



Inspector General (OMIG), an independent office within the Department, has the authority to pursue administrative enforcement actions against any individual or entity that engages in fraud, abuse or unacceptable practices in the Medicaid Program, and to recover improperly expended Medicaid funds.

The OMIG determined to seek restitution of overpayments by the Medicaid Program to William J. Green, DDS (Appellant). The Appellant requested a hearing pursuant to Social Services Law § 22 and former Department of Social Services (DSS) regulations at 18 NYCRR § 519.4 to review the determination.

### **HEARING RECORD**

OMIG witness: Dr. Martin Toomajian  
OMIG exhibits: 1-31  
Appellant witnesses: Appellant testified on his own behalf  
Appellant exhibits: A - J

A transcript of the hearing was made. (Transcript, pages 1-178.)

### **SUMMARY OF FACTS**

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

2. By draft audit reports dated July 21, 2017 for Audit # 17-4783 and August 3, 2017 for Audit # 17-5013, the OMIG notified the Appellant that it had determined to seek restitution of Medicaid overpayments in the amount of \$20,157.12 and \$52,137.66 respectively. (Exhibit 2,3.)

3. Pursuant to 18 NYCRR 517.5(b)&(c), the draft audit reports advised the Appellant that he was entitled to object to the proposed determinations and to submit documents in response to them. The Appellant submitted a response to both draft audits by letter dated July 26, 2017. (Exhibit 4.)

4. By final audit reports, both dated December 13, 2017, the OMIG notified the Appellant that its determinations remained unchanged and that it continued to seek restitution of Medicaid Program overpayments in the total amount of \$20,157.12 for Audit # 17-4783 and \$52,137.66 for Audit # 17-4783. (Exhibit 5,6.)

5. The Appellant billed the Medicaid program for code: D7540 Removal of reaction-producing foreign bodies – musculoskeletal system, when in fact, he was unbundling a procedure, a portion of which he misinterpreted as this billable code. (Exhibit 5, 6.)

6. The Appellant billed the Medicaid program for code: D2951 Pin Retention – per tooth in addition to restoration, when in fact he cut retention grooves into the tooth instead. (Exhibit 5, 6.)

### **ISSUE**

Is the OMIG entitled to recover Medicaid Program overpayments from the Appellant in the amount of \$20,157.12 for Audit # 17-4783 and \$52,137.66 for Audit # 17-4783, for a total of \$72, 294.78?

### **APPLICABLE LAW**

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 of

Health (Department). Providers agree to submit claims for payment only for services that were actually furnished and 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).

When the Department has determined that claims for medical services or supplies have been submitted 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). A person is entitled to a hearing to have the Department's determination reviewed if the Department requires repayment of an overpayment. 18 NYCRR § 519.4. At the hearing, the Appellant has the burden of showing that the determination of the Department was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR § 519.18(d), SAPA § 306(1).

### **DISCUSSION**

At the hearing, the OMIG presented the audit files and summarized the case as required by 18 NYCRR § 519.17. In addition, the OMIG presented documents and a witness as described above. The Appellant presented exhibits and testified on his own behalf. The OMIG conducted two separate audits of the Appellant. Audit # 17-4783 concentrated on "Fee for Service," Medicaid administered directly by New York state, and Audit # 17-5013 focused on "Managed Care Medicaid," for claims not paid directly by New York Medicaid, but paid by insurance or by subcontractors. (T. Toomajian.)

Audit # 17-4783

For Audit #17-4783, the OMIG investigated suspected overpayments for Codes D7540 (Foreign body removal) and D2951(pin placements).

Under Code D7540, the audit determined that the Appellant billed the Medicaid program for “Removal of reaction-producing foreign bodies – musculoskeletal system, when in fact, he was unbundling a procedure, a portion of which he misinterpreted as this billable code.”

