

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

In the Matter of the Appeal of	:	
	:	
VEZIRE SARAK, DDS	:	Decision After
	:	Hearing
	:	
from charges of unacceptable practices and a determination	:	
to recover Medicaid Program overpayments	:	Audit Number: 15-5195
	:	

Before: Natalie J. Bordeaux
Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, New York 10007

Hearing Dates: October 23, 2018
November 8, 2018
December 12, 2018
The record closed on March 1, 2019

Parties: New York State Office of the Medicaid Inspector General
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JURISDICTION

The New York State Office of the Medicaid Inspector General (OMIG) determined to censure Vezire Sarak, DDS (Appellant) as a Medicaid provider and to recover Medicaid Program overpayments. The Appellant requested a hearing pursuant to Social Services Law § 22 and Department of Social Services (DSS) regulations at 18 NYCRR § 519.4 to review the OMIG's determinations.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. At all times relevant hereto, the Appellant was a dentist enrolled as a provider in the New York State Medicaid Program.

2. By notice of agency action dated January 18, 2017, which included a copy of its final audit report, the OMIG advised the Appellant that it had determined to censure her for unacceptable practices under the Medicaid Program pursuant to 18 NYCRR § 515.3(a)(2). (Exhibit 25.)

3. The OMIG's January 18, 2017 notice also advised the Appellant of its determination to seek restitution of Medicaid Program overpayments in the amount of \$22,399 plus interest.

4. The OMIG's determinations were based on a review of the Appellant's Medicaid reimbursement for 12 patients.

5. The Appellant submitted 380 claims to the Medicaid Program for services rendered to these 12 patients during the period January 1, 2010 through March 31, 2013. (T 71.)

6. The OMIG identified one or more violations of Medicaid Program requirements and laws and regulations in 175 of the Respondent's submitted claims for services rendered to these 12 patients during the review period and disallowed \$22,399 in payments. (Exhibit 25.)

7. The OMIG organized the disallowed payments into the following categories:

1. Non-essential dental services/services outside the scope of the Medicaid Program.
2. Missing/Incomplete/Incorrect Documentation.
3. Failure to comply with manual requirements.
4. Failure to meet Medicaid Program standards.
5. Unfurnished dental care/services. (Exhibit 25, Schedule I.)

ISSUES

Did the Appellant engage in unacceptable practices in the Medicaid Program? If so, did the OMIG properly determine to censure the Appellant?

Is the OMIG entitled to recover Medicaid Program overpayments from the Appellant? If so, what is the amount of the overpayment?

DISCUSSION

The Department of Social Services (DSS) is responsible for auditing payments to providers for care, services and supplies under the Medical Assistance (Medicaid) Program. SSL § 364(1)(b). The functions of the former DSS pertaining to the Medicaid Program were transferred to the Department of Health (Department). Chapter 436 Laws of 1997. The OMIG is an independent entity within the Department.

By enrolling in the Medicaid Program, Medicaid providers agree to prepare contemporaneous records demonstrating the right to receive payment under the Medicaid program and to furnish such records and information, upon request, to the Department. Such records must be maintained for at least six years from the date of service. 18 NYCRR § 504.3(a). Providers agree to submit claims for payment only for services that were actually

furnished and which were medically necessary when rendered to Medicaid-eligible patients. 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(e), (h)-(i), § 517.3(b), § 540.7(a)(8).

The OMIG may require repayment of any amount not authorized to be paid under the Medicaid Program, as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake. 18 NYCRR § 515.3(b) and § 518.1. An unacceptable practice is conduct by a person which is contrary to: (1) the official rules and regulations of the department; (2) the published fees, rates, claiming instructions or procedures of the Department; (3) the official rules and regulations of the Departments of Health, Education and Mental Hygiene, including the latter department's offices and divisions, relating to standards for medical care and services under the program; or (4) the regulations of the Federal Department of Health and Human Services promulgated under title XIX of the Federal Social Security Act. 18 NYCRR § 515.2(a). An unacceptable practice constitutes fraud or abuse and includes, but is not limited to, false claims, unacceptable recordkeeping, and excessive services. 18 NYCRR § 515.2(b).

Upon a determination that a provider has engaged in an unacceptable practice, the OMIG may impose one or more sanctions, including censure. 18 NYCRR § 515.3(a). Censure serves as a warning that continued conduct of the type or nature cited may result in a more severe sanction against the same person or an affiliate on a subsequent matter, whether or not the subsequent matter is related to the matter for which a censure was issued. 18 NYCRR § 515.1(b)(2).

A Medicaid provider is entitled to a hearing to review the OMIG's final determination to impose a sanction or require repayment of any overpayment. 18 NYCRR § 519.4. The Appellant has the burden of establishing the following by substantial evidence: (1) the OMIG's determination was incorrect and that all claims submitted and denied were due and payable under the program; and (2) any mitigating factors affecting the severity of any sanction imposed. 18 NYCRR § 519.18(d); SAPA § 306(1).

At the hearing, the OMIG presented the audit file and summarized the case at the hearing, as required by 18 NYCRR § 519.17. In addition, the OMIG presented documents (Exhibits 1 - 36) and two witnesses: (1) Karey Quinn, Medicaid Investigative Specialist II, who was assigned to conduct this audit; and (2) Public Health Dentist Edmond Haven, the dental peer in this matter who reviewed the records and made the audit findings. (T 35-36, 51, 141, 146.) The OMIG submitted one post-hearing brief.

