STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Request of **Nataliya Berger, D.D.S.** Medicaid Provider ID # 00812088 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 determination to recover Medicaid overpayments and censure the provider.	:	**Decision After Hearing** Audit # 09-6867

Before: Denise Lepicier
Administrative Law Judge

Held at: New York State Department of Health

Hearing dates 12/13/16 and 4/18/17 at:
90 Church Street
New York, New York 10007

Hearing date 2/9/17 at:
150 Broadway
Suite 510
Albany, New York 12204

Parties: New York State Office of the Medicaid Inspector General
217 Broadway, 8th floor
New York, New York 10007
By: Ferlande Milord, Esq.

Nataliya Berger, DDS
290 174th Street
Apt. 505
Sunny Isles Beach, Florida 33160
By: Albert Dayan, Esq.
80-02 Kew Gardens Road
Kew Gardens, New York 11415

Jason M. Baxter, Esq., Of Counsel
267 Fifth Avenue
Suite SB100
New York, New York 10016

JURISDICTION

The Department of Health ("Department") acts as the single state agency to supervise the administration of the Medicaid program ("Medicaid") in New York State. Public Health Law ("PHL") § 201(1)(v), Social Services Law ("SSL") § 363-a. Pursuant to PHL §§ 30, 31 and 32, the Office of the Medicaid 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.

Subsequent to the audit in this matter, OMIG determined to seek restitution of overpayments made to Nataliya Berger, D.D.S., Appellant, and to censure her. (Ex. 6)[1] The Appellant requested a hearing pursuant to SSL § 22 and the former Department of Social Services ("DSS") regulations at 18 NYCRR § 519.4 to review OMIG's determination. (Ex. 7)

APPLICABLE LAW

Medicaid fee-for-service providers are reimbursed by Medicaid on the basis of the information they submit in support of their claims. The information provided in relation to any claim must be true, accurate and complete. Providers must maintain records demonstrating the right to receive payment, and all claims for payment are subject to audit for six years. 18 NYCRR §§ 504.3(a)&(h), 517.3(b), 540.7(a)(8).

Medicaid program participation is a voluntary, contractual relationship between the provider of service and the State. SSL § 365(a); 18 NYCRR § 504.1; Schaubman v.

[1] Exhibits will be referenced by an "Ex." in parenthesis followed by the appropriate exhibit number or letter. The transcript will be referenced by a "T." in parenthesis followed by the appropriate page numbers.

Blum, 49 NY2d 375 (1980); Lang v. Berger, 427 F.Supp. 2d 204 (S.D.N.Y. 1977). A Medicaid provider agrees to comply with all program requirements as a prerequisite to payment and continued participation in the program. 18 NYCRR §§ 504, 515, 517, 518. The provider certifies at both the time of enrollment and when submitting claims that the provider will comply or has complied with all its contractual responsibilities. 18 NYCRR §§ 504.3, 540.7(a)(8).

Based on these contractual obligations, the Medicaid program employs a pay-first-and-audit-later system to insure compliance. This process helps ensure that providers are paid promptly. All claims are subject to post-payment audit to determine if claims are supported by complete and accurate information. 18 NYCRR §§ 504.3, 540.7(a)(8). If a Department audit reveals an overpayment, the Department may require repayment of the amount determined to have been overpaid. 18 NYCRR §§ 504.8(a)(1), 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). Interest may be collected upon any overpayments determined to have been made. 18 NYCRR § 518.4(a).

Medicaid may also sanction a provider in appropriate circumstances, in addition to the recoupment of overpayments, when a provider has engaged in "unacceptable practices." 18 NYCRR §§ 515.1, 515.2, 515.3 & 515.4. "Unacceptable practices" include, in relevant part, failing to comply with official rules, regulations, and procedures of the department, and include the following conduct: false claims, false statements,

unacceptable recordkeeping, excessive services, and failure to meet professionally recognized standards. 18 NYCRR § 515.2(a) & (b)(1), (2), (6), (11) & (12).

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. The Appellant, however, may submit expert testimony and evidence to the contrary or an accounting of all claims paid, in rebuttal of the Department's proof. 18 NYCRR § 519.18(g).

A person is entitled to a hearing to have the Department's determination reviewed if the Department requires the repayment of an overpayment and/or the imposition of a sanction. 18 NYCRR §§ 515.6(b), 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 §§ 517.5(b), 519.18(d)(1). An Appellant may not raise issues regarding . . . "any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action." 18 NYCRR § 519.18(a).

