STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, New York 12204

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
ACTING MEDICAID INSPECTOR GENERAL

December 6, 2011

Scott E. Weiss, D.D.S
1423 Overing Street
Bronx, New York 10461-3592

FINAL AUDIT REPORT
Audit #2011Z10-019P
Provider [redacted]

Dear Dr. Weiss:

The New York State Office of the Medicaid Inspector General (OMIG) completed an audit of Medicaid claims paid for dental services provided to Medicaid patients. In accordance with Section 517.6 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18 NYCRR), this report represents the final determination on issues found during the OMIG's review.

After reviewing your response to the OMIG's February 10, 2011 Draft Audit Report, the OMIG reduced the Draft Audit Report disallowances of $136,330.43 to $74,978.16 in this Final Audit Report. A detailed explanation of the revision is included in the Final Report.

Based on this determination, restitution of the overpayments as defined in 18 NYCRR 518.1 is required in the amount of $74,978.16.

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below.

> OPTION #1: Make a full payment by check or money order within 20 days of the date of the final report. The check should be made payable to the New York State Department of Health and be sent with the enclosed Remittance Advice form, signed and dated, to:

New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 1237
Albany, New York 12237

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General to have the overpayments applied against your future Medicaid payments. If your repayment terms exceed 90 days from the date of the final report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final report, the OMIG will impose a 15% withhold after 20 days until the agreement is established. The OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. The OMIG will notify you no later than 5 days after initiating such action.

If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

Collections Management Group
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Do not submit claim voids or adjustments in response to this Final Audit Report.

If within 20 days you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to secure payment and liquidate the overpayment amount, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds.

In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.

You have the right to challenge this action and determination by requesting an administrative hearing within sixty (60) days of the date of this notice. In accordance with 18 NYCRR Section 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not

considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If the Facility wishes to request a hearing, the request must be submitted in writing to:

General Counsel
Division of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

If a hearing is held, the Facility may have a person represent the Facility or the Facility may represent itself. If the Facility chooses to be represented by someone other than an attorney, the Facility must supply along with the Facility's hearing request a signed authorization permitting that person to represent the Facility. At the hearing, the Facility may call witnesses and present documentary evidence on the Facility's behalf.

Questions concerning this audit may be directed to [redacted] at [redacted]

Sincerely,

[redacted]

Bureau of Business Intelligence
Office of the Medicaid Inspector General

Enclosure

CERTIFIED MAIL # [redacted]
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

Scott E. Weiss, D.D.S.
1423 Overing Street
Bronx, New York 10461-3592

AMOUNT DUE: $74,978.16

Provider [redacted]

AUDIT #2011Z10-019P

AUDIT TYPE	[X] PROVIDER [ ] RATE [ ] PART B [ ] OTHER:

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.

2. Make checks payable to: *New York State Department of Health*

3. Record the Audit Number on your check.

4. Mail check to:

[redacted]
Medicaid Financial Management
New York State Department of Health
GNARESP Corning Tower, Room 1237
File #2011Z10-019P
Albany, New York 12237

5. If the provider number shown above is incorrect, please enter the correct number below.

CORRECT PROVIDER NUMBER

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
ACTING MEDICAID INSPECTOR GENERAL

FINAL REPORT

SCOTT E. WEISS, D.D.S.
1423 OVERING STREET
BRONX, NEW YORK 10461-3592

DENTAL SERVICES
#2011Z10-019P

ISSUED DECEMBER 6, 2011

BACKGROUND, PURPOSE AND SCOPE

The New York State Department of Health (DOH) is responsible for the administration of the Medicaid program. As an independent office within DOH, the OMIG conducts audits and reviews of providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth in NY Public Health Law, NY Social Services Law, regulations of the Departments of Health and Social Services [Titles 10 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

The OMIG initiated a review of your Medicaid payments for dental services paid from January 1, 2006 through December 31, 2009. The review looked at:

- Inappropriate billing for edentulous patients;
- Inappropriate billing after complete upper or lower dentures;
- Partial upper dentures billed after complete upper dentures;
- Partial lower dentures billed after complete lower dentures;
- Dental services billed fee for service for recipients in skilled nursing facilities;
- Rebase, reline or repair within the six months of post delivery care for dentures;
- Consultation procedure billed with no referring provider information;
- Consultation procedure billed where the billing provider matches the referring provider;
- Multiple single surface restoration claims with surface codes I and O or F and B for the same patient, same tooth and same surface.