The Appellant presented five exhibits (Exhibits A-E), testified on her own behalf, and presented Peter Blauzvern, DDS as an expert witness. The Appellant also submitted one post-hearing brief.

The OMIG determined to audit the Appellant after receiving complaints from Patients 1 and 2 that they had not received certain services for which the Appellant had billed the Medicaid Program. For its audit, the OMIG requested the records for Patients 1 and 2, along with the records of ten additional patients (referred to as Patients 3-12) for the period of January 1, 2010 through March 31, 2013. The Appellant's claim submissions to the Medicaid Program for Patients 3-12 surpassed her claim submissions for her other Medicaid patients during that period. Among the records requested, the OMIG requested specific information regarding the Appellant's claimed provision of dental laboratory services in her office, a request prompted by

the Appellant's billing for certain services that would have required a dental laboratory. (T 50-54, 56, 75.) During the course of the OMIG's audit, Ms. Quinn confirmed that the Appellant had rendered the contested services to Patients 1 and 2. (Exhibit 25, NOAA Exhibit I; T 92.)

The Audit Findings

The OMIG organized the statutory and regulatory violations into five categories. (Exhibit 25.) The majority of the audit disallowances were in the first category.

1. Non-essential services/services not within the scope of the Medicaid Program.
2. No/missing/incomplete/incorrect documentation.
3. Failure to comply with manual requirements.
4. Failure to meet standards.
5. Non-diagnostic x-rays.

Dental care in the Medicaid Program includes only essential services and not comprehensive care. Medicaid providers are instructed to refer to the Medicaid Program's Dental Provider Manual (Dental Manual) to determine when the Medicaid Program considers services to be "essential." (Exhibit 1, stamped pages 22, 39, 99, 160.) The provision of dental care and services is limited to the procedures included in the Dental Fee Schedule and are to be provided within the standards and criteria listed in the procedure code descriptions. The Dental Manual explicitly advises that dental work for cosmetic reasons or for the personal preference of the Medicaid recipient or provider is not within the scope of the Medicaid Program. (Exhibit 1, pp. 41, 101, 162.)

All radiographs taken should be clear and allow for diagnostic assessment. Providers must make radiographic images (x-rays) available for review upon request by the Department of Health. (Exhibit 1, pp. 63, 103, 164.)

Disallowance Category 1: Non-essential services/services not within the scope of the Medicaid Program. (Exhibit 25, NOAA Exhibit III.)

The disallowed amounts in this category pertain to [REDACTED] that the Appellant provided to Patients 1-2 and 4-12 during the review period. The OMIG determined that these [REDACTED] were performed in contravention of the criteria set forth in the Dental Manual. The Appellant received \$10,435 for the disallowed services in this category.

Treatment done without clinical indication is considered outside the scope of the Medicaid Program as such services do not meet existing standards of professional practice. The Dental Manual instructs providers not to perform procedures without documentation of clinical necessity. The Dental Manual also advises providers that [REDACTED] placed solely for [REDACTED] ([REDACTED]) or [REDACTED] ([REDACTED]) and not associated with the treatment of any other pathology are beyond the scope of the Medicaid Program and are therefore not reimbursable. (Exhibit 1, pp. 101-02, 122, 184; Exhibit 25, p. 1180; T 155-56.)

In evaluating whether restorative services were medically necessary pursuant to Medicaid guidelines, Dr. Haven first reviewed the Appellant's documentation for patient complaints of [REDACTED] but found no such description in the disallowed claims. Secondly, he did not find other details to substantiate the medical necessity of these fillings, such as the Appellant's documented use of techniques to elicit a [REDACTED] [REDACTED], or signs of [REDACTED] in the patient x-rays that the Appellant submitted in response to OMIG's audit inquiry. (T 167.)

Patient #1:

On [REDACTED] 2011, the Appellant inserted [REDACTED] in Patient #1's tooth numbers [REDACTED] and [REDACTED]. Subsequently, on [REDACTED], the Appellant inserted [REDACTED] in Patient #1's tooth numbers [REDACTED]. The OMIG determined to disallow payment for the [REDACTED] placed other than tooth number [REDACTED] because the submitted radiographs did not show the presence of [REDACTED] in the other treated teeth, and the Appellant's records failed to document the patient's other symptoms that would necessitate these treatments. The Appellant's records described Patient #1 as having "[REDACTED]," signifying that the patient's teeth showed no signs of [REDACTED]. No other symptoms were described. (T 168.)

Patient #2:

On [REDACTED], 2010, the Appellant inserted [REDACTED] in Patient #2's tooth numbers [REDACTED]. The patient's chart references the patient's complaints of pain in teeth and the words "[REDACTED]" for this date of service. On [REDACTED] 2012, the Appellant inserted [REDACTED] in Patient #2's tooth numbers [REDACTED]. These fillings were all disallowed because the x-rays showed no signs of [REDACTED] and the Appellant's records showed no symptomatology other than the Appellant's [REDACTED], 2010 observation of [REDACTED] and [REDACTED] on tooth number [REDACTED], conditions which are insufficient to establish the medical necessity of the [REDACTED] pursuant to Medicaid guidelines.