The DSS regulations generally pertinent to this hearing are at: 18 NYCRR § 506.2 (dental care), 18 NYCRR § 517 (provider audits), 18 NYCRR § 518 (recovery and withholding of payments or overpayments), 18 NYCRR § 515 (provider sanctions) and 18 NYCRR § 519 (provider hearings).

The New York State Medicaid program issues Medicaid Management Information Systems (MMIS) provider manuals, which are available to all providers and include, *inter alia*, billing policies, procedures, codes and instructions. www.emedny.org. The Medicaid program also issues a monthly Medicaid Update with additional

information, policy and instructions. www.emedny.org. Providers are obligated to comply with these official directives. 18 NYCRR § 504.3(i); Lock v. NYS Department of Social Services, 220 A.D.2d 825, 632 N.Y.S.2d 300 (3d Dept. 1995); PSSNY v. Pataki, 58 A.D.3d 924, 870 N.Y.S.2d 633 (3d Dept. 2009).

ISSUE

Is OMIG's determination to recover Medicaid overpayments in the amount of $829,535 from Appellant, Nataliya Berger, D.D.S., and to censure her, correct?

FINDINGS OF FACT

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

2. Appellant submitted claims for dental services to Medicaid recipients and was paid for these claims by Medicaid. (Ex. 1)

3. By letter dated January 7, 2010, OMIG notified the Appellant that OMIG intended to conduct an audit of the records that support Appellant's Medicaid claims for dental services. (Ex. 1)

4. On January 14, 2010, OMIG conducted an entrance conference with Nataliya Berger, D.D.S., Leon Mayzler, Office Manager, and Richard Dillard of OMIG. (Ex. 2) At the entrance conference, the scope and purpose of the audit were explained, and Mr. Dillard collected some initial information about how Appellant operated. (Ex. 2)

5. OMIG conducted the audit of 100 randomly selected patients for whom services were rendered and whose claims were paid in the period between January 1, 2005, and June 30, 2009. (Ex. 6; Ex. 17; Ex. 17-A) The number (the "universe") of all patients in this period was 2,144 patients. (Ex. 3; Ex. 17; Ex. 17-A; Ex. 18)

6. On November 27, 2012, an exit or "closing" conference was conducted pursuant to 18 NYCRR §517.5(a). The attendees included Bethany Trachtenberg, Esq. Leonard Lipsky, Esq. and Leon Mayzler, and members of the OMIG audit team. (Ex. 3) Appellant's attorneys requested time to submit additional information prior to issuance of the Notice of Proposed Agency Action; they were granted additional time. (Ex. 3)

7. Appellant responded to the exit conference summary on or about December 7, 2012, and the audit team considered the additional information. (Ex. 3)

8. By letter dated December 20, 2013, a Notice of Proposed Agency Action ("NOPAA") was sent to Appellant seeking an overpayment in the amount of $1,025,214, and seeking an exclusion of the provider. (Ex. 4)

9. Appellant submitted a response to the NOPAA on or about February 21, 2014, and February 24, 2014. (Ex. 5; Ex. 6) No new or additional documentation was provided in the response as to any specific claim; the response was principally additional argument. (T. 195-196)

10. By report and letter dated June 29, 2015, OMIG issued a Notice of Agency Action ("NOAA") seeking an overpayment amount of $829,535, and changing the exclusion to a censure. (Ex. 6)

11. By letter dated August 21, 2015, Appellant requested a hearing. (Ex. 7)

12. By Notice of Hearing dated September 16, 2015, this matter was set for hearing on November 24, 2015. (Ex. 8) The hearing was adjourned a number of times and began on December 13, 2016.

13. Edmond Haven, D.D.S., who testified for the Department, was a well credentialed, credible witness concerning Appellant's failure to comply with program

requirements. He also persuasively discussed standards of care when those were in issue. (T. 13-18, 21-23; Ex. 19)

14. At hearing, OMIG presented representative samples of the claims paid in the audit period to demonstrate OMIG's right to seek repayment of overpayments. The Appellant did not testify about any claim in the sample at hearing and took an entirely new tact regarding her response to the audit, claiming she knew little about the audit or how her business was run by her Office Manager.

