



New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Suspicious and Fraudulent Medicaid Payments to Affiliated Brooklyn Dentists

**Medicaid Program
Department of Health**



Report 2010-S-64

April 2013

Executive Summary

Purpose

To determine if six affiliated Brooklyn dentists billed Medicaid for services that were not medically necessary or were not provided. We also sought to determine if the affiliated dentists used illegal tactics to solicit Medicaid recipients. The audit covered the period January 1, 2007 through June 8, 2011.

Background

The State's Medicaid program provides health insurance to individuals who are economically disadvantaged and/or have special health care needs. For dental care, the State's Medicaid program requires care to conform to acceptable standards of quality and professional practice, but covers only essential services (not comprehensive). For the fiscal year ended March 31, 2011, Medicaid paid about \$321 million for dental claims. From January 1, 2007 through June 8, 2011, Medicaid paid about \$6.9 million for services claimed by the six dentists.

Key Findings

- We identified about \$2.3 million in highly suspicious and possibly fraudulent claims that were submitted by the six dentists. The affiliated dentists defrauded the Medicaid program by creating false entries in medical records to support claims.
- It was not possible to perform all of the procedures the dentists billed in relation to the hours their offices were open. For example, on June 17, 2010, the dentists' two offices were open for a total of 19 hours. However, the dentists submitted claims for 198 procedures that should have taken nearly 59 hours to perform properly.
- The dentists routinely certified claims (in their own name) for services that were purportedly provided by another affiliated dentist. In addition, the dentists paid staff to recruit Medicaid recipients to their offices. These practices are prohibited by Medicaid regulations.
- We found questionable sanitary conditions at the two offices used by the dentists.
- We referred our findings to the Attorney General's Office for further investigation. In August 2012, one of the dentists pleaded guilty to multiple criminal charges (including felonies) for his conduct. The court ordered the dentist to make restitution to the State and could sentence the dentist to jail.

Key Recommendations

- Actively monitor the claims of the affiliated dentists. Deny or pend claims for excessive numbers of services (particularly within certain time intervals).
- Determine if the dentists should be allowed to participate in the Medicaid program.
- Direct the dentists to cease improper recipient solicitation practices.

Other Related Audits/Reports of Interest

[Department of Health: Inappropriate Medicaid Billings for Dental Restorations \(2007-S-71\)](#)

[Department of Health: Inappropriate Medicaid Billings for Dental Services \(2008-S-67\)](#)

[Department of Health: Inappropriate Medicaid Billings for Dental Services \(2007-S-3\)](#)

State of New York
Office of the State Comptroller

Division of State Government Accountability

April 4, 2013

Nirav R. Shah, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Dear Dr. Shah:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid Program entitled *Suspicious and Fraudulent Medicaid Payments to Affiliated Brooklyn Dentists*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

The New York State Medicaid program is a federal, state, and locally funded program which provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. Residents must meet certain medical and financial requirements to qualify for Medicaid coverage. In recent years, the Medicaid program grew significantly with enrollments increasing from 4.6 million individuals in 2007 to 5.2 million individuals in 2010; an increase of almost 600,000 enrollees.

The Office of Health Insurance Programs within the Department of Health (Department) administers the Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. The eMedNY system subjects claims to various automated edits to determine whether the claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate. Annually, eMedNY processes more than 320 million claims. For the fiscal year ended March 31, 2011, eMedNY paid \$50 billion in Medicaid claims.

Dental care in the State's Medicaid program is intended only for essential services (medically necessary services like cleanings, fluoride treatments, and x-rays; not services for cosmetic reasons) and must conform to acceptable standards of professional practice. In addition, all materials used must meet minimum specifications of the American Dental Association and must be acceptable to the State Commissioner of Health. For the fiscal year ended March 31, 2011, eMedNY paid about \$321 million for Medicaid dental claims. Providers should verify a client's eligibility before providing Medicaid services. If they do not, providers risk the possibility of nonpayment for any services provided.

The State operates a Medicaid Eligibility Verification System to help providers check a potential patient's Medicaid eligibility. Some providers use a Medicaid card swipe machine to access the Medicaid Eligibility Verification System. Small and portable, these machines are connected to a phone line similar to an answering machine. The card swipe machines allow a Medicaid provider to swipe a Medicaid benefit card (like a credit card) and immediately obtain information about a recipient's Medicaid eligibility. The machine accepts manually typed information (as well as a recipient's benefit card) as input, and it produces a printout that indicates the eligibility status of the recipient.

