

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

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: In the Matter of the Appeal of :
: :
: **Associated Dental Arts, P.C.** : **Decision After Hearing**
: :
: Provider # 02197400 :
: :
: 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 (NYCRR) to review a : **Audit #15-2880**
: determination to recover Medicaid overpayments. :
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Before: Dawn MacKillop-Soller
Administrative Law Judge

Held At: NYS Department of Health, Menands, New York and
by videoconference

Dates of Hearing: 2019: May 30 and 31, June 25, July 16, November 12,
December 17
2020: July 14, September 29, October 1 and 26
Record closed: January 22, 2021

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), an independent office within the Department of Health (Department), determined to recover payments made under the Medicaid Program to Associated Dental Arts, P.C. (Appellant.) The Appellant requested a hearing pursuant to Social Services Law § 22 and former Department of Social Service (DSS) regulations at 18 NYCRR 519.4 to review the determination. (Exhibit 72.)

Hearing Record

Appellant exhibits: A-E, H-L

OMIG exhibits: 1-76, 79

Appellant witnesses: Robert Santoro, D.D.S. (Transcript, p. 1,528-1,679.)

Theresa A. Gulum, OMIG Management Specialist 3. (Transcript, p. 1,117-1,269)

Karl W. Heiner, Ph.D., statistical consultant. (Transcript, p. 1,289-1,518.)

OMIG witnesses: Martin Toomajian, D.D.S. (Transcript, p. 46-1,115.)

A transcript of the hearing was made. (Transcript, p. 1-1,685.) Each side submitted one post-hearing brief.

Findings of Fact

1. Appellant, Associated Dental Arts, P.C., a dental care practice in Albany, New York, is enrolled as a dental provider in the New York State Medicaid Program. The Appellant is owned and operated by Robert Santoro, D.D.S. [Transcript, p. 1,532-1,533.]

2. By notification of intent to audit dated September 15, 2015, and pursuant to 18 NYCRR 517.3(c), the OMIG informed the Appellant it was conducting an audit of its records to determine whether they comply with Medicaid Program requirements for dental care provided to patients and paid by Medicaid during the period January 1, 2010 through December 31, 2012. [Exhibit 66.]

3. At an audit entrance conference held October 8, 2015 pursuant to 18 NYCRR 517.3(f), the Appellant was apprised of the nature and extent of the audit. The Appellant was

provided further audit details upon completion of a review of his records at an audit exit (closing) conference held on April 3, 2018 pursuant to 18 NYCRR 517.5(a). [Exhibits 67 and 68.]

4. By draft audit report dated April 24, 2018 and in accordance with 18 NYCRR 517.5 and 517.6, the OMIG identified proposed findings and notified the Appellant of its intent to seek restitution of Medicaid overpayments in the amount of \$108,585. Pursuant to 18 NYCRR 517.5(b), the draft audit report afforded the Appellant the opportunity to object to the proposed findings and present additional documentation to contest the disallowances within 30 days. [Exhibit 69.]

5. The Appellant did not submit a response to the draft audit findings. [Exhibits 63 and 64.]

6. During the period January 1, 2010 through December 31, 2012, the Appellant was paid \$828,312.70 by the Medicaid Program for claims submitted for dental services to 1,053 Medicaid recipients. The audit consisted of a review of all claims paid for a randomly selected audit sample of 100 of those patients, for which the Appellant was paid \$76,427. The OMIG disallowed 185 claims among 56 patients in the audit sample. Although the OMIG identified 388 reasons for disallowing these claims, each claim was disallowed only once, resulting in a total overpayment amount of \$10,312 in the audit sample. [Exhibits 69-71; Transcript, p. 131, 376, 442.]

7. By final audit reports dated July 24 and August 8, 2018¹, the OMIG notified the Appellant that after receiving no objections to the draft audit report, its audit findings remained unchanged. The draft and final audit reports identified each disallowed claim and the reasons for the disallowances. The final audit report determined the Appellant had received Medicaid Program

¹This audit report was issued to correct a typographical error in the first report. [Transcript, p. 119-120.]

overpayments in the total amount of \$108,585. [Exhibits 70-71.]

8. The OMIG's overpayment claim is an extrapolation based upon an audit utilizing a statistical sampling method certified as valid. The total sample overpayment of \$10,312 was divided by 100, the total number of beneficiary cases in the audit sample. This resulted in a mean overpayment per sampled beneficiary case of \$103.12, which was multiplied by the 1053 beneficiary cases with claims paid during the audit period to yield an overpayment of \$108,585. The details of the extrapolation methodology are set forth in the draft and final audit reports. [Exhibits 69-71, 76, 79.]

