10, tab 6, page 000094. That finding involved a one-surface amalgam on tooth [redacted] for Patient 3. The Appellant characterized Dr. Haven's finding as "[redacted] on an x-ray means you need a [redacted]" [T 144]. The Appellant took issue with that and testified that x-rays are not a sole determination of whether a filling is good or to determine if work is necessary, but it's a combination of x-rays and an oral physical exam.

The ALJ notes that the actual finding by Dr. Haven was that x-rays and progress notes showed no evidence of [redacted] and there was no documentation of diagnosis by visual or tactile examination or any other diagnostic method [Ex 10, tab 6, page 000094].

**Standards/Quality of Care:** The NOAA determined that records for 31 services failed to meet standards of care. Dr. Haven defined the standard of care as the level of care that is consistent with that of similar dentists in a geographical area who would be treating the same or similar condition and he testified that the 31 services at issue failed to meet the standard [T 119-120]. In the case of Patient 14, the Appellant billed for placing a [redacted] to [redacted] on tooth [redacted] Dr. Haven testified that the professional standard for the service requires placement on a [redacted] and that the Appellant failed to meet the standard because progress notes showed a defective post [T 120-121]. For Patient 13, the Appellant billed for a [redacted] on tooth [redacted] Dr. Haven testified that the standard of care required a tooth that was healthy and restorative, but records showed [redacted] for tooth [redacted] [T 122]. For Patient 18, the Appellant billed for a [redacted] for tooth [redacted] Once again,

the standard of care requires a sound tooth for the service. Dr. Haven testified that tooth [redacted] was migrating into the position of the missing tooth [redacted] and that tooth [redacted] was of limited function of value and quality and, therefore, of minimal function of being restorative [T 124].

**Inappropriate Billing:** The NOAA determined that the records for 23 services showed inappropriate billings. Dr. Haven testified that this finding meant that a better service could have been provided for the same tooth or condition than the service for which the Appellant billed [T 125]. In the case of Patient 5, the Appellant billed for a [redacted] on tooth number [redacted] Dr. Haven testified that tooth [redacted] had [redacted] and [redacted] so that the actual recommended treatment would have been [redacted] [T 125]. In the case of Patient 27, the Appellant billed for a [redacted] on tooth [redacted] Dr. Haven testified that due to [redacted], a [redacted] or [redacted] would have provided a functional alternative and that, less than a year later, the Appellant billed for the [redacted] Dr. Haven concluded that the Appellant should have done the [redacted] from the beginning and not bothered with the [redacted] [T 126]. For Patient 12, the Appellant billed for [redacted] in conjunction with [redacted] which is a service involving the [redacted] of [redacted] teeth at the same time [T 127]. In this case, the Appellant [redacted] only [redacted] teeth, [redacted] and [redacted] in the [redacted] of the Patient's mouth. The Appellant also billed for the same service in [redacted] teeth, [redacted] and [redacted] in another portion of the Patient's mouth. Dr. Haven testified that there was no evidence to support the extraction of [redacted] teeth [T 127-128].

**Unfurnished Care/Services:** The NOAA determined that records in 7 cases demonstrated unfurnished services. For Patient 2, the Appellant billed for [redacted] teeth [redacted] and [redacted] on [redacted], 2013 [Ex 10, tab 8, page 000118]. The OMIG found that records indicated that tooth [redacted] was [redacted] on [redacted] 2011 and billed to managed care that same month. The

OMIG found further that the removal of tooth [redacted] was not possible in [redacted] 2013 because the Appellant's charts indicated that tooth [redacted] was not present in the Patient's mouth on either [redacted], 2008 or [redacted] 2005. For Patient 18, the Appellant billed for surgical [redacted] of tooth [redacted] on [redacted], 2012. The OMIG determined that the Appellant's records for [redacted] 2009 and [redacted] 2010 indicated that tooth [redacted] was not present in the Patient's mouth on those dates [Ex 10, tab 8, page 000118]. For Patient 20, the Appellant billed for an [redacted] of tooth [redacted] on [redacted], 2012. The OMIG determined that subsequent x-rays for [redacted] 2013 and [redacted] 2013 showed no presence of an [redacted] [Ex 10, tab 8, page 000119]. Dr. Haven testified that there were no defects noted in x-rays and no verification by the Appellant in records of the material used [T 131].

The Appellant testified that, if he billed for [redacted] a tooth, he extracted the tooth [T 151]. For the errors in the extractions involving Patient 2, the Appellant suggested that the error could be due to "not the very best record keeping" or to putting down the wrong tooth number [T 152]. As noted above, the Appellant testified that he might omit to list a material used for a [redacted] in a [redacted] tooth, because he almost always uses [redacted] for [redacted] [redacted] teeth [T152].

**Evidence:** Title 18 NYCRR § 519.18(d) provides that the Appellant bears the burden to show a determination of the Department was incorrect and that all claims submitted were due and payable. The only evidence the Appellant presented was his own testimony, which the ALJ found lacking in credibility.

The Appellant conceded that he ignored the Dental Provider Manual billing requirements for dentures and he ended his testimony by indicating that what the Manual says is not what is always done in the practice of dentistry [T 161]. The Appellant also admitted that his record keeping was not the best, although he blamed a good deal of his deficiencies on his patients'

literacy and their ignorance about the medications they take. The Appellant indicated that his records are his records and not public records. In instances in which the Respondent billed for services he didn't furnish, such as the [redacted] for Patient 2 and the [redacted] for Patient 10, the Appellant offered no proof that he performed the services, and instead claimed there were errors because he wrote down the wrong tooth numbers or misread the prior approval. The Appellant also testified that he did what he thought was proper [T 143] and that he felt if he did his best for the patient, Medicaid would pay for it [T 150].

