

cc: Ms. Daniels Rivera by Scan
Ms. Mailloux by Scan
Ms. Bordeaux by Scan
Ms. Marks by Scan
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SAPA File



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

January 28, 2025

CERTIFIED MAIL/RETURN RECEIPT

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Nabil Eid Farra Samarneh, DDS
Mamaroneck Dental PLLC
397 Palmer Avenue
Mamaroneck, New York 10543

**RE: In the Matter of Nabil Eid Farra Samarneh, DDS
and Mamroneck Dental PLLC**

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter.

If the appellant did not win this hearing, the appellant may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the appellant wishes to appeal this decision, the appellant may wish to seek advice from the legal resources available (e.g. the appellant's attorney, the County Bar Association, Legal Aid, OEO groups, etc.). Such an appeal must be commenced within four (4) months after the determination to be reviewed becomes final and binding.

Sincerely,

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB: cmg
Enclosure

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

COPY

In the Matter of the Appeal of

**Nabil Eid Farra Samarneh, DDS and
Mamaroneck Dental PLLC
Provider # 02678866,**

Appellants,

**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.**

Decision After Hearing

**Audit # 18-9915
17-F-2567**

Before: Kathleen Dix
Administrative Law Judge

Held At: NYS Department of Health, Menands, New York
and by videoconference

Dates of Hearing: February 13 and 26, 2024

Record closed: August 16, 2024

Parties: NYS Office of the Medicaid Inspector General
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JURISDICTION

The New York State Department of Health (the Department) acts as the single state agency to supervise the administration of the Medicaid Program in New York State. 42 USC § 1396a, Public Health Law (PHL) § 201(1)(v), Social Services Law (SSL) § 363-a. The Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority to pursue administrative enforcement actions to recover improperly expended Medicaid Funds. PHL §§ 30, 31, and 32.

The OMIG determined to censure Nabil Eid Farra Samarneh, DDS and Mamaroneck Dental PLLC (Appellants) within the Medicaid Program and recover overpayments from the Appellants, jointly and severally. The Appellants requested a hearing pursuant to SSL § 145-a and former Department of Social Service (DSS) regulations at 18 NYCRR § 519.4 to review the determination.

HEARING RECORD

Appellant Exhibits: C and D

OMIG Exhibits: 1-5, 7-12, 14, 18, and 19

Appellant Witnesses: Nabil Eid Farra Samarneh, DDS (Transcript, pages 382-472.)

OMIG Witnesses: Megan Nadeau (Transcript, pages 39-133.)

George Jeffrey Glikes, DDS (Transcript, pages 134-381.)

A transcript of the hearing was made. (Transcript, pages 1-511.) After the OMIG submitted one and the Appellants submitted two post-hearing briefs, the record was closed on August 16, 2024.

SUMMARY OF FACTS

1. During the period under review, Nabil Eid Farra Samarneh, DDS, based in Mamaroneck, New York, was a dentist enrolled as a provider in the New York State Medicaid Program and was assigned Medicaid Management Information System

(MMIS) #02678866. (Exhibit 12.)

2. Mamaroneck Dental PLLC, is an affiliate of Nabil Eid Farra Samarneh, DDS, within the meaning of 18 NYCRR § 504.1(d), as Nabil Eid Farra Samarneh, DDS is the owner of Mamaroneck Dental PLLC. (Transcript, pages 42-43; Exhibits 4, 14.)

3. By notice dated September 27, 2018, the OMIG requested the Appellants provide complete copies of the entire patient record for 45 named patients who were Medicaid recipients. (Exhibit 1.)

4. During the period April 1, 2017 through July 31, 2018, the Appellants were paid \$362,948.10 for dental services rendered to 44 of the 45 Medicaid recipients for which records were sought. (Exhibits 2, 4.)