9. The audit report organized the disallowed claims into nine categories of disallowance:

1. Missing, Inadequate and/or Incorrect Dental Forms and/or Missing, Inadequate and/or Incorrect Information on Dental Forms. 170 claims among 56 patients. (Samples 4, 5, 7, 8, 11, 16, 19, 21, 23, 24, 27, 28, 29, 30, 32, 36, 37, 38, 39, 40, 41, 42, 43, 46, 47, 49, 51, 53, 54, 55, 56, 58, 59, 61, 62, 64, 65, 66, 70, 71, 73, 75, 78, 80, 81, 82, 86, 87, 88, 91, 92, 94, 96, 97, 98, 99.)
2. Missing Inadequate and/or Incorrect Documentation. 162 claims among 52 patients. (Samples 4, 5, 7, 8, 11, 16, 18, 19, 21, 23, 24, 27, 28, 29, 30, 36, 37, 38, 40, 41, 42, 43, 46, 47, 49, 51, 53, 54, 55, 61, 62, 64, 65, 66, 70, 71, 73, 75, 78, 80, 81, 82, 86, 87, 88, 91, 92, 94, 96, 97, 98, 99.)
3. Incorrect Procedure Code. 23 claims among 19 patients. (Samples 4, 7, 8, 21, 23, 27, 38, 41, 42, 43, 47, 58, 59, 65, 70, 73, 78, 81, 98.)
4. Dental Treatment/Service Provided is Not a Covered and/or Essential Service. 15 claims among 4 patients. (Samples 11, 40, 47, 54.)
5. Diagnostic Imaging Fails to Comply with Program Requirements. 12 claims among 7 patients. (Samples 14, 32, 41, 42, 56, 94, 98.)
6. Service Provided without Documentation of Medical Necessity. 2 claims pertaining to 1 patient. (Sample 37.)
7. Duplicate Billing, Frequency Exceeded and/or Conflicting Service. 2 claims pertaining to 1 patient. (Sample 65.)
8. Failure to Enroll as a Group Practice and/or Failure to be Added as a Member of a Group Practice. 1 claim pertaining to 1 patient. (Sample 19.)
9. Dental Services Billed to Medicaid for Which a Third Party is Liable. 1 claim pertaining to 1 patient. (Sample 39.)

Applicable Law

1. Medicaid providers are subject to audit by the Department and are required to reimburse the Medicaid Program for overpayments in accordance with Part 517.18 NYCRR 504.8(a)(1).

2. 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).

3. When the Department has determined that any person has submitted claims for services for which payment should not have been made, it may require repayment of the amount determined to have been overpaid. 18 NYCRR 518.1(b).

4. An extrapolation based upon an audit utilizing a statistical sampling method certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made. 18 NYCRR 519.18(g).

5. A Medicaid provider's record-keeping obligations include:

a. [to] prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the ... New York State Department of Health.

[¶] . . . [¶]

g. to permit audits, by the persons and agencies denominated in subdivision (a) of this section, of all books and records or, in the discretion of the auditing agency, a sample thereof, relating to services furnished and payments received under the medical assistance program...including...case files and patient-specific data.

- h. that the information provided in relation to any claim for payment shall be true, accurate and complete; and
- i. to comply with the rules, regulations, and official directives of the department. 18 NYCRR 504.3. *See also* 18 NYCRR 517.3(b)(1), 540.7(a)(8).

6. Requirements for billing dental services are set forth in the New York State Medicaid Program Dental Policy and Procedure Manual. The Medicaid provider manuals, which are available online for all providers, constitute the official rules of the Department. Dental providers are required to follow these rules. ADM 2011-1², 5/15/2011; 18 NYCRR 504.3, 517.3(b)(1), 540.7(a)(8). *See* Lock v. NYS Dept. of Social Services, 220 AD2d 825, 827 (3rd Dept. 1995) and www.emedny.org.

Issues

Has the Appellant met its burden of proving that the OMIG's disallowances in the final audit report were not correct?

Has the Appellant met its burden of proving that the overpayment determination in the amount of \$108,585 was not correct?

Discussion

The OMIG determined that 185 of the claims the Appellant submitted for the 100 patients in the audit sample were not authorized to be paid due to the Appellant's improper record-keeping practices in violation of 18 NYCRR 504.3, 517.3, 540.7(a)(8) and the New York State Medicaid Program Dental Policy and Procedure Manual. The OMIG representative responsible for conducting the audit, Martin Toomajian, D.D.S., testified in order "to present the audit file and summarize the case" in compliance with 18 NYCRR 519.17(a). Dr. Toomajian has extensive

²Version 2011-1 referenced in this decision contains the same pertinent provisions as other versions also in effect during this audit and cited in the final audit. *See* Versions 2006-1, 2008-1, 2008-2, 2010-1, 2010-2, 2011-1, 2011-2, 2012, and 2013.

experience as a practicing dentist encompassing almost four decades in the private and public sectors. His testimony demonstrated his expansive knowledge of Medicaid Program requirements, and he provided detailed, credible testimony about the individual disallowances. As the OMIG pointed out (Department's brief, p. 26), the Appellant made little attempt to refute any of the specific disallowances, and therefore failed to meet his burden of proving documented compliance with Medicaid Program requirements for payment of the disallowed claims. 18 NYCRR 519.18(d).