The ALJ found Dr. Haven to be a highly qualified and credible witness, who made his findings from the Appellant's own dental records. For each category of unacceptable practice, Dr. Havens gave examples of services to two and usually three specific patients who received the services. Dr. Haven then testified that the rest of the patient samples for the category were similar to the specific cases Dr. Haven discussed [T 199]. The Appellant responded to some of the findings by Dr. Haven; but made no response to other findings by Dr. Haven.

**Sanction:** The NOAA determined that Recoupment and Exclusion should constitute the sanction in this matter.

Title 18 NYCRR § 515.3(b) provides that the Department may require the repayment of overpayments determined to have been as a result of unacceptable practices. The evidence from this hearing showed that the Appellant committed unacceptable practices in six categories that resulted in overpayments the Appellant accepted, which totaled $46,521.20. The ALJ finds Recoupment in this amount appropriate.

Title 18 NYCRR § 515.4(a)(1) provides that exclusion from the Medicaid Program for a reasonable time constitutes one of the sanctions for unacceptable practices. Title 18 NYCRR § 515.4(b) lists six factors for consideration when imposing a sanction. Investigator Quinn testified

that she considered four of those factors in recommending that the OMIG exclude the Appellant from the Medicaid Program for three years:

- the number and nature of the violations or other related offenses,
- the nature and extent of any adverse impact the violations had on recipients,
- the amount of damages to the Program, and
- the previous record of the person under the Medicare, Medicaid or social services programs [T 30].

Investigator Quinn also prepared a written summary of her reasons for recommending Exclusion that appears as Ex 7 in the hearing record.

The Investigator's summary indicated that the nature of the violations concerned 395 claims that included rule and regulatory violations, unacceptable record keeping, failure to meet recognized standards and submitting false claims [Ex 7]. The false claims included the Appellant billing for:

- [redacted] a tooth previously [redacted] and billed to managed care,
- [redacted] teeth, and
- a [redacted] that failed to appear on a subsequent x-ray.

The adverse impact on recipients involved the Appellants failure to:

- record medications for patients with [redacted],
- indicate if a patient was/was not required to be pre-medicated for extractions, and
- document the amount and type of anesthetic and restorable material used.

The damages to the Program amounted to the $46,521.20 in overpayments in the cases of just 30 patients. The Appellant's previous record included:

- the 2007 Stipulation and Settlement with Medicaid to pay $3,098.00, following allegations that the Appellant violated the Medicaid Provider Manual by billing for

[redacted] or repair of [redacted] within twelve months prior to placement of a new [redacted] (2007Z10-13C), and

- the $1,459.00 recovery from the Appellant in 2009 for billing improperly to the Medicaid Program for services to Medicaid recipients after the recipients' date of death (2009Z12-219R).

Investigator Quinn's summary did not discuss two other factors for consideration under § 515.4(b): mitigation and other factors related to the seriousness of the violation [Ex 7].

The NOPAA listed Exclusion as one of the proposed sanctions. Title 18 NYCRR § 519.18(d)(2) provides that the Appellant holds the burden for proving any mitigating factors affecting the severity of any sanction imposed. The Appellant made no response to the NOPAA, despite receiving four extensions to respond [Ex 10]. The Appellant failed, therefore, to raise mitigating factors to challenge the Exclusion, such as any efforts he may have made to improve his record keeping or his compliance with the Manual since 2013 or any impact his exclusion from the Program may have on recipient access to services under the Program. The Appellant also raised no mitigating factors in his testimony at hearing. The Appellant made no mention of efforts to improve record keeping, but rather blamed his poor record keeping largely on his patients [T 153]. The Appellant also failed to mention any steps to improve compliance with the Dental Provider Manual, but rather concluded his testimony by stating that what the Manual says is not always what is done in the actual practice of dentistry [T 161]. The Appellant also testified that he did what he thought was proper [T 143]; that the dental records are his records, not public records [T 152-153]; and that he felt if he did his best for the patient, Medicaid would pay for it [T 150].

The ALJ finds the three-year Exclusion appropriate in this case. The Appellant received a Recoupment only sanction under the 2007 Stipulation and Settlement 2007Z10-13C that

involved failure to comply with the Dental Provider Manual. That Recoupment only sanction failed to impress upon the Appellant the need to improve the Appellant's compliance with the Manual. The Appellant's hearing testimony provides no reason for the ALJ to believe that the Appellant will reform his compliance with Medicaid rules and regulations if he can remain a provider under the Program with Recoupment alone as a sanction in this matter. An actual Exclusion from the Program may impress upon the Appellant the need to follow Medicaid rules and regulations, if he eventually returns as a provider under the Program.

## VI. Decision

After reviewing the evidence from the hearing and the parties' post-hearing briefs, the ALJ:

1. Affirms the OMIG Determination that the Appellant committed unacceptable practices under six categories in submitting and accepting payments for 395 services which resulted in overpayments totaling $46,521.20.
2. Affirms the OMIG Determination to recoup the $46,521.20 in overpayments.
3. Affirms the OMIG Determination to exclude the Appellant as a dental provider in the Medicaid Program for three years.

Administrative Law Judge James F. Horan renders this decision pursuant to the designation by the Commissioner of Health of the State of New York to render final decisions in hearings involving Medicaid provider audits.

Dated: March 5, 2019
Menands, New York

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James F. Horan
Administrative Law Judge

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