Dr. Green, while treating his patients for restorations, extractions and other procedures administered anesthetic. This anesthetic is considered an included service in the provision of such restorative and surgical procedures. During the administration of anesthetic, Dr. Green on occasion used the “X Tip” system from Dentsply Maillefer. He related during this procedure it was not uncommon for a piece of the device to subsequently require removal from the jaw and to complete the anesthetic procedure, he had to retrieve said piece of the X Tip device from the patient. He would then charge the Medicaid program (using the code D7540) for the removal of the device. The use of a second code to bill the program for a portion of an included component of a billable procedure is “unbundling per New York State Medicaid Regulations. (Exhibit 5,6.)

During the audit period from January 1, 2012 to June 20, 2017, the Appellant inappropriately billed Medicaid under Code D7540 numerous times as shown in Attachment A of Exhibit 5, for a total of \$4,785.00. (Exhibit 5 - Attachment A.)

Under Code D2951, the audit determined that the Appellant, rather than placing a pin or pins to retain a filling, [billed] this service when he cut retention grooves into the tooth.

Cutting retention grooves is not a billable procedure within the New York State Medicaid Program. Retention is an integral part of the preparation of the tooth for a restoration. Preparation of a tooth before it is restored is paid as part of the code billed for restoration. (Exhibit 5,6.)

During the audit period from January 1, 2012 to June 20, 2017, the Appellant inappropriately billed Medicaid under Code D2951 numerous times as shown in Attachment A of Exhibit 5, for a total of \$13,470.60. (Exhibit 5 - Attachment A.)

The combined amount billed inappropriately for the two dental procedures, including interest is \$18,255.60. (Exhibit 5.)

#### Audit # 17-5013

For Audit #17-50133, the OMIG again investigated suspected overpayments for Codes D7540 (Foreign body removal) and D2951(pin placements). The findings in this audit were of the same substantive nature.

Under Code D7540, during the audit period from January 1, 2012 to June 22, 2017, the Appellant improperly billed Medicaid numerous times as shown in Attachment A of Exhibit 6, for a total of \$21,706.50. (Exhibit 6 – Attachment A.)

Under Code D2951, during the audit period from January 1, 2012 to June 22, 2017, the Appellant improperly billed Medicaid numerous times as shown in Attachment A of Exhibit 6, for a total of \$27,287.38. (Exhibit 6 – Attachment A.)

“The combined amount billed inappropriately for the two dental procedures is \$48,993.88. (Exhibit 6.)

The total combined amount of overpayment to the Appellant, including interest, was \$20,157.12 for Audit # 17-4783 and \$52,137.66 for Audit # 17-4783, for a total of \$72, 294.78.

## Code D2951

OMIG witness Dr. Martin Toomajian (Dr. Toomajian) testified that the appropriate billing for code D2951 is for when a dentist inserts a “titanium or titanium alloy” pin into a patient’s tooth. The pin acts “almost like a screw and is used to replace tooth structure.” The pins “allow a tooth to retain a filling when the tooth structure itself is not adequate.” Dr. Toomajian testified that the Appellant “admitted during pre-payment review” that he didn’t place metal pins into the tooth. The Appellant admitted that he “made holes in the patient’s teeth,” but “used composite pins,” or pins made from the same material used to fill teeth, instead of metal pins. Despite not having used the metal pins as required for repayment under Code 2951, the Appellant still billed Medicaid for the use of metal pins. (Exhibit 5,6; T. Toomajian.)

The Appellant responded to the allegations in the Draft Audit Reports by letter and also testified about them at the hearing. (Exhibit 4.) His initial response was that the OMIG reviewers were at fault because he included a “narrative with each claim,” and stated that his claims should be accepted since it took the auditors “five years” to audit his claims. He claimed “They let me assume I was correct in what I did. Why did you wait five years?” He continued that his use of composite pins was acceptable because a pin is not adequately defined in the “CDT code book,” and that the “composite pins I use does (sic) cost money also.” He further stated, “In private practice, I have bought pins and still have them in my office. I just do not use them.” (Exhibit 4.)