Please note that due to the implementation of the National Provider Identifier (NPI) on September 1, 2008, there may be multiple Provider Identification Numbers associated with the Primary Provider Identification Number. The NPI is linked to the Primary Provider Identification Number. The Primary Provider Identification Number is used for correspondence and recoupment.

DETAILED FINDINGS

The exhibits are detailed in eight categories. All or a combination of the following eight exhibits are included in this Final Audit Report.

1. Inappropriate Billing for Edentulous Patients

Regulations state: "By enrolling the provider agrees ... that the information provided in relation to any claim for payment shall be true, accurate, and complete;"

18 NYCRR 504.3(h)

Regulations state: "By enrolling, the provider agrees... to comply with the rules, regulations and official directives of the department."

18 NYCRR 504.3(i)

Regulation 18 NYCRR 518.(c) defines "overpayment" as "any amount not authorized to be paid under the medical assistance program, whether paid as a result of ...improper claiming... or mistake" and 18 NYCRR 518.1(d) provides for the recovery by OMIG of these overpayments.

18 NYCRR 518.1(c) and (d)

Regulations also state: "By enrolling the provider agrees ... to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons."

18 NYCRR 504.3(e)

Medicaid recipients who have claims for both upper and lower denture, maxillary and mandibular, were identified as edentulous. Certain procedures billed for edentulous patients, including, among others, prophylaxis, amalgam, resin, resin-based composites, prefabricated post and core, are inappropriate. Exhibit 1 identifies detailed claims associated with this finding, resulting in overpayments totaling $0.

2. **Inappropriate Billing after Complete Upper or Lower Dentures**

Regulations state: "By enrolling the provider agrees ... that the information provided in relation to any claim for payment shall be true, accurate, and complete;"

18 NYCRR 504.3(h)

Regulations state: "By enrolling, the provider agrees... to comply with the rules, regulations and official directives of the department."

18 NYCRR 504.3(i)

Regulation 18 NYCRR 518.1(c) defines "overpayment" as "any amount not authorized to be paid under the medical assistance program, whether paid as a result of . . . improper claiming . . . or mistake" and 18 NYCRR 518.1(d) provides for the recovery by OMIG of these overpayments.

18 NYCRR 518.1(c) and (d)

Regulations also state: "By enrolling the provider agrees ... to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons."

18 NYCRR 504.3(e)

Medicaid recipients who have claims for complete maxillary or complete mandibular dentures were identified. Certain services performed after the placement of the complete denture, when the tooth location matches the denture location, are considered inappropriate. Such procedures include, among others, amalgam, resin and resin-based composites, prefabricated resin crowns, extractions and occlusal guards. Exhibit 2 identifies detailed claims associated with this finding, resulting in overpayments totaling $0.

3. **Partial Upper Dentures Billed after Complete Upper Dentures or Partial Lower Dentures Billed after Complete Lower Dentures**

Regulations state: "By enrolling the provider agrees ... that the information provided in relation to any claim for payment shall be true, accurate, and complete;"

18 NYCRR 504.3(h)

Regulations state: "By enrolling, the provider agrees... to comply with the rules, regulations and official directives of the department."

18 NYCRR 504.3(i)

Regulation 18 NYCRR 518.1(c) defines "overpayment" as "any amount not authorized to be paid under the medical assistance program, whether paid as a result of . . . improper claiming . . . or mistake" and 18 NYCRR 518.1(d) provides for the recovery by OMIG of these overpayments.

18 NYCRR 518.1(c) and (d)

Regulations also state: "By enrolling the provider agrees ... to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons."

18 NYCRR 504.3(e)

Medicaid recipients who have claims for complete maxillary or complete mandibular dentures were identified. Partial denture services performed after the placement of the complete denture when the partial location (arch) matches the complete denture location (arch) are considered inappropriate. Exhibit 3 identifies detailed claims associated with this finding, resulting in overpayments totaling $0.

4. **Dental Services Billed Fee for Service for Recipients in a Skilled Nursing Facility**

Regulations state: "Dental services. The facility shall provide oral hygiene care and routine and 24-hour emergency dental care in accordance with the comprehensive resident care plan..."

10 NYCRR 415.17

The MMIS Manual states: "Dental services are included in certain facility rates. Payment for services to residents of such facilities will not be made on a fee-for-service basis. Dental providers should seek reimbursement for services provided to Medicaid-eligible residents of all New York State Residential Health Care Facilities (RHCF) and some Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) directly from such facilities.