Billing prior to completion of procedure (Exhibit 6, sub-exhibit II)

15. OMIG demonstrated through a review of claim sample number 33 from the audit that Appellant billed for a crown before the crown was placed in the patient's mouth. (T. 24-30; Ex. 6, sub-exhibit II)

16. OMIG demonstrated through a review of claim sample number 67 from the audit that Appellant billed for a root canal before there was documentation of the root canal having been completed. (T. 33-34' Ex. 6, sub-exhibit II)

Need for services billed not evident (Exhibit 6, sub-exhibit III)

17. OMIG demonstrated through a review of claim sample number 77 from the audit that Appellant billed for a "surface resin filling," but the pre-treatment X-ray did not demonstrate the need for the filling, i.e., there was no decay or defect evident and no need for the filling documented in the record. The need for the services billed was not evident in Appellant's records. (T. 48-59; Ex. 6, sub-exhibit III)

18. OMIG demonstrated through a review of claim sample number 59 from the audit that Appellant billed for surgical removal of an erupted tooth, but there was no X-ray of the tooth or documentation of the surgical procedure in the record. The need for

the services billed was not evident in Appellant's records. (T. 60-64; Ex. 6, sub-exhibit III)

No documentation of the necessity for the service (Exhibit 6, sub-exhibit IV)

19. OMIG demonstrated through a review of claim sample number 55 from the audit that Appellant billed for five root canals on the same day and no documentation of the necessity of these procedures is in the record. (T. 67-74; Ex. 6, sub-exhibit IV)

20. OMIG demonstrated through a review of claim sample number 12 from the audit that Appellant billed for a prefabricated post and core, but there was no documentation of a completed root canal or an endodontic X-ray in the record to justify the necessity for the procedure. (T. 75-81; Ex. 6, sub-exhibit IV)

Filing a false claim (Exhibit 6, sub-exhibit V)

21. OMIG demonstrated through a review of claim sample number 67 from the audit that Appellant billed for multi-surface restorations with composite resins on three different teeth when final restorations were not performed on the date of service. (T. 82-87; Ex. 6, sub-exhibit V)

22. OMIG demonstrated through a review of claim sample number 84 from the audit that Appellant billed for a consultation, rather than a simple periodic exam, but nothing in the record supports the fact that a consultation was performed. The documentation in the record does not support a charge for a consultation. (T. 88-93; Ex. 6, sub-exhibit V)

Failed to meet professional dental standards (Exhibit 6, sub-exhibit VI)

23. OMIG demonstrated through a review of claim sample number 79 from the audit that Appellant billed for a prefabricated post and core, but the post-root- canal

X-ray revealed that the length of the post was too short. (T. 96-101; Ex. 6, sub-exhibit VI)

24. OMIG demonstrated through a review of claim sample number 53 from the audit that Appellant billed for a middle crown but the crown was of poor quality with an open distal margin (or unsealed edge) as evidenced on X-ray. (T. 102-109; Ex. 6, sub-exhibit VI)

Maximization of billing procedure codes (Exhibit 6, sub-exhibit VII)

25. OMIG demonstrated through a review of claim sample number 26 from the audit that Appellant billed for the surgical extraction of two teeth, but no description of the surgical procedures was in the patient's record. (T. 110-113; Exhibit 6, sub-exhibit VII)

26. OMIG demonstrated through a review of claim sample number 79 from the audit that Appellant billed for a four-surface composite restoration when a subsequent X-ray of the tooth shows that only two surfaces were treated. (T. 113-118; Ex. 6, sub-exhibit VII)

Non-diagnostic X-ray (Exhibit 6, sub-exhibit VIII)

27. OMIG demonstrated through a review of claim sample number 36 from the audit that Appellant billed for a complete series of X-rays, including bitewing X-rays, which were of no diagnostic value. (T. 118-123; Ex. 6, sub-exhibit VIII)

28. OMIG demonstrated through a review of claim sample number 96 from the audit that Appellant billed for a complete series of X-rays, including bitewing X-rays,

which were of no diagnostic value. (T. 130-134; Ex. 6, sub-exhibit VIII)

Restoration of teeth with poor prognosis (Exhibit 6, sub-exhibit IX)[2]