New York State Medicaid's payments for dental services have come under scrutiny in recent years. In 2007 and 2008, we issued three audit reports¹ of suspected fraudulent dental claims - in which we disallowed \$692,130 for unsupported billings and questioned over \$12 million more in paid dental claims. Also, in 2010, the media reported that dentists in New York City paid employees commissions to solicit and send Medicaid recipients to their offices. Medicaid recipients were also given cash or gifts as incentives to sit for dental services. Paying employees a commission to

¹ *Inappropriate Medicaid Billings for Dental Services (2007-S-3); Inappropriate Medicaid Billings for Dental Restorations (2007-S-71); and Inappropriate Medicaid Billings for Dental Services (2008-S-67).*

steer patients to a practice violates federal anti-fee splitting laws. Medicaid prohibits this as well as the provision of cash or gifts to patients who receive services.

In this audit and resulting investigation, we identified a dentist (Lawrence Bruckner) whose Medicaid billing pattern was highly unusual. Lawrence Bruckner operated two office locations in Brooklyn: his primary office at 1155 Broadway Street (Broadway); and his secondary office at 1218 Remsen Avenue (Remsen). There is only one functioning dental exam chair at each office. As a result, only one dentist can work at each location at any one time. In addition, each office maintained regular business hours (generally Monday through Friday between 9:00 a.m. and 6:00 p.m.).

Other dentists reportedly practicing at these offices included: David Bruckner (Lawrence's brother); Joseph Bruckner (Lawrence's son); Arthur Bruckner (Lawrence's father); Allan Lebovitz² and Robert Thaler. For Medicaid billing and payment purposes, the six dentists were registered as individual practitioners, although our examination revealed that they actually functioned as an unregistered group practice. From January 1, 2007 through June 8, 2011 Medicaid paid about \$6.9 million for services purportedly performed by the six dentists at the aforementioned Brooklyn addresses. (Note: Lawrence Bruckner also operated a dental group, called Premier Dental, that billed Medicaid for services from the Broadway office in Brooklyn. Premier Dental includes Lawrence and Arthur Bruckner. However, during our audit period, Medicaid payments to Premier Dental were limited.)

The Office of the State Comptroller's Investigations Unit, Division of Legal Services, participated in this audit and investigation. We also worked collaboratively with the Attorney General's Medicaid Fraud Control Unit due to the nature of the transgressions we identified. In August 2012, Lawrence Bruckner pleaded guilty to various criminal charges (including felonies) stemming from his abuse of the Medicaid program. The plea agreement included restitution to the State, and the court could sentence Lawrence Bruckner to jail. In addition, Joseph Bruckner agreed to a civil settlement.

² Allan Lebovitz has a primary office located at 1490 Ocean Avenue, Brooklyn, NY.

Audit Findings and Recommendations

We concluded that about \$2.3 million of the \$6.9 million paid to the six dentists was highly suspicious and possibly fraudulent. This includes payments totaling \$2.1 million for procedures the dentists likely could not have performed and payments totaling \$185,000 where dental office records contradicted information on the related claims. In addition, we concluded that the dentists sometimes provided substandard care to patients, and we observed potential sanitary deficiencies at the dentists' offices.

Although the Department has controls in place to ensure that persons seeking dental services are eligible for Medicaid benefits, there are inherent limitations in any system of internal controls. No matter how well controls are designed, they can only provide reasonable assurance that objectives have been achieved. In addition, controls can be circumvented by collusion. For example, individuals acting collectively can alter financial and management information in a manner that may not be readily detected. We concluded that the affiliated dentists colluded to circumvent controls within the Medicaid claims processing and payment system. Specifically, they: (1) created entries in medical records for services that were not or could not realistically have been rendered; and (2) used illegal tactics to solicit Medicaid recipients.

Department officials, along with other State oversight authorities as needed, should investigate and recover all inappropriate payments. Further, steps should be taken to determine whether the dentists should be allowed to continue to participate in the Medicaid program.