Patient #4:

On [REDACTED], 2010, the Appellant inserted [REDACTED] in Patient #4's tooth numbers [REDACTED] and [REDACTED] and inserted a [REDACTED] in the patient's tooth number [REDACTED] on [REDACTED]. The OMIG determined to disallow the [REDACTED] for tooth numbers [REDACTED], and [REDACTED]. In Patient #4's chart, the Appellant noted the presence of [REDACTED] and [REDACTED] on [REDACTED] 2010. However, she

did not specify which teeth had those conditions. Nor did she describe any other symptoms that the patient was experiencing. The Appellant also provided no description of the patient's symptoms to justify the [REDACTED] placed in tooth number [REDACTED] on [REDACTED], 2010 and the x-rays taken on that dates of service showed no signs of [REDACTED] in tooth numbers [REDACTED] and [REDACTED]. The Appellant did not satisfy the medical necessity criteria for these [REDACTED] set forth in the Medicaid guidelines.

Patient #5

The OMIG determined to disallow the [REDACTED] that the Appellant inserted in Patient #5's tooth numbers [REDACTED], and [REDACTED] on [REDACTED] 2010. The Appellant's dental charting did not indicate the presence of [REDACTED] for any of those teeth. Although notes for the [REDACTED] 2010 date of service include the words "[REDACTED]" and "[REDACTED]" the Appellant did not describe symptoms tied to those conditions. Nor did the submitted x-rays justify the medical necessity of the fillings pursuant to Medicaid guidelines.

On [REDACTED] 2011, the Appellant inserted [REDACTED] in Patient's #5's tooth numbers [REDACTED] and [REDACTED] which were disallowed because the Appellant provided no evidence of symptomatology to justify these services. The Appellant's charting and progress notes do not describe [REDACTED] or other symptoms that would necessitate the [REDACTED]. In addition, upon review of the Appellant's x-rays for this date of service, Dr. Haven was unable to identify any condition in either tooth that would require [REDACTED].

Subsequent [REDACTED] inserted on [REDACTED], 2012 (tooth number [REDACTED]) [REDACTED] 2012 (tooth numbers [REDACTED]), and [REDACTED] 2012 (tooth numbers [REDACTED]) were all disallowed for the same reason. A review of the Appellant's documentation shows no more than a general mention of [REDACTED] and [REDACTED] without any description of conditions attributable to specific

teeth. Although the Appellant habitually inserted information in the patient's dental charting, she did not record the presence of [REDACTED] in any of these teeth. In addition, the OMIG was unable to ascertain from the x-rays captured of this patient whether the treated teeth possessed a condition that necessitated the treatment received.

Patient #6:

The OMIG determined to disallow [REDACTED] placed in Patient #6's tooth numbers [REDACTED] [REDACTED] on [REDACTED] and [REDACTED] 2010. The Appellant's progress notes for these dates of service report that Patient #6 refused to [REDACTED] these teeth and documented that these teeth were "[REDACTED] with [REDACTED] of the [REDACTED] likely attributable to the patient's tooth [REDACTED]. Since the Appellant did not provide x-rays for tooth numbers [REDACTED] and [REDACTED] the OMIG investigators' review was confined to the Appellant's charting and progress notes to determine medical necessity of the procedures. The Appellant's notation that the teeth were [REDACTED] demonstrates that the Appellant's provision of [REDACTED] for tooth numbers [REDACTED] and [REDACTED] did not comport with Medicaid coverage guidelines. Furthermore, submitted x-rays for tooth numbers [REDACTED] and [REDACTED] showed no [REDACTED] and some [REDACTED] of the patient's dental [REDACTED] a condition which does not establish the medical necessity of the [REDACTED] rendered.

Patient #6 elected to avoid [REDACTED]. Services performed based upon a patient's preference are not services covered by the Medicaid Program. (Exhibit 1, p. 41.) The Appellant also performed several [REDACTED] (a [REDACTED] procedure) on teeth (numbers [REDACTED], and [REDACTED] which were awaiting a [REDACTED] for which the patient had not yet received prior approval. Dentures require prior approval in order to be reimbursable. When any portion of a treatment plan requires prior approval, no treatment, other than the provision of pain relief or infection treatment, may commence on the affected teeth before a prior approval determination has been

made. (Exhibit 1, p. 106.) The Appellant did not adhere to these requirements as she provided [REDACTED] treatment for notably [REDACTED] teeth with [REDACTED] awaiting a yet-to-be-approved [REDACTED].

Patient #7

The OMIG disallowed the [REDACTED] placed in Patient #7's tooth numbers [REDACTED] [REDACTED] on [REDACTED] and [REDACTED] 2011. The patient's chart documents [REDACTED] and [REDACTED] with [REDACTED] on unspecified teeth. The Appellant's handwritten notes indicate that only tooth number [REDACTED] has a secondary diagnosis of [REDACTED]. No other tooth was described as having symptoms that necessitated [REDACTED] and the submitted x-rays reflected no signs of [REDACTED]. The OMIG also disallowed the [REDACTED] that the Appellant provided on [REDACTED], 2013 for tooth numbers [REDACTED] and [REDACTED] because no evidence of [REDACTED] or other condition other than [REDACTED] and [REDACTED] was identified in the x-rays, progress notes or dental charting. These determinations are consistent with coverage criteria set forth in the Dental Manual.

Patient #8

The OMIG disallowed the [REDACTED] placed in Patient #8's tooth numbers [REDACTED] and [REDACTED] on [REDACTED], 2010. The submitted x-rays showed existing [REDACTED] and no signs of [REDACTED]. The patient's progress notes and dental charting reflected no symptoms justifying coverage for this procedure by the Medicaid Program.

