NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF YEKATERINA LEVIN, DDS
DENTAL PAYMENTS FOR MEDICAID MANAGED CARE ENROLLEES
JULY 1, 2012 – FEBRUARY 15, 2013

FINAL AUDIT REPORT
AUDIT # 13-2571

James C. Cox
Medicaid Inspector General

October 30, 2013

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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
MEDICAID INSPECTOR GENERAL

October 30, 2013

Yekaterina Levin, DDS
7000 Bay Parkway, Suite C
Brooklyn, NY 11204-5531

Re: Final Audit Report
Audit # 13-2571
Provider #[redacted]

Dear Dr. Levin:

The New York State Office of the Medicaid Inspector General (OMIG) has identified Medicaid fee-for-service dental payments that were inappropriately made for managed care enrollees; these enrollees already had dental care included in their Managed Care Organization (MCO) benefit package. 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 the issues found during the OMIG's review.

BACKGROUND

The New York State Department of Health (the Department) is the state agency responsible for the administration of the Medicaid program. As part of its responsibility as an entity within the Department, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assessing provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth in New York Public Health Law, New York Social Services Law, the regulations of the Department of Health (Titles 10 and 18 of the NYCRR), the regulations of the Office of Mental Health (Title 14 of the NYCRR) and the Department's Medicaid Provider Manuals, *Medicaid Update* publications, and the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract (Contract).

OBJECTIVE AND SCOPE

Audit Objective

The objective of this audit was to ensure that Yekaterina Levin, DDS (Provider) was in compliance with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify whether dental service claims submitted were properly paid.

Audit Scope

The review identified Medicaid payments made to dental providers after July 1, 2012 for services provided to individuals enrolled in a managed care organization that included dental services in the scope of benefit package.

FINDINGS

A Draft Audit Report was issued June 5, 2013, identifying $1,305 in fee-for-service payments inappropriately made to the Provider for services covered under the managed care enrollee's benefit package with a MCO. In response to the Draft Audit Report the Provider submitted documentation contesting a portion of the claims (Attachment I). The submitted documentation was considered; however, a determination was made that the overpayment will remain the same. As stated in the Contract, specifically Section 3.6 (*Compensation – State Department of Health Right to Recover Premiums*) and, Appendix H, as well as 18 NYCRR Parts 517 and 518, the OMIG, on behalf of the Department, has a right to recover overpayments paid for enrollees listed on the monthly roster.

The total amount of overpayment, as defined in 18 NYCRR §518.1, is $1,305 which is due the New York State Department of Health (Attachment II).

PAYMENT OPTIONS

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

OPTION #1: Make full payment by check or money order within 20 days of the date of the Final Audit Report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File # 13-2571
Albany, New York 12237-0016

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the Final Audit 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 Audit 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:

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

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.

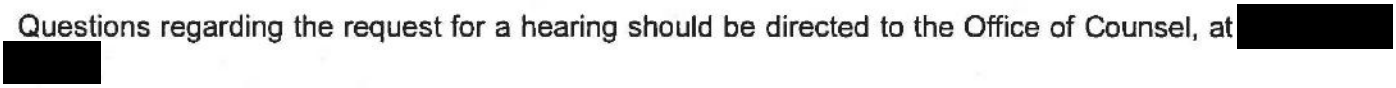
PROVIDER RIGHTS

The Provider has 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 Provider wishes to request a hearing, the request must be submitted in writing to:

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

Questions regarding the request for a hearing should be directed to the Office of Counsel, at



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

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid program, take action where appropriate, and recover any associated overpayments. If you have any questions regarding the above, please contact [redacted] or by email at [redacted] Thank you for your cooperation.

Sincerely,

[redacted]

Division of Medicaid Audit
Office of the Medicaid Inspector General

Attachments (2)

CERTIFIED MAIL #[redacted]
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

Yekaterina Levin, DDS
7000 Bay Parkway, Suite C
Brooklyn, NY 11204-5531

AMOUNT DUE: $1,305.00

PROVIDER [redacted]

AUDIT # 13-2571

PROVIDER TYPE

- ☒ Fee For Service
- ☐ Rate - LTC
- ☐ Rate - NH
- ☐ Managed Care
- ☐ 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]
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
Albany, New York 12237-0016

Thank you for your cooperation.