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

NEW YORK STATE Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

February 26, 2026

CERTIFIED MAIL/RETURN RECEIPT

Daniel Weisbard, Esq.
NYS Office of the Medicaid Inspector General
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Albany, New York 12204

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New York, New York 10165

Babak Behmanesh, DDS
Babak Behmanesh, DDS PC
63-54 Fresh Pond Road
Ridgewood, New York 11385

RE: In the Matter of Babak Behmanesh, DDS
Medicaid Provider #02701733
Babak Behmanesh DDS PC

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 udge
Bureau of Adjudication

NJB:nm
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **Babak Behmanesh, DDS** Medicaid Provider #02701733 **Babak Behmanesh DDS PC** from charges of unacceptable practices and a determination to recover Medicaid Program overpayments.	**Decision After Hearing** #19-F-3728 19-7720

Before: John Harris Terepka
Administrative Law Judge

Hearing date: January 15, February 12, 2026
By videoconference
Transcript, received February 25, 2026

Parties: NYS Office of the Medicaid Inspector General
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JURISDICTION

The Department of Health acts as the single state agency to supervise the administration of the Medicaid Program in New York. 42 USC 1396a; PHL 201(1)(v); 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 against any individual or entity that engages in fraud, abuse or unacceptable practices in the Medicaid Program, and to recover improperly expended Medicaid funds. PHL 30, 31 & 32.

The OMIG determined to censure Babak Behmanesh, DDS (the Appellant), and his affiliate Babak Behmanesh DDS PC, and to recover Medicaid Program overpayments. The Appellant requested a hearing pursuant to SSL 145-a and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the OMIG determinations.

HEARING RECORD

OMIG witnesses:	Megan Nadeau, OMIG division of Medicaid investigations Jeffrey Glikes, DDS, OMIG public health dentist
OMIG exhibits:	1-58
Appellant witnesses:	none
Appellant exhibits:	none

A transcript of the hearing was made. (Transcript I, pages 1-169; II, pages 1-9.)

SUMMARY OF FACTS

1. During the period under review, Appellant Babak Behmanesh, DDS, was enrolled as a provider in the New York State Medicaid Program. Between 2017 and 2019, he owned and operated Babak Behmanesh DDS PC, a group dentistry practice in Ridgewood, New York. (Exhibits 1, 2.)

2. In October 2019, the OMIG requested complete patient records for 50 patients for whom the Appellant submitted claims to the Medicaid Program as the treating provider and under his Medicaid Provider number during the period January 1, 2017 through May 15, 2019. (Exhibit 3.)

3. After reviewing the 50 records provided by the Appellant, the OMIG issued a notice of proposed agency action dated February 9, 2023. The notice advised the Appellant that the OMIG proposed to censure him and his affiliate Babak Behmanesh DDS PC for committing unacceptable practices in the Medicaid Program, and to recover overpayments totaling $65,512.74 attributable to 581 claims for services that failed to comply with Medicaid Program requirements. (Exhibit 4.)

4. Pursuant to 18 NYCRR 515.6, the notice of proposed agency action afforded the Appellant 30 days to submit documents or written arguments objecting to the proposed action. The Appellant requested and received an extension of time to respond but thereafter failed to submit any documents or written arguments in objection to the proposed agency action. (Exhibit 5.)

5. By notice of agency action dated March 13, 2025, the OMIG notified the Appellant that its determination was unchanged and that the OMIG had determined to censure and seek restitution of Medicaid Program overpayments in the total amount of $62,160.03[1] plus interest. (Exhibit 6.)

ISSUES

Did Appellant Babak Behmanesh DDS, engage in unacceptable practices in the Medicaid Program?

[1] Reflecting credit in the amount of $3,352.71 recouped by a withhold imposed and then lifted in February 2023. (Exhibit 6, point 5, page 299.)

If so, did the OMIG properly determine to censure Babak Behmanesh DDS and Babak Behmanesh DDS PC and recover Medicaid Program overpayments in the amount of $62,160.03?

APPLICABLE LAW

Medicaid providers are required, as a condition of their enrollment in the program, to prepare, maintain and furnish to the Department upon request, contemporaneous records demonstrating their right to receive payment from the Medicaid Program and fully disclosing the nature and extent of the care, services and supplies they provide. All information regarding claims for payment is 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 services 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 504.8, 518.1(b). An overpayment includes any amount not authorized to be paid, whether paid as the result of improper claiming, unacceptable practices, fraud, abuse or mistake. 18 NYCRR 515.3(b), 515.9 518.1(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 include:

> - unacceptable recordkeeping: failing to maintain or to make available for 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. 18 NYCRR 515.2(b)(6).

- false statements: making or causing to be made any false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a Medicaid payment. 18 NYCRR 515.2(b)(2)(i).