Patient #9

The OMIG disallowed [REDACTED] inserted in Patient #9's tooth numbers [REDACTED] on [REDACTED] 2011. The submitted progress notes mention [REDACTED] on tooth number [REDACTED] and [REDACTED] and [REDACTED] more generally. Similarly, radiographic images of Patient #9's teeth

revealed only the [REDACTED] of dental [REDACTED] without [REDACTED] or other symptoms. These services were rendered in contravention of Medicaid guidelines.

Patient #10

The OMIG disallowed [REDACTED] inserted in Patient #10's tooth numbers [REDACTED] on [REDACTED], 2010, along with [REDACTED] placed in tooth numbers [REDACTED] on [REDACTED] and [REDACTED] for tooth numbers [REDACTED] and [REDACTED] on [REDACTED] 2011. Neither the x-rays nor the patient's dental chart indicate that any of these teeth were [REDACTED]. The progress notes mention only that the patient was [REDACTED] her teeth and received education regarding [REDACTED] and [REDACTED] [REDACTED] that Patient #10 received on [REDACTED], 2011 for tooth numbers [REDACTED] and [REDACTED] were also disallowed, as were [REDACTED] inserted on [REDACTED], 2013 for tooth numbers [REDACTED]. Here too, medical necessity was not substantiated as the only conditions associated with these teeth were [REDACTED] and [REDACTED].

Patient # 11:

The OMIG disallowed [REDACTED] placed in Patient #11's tooth numbers [REDACTED] on [REDACTED] 2010. In response to the OMIG's requests for additional information, the Appellant supplied radiographic images of poor quality that did not allow for diagnostic assessment of the teeth in question, thus precluding independent verification of a clinical need for the [REDACTED] in conformity with Medicaid guidelines. The Dental Manual explicitly requires providers to capture clear x-rays that enable diagnostic assessment of a patient's teeth by reviewing the images. The chart notes corresponding to this date of service only mention [REDACTED] and [REDACTED] for these teeth, with no secondary diagnosis. Medical necessity of these [REDACTED] is not established.

Patient # 12:

The OMIG disallowed a total of [REDACTED] that the Appellant inserted in Patient #12's mouth from [REDACTED] 2010 through [REDACTED] 2012. In response to the OMIG's requests, the Appellant supplied x-rays of poor, non-diagnostic quality, along with progress notes and dental charting. The provided information showed no symptoms for these teeth other than [REDACTED] and [REDACTED]

It is the Appellant's position that all [REDACTED] disallowed in this audit were medically necessary, in accordance with recommended dental practices, as the [REDACTED] likely preserved her patients' teeth and saved the Medicaid Program additional expenses for those teeth by preventing further damage. The Appellant's expert witness, Peter Blauzvern, DDS, is a licensed dentist, a member of the American Dental Association (ADA) and the New York State Dental Association (NYSDA). Dr. Blauzvern is also a member of the Nassau County Dental Association, where he participates in an advisory council which researches, evaluates, and formulates dental practice guidelines. (T 337-38.) Although he is not a Medicaid provider, Dr. Blauzvern testified that he is an instructor in an Article 28 facility (a Medicaid provider) and reviewed all applicable Medicaid guidelines before reviewing the Appellant's records for Patients 1-12 for the review period. (T 339, 367.)

Dr. Blauzvern was satisfied with the Appellant's documentation of treatment for Patients 1-12. In addition, he disagreed with the medical necessity criteria set forth in the Dental Manual. Dr. Blauzvern explained that the [REDACTED] or [REDACTED] of a tooth is not usually caused by just one mechanism, such as [REDACTED] or [REDACTED]. Instead, several conditions likely contributed to a tooth's [REDACTED] and require treatment. (T 350.) He cautioned that not all tooth defects are visible on an x-ray or radiographic image since these images only capture [REDACTED] (i.e., [REDACTED])

██████████). (T 356.) Even then, depending on the surface that is damaged by ██████████) or otherwise ██████████ such condition may not be identified on a radiograph. As examples, Dr. Blauzvern noted that ██████████ located on the ██████████ surfaces of the tooth are unlikely to appear on x-ray images. (T 365-66.) Even in the absence of reported symptoms, such as tooth ██████████ the Appellant's expert contended that treatment is needed to avoid further ██████████ of the tooth's ██████████. (T 355.)

Dr. Blauzvern focused on ideal practices for dentistry. However, he conceded that he is not now, and never was, a Medicaid provider. (T 371-72.) Although a considerable portion of his testimony revolved around his disagreement with established Medicaid Program standards for dentistry, Medicaid Program standards are not the subject of review in this hearing. The purpose of the OMIG's audit and the objective of this hearing is to ascertain whether the Appellant's documentation (patient notes and radiographs) established the Appellant's entitlement to payment for the dental services rendered. The Medicaid Program includes essential, but not optimal, care for adults within the constraints of a publicly-funded program. Comprehensive dental care is not available to adult Medicaid recipients. (T 152-53.)

The Appellant concurred with the statements made by Dr. Blauzvern. She testified that ██████████ is not always detectable when reviewing a radiographic image. The Appellant asserted that ██████████ is diagnosed by "[c]linical judgment, clinical evaluation and we are using the explorer." (T 448.) However, the Appellant also insisted that her original x-rays were significantly clearer than the duplicates which the OMIG entered into evidence. (T 474.)