Dr. Toomajian explained that the New York State Medicaid system is a “pay first and audit later system. Therefore, the Appellant’s narrative with each claim would not be read prior to payment on the Appellant’s claims.” Dr. Toomajian also pointed out that in

the “Glossary of Dental Clinical and Administrative Terms,” a pin is clearly defined as “a small metal rod, cemented or driven into dentin to aid in retention of a restoration.” (Exhibit 29.) When asked why the use of a composite pin would not be acceptable, Dr. Toomajian responded, “Because the restoration fee includes all prep of tooth, including holes.” The Appellant should have billed for the use of composite pins as part of his bill for restoration, and he actually did bill for restoration, so the composite pins were covered. Additionally, an X-ray taken of one of the Appellant’s patients was offered and admitted into evidence. This X-ray shows the teeth of a patient for whom the Appellant claimed to have used a pin. The X-ray clearly shows that no pin was used. (Exhibit 13.)

Accordingly, regarding code D2951, the Appellant has not met his burden of proving by substantial evidence that the determination of the Department was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR § 519.18(d), SAPA § 306(1).

#### Code D7540

OMIG witness Dr. Toomajian also explained what the “Removal of foreign bodies” meant, as described in Code D7540. According to Dr. Toomajian, this code applies to the removal of a foreign body introduced to a patient’s jaw by accident, like a “pellet from shotgun wound, or (a shard) of glass within the jaw area after an automobile accident.”

The Appellant repeatedly billed Medicaid for his use of an “X-tip.” The X-tip is a device used “for the infiltration of anesthetic when a block injection doesn’t work.” A guide sleeve is initially inserted into the patient’s jaw. After the guide sleeve is in place,



the X-tip drill is inserted into the guide sleeve for effective delivery of anesthesia into a patient's jaw bone. (Exhibit 27.) The Appellant used this device to deliver anesthesia to his patients, and then billed Medicaid for the removal of the guide sleeve. When asked if the X-tip guide sleeve should be considered a foreign object, Dr. Toomajian replied, "No. It's trivial to remove it and its part of any type of removal. It's part of the procedure for administering the anesthetic, part and parcel with delivery. The removal of the guide sleeve is the final step when using the X-tip." When asked if the Appellant billed "for the removal of the guide sleeve as a separate procedure from the restorative billing, which would include anesthesia," Dr. Toomajian replied, "Yes. And he was paid for it."

Again, the Appellant responded to the allegations in the Draft Audit by letter and also testified on his own behalf. (Exhibit 4.) He explained that on the times he billed for the removal of the X-tip guide sleeve, the "instrument separated leaving an iatrogenic foreign body. An entire separate procedure was required to remove the foreign body." (Exhibit 4.)

In his response to the draft audit, the Appellant argued that it was inappropriate to attempt to recover payments from him, especially when seen through the lens of the BP Deepwater Horizon oil spill, wherein:

"the claims administrator "payed some ridiculous claims that had nothing at all to do with the oil spill, including paying \$60,000 to colorectal surgeons and \$173,000 to an escort service. These claims were paid because of the ambiguous way in which the settlement policy was written and signed. If claims met the criteria of the settlement, they had to be paid no matter what." (Exhibit 4.)

Not surprisingly, Dr. Toomajian did not have a response for this argument. The Appellant's assertion that an object placed in a patient's mouth by the Appellant himself

is a foreign object is unpersuasive, as is his implication that the Medicaid rules of reimbursement are ambiguous and therefore should be not be followed.

Accordingly, regarding code D7540, the Appellant has not met his burden of proving by substantial evidence that the determination of the Department was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR § 519.18(d), SAPA § 306(1).

The Appellant failed to offer argument or evidence to challenge the OMIG's determination regarding the imposition or the amount of interest as authorized under 18 NYCRR § 518.4.

**DECISION:** The OMIG's determination to recover Medicaid Program overpayments, with interest, is affirmed. The amount of the overpayment is \$72, 294.78.

This decision is made by Matthew C. Hall, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Albany, New York  
May 23, 2019

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Matthew C. Hall  
Administrative Law Judge

Kathleen Dix, Esq.  
Associate Attorney  
New York State Office of Medicaid Inspector General  
40 N. Pearl Street  
Albany, New York 12243

William J. Green, DDS  
214 Center Street  
Corinth, New York 12822