- false claims: submitting or causing to be submitted a claim for unfurnished medical care. 18 NYCRR 515.2(b)(1)(i)(a).

- failure to meet recognized standards: furnishing or ordering medical care that fails to meet professionally recognized standards for health care. 18 NYCRR 515.2(b)(12).

- conduct contrary to the published fees, rates, claiming instructions, or procedures of the Department. 18 NYCRR 515.2(a)(2).

Upon a determination that a person has engaged in an unacceptable practice, the Department may impose one or more sanctions, including censure or exclusion from the Medicaid Program, 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).

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. 18 NYCRR 519.4. At the hearing, the Appellant has the burden of showing that the determination of the Department was incorrect and of proving any mitigating factors affecting the severity of any sanction imposed. 18 NYCRR 519.18(d).

DISCUSSION

The records reviewed by the OMIG were all for services billed under the Appellant's Medicaid provider number and provided at Babak Behmanesh DDS PC, a group practice owned by him. The 50 charts requested from and submitted by the Appellant were reviewed by OMIG public health dentist Jeffrey Glikes, DDS, who made

the audit report's detailed written findings (Exhibit 6c) and then summarized and explained them at the hearing.

The Appellant did not submit any response to the draft audit findings, nor did he offer any evidence or witnesses to rebut Dr. Glikes' criticisms and findings. He did not testify on his own behalf and did not attend the hearing. (Transcript I, page 3; II, pages 2-3.) He did not attempt to meet his burden under 18 NYCRR 519.18(d) to demonstrate his entitlement to payment of any of the 581 claims disallowed by the OMIG, or dispute the reasons for disallowing them or the criticisms and concerns explained by Dr. Glikes in his report and testimony.

Unacceptable practices

The OMIG's record review revealed numerous deficiencies in the Appellant's documentation and patient care that were attributable to unacceptable practices. The notice of proposed agency action gave a detailed explanation of these findings but the Appellant did not object to them by submitting either argument or evidence in response. The notice of agency action also reviewed the findings in detail, noting that the Appellant had not addressed any of them in a response.

Dr. Glikes' 241 page report attached to the draft and final notices of agency action (Exhibits 4c, 6c) and further explained in his testimony at the hearing with specific reference to the Appellant's own records (Exhibits 9-50), detailed 581 claims disallowed for unacceptable practices and because the records failed to document the Appellant's entitlement to payment. The issues Dr. Glikes found to be of most serious concern included on the one hand a failure to establish or document the need for hundreds of treatments that were billed to the Medicaid Program, and on the other hand a failure to

address or provide care the need for which was documented in the charts. (Transcript I, pages 163-164.)

The OMIG charged the following unacceptable practices with their resulting overpayments:

Finding I. Unacceptable recordkeeping. 18 NYCRR 515.2(b)(6). The OMIG disallowed 499 claims for unacceptable recordkeeping. Among these claims were 223 claims for composite restoration, 104 claims for inadequately documented examinations, and 84 claims for non-surgical periodontal services. (Exhibit 6a.)

In his testimony, Dr. Glikes explained representative examples among these claims of services for which need was not documented. Claims for Patient 4 included twelve fillings for which the chart documented no need or reason. (Exhibit 6c, pages 349-354; Exhibit 12; Transcript I, pages 55-56, 77-79.) Claims for Patient 14 included eleven fillings for which the chart failed to document need and failed to document the use of anesthesia. (Exhibit 6c, pages 360-363; Exhibit 22; Transcript I, pages 84-85, 90, 100.) Restoration was billed for worn teeth, which is not billable under Medicaid guidelines. (Exhibit 6c, page 364; Exhibit 7, page 623; Exhibit 22, page 1105, 1114; Transcript I, pages 93-96.) Several procedures were billed for Patient 34 on January 2, 2019 but the chart contained no treatment notes. (Exhibit 6c, page 410; Transcript I, pages 100-102.)

There was a pattern of failure to document medical need for billed services (Transcript I, pages 94, 108), instructions for lab orders were commonly missing, and the use of anesthesia was not noted (Transcript I, pages 97, 99-100).

Finding II. False statements. 18 NYCRR 515.2(b)(2)(i). In 31 instances the records failed to substantiate that claimed services were provided, were provided as documented, were provided prior to submission of a claim, and that the billing provider rendered the service. Services disallowed included 16 claims for composite restoration and 5 claims for crowns. (Exhibit 6a.)

Dr. Glikes pointed out as examples of false statements, that the Appellant billed for a crown for Patient 5 before the crown was received. (Exhibit 6c, page 556; Transcript I, pages 110-113.) For Patient 6, the Appellant's Medicaid claims reported he provided the treatment but the chart documents it was provided by another dentist. (Exhibit 6c, pages 548-553; Exhibit 14, pages 910-912; Transcript I, pages 113-115, 117-119.) Dr. Glikes testified that these issues were representative of the findings he made for other patients. (Transcript I, page 120.)