The Appellant claims he met his burden under 18 NYCRR 519.18(d)(2) to prove "mitigating factors affecting the imposition of a lesser penalty," but such factors are not relevant to the audit findings or overpayment determination. [Appellant's brief p. 1-2.] The Appellant confuses this fiscal audit of Medicaid claims under 18 NYCRR Part 517 with an audit alleging unacceptable practices pursuant to 18 NYCRR Part 515. [Transcript, p. 136.] The OMIG has made no determination that the Appellant has engaged in fraud or abuse or unacceptable practices and sanctions are not under consideration in this decision. 18 NYCRR 515.2, 515.3(a). [Transcript, p. 358.] The Department instead seeks only repayment of overpayments under 18 NYCRR Part 517.

The Appellant's complaint that the "OMIG waited years to move forward with this matter," requiring him "to dispute treatments and payments that were eight to ten years old," is without merit. [Appellant's brief, p. 2-3.] The OMIG met its obligation to notify the Appellant of its intent to audit claims furnished or billed within six years. 18 NYCRR 517.3(c). By letter dated September 15, 2015, the OMIG issued notification to the Appellant of its intent to review records supporting billings from January 1, 2010 through December 31, 2012. [Exhibit 66.] An entrance conference commencing the audit was held less than 30 days later, in full compliance with 18 NYCRR 517.3(c) and (d). The audit exit or closing conference pursuant to 18 NYCRR 517.5(a) that was held, and the draft audit report, further notified the Appellant of audit procedures and explained

the basis for the overpayments. 18 NYCRR 517.5(b), 517.3(f), 517.3(b)(2). [Exhibits 67-69.] These efforts confirm the Appellant's notice of the audit and the tolling of his recordkeeping obligations for claims paid within the audit period. 18 NYCRR 517.3(c). They also establish there was no unreasonable or improper delay in the OMIG's conduct of this audit.

The Appellant denies awareness of "allegations of overpayments" and of an "opportunity to remedy any perceived issues" despite never raising any objections to the OMIG's findings. [Exhibit 69; Appellant's brief, p. 2.] The history of this audit and Dr. Santoro's involvement in it during each step of the audit process renders his complaints of "shock" regarding the overpayments and lack of adequate notice before the final audit report was finalized not credible. [Appellant's brief, p. 2-3.] Dr. Santoro expressed his awareness of the audit findings to Dr. Toomajian during a July 2, 2018 telephone conference call when he stated he had no response to the draft audit report and requested issuance of the final audit report. [Exhibit 64.] The Appellant's attempt to characterize draft audit reports as "government nomenclature" familiar only to "the OMIG employees that are intimately familiar with how their government audit process is conducted" is not persuasive. [Appellant's brief, p. 3.] They are formal audit reports required to be issued to providers that clearly explain why payments received were improperly paid after completion of the on-site review of the Appellant's records. 18 NYCRR 517.2(b).

Audit Findings

The categories of the Department's disallowances are:

1. Missing, Inadequate and/or Incorrect Dental Forms and/or Missing, Inadequate and/or Incorrect Information on Dental Forms
 - periodontal scaling and root planing

83 out of the 170 claims disallowed were for periodontal scaling and root planing, four or more teeth per quadrant, billed under procedure code D4341 in the amount of \$58, \$45, or \$29

for each claim. [Exhibit 71; Transcript, p. 52, 189.] Periodontal scaling and root planing is the deep cleaning of teeth to remove tartar and plaque above and below gum tissue and smooth out roots. [Transcript, p. 1,566.] The following documentation is required for billing these procedures:

the need for periodontal scaling and root planning, including a copy of the pre-treatment evaluation of the periodontium, a general description of the tissues (e.g., color, shape, and consistency), the location and measurement of periodontal pockets, the description of the type and amount of bone loss, the periodontal diagnosis, the amount and location of subgingival calculus deposits, and tooth mobility. ADM 2011-1, p. 37.

Dr. Toomajian emphasized the importance in dental providers following these documentation requirements to present coherent records and to protect the health of patients. [Transcript, p. 136, 195.] To meet these requirements, the Appellant relied on a preprinted form titled “Initial Exam/Diagnosis” containing numbers on a scale of 1-4 and abbreviations for categories. [Transcript, p. 1,569-1,579.] For example, Samples 5, 8, 16, 21, 23, 24, 30, 36, 46, 51, 53, 55, 64, and 66 include either handwritten circles or no circles around numbers from 1-4, some with a written “+”, for the categories “scaling necessary” and “perio classification.” Some forms contain handwritten numbers, such as 0, 1, 1-3, 2-3, 2, 1-4, 1-5, 3 or 3+, for the categories “pocketing,” “stain,” “supra calc,” “sub calc,” “bleeding,” and/or “gen mobility.” Samples 19, 71, 73, 86, 88, 91 94, 96 contain similar documentation. [Exhibits 3, 5, 8, 10-13, 17, 19, 27, 30, 31, 33, 39, 41, 43, 44, 50, 52, 53, 55, 56.]