Suspicious and Possibly Fraudulent Claims

Based on our medical record reviews and interviews with the affiliated dentists, we concluded payments of \$2.1 million were highly suspicious and possibly fraudulent because the related dental services most likely could not have been performed. We base this on the fact that each office could only accommodate one patient at a time and their hours of operation were insufficient to perform all the procedures the dentists claimed they provided. In addition, our review (which incorporated input from Department dental experts) called into question the medical necessity and quality of some of the dental services that were allegedly provided.

Unreasonably High Service Volumes

Given the number of functioning dental chairs available (one at each of the two locations) and the offices' hours of operation, we concluded that the six dentists billed for high volumes of procedures they did not have sufficient time to perform. Each dental procedure requires a certain minimum amount of time to be completed properly. For each procedure, we requested Department dental experts to provide us with an estimate of the amount of time it would take to complete the procedure safely. Based on the estimates provided by the Department's experts, we calculated the total amount of time required to properly perform the procedures billed by the six dentists. Based on our analysis, we concluded that it was impossible to properly perform all of the procedures that were billed.

During the year ended April 18, 2011, the dentists used the card swipe machines on 242 days. We determined that for 230 (95 percent) of the 242 days, it was not realistically possible to properly perform all of the procedures billed in relation to the offices' business hours. For example, on June 17, 2010, we estimated that the two dental offices were open for a total of 19 hours. However, on that date, the dentists were paid for 198 procedures that should have taken nearly 59 hours to perform. Moreover, the six dentists routinely submitted claims for procedures that were far in excess of what could have been performed during normal business hours. We concluded that claims for 23,853 procedures (totaling \$1,549,653 in payments) were fraudulent or highly suspicious because the hours required to perform the services exceeded (often significantly) the offices' business hours.

Based on this analysis, we expanded our review to identify unusual billing patterns over our 53-month audit period. We identified 144 days wherein the dentists were paid for 13,749 more procedures (totaling \$865,992) than they could have performed in any 24 hour period. For example, Robert Thaler received payments for 119 procedures on September 29, 2010. However, it would have taken him at least 38 hours to perform these procedures properly. The dental offices were not open 24 hours a day, nor was there any indication that Dr. Thaler (or any of the other dentists) work 24 hours a day. Consequently, we question all the services billed for these 144 days. (Note: Payments of \$288,288 were included in both analyses we performed. Thus, the fraudulent or suspicious payments for services claimed beyond the actual or available operating hours totaled \$2,127,357 {\$1,549,653 + \$865,992 - \$288,288}.)

Problems With Specific Procedures Claimed

Given the results of our prior analysis, we sought to determine if specific claimed services were actually performed. Consequently, we reviewed the supporting documentation (including medical records) for selected claim payments. We also interviewed selected recipients who purportedly received the services in question. Based on this review, we identified \$21,138 in payments for services that were not performed or documented. In addition, we identified \$3,829 in highly questionable billings.

We selected and reviewed two samples. The first was a judgmental sample of 1,186 procedures totaling \$90,470 for services performed by the dentists over our 53-month audit period. The second was a review of the complete medical records for six recipients with high numbers of procedures claimed by the dentists. For both samples, we determined whether there was appropriate medical documentation for the services performed, as required by the Department and the State Education Department's Office of the Professions. We also requested the Department's dental experts to review x-rays to confirm the medical necessity of the procedures and to determine whether the procedures were actually performed.

From our sample of 1,186 procedures, we disallowed \$16,506 pertaining to 196 procedures. We disallowed payments when there was no supporting documentation for the claims and when the available medical records did not confirm that the procedures claimed were actually performed. We also categorized an additional 31 procedures, totaling \$3,829, as highly questionable - when medical charts displayed one of two unlikely scenarios:

- The same tooth was purportedly filled twice (just days apart) by different affiliated dentists, and the documentation indicated both procedures were performed. We questioned the procedure rendered on the later date; and
- Services for the same recipient were billed on the same day by more than one affiliated dentist. The medical charts had standard record entries with procedure notes scribbled in the margins of the pages. However, the scribbled notes pertained to procedures billed by a second dentist (not the dentist who billed for the other procedures in the patient's chart). As such, we questioned the propriety of claims for the procedures scribbled in the margins of charts.

Our review of six high service recipients resulted in additional disallowances totaling \$4,632, based on input from Department dental experts. The majority of these findings reveal poor quality dental care and evidence of false claims for work that was not performed. The disallowances include \$4,105 for claims for services that were unnecessary, unprofessional, or were not done. Specifically, Department experts indicated that Medicaid paid for:

- 33 fillings that were either not medically necessary or not likely performed - or were performed on teeth that were either falling out or needed to be extracted;
- 13 fillings that were not visible (i.e., not completed) based on x-rays taken after the procedures; and
- 4 fillings on teeth that the recipient did not have.