Dr. Haven had reviewed the x-rays provided by the Appellant's then-attorney and upheld his findings that most of the dental ██████████ performed for Patients 1-12 were not medically necessary pursuant to Medicaid guidelines. When ██████████ was visible in the x-rays or when the

Appellant's explanations in response to the Proposed Agency Action justified the medical necessity of the procedures, payment for those specific [REDACTED] was removed from the disallowance amount and the Final Audit Report was adjusted accordingly. (T 258-59.) Dr. Haven also received and reviewed the original x-rays that the Appellant provided more than one year before the first hearing date. The original x-rays did not cause him to alter his findings in the Final Audit Report that the x-rays for the teeth discussed above did not show [REDACTED] (T 99-100, 512-16; Exhibits 35-36.)

By enrolling in the Medicaid Program, the Appellant agreed to maintain contemporaneous records that demonstrated her right to receive payment under the program's guidelines. Those records must include captured radiographic images that are clear and enable a diagnostic assessment. The OMIG was entitled to rely on the Appellant's records (including x-rays) to ascertain whether the inserted [REDACTED] were medically necessary, based upon the guidelines contained in the Dental Manual. Neither the Appellant nor her expert witness identified instances where the Appellant's documentation established medical necessity pursuant to Medicaid guidelines and the fillings were disallowed. The Appellant failed to establish that the OMIG's disallowances in this category were incorrect and that the amounts denied were payable under the Medicaid Program. The amount disallowed in this category is upheld.

Disallowance Category 2: Non-essential services/services not within the scope of the Medicaid Program. (Exhibit 25, NOAA Exhibit IV.)

The OMIG disallowed 21 claims in this category with total payments of \$7,776. [REDACTED] [REDACTED] related services, and [REDACTED] were disallowed because the Appellant failed to provide laboratory prescriptions describing the design of the [REDACTED] type of materials to be used, or any other instructions given to the laboratory technician. In support of

these 21 claim disallowances, the OMIG referred to the requirement set forth in the Dental Manual that a complete dental record must include “all treatment notes, x-rays, laboratory prescriptions and laboratory invoices.” Audit findings also cite guidelines for dental laboratory prescriptions set forth in Education Law § 6611 and 8 NYCRR § 61.5. Education Law § 6611 prohibits dental laboratories from furnishing dental devices, prostheses or appliances without a prescription, while 8 NYCRR § 61.5 identifies information that a dental laboratory prescription must include, specifically: (a) the name of the laboratory to which the prescription is addressed; (b) the date on which it was written; (c) a clear description of the work to be done; (d) a clear specification of the character of materials to be used; and (e) the signature and license number of the prescribing dentist.

The Dental Manual clearly contemplates a dental provider’s use of a dental laboratory for the services disallowed in this category, and advises providers that “all treatment notes, radiographic images, laboratory prescriptions and laboratory invoices should be made part of the member’s treatment record to be made available upon request in support of any treatment provided.” Further illustration is provided with respect to denture relining, a service that the Appellant rendered to Patient #2 ([REDACTED]) which the OMIG determined to disallow. The procedure code’s description specifically references a laboratory. However, “[f]or cases in which it is impractical to complete a laboratory [REDACTED] prior approval for an office (‘chairside’ or ‘cold cure’) reline may be requested with credible documentation which would preclude a laboratory [REDACTED]. The Dental Manual includes separate procedure codes for a chairside [REDACTED] with procedure codes [REDACTED].

During the audit, the Appellant submitted a written explanation to the OMIG inspectors explaining that she had a laboratory onsite and provided a copy of her promotional material

which advises patients of “same day [REDACTED] and repairs.” Dr. Haven concluded that the Appellant offered insufficient information to support her explanation, as she only provided a “photograph of a sign somewhere indicating that there was a lab on premises.” (T 190-97.) At the hearing, the Appellant explained that she had provided the OMIG with her promotional flyers. While these advertisements inform prospective patients that they may obtain [REDACTED] and repairs on the same day, they do not state or even suggest that the Appellant utilized an in-house dental laboratory to fabricate dental [REDACTED]. (Appellant Exhibit B; T 520-22.)

At the hearing, the Appellant submitted into evidence photographs of dental laboratory equipment. (Appellant Exhibits A-B.) The Appellant explained that she has dental equipment in her office with which her [REDACTED] a dental technician and a salaried employee at her office, helps her make [REDACTED], and other [REDACTED]. (T 433-35.) She asserted that she did not provide the OMIG with photographs or similar evidence of an in-house laboratory during the audit because the OMIG never requested such evidence. (T 517-18.)

As a Medicaid provider, the Appellant has a continued obligation to furnish all relevant information to the OMIG. The information provided by the Appellant to the OMIG did not adequately establish the presence of such a laboratory, and certainly did not establish that the Appellant owned the lab and directly employed a lab technician. Furthermore, the photographs of the Appellant’s dental office provided at the hearing fail to satisfy the documentation requirements for these services. A prescription is required for a dental laboratory technician employed by the Appellant who was working in the Appellant’s onsite dental laboratory to detail the instructions given to the technician. (T270-72.) The Appellant’s documentation contains no

description of the fabricated appliances in the records, either in the form of an actual laboratory prescription as required by Education Law § 6611(1), or in notes within the patients' charts.

The Appellant has not established that the OMIG's disallowances for these claims was incorrect and that she was entitled to payment under the Medicaid Program for these services. Therefore, the disallowances in this category are upheld.

Disallowance Category 3: Failure to comply with manual requirements. (Exhibit 25, NOAA Exhibit V.)