MMIS Provider Manual for Dental Version 2006-1, Section III

Dental claims for recipients residing in a skilled nursing facility were identified. These claims should be reimbursed by the skilled nursing facility. Claims billed on the day of admission or the day of discharge were removed from the finding. Exhibit 4 identifies detailed claims associated with this finding, resulting in overpayments totaling $0.

5. **Rebase, Reline or Repair Service Within Six Months after the Delivery of New Dentures**

The MMIS Manual states: "All prosthetic appliances such as complete dentures, partial dentures, denture duplication and relining procedures include six months of post delivery care."

MMIS Provider Manual for Dental Version 2005-1, Section VI

Rebase, reline or repair services completed within six months of receiving new dentures when the rebase, reline, or repair location (arch) matches the denture location (arch) were identified. These procedures are not reimbursable during the six months of follow-up care included in the fee for the denture. Exhibit 5 identifies detailed claims associated with this finding, resulting in overpayments totaling $0.

6. **Dental Consultation Claims with no Referring Information**

Regulations state: "By enrolling the provider agrees ... that the information provided in relation to any claim for payment shall be true, accurate, and **complete**;"

18 NYCRR 504.3(h)
(Emphasis Added)

The MMIS Manual States: "Fields 23 (Ordering/Referring Provider ID/License Number), 23A (Profession Code), and 23B (Name) must be completed when the recipient has been referred by another provider. . . If the patient was referred for treatment by another provider, enter the referring provider's Medicaid ID number in this field. "

MMIS Provider Manual for Dental Version 2005-1 Section II

The MMIS Manual States: "To expedite review, indication of the referring provider must be included".

MMIS Provider Manual for Dental Version 2005-1, Section XII

A dental consultation is a patient encounter with a practitioner whose opinion or advice regarding evaluation or management of a specific problem has been requested by another practitioner other than the requesting dentist or physician. Indication of the referring provider must be included on the claim. Dental consultation services with no referring information included on the claim were identified.

The disallowance for Exhibit 6 is the result of a 25 claim random sample of all claims in Exhibit 6. Of the 25 claims in the random sample, 8 claims totaling $408.00 were disallowed; 17 claims (Procedure Code D9310) were reduced to Periodic Oral Evaluation claims (Procedure Code D0120) totaling $374.00. Total sample disallowance of $782.00 projected over the universe of claims contained in the Draft Audit Report Exhibit 6, is $74,978.16.

Attachment A contains the sample design and methodology used to calculate this random sample disallowance. It also contains the random sample claims. The universe of claims can be found in the Draft Audit Report issued to you on February 10, 2011.

7. **Dental Consultation Claims in which the Billing Provider Matches the Referring Provider**

   Regulations state: "By enrolling the provider agrees... that the information provided in relation to any claim for payment shall be true, accurate, and complete;"

   18 NYCRR 504.3(h)

   The MMIS Manual States: "Consultation is defined as advice and counsel from an accredited specialist, which is provided at the request of the attending dentist in regard to the further management of the case by the attending dentist".

   MMIS Provider Manual for Dental Version 2005-1, Section XII

A dental consultation is a patient encounter with a practitioner whose opinion or advice regarding evaluation or management of a specific problem has been requested by another practitioner other than the requesting dentist or physician. Indication of the referring provider must be included on the claim. Dental consultation services where the Referring Provider matches the Billing Provider were identified. Exhibit 7 identifies detailed claims associated with this finding, resulting in overpayments totaling $0.

8. **Multiple Single Surface Restoration Claims With Surface Codes I and O or F and B Billed for the Same Patient , Same Tooth and Same Surface**

   The MMIS Manual States: "For codes D2140, D2330 and D2391, only a single restoration will be reimbursable per surface.

   MMIS Provider Manual for Dental Version 2005-1, Section III

There are a maximum of five (5) surfaces on a tooth, Mesial (M); Incisal (I)/Occlusal (O); Distal (D); Facial(F)/ Buccal (B); and Lingual (L). The combination of Occlusal surface and Incisal surface cannot be billed for the same tooth, and the combination of Facial surface and Buccal surface cannot be billed for the same tooth.

Multiple single surface restoration claims with Surface Codes I and O or F and B, billed for the same patient, same tooth and same surface were identified. Exhibit 8 identifies detailed claims associated with this finding, resulting in overpayments totaling $0.

DETERMINATION

Based on this determination, the total amount of overpayment, as defined in 18 NYCRR 518.1(c) is $74,978.16.