Finding III. False claims. 18 NYCRR 515.2(b)(1)(a). In 29 instances the records failed to substantiate that a claimed service was provided. Of these claims, 28 were for diagnostic imaging. (Exhibit 6a.)

Dr. Glikes' findings included four radiographs that were billed for Patient 19 on [redacted] 2018, but the chart did not contain the images. (Exhibit 6c, page 570; Transcript I, pages 120-124.) This was also the case for Patient 32 on [redacted], 2018. (Exhibit 6c, page 571; Exhibit 40, page 1517; Transcript I, pages 124-127.) For Patient 39 on [redacted] 2018, four radiograph claims were submitted but only one radiograph was in the chart. (Exhibit 6c, page 572-573; Exhibit 47, page 1669; Transcript I, pages 132-133.) Dr. Glikes testified that these were representative examples of his findings of false claims. (Transcript I, page 133.)

Finding IV. Failure to meet recognized standards. 18 NYCRR 515.2(b)(12). In 11 instances treatment did not meet an appropriate standard of care for the patient's condition. (Exhibit 6a.) Dr. Glikes found that "the main issue with the failed to meet standards was failure to diagnose and treat decay in a timely manner." (Transcript I, page 159.)

For Patient 14 a restoration was done on [redacted] 2018 that did not address decay at a different part of the same tooth that was evident in the radiograph. (Transcript I, page 135.) Patient 14's worsening decay was left untreated although it was noted in the chart on subsequent visits. (Exhibit 6c, page 578; Exhibit 22; Transcript I, pages 135-138.)

For Patient 16, "incredibly obvious" (Transcript I, page 143) decay was apparent on the radiographs but was not addressed on multiple visits. The six-month frequency limit for routine examinations was also exceeded for this patient. (Exhibit 6c, pages 579-580; Exhibit 24, pages 1178, 1191-94; Transcript I, pages 138-144.) For Patient 34, on [redacted] 2017 the Appellant sought prior approval for crowns, which was denied as not documented to be necessary. The patient should have received fillings instead but was not treated despite repeated visits. By [redacted], 2019 the advancing decay required a root canal. (Exhibit 6c, pages 581-582; Exhibit 42, pages 1549, 1555, 1575-78; Transcript I, pages 145-159.)

Finding V. Conduct contrary to Department claiming instructions and procedures. 18 NYCRR 515.2(a)(2). In 11 instances claims did not comply with claiming instructions or treatment exceeded the scope of the Medicaid Program. (Exhibit 6a.) Services were claimed with excessive frequency. For example, for Patient 10, the

six-month frequency limit was exceeded by claims for cleaning on [redacted] and [redacted], 2015. (Exhibit 6c, page 584; Transcript I, pages 160-161.) For Patient 22, the Appellant billed for insertion of a crown on [redacted] 2019 which was not done because the crown was broken. (Transcript I, page 162.) Radiographs were billed for Patient 39 on [redacted] and again on [redacted] 2017, a frequency that was not justified and not payable by Medicaid. (Exhibit 6c, page 584; Exhibit 47, page 1669; Transcript I, pages 132-133.)

The Appellant's response

The Appellant's "holistic" defense (Transcript I, page 11) to the notice of agency action is that the overpayment determination and imposition of a censure are excessive and unwarranted because many other dentists have committed violations of dental care and Medicaid billing requirements, and because he no longer has much of the money he received from his improper Medicaid claims.

The Appellant's suggestions that "no practice is ever going to be perfect" (Transcript I, page 10) and "just because something is not documented or record is not kept, does not necessarily mean that the doctor did not render the service" (Transcript I, page 37) do not answer the findings and are without merit as support for a reduction of either the overpayment or sanction determination. A provider's obligation to fully and properly document entitlement to payment and to produce that documentation for audit goes to the heart of the Department's ability to oversee expenditures in this government funded program. A provider's obligation to maintain appropriate medical/dental records is also critical to the provision of adequate patient care. It is entirely reasonable and appropriate to hold the Appellant to those obligations, and Department regulations

specifically authorize the recovery of payments and imposition of sanctions for claims not supported by adequate documentation or resulting from unacceptable practices.

The Appellant objected that the overpayment "is not funds that my client is even alleged to have pocketed. Any dental practice has all kinds of overhead," and that "whatever dollar amount that is even alleged to be recoupable is usually negotiated between the health plan and the doctor to reflect essentially the profit that the doctor has received here." (Transcript I, pages 8-9; II, page 3.) These objections have no basis in Medicaid law or regulation, nor did he identify any other policy or authority supporting them. He proposed a reduction of the $62,000 overpayment to $25,000 on the supposition that perhaps twenty-five percent of his billings may have resulted in profit to him. (Transcript II, page 4.) This argument that he should be excused from repayment of improperly claimed Medicaid funds to the extent that they were used for "overhead" expenses of the dental practice he was using to obtain and profit from those improper payments to begin with, is particularly unpersuasive. Medicaid payments were claimed and received by him, and if they were not properly payable they are overpayments for which he is responsible. What he did with the overpayments he received has no bearing on the amount of those overpayments or his responsibility to make restitution.