5. By Notice of Proposed Agency Action (NOPAA) dated December 21, 2022, the OMIG advised the Appellants that it had reviewed 44 of the 45 dental records submitted in support of Medicaid claims totaling \$362,948.10 which were billed by them for dental services rendered to Medicaid recipients during the period April 1, 2017 through July 31, 2018. The OMIG further advised the Appellants that it had determined that dental services rendered, and dental records associated with 534 dental claims totaling \$340,659.10, failed to comply with the requirements of the Medicaid Program. The OMIG also advised the Appellants that it had determined that they had engaged in unacceptable practices, proposed to censure them within the Medicaid Program, and proposed to recover Medicaid overpayments in the amount of \$340,659.10, plus interest from the Appellants, jointly and severally. (Exhibit 2.)

6. The Appellants submitted an undated response to the NOPAA which contained patient records and offered explanations of the services provided for some of

the disallowed claims. (Exhibit 3.)

7. After review of the Appellants' response to the NOPAA, by Notice of Agency Action (NOAA) dated August 23, 2023, the OMIG determined that the Appellants had engaged in three unacceptable practices, and disallowed 207 Medicaid claims as follows:

- I. Unacceptable recordkeeping. 18 NYCRR § 515.2(b)(6); 138 services disallowed totaling \$119,533.00.
- II. Submitting or causing to be submitted a claim(s) for unfurnished medical care, services or supplies; 18 NYCRR § 515.2(b)(1),(i)(a); 56 services disallowed totaling \$18,135.00.
- III. Making or causing to be made any false, fictitious, or fraudulent statement or misrepresentation of material fact in claiming a medical assistance payment; 18 NYCRR § 515.2(b)(2)(i); 13 services disallowed totaling \$10,017.10.

The OMIG determined to censure the Appellants and recover Medicaid overpayments for the 207 disallowed claims in the amount of \$147,685.10, plus interest, from the Appellants, jointly and severally. (Exhibit 4.)

ISSUES

Did the Appellants engage in unacceptable practices in the Medicaid Program?
If so, did the OMIG properly determine to censure the Appellants within the Medicaid Program?

Is the OMIG entitled to recover Medicaid Program overpayments in the amount of \$147,685.10, plus interest, from the Appellants, jointly and severally?

APPLICABLE LAW

As a condition of their voluntary enrollment in the Medicaid Program, providers are required to prepare, maintain, and furnish to the Department upon request,

contemporaneous records fully disclosing the nature and extent of the care, services and supplies they provide and demonstrating their right to receive payment from the program. The information provided in relation to any claim must be true, accurate and complete. All records necessary to disclose the nature and extent of services furnished must be kept by the provider and are subject to audit for six years. 18 NYCRR §§ 504.3(a)&(h), 517.3(b), 540.7(a)(8). Providers are required to permit such audits, the time, manner, and place of which will be determined by the Department. 18 NYCRR §§ 504.3(g), 517.3(f).

When the Department has determined that claims for medical care, 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). 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 §§ 504.8, 518.1(b)&(c).

An unacceptable practice in the Medicaid Program is conduct contrary to the official rules, regulations, claiming instructions or procedures of the Department. 18 NYCRR § 515.2(a)(1). Unacceptable practices are defined at 18 NYCRR § 515.2 and include unacceptable recordkeeping (§ 515.2(b)(6)); submitting or causing to be submitted a claim(s) for unfurnished medical care, services or supplies (§ 515.2(b)(1)(i)(a)); making or causing to be made any false, fictitious, or fraudulent statement or misrepresentation of material fact in claiming a medical assistance payment (§ 515.2(b)(2)(i)); and failure to meet recognized standards (§ 515.2(b)(12)).

Upon a determination that a person has engaged in an unacceptable practice, the Department may impose one or more sanctions, including censure, and may require the repayment of overpayments determined to have been made as a result of an unacceptable practice. 18 NYCRR §§ 515.3(a)&(b), 515.9, 518.1(c). Whenever the Department sanctions a person, it may also sanction any affiliate of the person. 18 NYCRR § 515.3(c). An affiliate means any person having an overt, covert, or conspiratorial relationship with another such that either of them may directly or indirectly control the other or such that they are under the same common control or ownership. 18 NYCRR § 504.1(d).