In one case, Department experts concluded that the fillings clearly constituted dental malpractice. According to the experts, it appeared that the dentist filled above abscesses that were not completely removed and filled teeth that should have been extracted. According to Department experts, the dentist did more harm by treating the patient than if he provided no treatment at all.

The remaining \$527 was disallowed because the x-rays were either not of diagnostic quality or not accurate. Medicaid policy requires x-rays be of diagnostic quality. However, Department experts were unable to derive clinical information from 12 x-rays of poor quality. We disallowed payments for two other claims because the x-rays appeared to be of another recipient's mouth. In these instances, Department experts found natural teeth missing in certain x-rays, but then found the teeth were present in subsequent x-rays.

Our detailed review of claim payment and other related records indicated that services were sometimes not performed, not medically necessary, and not done properly. Further, our interviews of selected recipients confirmed the dubious nature of these billings. Although the recipients indicated that the dentists rendered only brief examinations, the dentists submitted claims for additional services (such as fillings) that were not performed. Consequently, we concluded that the dentists collaborated to defraud the Medicaid program.

Improper Practices Used to Increase Payments

The dentists consistently used improper and illegal practices to increase their Medicaid payments. Specifically, they routinely certified claims (in their own name) for services that were

purportedly provided by another affiliated dentist, according to records (including a log book) we examined. Also, in many instances, the log book did not include the names of patients for whom services were claimed and paid. Consequently, we questioned payments totaling \$184,763 that corresponded with these discrepancies. In addition, the dentists unlawfully paid staff to recruit and transport Medicaid recipients to their offices. Taken together, the record-related actions and patient solicitations provide further evidence that the dentists collaborated to obtain improper Medicaid payments.

Record Discrepancies

Medicaid policy requires providers to identify the dentist who performed the dental services on Medicaid claims. When a dentist signs the Medicaid claim form, he/she certifies that the services claimed were actually provided and all statements made on the form are true and accurate. At the Broadway office, a log book is maintained that lists (by date) the dentist(s) who worked and the recipients they treated. We reviewed this information for the period June 9, 2010 through March 2, 2011 to ensure the identities of the dentists were indicated accurately on claims submitted for payment.

We found 497 cases (totaling \$184,763) in which documentation maintained at the dental offices contradicted information on the related Medicaid claims. Of these, there were 250 cases (totaling \$109,410) in which the dentist identified on the claim was not the dentist indicated in the log book at the Broadway office. The following table summarizes the results of this review:

Dentist Listed In Log Book	Dentist Paid for Medicaid Claim	Case Count	Amount Paid
Lawrence Bruckner	Joseph Bruckner	146	\$62,642
Lawrence Bruckner	David Bruckner	53	21,399
Lawrence Bruckner	Arthur Bruckner	13	5,725
Lawrence Bruckner	Robert Thaler	12	7,272
David Bruckner	Lawrence Bruckner	24	10,572
Robert Thaler	Lawrence Bruckner	2	1,800
	Totals	250	\$109,410

Based on the records we reviewed, Lawrence Bruckner directed Medicaid payments of \$97,038 to other dentists for services he purportedly rendered. The majority of these redirected payments went to his son, Joseph, who told us that he never worked at the Broadway office. Yet, Medicaid paid Joseph Bruckner \$62,642 for claims for services he purportedly rendered at Broadway. Although the dentists might have provided services in some portion of these cases, there is considerable risk that no services were provided in other cases. Furthermore, because Lawrence Bruckner was associated with each of the 250 unusual cases in question, we believe he likely played a major role in this suspicious billing scenario. (Note: On August 13, 2012, Lawrence Bruckner pleaded guilty to a felony, Health Care Fraud in the Second Degree, stemming from his

submission of false claims in the name of his son, Joseph Bruckner.)

In the remaining 247 cases (totaling \$75,353), the patient log book contained no entry showing the recipients were at the office on the claimed dates of service. This includes 167 cases (totaling \$53,751) for Allan Lebovitz and 80 cases (totaling \$21,062) for David Bruckner for services rendered at the Broadway office. Consequently, we questioned whether these 247 services were actually performed.