Dr. Toomajian explained in convincing and persuasive detail why such notations are inadequate to document a periodontal diagnosis to support the services billed by the Appellant. Dr. Santoro’s shorthand of symbols and numbers fail to provide the mandatory descriptions of the condition of the periodontium to include the amount and location of bone loss and subgingival

calculus deposits, individual periodontal pocket measurements, tooth mobility for individual teeth, and a description of the tissues to include their color, shape, or consistency. ADM 2011-1, p. 37. [Transcript, p. 54, 179, 185-196, 205-209, 217, 224, 269-273, 284, 310-311, 325-327.] His use of non-standard “pocketing” readings on a scale of 1-4 are not an adequate substitute for the specific periodontal pocket measurements required, which are obtained by using a periodontal probe ruler to measure in one to ten millimeters at six points around teeth in the quadrants scaled. ADM 2011-1, p. 37. [Transcript, p. 189-191, 195.]

The Appellant’s criticisms of Dr. Toomajian for not being able to “reconcile categories on Appellant’s charts with the necessary information required by the Medicaid Manual” and for not seeking “clarification” from him regarding his “dental hygiene number scale” are failed attempts to shift the burden of his recordkeeping responsibilities to others. [Appellant’s brief, p. 2, 5.] The Appellant admitted that his preprinted forms are devoid of descriptions of the shape of tissues and the location and measurements of periodontal pockets. [Transcript, p. 1,655, 1,657.] He also conceded the forms provided no context for the numbers themselves, thereby undermining his own testimony that the numbers assigned to “bleeding” somehow describe tissue color and consistency. [Transcript, p. 1,644, 1,649, 1,651.] It was the Appellant’s duty to provide documentation fully disclosing “the nature and extent of services furnished” and not the responsibility of Dr. Toomajian or any other reviewer to seek out information not documented in charts. 18 NYCRR 517.3(a).

The Appellant’s claim that “simply giving each chart a cursory review would allow any licensed dentist to easily determine what the Appellant’s system of numbers articulated and match that up with Medicaid requirements” is not supported by the evidence. [Appellant’s brief, p. 5.] Even with almost 40 years’ experience as a dentist, Dr. Toomajian was unable to understand “what the numbers represented” and had “never seen this type of a rating for scaling necessary in another

office's charts." [Transcript, p. 191, 194, 326.] Dr. Toomajian's professional opinion that the Appellant's periodontal charting "would mean nothing" to outside providers, suggesting they too would be deprived of important treatment details when providing dental care to the Appellant's patients, is credited. [Transcript, p. 309.] This opinion casts serious doubt on the Appellant's claims that his charts were intelligible and documented in compliance with professional and Medicaid standards. ADM 2011-1, p. 37; 18 NYCRR 504.3, 517.3(b)(1), 540.7(a)(8).

The Appellant defends his preprinted forms on the ground that they were developed to facilitate its internal office operations for staff to communicate "as to the needs of the patient." [Transcript, p. 1,644, 1,651.] Furthering the Appellant's intra-office operations is not the standard for medical recordkeeping. ADM 2011-1; 18 NYCRR 504.3(i), 517.3(b)(1), 540.7(a)(8). Dr. Toomajian made clear, and Department regulations provide, that dental providers are obligated to document charts in a manner that allows Medicaid staff or other reviewers "to make a correlation between what was done for the patient and what was paid for by the program" after claim submission. [Transcript, p. 133.] 18 NYCRR 504.3(i), 517.3(b)(1), 540.7(a)(8). This requirement is not met by a form understood by only the Appellant and his staff.

- surgical extractions

12 out of the 170 claims disallowed were for surgical extraction billed under code D7210 in the amount of \$85 or \$90 for each claim. [Exhibit 71.] Surgical extractions require documentation of "removal of bone and/or section of tooth." ADM 2011-1, p. 46. The Appellant claims he met this documentation requirement by recording phrases such as "root tip extraction done" in Sample 4, "Surgical extraction-post op care instructions" in Sample 8, "surgical extraction" in Samples 21 and 38, and "Patient signed consent form. Extraction of number thirty maintained hemostasis" in Sample 81. [Exhibits 2, 5, 11, 21, 48; Transcript, p. 1,587-1,588.] These

notations accomplish little more than recording what was going to be billed. None of these notations are an adequate substitute for clear documentation of the nature, extent, and completion of this medical procedure or the service provided. 18 NYCRR 504.3(a); ADM 2011-1, p. 46. [Transcript, p. 152-153, 177, 202, 228.] Adhering to this rule is especially important, Dr. Toomajian pointed out, given the several other claims with medical evidence establishing a less costly simple or routine extraction was done and not the surgical extraction billed (i.e. the dental chart in Sample 81 showing the surgical extraction billed could not have been done due to a lack of bone density around the roots.) [Exhibit 48; Transcript, p. 346.] *See also* Samples 4, 8, 21, 27, 38, 43, 70, 78, and 81.