A person is entitled to a hearing to have the Department's determination reviewed if the Department imposes a sanction or requires repayment of an overpayment or restitution. 18 NYCRR § 519.4. At the hearing, the Appellant has the burden of showing that the determination of the Department was incorrect, that all claims submitted were due and payable under the Medicaid Program and of proving any mitigating factors affecting the severity of any sanction imposed. 18 NYCRR § 519.18(d).

Requirements for billing dental services are set forth in the New York State Medicaid Program Dental Policy and Procedure Manual. The Medicaid provider manuals, which are available online for all providers, constitute official rules of the Department with which providers are required to comply. See, Lock v. NYS Dept. of Social Services, 220 AD2d 825, 827 (3rd Dept. 1995) and www.emedny.org.

DISCUSSION

The OMIG identified claims in which dental services were billed prior to being completed; dental records that lacked documentation to substantiate that the services

were rendered as billed and the necessity for the services billed; documentation that did not correlate with the billed services and/or was either incomplete or missing from the record; and many radiographs which were undated and/or non-diagnostic. Additionally, the OMIG's review determined treatment was excessive and beyond the scope of the Medicaid Program as set forth in the New York State Medicaid Program - Dental Policy and Procedure Code Manuals, Version 2017 and Version 2018 which state, "Dental Care in the Medicaid program shall include only ESSENTIAL SERVICES rather than comprehensive care."

In particular, the OMIG determined that 207 claims submitted for the 44 dental records reviewed were not authorized to be paid due to the Appellants' unacceptable practices: 138 claims for unacceptable recordkeeping (18 NYCRR § 515.2(b)(6)); 56 claims for unfurnished medical care, services or supplies (18 NYCRR § 515.2(b)(1),(i)(a)); and 13 claims for false, fictitious, or fraudulent statement or misrepresentation (18 NYCRR § 515.2(b)(2)(i)).

The Appellants contend that while OMIG alleges 207 program violations, there are only three unacceptable practices alleged. (Appellants' brief, page 8.) The Appellants argue that the alleged unacceptable practices had no adverse impact on the dental services provided to Medicaid recipients, nor did they cause financial damage to the Medicaid Program, and that that the regulatory factors for imposing a sanction were only "cursorily addressed" in the NOAA and "minimally" addressed during the hearing. (Appellants' brief, page 9.)

The Appellants further contend that the NOAA process is a violation of their due process rights; that Dr. Samarneh provided all the challenged services; and that the

OMIG failed to follow the regulatory requirements when imposing a sanction. The Appellants argue that they should not be censured within the Medicaid Program, nor should they be required to make restitution because the dental services at issue were clinically necessary and provided with a high standard of care. (Appellants' brief and reply brief.) The Appellants failed to meet their burden of proving any of these contentions.

The OMIG representative responsible for conducting the audit, George Jeffrey Glikes, DDS, testified in order "to present the audit file and summarize the case" in compliance with 18 NYCRR § 519.17(a). Dr. Glikes has extensive experience as a practicing dentist encompassing more than four decades in the private and public sectors. His testimony demonstrated his expansive knowledge of Medicaid Program requirements, and he provided detailed, credible testimony about the individual disallowances.

The Appellants allege that they were deprived of their due process rights because the "proposed censure evolved from a records request . . . not an audit that would be subject to applicable due process protections." (Appellants' brief, page 4.). This assertion is without merit. The OMIG's investigative process provided the Appellants their full due process rights. There is no evidence that the OMIG has behaved unreasonably in the exercise of its authority and the OMIG followed the regulatory procedure set forth in 18 NYCRR § 515.6, which the Appellants concede. (Appellants' brief, page 2.) 18 NYCRR § 515.6 affords the Appellants their full due process rights, as is clearly stated in Daniel v. NYS Department of Health, et. al., No. 21-CV-4097, 2022 WL 21781460, at p. 11, (EDNY August 24, 2022):