As noted previously, Lawrence Bruckner operated the offices used by the six dentists. There is considerable risk that the irregularities we observed likely resulted, at least in part, from his efforts to obtain “rents” from the other dentists. According to the other dentists, Lawrence Bruckner recovered portions of his redirected claim payments from them as rent. Allan Lebovitz, for example, said he pays 45 percent of his Medicaid reimbursements to Lawrence Bruckner as rent. David Bruckner said Lawrence Bruckner determined the amount of rent to be paid. Consequently, we concluded from the dentists’ business records and billing patterns, that they conspired to share the improper claim payments. (Note: On August 13, 2012, Lawrence Bruckner pleaded guilty to felony tax evasion for the failure to report the income he received from the other affiliated dentists.)

Recipient Solicitations

Medicaid prohibits any provider from soliciting or offering any payment to recipients to influence their use of a specific provider for services. However, Lawrence Bruckner admitted that he ran a scheme to solicit Medicaid recipients. Specifically he stated he owned a van and employed two people to solicit and transport recipients from soup kitchens to his dental offices. He also stated that another employee steered recipients on the street to his Broadway office. The other dentists denied direct involvement with this practice. However, David Bruckner and Robert Thaler stated they were aware that a van brought patients to the Broadway office. Moreover, all of the affiliated dentists benefited from Lawrence Bruckner’s patient solicitation scheme.

In addition, Lawrence Bruckner stated he provided an electric toothbrush to his Medicaid recipients after treatment. Other network dentists also admitted they give their Medicaid recipients the electric toothbrushes at the conclusion of their office visits. A nominal gift such as a manual toothbrush or small tube of toothpaste given by dentists to their patients to encourage good oral hygiene is acceptable. However, in this instance, Lawrence Bruckner indicated that patients exchanged the electric toothbrushes for cash upon leaving the dentists’ offices. The provision of the toothbrush was a signal to the dentists’ associates to pay the patient and an indicator of an improper Medicaid claim.

We concluded Lawrence Bruckner and his affiliated dentists solicited Medicaid recipients and rewarded them for going to their offices for treatment. Per State regulations, both of these unacceptable practices are “conduct which constitutes fraud or abuse.”

Unsanitary Conditions

To prevent infections, dental providers are expected to sterilize dental instruments, clean and disinfect work surfaces, use covers for contamination-prone equipment, and properly dispose of needles and sharp instruments. In New York State, it is considered professional misconduct if a dentist willfully neglects or fails to use acceptable techniques of infection control. Infection control also includes the general cleanliness of the exam room and all of its equipment.

The affiliated dentists likely subjected patients to substandard cleanliness and quality of care. We found questionable sanitary conditions at both the Broadway and Remsen dental offices (owned and operated by Lawrence Bruckner). At the Broadway office we observed: dusty equipment and dirty floors; an inappropriate water source for patient use; badly damaged walls; and a used glove and hypodermic needle on the floor. At the Remsen office, we noted portions of the ceiling surface were peeled and stains from apparent water damage were in the examination room.

We recommend the Department (with assistance from the Office of the Medicaid Inspector General as needed) perform site inspections to determine whether the Broadway and Remsen offices meet the dental profession's standards for cleanliness. If deemed inadequate, steps should be taken to protect the health and welfare of the recipients served by these dentists.

Recommendations

1. Determine if additional recoveries should be made of claim payments made to the other affiliated dentists involved in the activities described in this report.
2. Determine whether the dentists should be allowed to continue to participate in the Medicaid program. The assessment should also address the propriety of referring the dentists to the State Education Department's Office of the Professions.
3. Actively monitor the claims of the dentists identified in this report. Deny or pend claims for excessive numbers of services (particularly within certain time intervals).
4. Direct the dentists to cease improper recipient solicitation practices. Notify the dentists of the regulations that prohibit certain practices to solicit recipients.
5. Inspect the Broadway and Remsen office locations for unsanitary conditions and take appropriate actions.

Audit Scope and Methodology

The objectives of our audit were to determine whether a dental network was billing Medicaid for services that were not medically necessary or that were not provided, and determine if they were using illegal tactics to solicit Medicaid recipients. Our audit covered the 53-month period from January 1, 2007 through June 8, 2011.