- Other issues

53 out of the 170 claims disallowed were for resin-based composite restorations on anterior/front teeth or posterior/back teeth billed under codes D2330, D2331, D2332, D2391, D2335, D2392, , D2393, and D2394 in the amounts of \$50, \$55, \$67, \$73, \$82, \$84, \$87, \$98, \$106, \$108, \$142 or \$145 for each claim. [Exhibit 71.] ADM 2011-1, p. 31. Dental providers must certify that the services they bill were provided. ADM 2011-1, p. 9. The Appellant billed for restoration services not performed, such as billing (1) three surface restorations instead of the two or one diagnosed in Samples 49, 73, and 80; (2) two surface restorations instead of the one noted in Sample 55; and (3) eight restorations instead of the seven completed in Sample 28. [Exhibits 15, 29, 33, 44, 47; Transcript, p. 212, 266, 285, 337, 343.]

Dental work performed on teeth for cosmetic reasons or to suit a person's preference is not reimbursable under the Medicaid Program. ADM 2011-1, p. 9. The program manual explicitly prohibits placing restorations solely to address abrasion or attrition and on teeth with a hopeless prognosis that require extraction. ADM 2011-1, p. 10, 31. The Appellant disregarded these rules,

for instance, by billing restorations solely for aesthetic purposes in Sample 43 to see “how (the patient) likes it” and to address a patient’s attrition due to minor chipping in Sample 29. [Exhibits 16, 26; Transcript, p. 214, 257.] Also, he placed a large restoration on a severely decayed tooth with a poor prognosis in Sample 53 that should have been extracted instead of restored. [Exhibit 31; Transcript, p. 275.]

The remaining 22 claims disallowed in this category include the following:

- periodic oral evaluations billed at \$25 or \$29, code D0120
- limited oral evaluations billed at \$14, code D0140
- palliative (emergency) treatment of dental pain - minor procedure, billed at \$25, code D9110
- intraoral - periapical first film billed at \$7, code D0220
- intraoral - periapical each additional film billed at \$5, code D0230
- panoramic film billed at \$35 or \$40, code D0330
- bitewing x-rays billed at \$24 or \$29, code D0274

Clinical oral evaluations billed under codes D0120 or D0140 include a diagnosis, treatment planning, and medical history. ADM2011-1, p. 25. Adhering to these documentation requirements is necessary, Dr. Toomajian explained, to describe “the condition of the mouth.” [Transcript, p. 368.] Dr. Toomajian pointed out that in Sample 99, a periodic oral examination did not include basic components of an assessment of gum or soft tissue health and a cancer screening. [Exhibit 59; Transcript, p. 369.] A limited oral evaluation in Sample 62 of an obvious large defect in a crown from a restoration was not accurately diagnosed, resulting in a failure to address the patient’s complaints of sensitivity and foul odor. [Exhibit 38; Transcript, p. 305.] Dr. Toomajian concluded that an accurate diagnosis is “part and parcel” of every examination. [Transcript, p. 305.]

Billing palliative treatment under code D9110 requires that the procedure “add significantly to the length of time and effort of the treatment provided during that particular visit.” ADM 2011-1, p. 58. Dr. Toomajian explained palliative treatment as a minor procedure performed on patients to “relieve pain” and “distress.” [Transcript, p. 363.] In Sample 98, the Appellant billed

palliative (emergency) treatment, but the chart failed to document he provided any such care to the patient with a “bad infection,” such as by performing a procedure to relieve pain. [Exhibit 58; Transcript, p. 364.]

Dental providers are required to obtain x-rays that are clear and allow for diagnostic assessment. ADM 2011-1, p. 11, 26-27. Examples of the Appellant not following this rule include billing periapical x-rays in Samples 56 and 94 that failed to allow for diagnostic assessment by not visualizing full apices of teeth to assess patients’ deep decay and render diagnoses. [Exhibits, 34, 55; Transcript p. 288, 360.] In Sample 98, there was no diagnostic value in three periapical x-rays that failed to show apices of teeth to assess the cause of a patient’s discomfort. [Exhibit 58; Transcript, p. 365.] The Appellant also impermissibly billed x-rays, such as a panoramic x-ray in Sample 82 and bitewing x-rays in Sample 92, because they were not contained in the charts. [Exhibits 50 and 54; Transcript, p. 350, 356.]

The Appellant failed to meet his burden of proving entitlement to payment for 170 claims in Samples 4, 5, 7, 8, 11, 16, 19, 21, 23, 24, 27, 28, 29, 30, 32, 36, 37, 38, 39, 40, 41, 42, 43, 46, 47, 49, 51, 53, 54, 55, 56, 58, 59, 61, 62, 64, 65, 66, 70, 71, 73, 75, 78, 80, 81, 82, 86, 87, 88, 91, 92, 94, 96, 97, 98, and 99. The OMIG’s disallowances for category 1 are affirmed.