It is noted that the Appellant did not even attempt to provide evidence of the actual amounts he "pocketed" or explain how that might be determined. In any event, this issue is irrelevant to this hearing, the purpose of which is to identify overpayments claimed and received by him from the Medicaid Program. The 18 NYCRR 515.4(b) factors applicable to the determination of a sanction are not applicable to that

overpayment determination, which the OMIG is entitled to make in addition to any sanctions.

Most importantly, it is hardly the case that the unacceptable practices identified by Dr. Glikes reflect only minor care and recordkeeping matters. They included provision of unneeded care, failure to document the use of anesthesia which is necessary in case the patient should later experience an adverse effect (Transcript 1/15/26, pages 97, 99-100), and repeated failure to address matters such as progressive tooth decay by providing care that was clearly needed according to the Appellant's own charts.

Medicaid Program overpayments

The OMIG determined that claims for 581 services were submitted under the Appellant's Medicaid provider number for services claimed to have been provided by him to 50 patients. The Department's records of the nature and amount of Medicaid payments are presumed accurate. 18 NYCRR 519.18(f). The Appellant produced records for all 50 patients. He did not raise any objection to the proposed audit findings that the 581 disallowed claims were billed by him under his Medicaid provider number and that the Medicaid payments were issued to and received by him. He did not even respond to the proposed findings and is not now entitled to raise that objection in this hearing. 18 NYCRR 519.18(a). In any event he did not even attempt to offer any evidence to support such an objection. (Transcript I, pages 115-117.)

The Appellant failed to meet his burden of proving his entitlement to any of the 581 disallowed claim payments. 18 NYCRR 519.18(d). Indeed, he did not challenge a single disallowance. The OMIG is entitled to recover the overpayments. 18 NYCRR 518.3.

Medicaid Program censure

Upon a determination that a person has engaged in an unacceptable practice, the Department may impose sanctions, including censure or exclusion from the Medicaid Program for a reasonable time. 18 NYCRR 515.3(a), 515.4(a). Censure is defined at 18 NYCRR 515.1(b)(2) and means a warning that continued conduct of the type or nature cited may result in a more severe sanction on a subsequent matter. Whenever the Department sanctions a person, it may also sanction any affiliate of the person. 18 NYCRR 504.1(d)(1), 515.3(c).

In determining the sanction to be imposed the following factors are considered:

(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 Medicare, Medicaid and social services programs. 18 NYCRR 515.4(b).

Over $62,000 in restitution is due to the Medicaid Program. The nature of the program violations goes directly to issues of both billing and patient care. Necessity for and provision of many services was not documented, and services did not meet recognized standards for medical care. Dr. Glikes also expressed serious concern that these charts showed that needed care was ignored and not provided.

The Appellant's argument that censure is inappropriate in this case because the dollar amount of the overpayment "is rather small in the large scheme of things" (Transcript II, page 4) is unpersuasive. The amount of damages to the program is only one factor in the imposition of a sanction. Dr. Glikes testified, and his detailed findings

show, that the pattern of unacceptable practices was pervasive. The OMIG's investigator testified, in response to the Appellant's questioning, that the audit found a 47% error rate in the claims submitted for these 50 patients. (Transcript I, page 39.) There were missing records, inaccurate records, claims for services not provided, services that did not meet recognized professional standards, and services provided more frequently than authorized for Medicaid payment. Dr. Glikes' findings, which were fully supported by the evidence, were unrebutted.

The Appellant has the burden of proving any mitigating factors affecting the severity of any sanction imposed. 18 NYCRR 519.18(d)(2). He has not established mitigating circumstances. He did not testify or offer any evidence to defend his practice or his claims and indeed did not even personally attend the hearing. A Medicaid Program censure and restitution of payments that were not provided and documented in conformity with Medicaid Program requirements are entirely reasonable and appropriate and within the Department's discretion to impose. It is appropriate to impose censure and restitution upon both the Appellant individually and on his affiliate Babak Behmanesh DDS PC. 18 NYCRR 504.1(d)(1), 515.3, 515.9, 518.3.

DECISION: The OMIG's determination to censure Appellant Babak Behmanesh, DDS, and his affiliate Babak Behmanesh DDS PC in the Medicaid Program is affirmed.

The OMIG's determination to recover Medicaid Program overpayments in the amount of $62,160.03, plus interest, is affirmed.

This decision is made by John Harris Terepka, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Rochester, New York
February 26, 2026

Bureau of Adjudication