... Plaintiff has had ample notice and process to contest any purported errors by OMIG. Plaintiff has been provided a NOPAA, a NOAA, a pending administrative hearing, and can challenge OMIG's findings in a (*sic*) Article 78 proceeding if necessary. *Fleming v. Kerlikowske*, 201 F.3d 431 (2d Cir. 1999) ("Article 78 proceeding is a sufficient post-deprivation hearing for due process purposes"); *Cutie v. Sheehan*, No. 1:11-CV-66 MAD/RFT, 2014 WL 4794195, at *17-18 (N.D.N.Y. Sept. 25, 2014), *aff'd*, 645 F. App'x 93 (2d Cir. 2016) (plaintiffs received adequate due process because they were notified of the administrative appeal process and could challenge the result in an Article 78 proceeding).

Next, the Appellants assert that "[t]here is no credible dispute that Dr. Samarneh provided **all** of the dental services which were billed to Medicaid and that these services were clinically necessary" (*emphasis added*), and that the disallowances were "related to documentation errors and questions as to the necessity of service." (Appellants' brief, page 7.) These assertions are not supported by this record.

The basis for the disallowances is not limited to the Appellants' failure to have the appropriate records to demonstrate their entitlement to payment. The evidence also affirmatively shows that there were billed services that were not, in fact, performed, and that information in patient charts was indeed false or fictitious. *E.g.*, for patient number 11, the Appellants' treatment notes documented that teeth numbered [REDACTED] through [REDACTED] were prepared for [REDACTED] on [REDACTED] 2017 and [REDACTED] were inserted on [REDACTED] 2017, at which time the Appellants billed Medicaid. The patient record also documents that [REDACTED] were inserted on teeth numbered [REDACTED] and [REDACTED] on [REDACTED] 2017. Although the patient records document that the [REDACTED] on teeth numbered [REDACTED] and [REDACTED] were done after [REDACTED] on teeth numbered [REDACTED] through [REDACTED], radiographic evidence (undated) which shows [REDACTED] on teeth numbers [REDACTED] and [REDACTED] should also, but does not, show any [REDACTED] or preparation for [REDACTED] on teeth numbers [REDACTED] and [REDACTED]. Eight months later, an [REDACTED] 2018,

radiographic evidence still did not show any [REDACTED] on teeth numbers [REDACTED] or [REDACTED]. Therefore, no [REDACTED] were inserted on teeth numbers [REDACTED] through [REDACTED] when billed in [REDACTED] 2017. This conclusion is further supported by the lack of a lab slip to show that [REDACTED] for teeth numbered [REDACTED] through [REDACTED] were ever ordered. The Appellants did not address this discrepancy in their response to the NOPAA. (Transcript, pages 162-175; Exhibit 3, bates pages 818, 820, 825; Exhibit 5, bates pages 2386, 2392-2393, 2399-2400; OMIG brief, pages 11-12.)

The Appellants also billed Medicaid for unfurnished services to patient 33. The Appellants billed Medicaid for six [REDACTED] on [REDACTED] 2018, but no documentation, lab slips, treatment notes or radiographs were produced for that date of service; there is no documentation to show the necessity of the treatment or that the treatment was rendered at all. Furthermore, the patient's file contains a notation that patient number 33 was not in the Appellants' offices between [REDACTED] 2018 and [REDACTED] 2018. While the Appellants' response to the NOPAA stated that they tried many times, unsuccessfully, to reach the patient for final x-rays; the response did not include any treatment notes or lab slips which would verify the [REDACTED] were done, nor was any explanation offered regarding the notation that the patient was absent from the office during the time period that [REDACTED] crowns were billed. (Transcript, pages 175-186; Exhibit 3, bates page 1578, 1580; Exhibit 4, bates page 2170; Exhibit, 5 bates pages 2538-2539; Department's brief, page 12.)