2. Missing Inadequate and/or Incorrect Documentation

This category contains an overlap of claims disallowed in both categories 1 and 2. [Transcript, p. 376.] The disallowances in both categories are upheld because the Appellant failed to document his entitlement to payment of the disallowed claims. Examples of claims disallowed only in this category include Samples 18, 47, and 54. In Sample 18, the Appellant was not entitled to payment for two out of the four bitewings and the periapical x-rays he billed because contrary to his duty to keep those films for a period of six years, they were not maintained in the chart or

furnished to the OMIG upon request, as required. 18 NYCRR 504.3(a); ADM 2011-1, p. 9. [Exhibit 32; Transcript, p. 383.] In Sample 47, the Appellant billed for patching a pre-existing large restoration of four surfaces of a tooth to repair a core buildup, which is non-billable because it is not presented in the dental fee schedule. ADM 2011-1, p. 9. [Exhibit 28; Transcript, p. 421.] In Sample 54, the Appellant was not entitled to payment for restorations of two surfaces of one tooth and four or more surfaces of another tooth due to “worn teeth” because this diagnosis does not include circumstances, such as decay or fracture, to justify such a non-essential service. ADM 2011-1, p. 7, 9, 31. [Exhibit 32; Transcript, p. 427.]

The Appellant failed to meet his burden of proving entitlement to payment for 162 claims in Samples 4, 5, 7, 8, 11, 16, 18, 19, 21, 23, 24, 27, 28, 29, 30, 36, 37, 38, 40, 41, 42, 43, 46, 47, 49, 51, 53, 54, 55, 61, 62, 64, 65, 66, 70, 71, 73, 75, 78, 80, 81, 82, 86, 87, 88, 91, 92, 94, 96, 97, 98, and 99. The OMIG’s disallowances for category 2 are affirmed.

3. Incorrect Procedure Code

Medical Providers are entitled to be paid by the Medicaid Program only for services which are furnished. 18 NYCRR 500.1(b). Dental providers are obligated to use dental codes set forth in the provider manual to support billing Medicaid services. ADM 2011-1, p. 20. The Appellant billed for services that were not performed or needed, such as by billing (1) the code for surgical extractions in Samples 4, 8, 21, 27, 38, 43, 70, 78, 81 instead of the code for simple or routine extractions; (2) the code for restorations of two or four surfaces in Samples 7, 23, and 41 instead of the code for a one surface restoration; (3) the code for a restoration instead of the code for palliative care to address a patient’s pain in Sample 47; (4) the code for a comprehensive exam without a complete oral evaluation instead of the code for a limited exam in Sample 58; (5) the code for four bitewings instead of the code for three in Sample 59; and (6) the code for palliative

care without treatment provided instead of the code for a limited oral exam in Sample 98. [Exhibits 2, 4, 5, 11, 12, 14, 21, 24, 26, 28, 35, 36, 42, 46, 48, 58.]

The Appellant failed to meet his burden of proving entitlement to payment for 23 claims in Samples 4, 7, 8, 21, 23, 27, 38, 41, 42, 43, 47, 58, 59, 65, 70, 73, 78, 81, and 98. The OMIG's disallowances for category 3 are affirmed.

4. Dental Treatment/Service Provided is Not a Covered and/or Essential Service

Medicaid providers are authorized to submit claims and be paid by the Medicaid Program only for services which are medically necessary and appropriate, consistent with quality care and generally accepted professional standards. 18 NYCRR 500.1(b). According to Dr. Toomajian, the Medicaid Program is an “essential services-only program with limited dollars.” [Transcript, p. 244, 515.] See ADM 2011-1, p. 7. Contrary to this requirement, the Appellant billed non-essential services, such as restorations of teeth with attrition caused by normal wear and tear in Samples 11 and 54 and patchwork restorations instead of replacement restorations of existing fillings to address the entire tooth in Samples 40 and 47. [Exhibits 6, 23, 28, 32.]

The Appellant failed to meet his burden of proving entitlement to payment for 15 claims in Samples 11, 40, 47, and 54. The OMIG's disallowances for category 4 are affirmed.

5. Diagnostic Imaging Fails to Comply with Program Requirements

Dental x-rays must be “of good diagnostic quality” and performed “based on need, age, prior dental history and clinical findings.” ADM 2011-1, p. 11. The Appellant obtained four or two bitewing x-rays in Samples 14, 32, and 42, but only one or two were readable and therefore acceptable. In Samples 56 and 94, the periapical x-rays taken failed to show the apices of teeth to assess extreme tooth decay. In Sample 41, a diagnosis of a tooth was inadequate because there was no current x-ray contained in the chart. [Exhibits 7, 18, 24, 25, 34, 55.] At the hearing, the

Department withdrew Sample 98 in this category. [Transcript, p. 533.] This withdrawal does not affect the overpayment because Sample 98 remains disallowed in other categories.