The OMIG disallowed 10 claims in this category with total payments of \$2,639. The Dental Manual instructs providers that claims are not to be submitted for dental [REDACTED] until after the [REDACTED] is completed and delivered to the beneficiary. (Exhibit 1, pp. 70-77.) The Appellant submitted claims for [REDACTED] before the date upon which the [REDACTED] were inserted. She was not entitled to payment until all work related to furnish the [REDACTED] was completed.

On [REDACTED] 2010, the Appellant submitted claims for [REDACTED] provided to Patient #10 before they were inserted on [REDACTED]. In her response to the proposed audit findings, the Appellant explained that she commenced treatment immediately after receiving prior approval on [REDACTED] and that she now clearly understands that "Medicaid is not functioning like other dental insurances." (Exhibit 24.) She was responsible for learning Medicaid billing requirements before she began to submit claims for payment.

The Appellant made other errors in the submitted claims disallowed in this category. For instance, she submitted a claim with procedure code [REDACTED] [REDACTED] [REDACTED] for Patient #4's [REDACTED]; however, on the date of service, Patient #4 only had [REDACTED] teeth in the [REDACTED]. Another misstep

occurred when the Appellant inserted, and billed for, a prefabricated [REDACTED] in addition to a [REDACTED] for Patient #3's tooth number [REDACTED]. Although this procedure itself does not require prior approval, the related procedure (a [REDACTED] does. (T 207-08.) The requested [REDACTED] was denied several months before the [REDACTED] was inserted because the [REDACTED] was not medically necessary as a [REDACTED]. There was no legitimate purpose for inserting the [REDACTED]. In doing so, the Appellant acted in direct contravention of coverage guidelines set forth in the Dental Manual.

The Appellant explained that the patient refused [REDACTED] and paid out-of-pocket for his [REDACTED] for this tooth. That explanation does not justify submitting a claim to the Medicaid Program for the [REDACTED]. When any portion of a treatment plan requires prior approval, a complete treatment plan listing all necessary procedures must be listed and coded on the prior approval request form. When a treatment plan has been denied, services that were included in the proposed treatment plan are not eligible for payment by the Medicaid Program. (Exhibit 1, pp. 28, 46, 167-68.) Services associated with a non-approved procedure will not be considered for reimbursement. In addition, as has already been noted above, services based upon a patient's preference are outside the scope of the Medicaid Program.

The OMIG also disallowed two payments for [REDACTED] [REDACTED] for Patient #4. An [REDACTED] is a covered service when at least [REDACTED] teeth are [REDACTED]. Medicaid guidelines explain that this procedure is not reimbursable in addition to surgical [REDACTED] performed on the same [REDACTED] (Exhibit 1, pp. 79, 138, 200, 239, 271; T 202.) The Appellant submitted a claim for this procedure for Patient #4's [REDACTED] [REDACTED]. However, this patient's tooth number [REDACTED] was surgically [REDACTED] and the remaining [REDACTED] teeth in this [REDACTED] were not [REDACTED] thus eliminating the availability of

payment from the Medicaid Program for this procedure. The Appellant also billed the Medicaid Program for an [REDACTED] for Patient #4's [REDACTED] on [REDACTED], 2010 when the progress notes showed that the procedure was performed for the patient's [REDACTED]

In the Appellant's written response to the OMIG's proposed audit findings, she explained that "[REDACTED] or more teeth" were [REDACTED] on the same day. She expressed confusion about Medicaid billing requirements because other insurance companies do not differentiate between simple or surgical [REDACTED] as long as at least [REDACTED] teeth are [REDACTED] (Exhibit 24.) That information was unresponsive to the OMIG's inquiry.

At the hearing, the Appellant testified that an [REDACTED] is necessary after a tooth [REDACTED] because a [REDACTED] may lead to infection and pain. She stated that the [REDACTED] of [REDACTED] tooth may require this procedure, and necessity is not determined by the [REDACTED] of [REDACTED] teeth. (T 472-73.) The disallowed payments involved a procedure code that is specifically described as requiring the [REDACTED] of [REDACTED] or more teeth per [REDACTED] a description that is included alongside the listing of procedure code [REDACTED] in the Dental Manual.

The Appellant's contentions in this disallowance category were not relevant to the basis of the OMIG's findings. Her repeated comparisons between Medicaid billing and other dental insurance neither refute nor diminish the disallowances. The Appellant's opinion regarding medical necessity is also not a basis for disproving the OMIG's findings, as the Dental Manual clearly outlines what may appropriately be billed under Medicaid guidelines. While the Appellant's continued insistence that Medicaid criteria is wrong or inadequate may prompt her to discontinue her participation in the Medicaid Program and stop accepting Medicaid funds, the findings at issue here are based solely on the Appellant's receipt of Medicaid funds for services that were already rendered. In billing for the wrong [REDACTED] and using incorrect and

inapplicable procedure codes, the Appellant did not provide true, complete, and accurate information that entitles her to payment by the Medicaid Program. She has not established that the OMIG's disallowances in this category were incorrect.

Disallowance Category 4: Failed to meet standards. (Exhibit 25, NOAA Exhibit VI.)

The OMIG disallowed 5 claims in this category with total payments of \$1,401. The Appellant inserted [REDACTED] in Patient #7's tooth number [REDACTED] less than [REDACTED] years apart ([REDACTED] 2011 and [REDACTED] 2013 dates of service), despite noting in her records that a [REDACTED] [REDACTED] would have been more appropriate (the tooth's [REDACTED] was gone.) As noted in the first disallowance category, [REDACTED] inserted merely for [REDACTED] and [REDACTED] are not covered. Notwithstanding the Appellant's recommendations for a [REDACTED], the Appellant never submitted a prior approval request for a [REDACTED] for this tooth. Services performed at the preference of the patient or which have a poor long-term prognosis are considered outside the scope of the Medicaid Program. (Exhibit 1, page 25.)