To accomplish our objectives, we reviewed relevant Federal and State laws and regulations and examined the Department's Medicaid policies and procedures. We interviewed officials from the Department and the Office of the Medicaid Inspector General. We analyzed eMedNY data, including paid and denied claims, as well as provider transactions inquiring about recipient eligibility and prior authorizations. We selected a judgmental sample of 1,186 dental procedures from the affiliated dentists to determine if they were supported by medical records and appropriately claimed. Samples selected were part of an excessive volume or frequency of procedures identified per dentist, recipient, or date of service. We consulted Department dental experts to estimate the amount of time each procedure should take to be performed adequately.

Due to fraud indicators noted during our fieldwork, we obtained all Medicaid claims and medical records for six recipients who received high volumes of services (per claims and payments) to determine if the procedures were medically necessary and actually performed. In addition, we compared the log book, which listed dates the dentists treated recipients at the Broadway office, to paid claims to determine claim validity. With OSC investigative staff, we visited each of the dentists' office, observed operations and obtained medical records. We also contacted each of the six affiliated dentists and interviewed several recipients who purportedly received services from these dentists.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials generally concurred with our recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinder to a Department comment is included in a State Comptroller's Comment.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Contributors to This Report

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

Nirav R. Shah, M.D., M.P.H.
Commissioner

NEW YORK
state department of
HEALTH

Sue Kelly
Executive Deputy Commissioner

November 16, 2012

Mr. Brian Mason, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street -11th Floor
Albany, NY 12236-0001

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments regarding Office of the State Comptroller's Draft Audit Report 2010-S-64 on "Suspicious and Fraudulent Medicaid Payments to Affiliated Brooklyn Dentists."

Thank you for the opportunity to comment.

Sincerely,



Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Michael Nazarko
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**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2010-S-64 on
Suspicious and Fraudulent Medicaid Payments
to Affiliated Brooklyn Dentists**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2010-S-64 on "Suspicious and Fraudulent Medicaid Payments to Affiliated Brooklyn Dentists."

Recommendation #1:

Determine if additional recoveries should be made of claim payments made to the other affiliated dentists involved in the activities described in this report.

Response #1:

The Office of the Medicaid Inspector General (OMIG) is currently working with the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU), and will address potential additional recoveries following finalization of this joint investigation.

Recommendation #2:

Determine whether the dentists should be allowed to continue to participate in the Medicaid program. The assessment should also address the propriety of referring the dentists to the State Education Department's Office of the Professions.

Response #2:

One provider pled guilty to healthcare fraud and the OMIG is in the process of excluding this provider from participation in the Medicaid Program. The OMIG is considering administrative action regarding the other providers.

Recommendation #3:

Actively monitor the claims of the dentists identified in this report. Deny or pend claims for excessive number of services (particularly within certain time intervals).

Response #3:

The Department initiated 10 questionable billing practice referrals to the OMIG between 2006 and 2010 on the providers identified in this report, which OMIG subsequently referred to MFCU for investigation. The OMIG would not place a provider that is under active investigation on prepayment review unless requested to do so.

*
Comment

* See State Comptroller's Comment, page 18.

Recommendation #4:

Direct the dentists to cease improper recipient solicitation practices. Notify the dentists of the regulations that prohibit certain practices to solicit recipients.

Response #4:

The OMIG has conducted surveillance activities of some of the providers' office locations. To date, nothing has been observed that would indicate the providers are engaging in the improper solicitation of recipients. Additional surveillance activities may be conducted in the future.

Recommendation #5:

Inspect the Broadway and Remsen office locations for unsanitary conditions and take appropriate actions.

Response #5:

The OMIG conducted several Credential Verification Reviews and on-site inspections at the Broadway and Remsen office locations. The OMIG determined that each location appeared to have several health and safety issues and consulted with the New York City Department of Health.

When the OMIG attempted to conduct a follow-up inspection at the Broadway office, the office was closed and a sign was posted indicating the office had moved. In addition, the OMIG contacted the Remsen office and the person answering the phone stated that the provider no longer accepts Medicaid.

State Comptroller's Comment

1. Although the Department referred the dentists in question to the OMIG (which subsequently referred them to the MFCU), the dentists' suspicious and fraudulent claim payments were not addressed by oversight authorities until our audit identified them. Consequently, we maintain that the Department should take further action with the OMIG to actively monitor the dentists' current and future claims.