The Appellant failed to meet his burden of proving entitlement to payment for 11 claims in Samples 14, 32, 41, 42, 56, and 94. These disallowances for category 5 are affirmed.

6. Service Provided without Documentation of Medical Necessity

As a condition of enrollment in the program, Medicaid providers are required to prepare, maintain, and furnish to the Department, upon request, contemporaneous documentation demonstrating their right to receive payment from the Medicaid Program fully disclosing the nature and extent of the services, including their medical necessity. 18 NYCRR 504.3(a), 517.3(b), 540.7(a)(8). Enforcing these requirements by ensuring dental providers bill only medically necessary services is critical to protecting the integrity of the Medicaid Program. [Transcript, p. 244, 275, 537.] According to Dr. Toomajian, in Sample 37, there was no medical necessity demonstrated for restoring two teeth with significant pathology, especially considering there were no contemporaneous x-rays in the chart and those obtained three years prior showed significant root decay. [Exhibit 20; Transcript, p. 538-540.]

The Appellant failed to meet his burden of proving entitlement to payment for 2 claims in Sample 37. The OMIG's disallowances for category 6 are affirmed.

7. Duplicate Billing, Frequency Exceeded and/or Conflicting Service

All dental treatment must be clinically indicated and document clinical necessity. ADM 2011-1, p. 10. In Samples 65 and 69, two restorations were redone on different surfaces of the same tooth, one of which was redone 25 days later and the other of which was redone one year and four months later. [Exhibit 40.] Dr. Toomajian explained that there was no documentation of clinical need, such as decay, a defect, or a cavity, to explain the reasons for redoing these

restorations. The Appellant failed to meet his burden of proving entitlement to payment for 2 claims in Sample 65. The OMIG's disallowances for category 7 are affirmed.

8. Failure to Enroll as a Group Practice and/or Failure to be Added as a Member of a Group Practice

A dental provider practicing in a group setting must be added as a member of a group practice to be eligible for reimbursement of Medicaid services. ADM 2011-1, p. 5. In Sample 19, the Appellant was not entitled to payment of \$25 for a periodic oral evaluation provided to a patient under code D0120 because the provider who rendered the service was not registered with the Medicaid Program as a member of the group practice. [Exhibit 10; Transcript, p. 546-547.]

The Appellant failed to meet his burden of proving entitlement to payment for 1 claim in Sample 19. The OMIG's disallowance for category 8 is affirmed.

9. Dental Services Billed to Medicaid for Which a Third Party is Liable

Providers are prohibited under the Medicaid Program from billing services provided to patients covered under a managed care program. AMD 2011-1, p. 12. In Sample 39, the Appellant was improperly paid \$45 by the Medicaid Program for a dental prophylaxis under code D1110 because the patient had coverage under Capital District Physicians Health Plan, a managed care program. [Exhibit 22.]

The Appellant failed to meet his burden of proving entitlement to payment for 1 claim in Sample 39. The OMIG's disallowance for category 9 is affirmed.

Medicaid Program overpayments

The audit findings for the 100 Medicaid beneficiary cases in the sample were extrapolated to the universe of 1053 Medicaid beneficiary cases for which the Department's computer billing and payment records show claims were paid during the audit period. [Exhibit 71.] The Appellant was afforded the right to submit expert testimony challenging the extrapolation or an actual

accounting of all claims paid in rebuttal to the Department's proof. 18 NYCRR 519.18(g).

The Appellant states in his brief that the OMIG "did not call any witness regarding the statistical extrapolation done in regards to the audit of Associated Dental" and "relied on two certifications." [Appellant's brief, p. 6.] The OMIG's reliance on the certifications is precisely what is authorized by the regulations. 18 NYCRR 519.18(g). The Appellant even agrees that the certifications "qualify as substantial evidence that OMIG may rely on to justify the overpayments." [Appellant's brief, p. 6.] By producing the certifications of Dr. Heiner and Ms. Gulum, the OMIG presumptively established the validity of the statistical sampling methodology. [Exhibits 76 and 79.] 18 NYCRR 519.18(g). Extrapolations certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made. 18 NYCRR 519.18(g). Matter of Mercy Hospital of Watertown v. NYS Dept. of Social Services, 79 NY2d 197, 216 (1992). The Appellant failed to produce any evidence to overcome this presumption of accuracy.

The Appellant not only failed to submit expert testimony challenging the extrapolation, it presented the OMIG's own statistical expert, Karl W. Heiner, Ph.D., and OMIG management specialist 3, Theresa A. Gulum, as its witnesses. Rather than provide testimony challenging the extrapolation, these witnesses provided credible, persuasive testimony that completely validated the accuracy of the OMIG's statistical sampling methodology. Dr. Heiner has master's and doctorate degrees in statistics and has decades of experience as a statistical consultant for the OMIG, federal and other state agencies, and nongovernmental institutions. He has taught statistics at various universities, lectured at numerous academic conferences on statistics, and issued publications on sampling and extrapolation and solving mathematical problems. Ms. Gulum based her testimony on her many years of experience producing statistical sampling materials for audits

and certifying the results. [Transcript, p. 1,119-1,125, 1,242, 1,256, 1,291-1,293, 1,425-1,434, 1,468.] These witnesses fully supported the OMIG's case.