In response to the OMIG's inquiry regarding Patient #7's tooth number [REDACTED] the Appellant contended that the [REDACTED], 2011 progress note mentions [REDACTED] and that, "[i]deally, p[atient] needed [REDACTED] but as we know that insurance does not cover [REDACTED] on this tooth [sic]...Tooth [REDACTED]." (Exhibit 24.) The July 7, 2011 progress notes only describe the patient's tooth number [REDACTED] (a different tooth) as having [REDACTED]. Her explanation does not excuse her failure to comply with Medicaid guidelines.

The Appellant also provided a [REDACTED] to Patient #4 at the patient's election, despite the Appellant's advisement that waiting several months would allow for better retention. As repeated throughout Medicaid guidelines and the Dental Manual, treatment at a patient's preference is not considered an essential service and is therefore not covered by the Medicaid

Program. (T 154.) In her response to the OMIG's inquiries, the Appellant contended that the patient required an [REDACTED] (a non-covered service.) She insisted that waiting [REDACTED] after [REDACTED] was perfectly reasonable. However, she claimed that she was required by Medicaid guidelines to insert a notation in the progress notes confirming that she informed the patient of the optimal timeframes. (Exhibit 24.) The Appellant's response only bolsters the OMIG's finding that the Appellant's insertion of this [REDACTED] was inappropriate and in contravention of Medicaid guidelines.

The OMIG disallowed a payment received by the Appellant for an [REDACTED] provided to Patient #8 because the [REDACTED] was prepared before the completion of needed [REDACTED] treatment. Audit findings also noted that the Appellant's failure to include a dental laboratory prescription and laboratory invoice offered insufficient information to explain what type of [REDACTED] was given to the patient. The Medicaid Program's payment requirements for [REDACTED], which are provided immediately below the procedure code in the Dental Manual, advise that claims should be submitted on paper with documentation of necessity submitted as an attachment to the claim. The Appellant's record for Patient #8 omits critical information, including the need for the [REDACTED] the device's measurements and other specifications pertaining to the fabrication of the [REDACTED]. Given the Appellant's omission of critical information required by law and the Dental Manual, the Appellant was not entitled to payment for this service.

Disallowance Category 5: Non-diagnostic x-rays. (Exhibit 25, NOAA Exhibit VII.)

The OMIG disallowed 7 claims in this category with total payments of \$148 because the images were of poor quality and did not enable diagnostic assessment when reviewing the radiographs. In one instance, the Appellant took [REDACTED] bitewing x-rays with the patient's [REDACTED]

██████ in place, thereby obstructing from view the patient's ██████. X-rays captured of a patient wearing a ██████ is not of diagnostic quality. (T 215-16.) Medicaid guidelines explicitly require radiographs to be clear and in good quality for diagnostic assessment.

The Appellant's submitted response to the OMIG contained an explanation that she cannot afford proper equipment. (Exhibit 24.) This explanation does not absolve her of her responsibilities as a Medicaid provider. The purpose of radiographs is to identify conditions that warrant treatment. Unclear images, due to obstructions or inadequate radiographic equipment, serve no medical purpose and do not adhere to Medicaid guidelines.

The Appellant provided original x-rays to OMIG which Dr. Haven found unclear. Dr. Haven confirmed that he had not performed clinical assessments of Patients 1-12 and relied on the Appellant's dental records, including x-rays, to determine if a procedure was medically necessary. (T 149-52; Exhibit 1.)

While Dr. Blauzvern affirmed that he had recently reviewed the same original x-rays and deemed them to be clear, he did not identify any disallowances which he believed should be reversed due to the clarity of the submitted images. Instead, he opined in general terms that many conditions were simply not identifiable on radiographic images, but the treating provider would observe them in person. Medicaid guidelines explicitly require the capture of clear, good-quality images that would enable a person reviewing the images, such as Dr. Haven, to diagnose a patient's teeth. (Exhibit 1, p. 26; T 216-17.) Dr. Haven's opinion that the Appellant's radiographs did not adhere to this standard is credited. The disallowances in this category are affirmed.

Unacceptable Practices

Based upon the OMIG's findings, the Appellant was charged with engaging in the following unacceptable practices set forth in 18 NYCRR § 515.2(b):

- (1) False claims.
 - (i) Submitting, or causing to be submitted, a claim or claims for:
 - (b) an amount in excess of established rates or fees;
 - (c) medical care, services or supplies provided at a frequency or in an amount not medically necessary;
- (2) False statements.
 - (i) Making, or causing to be made any false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a medical assistance payment, or for use in determining the right to payment.
- (6) Unacceptable recordkeeping. 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.
- (11) Excessive services. Furnishing or ordering medical care, services or supplies that are substantially in excess of the client's needs.
- (12) Failure to meet recognized standards. Furnishing medical care, services or supplies that fail to meet professionally recognized standards for health care or which are beyond the scope of the person's professional qualifications or license.