29. OMIG demonstrated through a review of claim sample number 28 from the audit that Appellant billed for a two-surface amalgam restoration, but the tooth had severe decay, was extruded, and was severely misplaced, and there was no hope of saving this tooth. The tooth should have been extracted. (T. 138-142; Ex. 6, sub-exhibit IX)

30. OMIG demonstrated through a review of claim sample number 33 from the audit that Appellant billed for a post and core, but put a filling in the tooth that had a previous root canal. Within three-and-one-half months of the filling, the tooth had: 1) a post placement; 2) an infection at the site; and 3) a surgical extraction. (T. 144-152; Ex. 6, sub-exhibit IX)

DISCUSSION

OMIG presented the audit file and summarized the case, as is required by 18 NYCRR § 519.17. OMIG presented documents (Exhibits 1 through 20), the testimony of Edmond Haven, D.D.S., and Suzanne Cumm, a dental hygienist, both of whom work for OMIG. The Appellant presented documents (Exhibits A and B) and the testimony of Nataliya Berger, D.D.S., the Appellant. This appeal is limited to issues raised by Appellant in its responses to the NOPAA. 18 NYCRR §519.18(a).

Dr. Haven's testimony was credible. He explained why each of the sample claims discussed failed to comply with Medicaid program requirements as enunciated in the NOAA. He also persuasively explained why a particular claim did not meet the standard of care when that was the issue.

---

[2] Sub-exhibit IX is found between sub-exhibits IV and V.

Appellant failed to address any specific claim in the sample at hearing and essentially claimed that anything done by attorneys in the past had nothing to do with her.[3] Her argument was that, although she attended the entrance conference for the audit and signed an affidavit which was submitted with her response to the NOPAA, she trusted her office manager, Leon Mayzler, to deal with the audit and all subsequent issues that arose. Indeed, she admitted that she had given her NPI number (Medicaid number) to Mr. Mayzler and that he was responsible for all the billing. Whether with or without her consent, claims were submitted under her Medicaid number which were in many cases services provided by other dentists. (T. 249-350) Having given permission to Mr. Mayzler to sign her name, to conduct her billing and banking, and to deal with this audit, and, having absented herself from the management and financial issues involved with her practice, she can hardly claim she is a victim of ignorance or of Mr. Mayzler's alleged malfeasance. Appellant should have known or been aware of what was going on in her practice. Appellant is responsible for the billing submitted to Medicaid under her Medicaid number.

OMIG has shown that Appellant has received overpayments to which she was not entitled under the Medicaid program. OMIG also determined that Appellant should be sanctioned for her unacceptable practices. OMIG determined that the appropriate sanction in this matter, in addition to repayment of the overpayments, is to censure Appellant. 18 NYCRR § 515.4 governs the guidelines for sanctions and states, in relevant part:

> (b) In determining the sanction to be imposed, the following factors will be considered:

---

[3] None of Appellant's arguments at hearing had ever been raised before and are, therefore, not properly raised at this hearing. They will be dealt with very briefly.

(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 . . . Medicaid and social services programs.

Considering these factors, a censure is an appropriate sanction in this matter. Appellant's violations are many. Many of the charged violations were serious involving unnecessary procedures, non-diagnostic X-rays, failure to comply with professional dental standards, and false claims. Medicaid recipients were subjected to unnecessary procedures and received poor care. The amount of the overpayment also is significant.

In mitigation, Appellant argued that she was duped by her Office Manager who submitted bills to Medicaid under her number and managed the practice for her. Even if this is true, Appellant was responsible for the billing to Medicaid, no one else. If she chose to relinquish this responsibility, she must bear the consequences. Her failure to be involved in her Medicaid billing is not mitigation in this matter. The only mitigating factor in this case is that Appellant has apparently never been sanctioned by Medicaid before. However, having not been sanctioned before is not enough in the context of this case to persuade that the censure should be removed. Appellant's conduct was serious and egregious enough to warrant a censure.

Finally, the average overpayment per patient in the 100 patient samples was $386.81. When this amount is extrapolated over the universe of patients (2,144) in the audit period, the amount is $829,535. This is the amount Appellant must repay.

DECISION:

OMIG's determination to recover Medicaid overpayments in the amount of $829,535.00, and to censure Nataliya Berger is affirmed. This decision is made by Denise Lepicier, who has been designated to make such decisions.

DATED:
August 16, 2017
New York, New York

Denise Lepicier
Administrative Law Judge