The Appellants also billed Medicaid for unfurnished services and/or made false or fictitious statements regarding patient number 15 (Transcript, pages 186-196; Exhibit 3, bates pages 965-967; Exhibit 4, bates page 2024; Exhibit 5, bates pages 2448-2449,

2452; Department's brief, pages 12-13) and patient number 17 (Transcript, pages 196-201; Exhibit 3, bates pages 1028; Exhibit 4, bates pages 2110-2111; Exhibit 5, bates pages 2458-2459; Department's brief, page 13).

The Appellants next contend that recoupment of Medicaid payments, where the "sole basis for disallowances are documentation errors" will provide the Medicaid program with a "financial windfall." (Appellants' brief, page 1.) This contention is completely inconsistent with the evidence just discussed herein. In any event, Dr. Glikes testified that providers are required to keep records that are contemporaneous; that accurately document the treatment provided and the medical necessity therefore; that document that the patient did receive the treatment; and that document the provider billed for the treatment upon completion and not before. (Transcript, page 153.) As Dr. Glikes correctly noted, accurate records demonstrate the provider's right to receive payment under the Medicaid Program for services that were rendered and demonstrate that the treatment was done in an acceptable clinical manner. (Transcript, pages 154-155.) Dr. Glikes explained that keeping accurate and contemporary records is important because treatment charts and treatment notes are legal documents, and in the Medicaid Program, the accurate records are used to maintain program integrity, *i.e.*, that taxpayer dollars are appropriately spent on treatment that is medically necessary and provided with the appropriate standard of care. (Transcript, pages 154-155.)

Megan Nadeau, Investigative Specialist 2, testified likewise, that incomplete dental records impact the integrity of the Medicaid Program and the quality of patient care. The lack of proper record keeping, false statements and false claims, resulting in inaccurate and/or incomplete patient dental records, can impact a patient's future dental

care and undermines the integrity of the Medicaid Program. Claims that are not supported by the record and/or claims that are billed for services which were not rendered will be disallowed, and an overpayment will be determined. (Transcript, pages 50-52, 62, 155.) Thus, recoupment of the overpayment is just and appropriate and fully authorized under 18 NYCRR §§ 517.3, 518.1 and 518.3.

At the hearing, the OMIG conceded the Appellants' entitlement for payment for three claims in category number 1, unacceptable recordkeeping, which had been disallowed in the NOAA, to wit: claims for Patient number 7, date of service of [REDACTED] 2017, for tooth number [REDACTED], in the amount of \$1015 (Transcript, pages 264-266; Exhibit 4, bates page 2125); Patient number 12, date of service of [REDACTED] 2018, for tooth number [REDACTED], in the amount of \$300 (Transcript, pages 301-304; Exhibit 4, bates page 2080); and Patient number 36, date of service [REDACTED] 2018, for tooth number [REDACTED], in the amount of \$435 (Transcript, pages 357-358; Exhibit 4, bates pages, 2044-2045). The OMIG is no longer seeking restitution for those three identified claims. Thus, the number of claims disallowed for unacceptable recordkeeping in category number 1 is reduced by 3 to 135, and the amount of restitution being sought for these 135 claims is reduced accordingly, to \$117,783.00. Consequently, the overall total number of claims disallowed in this matter is reduced to 204 disallowed claims and the restitution being sought by the OMIG is reduced to \$145,935.10. (See, OMIG's brief, page 20.)

Ms. Nadeau also testified regarding the appropriateness of the sanction. A sanction can be imposed when there is a finding of unacceptable practices, which is conduct that is contrary to the rules and regulations of the Medicaid Program. 18 NYCRR § 515.3. The OMIG reviewed all six factors set forth in 18 NYCRR § 515.4: the

number and nature of the violations, the nature and the impact of the violations on the recipient, the financial impact or harm to the program, the previous history, if any, of the provider, (*i.e.*, were there any sanctions or censures or exclusions in the past), and then took into consideration any mitigating and/or other factors presented in the case. Ms. Nadeau testified that an example of a mitigating factor would be that a provider is unable to provide information requested due to a natural disaster. The Appellants did not meet their burden of proving any mitigating factors in this case. 18 NYCRR § 519.18(d)(2). (Transcript, pages 50-55.)