The evidence does not support the OMIG's contention that the Appellant furnished services and care that did not meet professionally recognized standards for health care or which were beyond the scope of her professional qualifications or license. Dr. Blauzvern testified that the Appellant treated patients proactively, so as to prevent further damage to the patients' teeth. While such services, other than prophylaxis, are generally outside the scope of services available through the Medicaid Program, no information controverted the Appellant's witness' testimony regarding the acceptability of the Appellant's treatment for Patients 1-12. Nor was it shown via evidence or testimony that the Appellant somehow exceeded the scope of her professional

qualifications as a dentist. She is a licensed dentist whose provision of dental services prompted the OMIG's review and final agency action.

However, the evidence does support the OMIG's charge that the Appellant submitted false claims by rendering dental services that were not medically necessary pursuant to Medicaid guidelines. The evidence also supports the OMIG's charge that the Appellant made false statements by submitting claims for procedures that did not comport with the actual services rendered (i.e., billing for services rendered in the wrong [REDACTED] and billing for a service which, by its very description provided in the Dental Manual, did not reflect the services provided by the Appellant.) Finally, the OMIG's charges that the Appellant performed unacceptable recordkeeping and ordered excessive services are also reflected throughout the record. The Appellant repeatedly failed to document the medical necessity of the disallowed procedures. Thus, it was reasonable for the OMIG to find that the Appellant ordered unnecessary services for these patients.

The review of 380 submitted claims for 12 patients during an approximate three-year period resulted in findings that the Appellant rendered services in contravention of Medicaid guidelines, at the preference of a patient, before prior approval was obtained, or for purposes outside the scope of a comprehensive public program in 175 submitted claims (46% of the total claims reviewed for these patients.) The Appellant's records also reflected that several services were billed for prior to completion, and other procedure codes were improperly utilized for services rendered.

The Appellant has submitted a signed certification statement to the New York State Department of Health annually since November 4, 2009. By signing the certification, the Appellant acknowledged that she

shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Health and [OMIG] as set forth in statute or title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other publications of the Department, including eMedNY Provider Manuals...

(Exhibit 21.)

In her response to the OMIG's Notice of Proposed Agency Action, the Appellant contended that all rendered services and corresponding billing were effectuated in good faith. While the Appellant acknowledged certain "educational" errors and described certain corrective measures that would be employed prospectively, the Appellant strongly disputed the OMIG's determination that she had engaged in unacceptable practices. (Exhibit 24.)

The Appellant did not properly understand and adhere to applicable Medicaid requirements. The standards to which the Appellant are held apply to all Medicaid providers in the State of New York and are publicly available. There is no justification for billing the Medicaid Program for codes that contain an explicit description of a certain number of teeth when a patient has fewer teeth than the procedure code requires, billing for services rendered to a different oral quadrant, billing for services prior to their completion, or rendering services to accommodate a patient's preferences.

Censure and Reprimand

Upon a determination that a person has engaged in an unacceptable practice, the Department may impose sanctions, including censure and reprimand. 18 NYCRR § 515.3(a)(2).

In determining the sanction to be imposed, the following factors will be considered:

- (1) the number and nature of the program violations 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 program;
- (4) mitigating circumstances;
- (5) other facts related to the nature and seriousness of the violations; and

(6) the previous record of the person under the Medicare, Medicaid and social services programs. 18 NYCRR § 515.4(b).

The Appellant submitted letters of gratitude that she obtained from three of the patients who were the subject of the OMIG's review. (Exhibit C.) These letters were written by the Appellant and signed by the patients. (T 441.) Both the Appellant and her witness maintained the position that the Appellant had helped Patients 1-12 and certainly caused no harm to these individuals. (T 299-300, 437-43.) Neither OMIG witness contended that the Appellant had harmed her patients. A lack of physical harm to patients, when the issues for the hearing involve improper billing practices and inadequate recordkeeping, does not reduce the impact of the Appellant's actions to the Medicaid Program.

The Appellant provided and billed for services to Medicaid patients in a manner that was inconsistent with Medicaid requirements. Nearly half of the 380 claims submitted for services rendered to just 12 patients during a three-year period were correctly disallowed. In her testimony and her responses to OMIG inquiries, the Appellant insisted that she rendered services consistent with her clinical judgment and that when Medicaid rules would have otherwise disallowed coverage and payment, such rules must be wrong. By accepting Medicaid funds, the Appellant was bound by Medicaid coverage guidelines. Those guidelines were not, and are not, subject to renegotiation or reinterpretation in this hearing. The Appellant failed to establish the existence of any mitigating factors.

As explained in 18 NYCRR § 515.1(b)(2), the purpose of a censure is to warn providers that their actions are unacceptable and, if any improper behavior persists in the future, the provider may be subject to harsher sanctions. Upon review of the Appellant's responses to the OMIG, her testimony, and her post-hearing brief, the Appellant has shown a continued obstinacy to learning Medicaid dental coverage guidelines and billing practices. For that reason, a sanction

is necessary to alert her to a need for a change of course. The Appellant has failed to establish that the OMIG's determination to censure the Appellant was improper.

Medicaid Program Overpayments

When it is determined that claims for medical services have been submitted for which payment should not have been made, the OMIG 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 175 claims disallowed in this audit (46% of the audit sample) were not authorized to be paid under the Medicaid Program because they were not supported by documentation demonstrating compliance with Medicaid Program requirements. The OMIG is entitled to recover the overpayments made.

DECISION

1. The OMIG's determination to censure the Appellant is affirmed.
2. The OMIG's determination to recover Medicaid Program overpayments from the Appellant is affirmed. The amount of the overpayment is \$22,399.

DATED: New York, New York
March 7, 2019

Natalie J. Bordeaux
Administrative Law Judge