The Appellant criticized Ms. Gulum as not qualified to certify "that the program was run correctly without error" because she "did not understand how the random sample is selected, only that the computer program she used generated a list of numbers" and lacked "even the most basic understanding of the program." [Appellant's brief, p. 6.] This complaint disregards Ms. Gulum's chief job responsibility, which was simply to run the program — not understand it. [Transcript, p. 1,229.] The Appellant even points this out by referring to Dr. Heiner's description of her role in his brief as: "Ms. Gulum may run the program, but she would not know how it works or how it achieves randomness." [Appellant's brief, p. 7.]

The Appellant agrees "that the sample was random" and that Dr. Heiner's "extrapolation technique" was correct. [Appellant's brief, p. 7.] Dr. Santoro's insistence that there may be inaccuracies in Dr. Toomajian's findings disallowing specific claims in the sample is not relevant to the issue of the validity of the extrapolation and is not a basis for his conclusion that "the overpayment total using Dr. Heiner's extrapolation method is incorrect." [Appellant's brief, p. 7.] The Appellant is confused about the extrapolation methodology. Dr. Heiner's certification explains the methodology and that it is independent of specific findings. [Exhibit 76.] Dr. Heiner pointed out this information in his certification (Exhibit 76) and further explained this when he testified that "if the hearing concludes" an error, "you don't take the sampled point out. You just say that there's zero errors associated with it" and "the same methodology" would apply. [Transcript, p. 1,467-1,468.] Even if there had been errors in the specific disallowances, which the Appellant failed to prove, Dr. Heiner's certification would remain statistically valid and the extrapolation would simply be recalculated in accordance with the methodology set forth in Dr. Heiner's

certification. [Exhibit 76.]

The extrapolation procedure set forth in the OMIG's certification is authorized by the regulations and has consistently been upheld in administrative hearings and by courts, including the Court of Appeals. Mercy Hosp. of Watertown v. NYS Dept. of Social Services, 79 NY2d 197, 204 (1992); Matter of Clin Path v. NYS DSS, 193 AD2d 1034 (3d Dept. 1993); Matter of Rite Aid of New York, Inc., Dept. of Health Admin. Decision, ALJ John Harris Terepka, July 7, 2010; Matter of Pharmhealth Infusion, Dept. of Health Admin. Decision, ALJ John Harris Terepka, May 28, 2009; Matter of United Cerebral Palsy Association of Putnam and Southern Dutchess a/k/a Hudson Valley Cerebral Palsy, Dept. of Health Admin. Decision, ALJ Dawn MacKillop-Soller June 17, 2019; Matter of Byram Health Care, Dept. of Health Admin. Decision, ALJ John Harris Terepka, December 19, 2019; Matter of Madison York Assisted Living Community, Dept. of Health Admin. Decision, ALJ Natalie J. Bordeaux, October 30, 2020; Matter of Maplewood Assisted Living, Dept. of Health Admin. Decision, ALJ Natalie J. Bordeaux, March 3, 2021. It is upheld in this hearing decision as well.

Conclusion

Dr. Santoro's testimony highlighted his substantial experience as a practicing dentist for more than 50 years and his dedication to his patients. It also, however, laid bare his unfamiliarity with pertinent Medicaid Program requirements that applied to him. His repeated blaming of Dr. Toomajian and Medicaid staff for not questioning him on his billing until years after-the-fact, and his assertions that information not recorded can somehow be inferred, highlighted his lack of understanding of his recordkeeping responsibilities. These false assertions were concerning considering his long-standing history of providing Medicaid services to patients and his submission of more than \$800,000 in claims to the Medicaid Program during the three year audit

period alone. [Appellant’s brief, 2, 5; Transcript, p. 1,530-1,534, 1,644-1,649, 1,651-1,652.] The OMIG’s audit identifying 185 claims disallowed for 388 reasons involving more than half of the 100 sampled patients evidences the need for significant changes to his existing office structure to ensure future compliance with Medicaid Program requirements, a system he readily admits is not in place at his office. [Transcript, p. 1,650.]

The Appellant has failed to meet its burden of proving entitlement to payment for the claims disallowed by the OMIG.

DECISION:

The OMIG’s determination to recover Medicaid Program overpayments from Associated Dental Arts, P.C. is affirmed. The overpayment is in the total amount of \$108,585.

This decision is made by Dawn MacKillop-Soller, who has been designated by the Commissioner of the New York State Department of Health to make such decisions.

Dated: June 18, 2021
Albany, New York

Dawn MacKillop-Soller
Administrative Law Judge