The OMIG considered the regulatory factors and noted while there were three categories of unacceptable practices in the NOAA, these three categories encapsulated 207 claims, which evidenced a pattern of conduct. (Transcript, pages 58-61, 89; Exhibit 10.) The Appellants failed to prove the presence of any mitigating factors or that the OMIG did not follow the regulatory requirements of 18 NYCRR § 515.4(b) when it chose to impose a censure and require repayment of claims attributable to the unacceptable practices. (18 NYCRR § 519.18(d)(2); Appellants' brief, page 8; Appellants' reply brief, page 2.)

CONCLUSION

The Appellants engaged in unacceptable practices within the Medicaid Program in violation of 18 NYCRR §§ 504.3 and 540.7(a)(8), and the New York State Medicaid Program Dental Policy and Procedure Manual. The Appellants have committed the following unacceptable practices:

1. 18 NYCRR § 515.2(b)(6) Unacceptable recordkeeping. The Appellants engaged in unacceptable recordkeeping by failing to maintain or to make available for

the purposes of audit or investigation records necessary to fully disclose the medical necessity for and the nature and extent of the medical care, services or supplies furnished for 135 claims in this category. The Appellants' records lacked documentation to substantiate the necessity for billed services, and documentation was incomplete, missing, and/or did not correlate with billed services. The OMIG's disallowance of 135 claims totaling \$117,783.00 for unacceptable recordkeeping is affirmed. The OMIG is entitled to restitution in the amount of \$117,783.00 for unacceptable recordkeeping.

2. 18 NYCRR § 515.2(b)(1)(i)(a) False Claims. The Appellants filed false claims by submitting, or causing to be submitted, a claim or claims for unfurnished medical care, services or supplies for which there is no documentation that services were rendered. The OMIG's disallowance of 56 false claims totaling \$18,135.00 is affirmed. The OMIG is entitled to restitution in the amount of \$18,135.00 for filing false claims.

3. 18 NYCRR § 515.2(b)(2)(i) False Statements. The Appellants made false statements by making or causing to be made false, fictitious or fraudulent statements or misrepresentations of material fact by billing for services prior to the same being rendered, and/or where records lacked documentation to substantiate that services were rendered as billed, and/or where the documentation did not correlate with the billed services. The OMIG's disallowance of 13 claims totaling \$10,017.10 for making false statements is affirmed. The OMIG is entitled to restitution in the amount of \$10,017.10 for making false statements.

The OMIG's determination to censure the Appellants within the Medicaid Program was proper. The Appellants failed prove their entitlement to payment for 204

claims or that restitution for these claims in the amount of \$145,935.10 is unreasonable, inappropriate, or not within the Department's discretion to impose. Mamaroneck Dental PLLC, owned by Appellant Samarneh, is an affiliate and it is entirely appropriate to censure it and hold it jointly and severally responsible for the overpayments.

DECISION

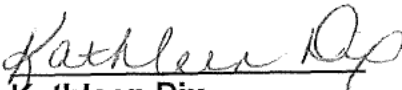
The OMIG's determination that Appellants Nabil Eid Farra Samarneh, DDS and Mamaroneck Dental PLLC engaged in unacceptable practices in the Medicaid Program is correct and is affirmed.

The OMIG's determination to censure Appellants Nabil Eid Farra Samarneh, DDS and Mamaroneck Dental PLLC within the Medicaid Program is correct and is affirmed.

The OMIG's determination to recover Medicaid Program overpayments in the amount of \$145,935.10 from the Appellants Nabil Eid Farra Samarneh, DDS and Mamaroneck Dental PLLC, jointly and severally, is correct and is affirmed.

This decision is made by Kathleen Dix, Bureau of Adjudication, who has been designated to make such decisions.

**Dated: Menands, New York
January 28, 2025**


Kathleen Dix
Administrative Law Judge

To: Michael Joseph, Esq.
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