

ASSURING MEDICAID DENTAL COMPLIANCE 06/29/2011

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PURPOSE OF OMIG WEBINARS- FULFILLING OMIG'S DUTY IN NYS PHL SECTION 32 -

- **§ 32(17) " . . . to conduct educational programs for medical assistance program providers, vendors, contractors and recipients designed to limit fraud and abuse within the medical assistance program."**
- **These programs will be scheduled as needed by the provider community. Your feedback on this program, and suggestions for new topics are appreciated.**
- **Next program: Preschool/School Supportive Health Services Program (SSHSP) Medicaid-in-Education**

GOALS OF THIS PROGRAM

- Medicaid Redesign Team (MRT) changes for dental services
- Medicaid rules and policies governing dentistry services
- Office of Medicaid Inspector General reviews of dental practices
 - Prepayment review
 - System match project audits
 - Credentials verification

Medicaid Redesign Team Proposal #17 –

Reduce Fee-for-Service Dental Payment on Select Procedures

Background:

Medicaid spending for the highest volume dental procedures totaled \$237 million for the 2009 calendar year.



MRT -11 Reduce
FFS Dental Proc...

Proposal:

Reduce fee-for service payments to match rates paid by manage care providers on high volume dental procedures.

FY 2011 - 2012

- State Savings: (\$27.70) million
- Federal Savings: (\$55.40) million

FY 2012 – 2013

- State Savings: (\$30.20) million
- Federal Savings: (\$60.40) million

Note: Children's preventative dental procedures and Orthodonture is excluded. All other codes are subject to reduction.

THE FOCUS ON DENTAL PRACTICE IN FRAUD AND ABUSE PROGRAMS

- Attorney General Medicaid Fraud Control Unit/US Department of Justice
- Federal Office of Inspector General (HHS)
- Office of State Comptroller
- CMS (Center for Medicare and Medicaid Services) reviews

- Data analytic capabilities
- Managed Care Focus-Delta Dental
- Fraud by clients/patients-identity theft, card rental and lending

- Is it fair?
- What can practices do to protect themselves from fraud and abuse risks?

THE FOCUS ON DENTAL PRACTICE IN FRAUD AND ABUSE PROGRAMS

- Media coverage: **"'Rip-off' dentists clean up**
- A single dental clinic that illegally pays low-income patients \$15 or \$20 cash as an enticement to undergo routine checkups could rake in more than \$2 million a year in Medicaid reimbursements from the state, a Post analysis has found." New York Post March 31, 2010
- "Heartland Dental, Inc., agreed to pay \$1,650,000 to resolve allegations of improper billing to Illinois Medicaid. (2008) submitting claims for crown buildups, non-covered services, as restorations and claims for surgical extractions which were or should have been simple extractions.
- FORBA Holdings settlement-2010

OTHER AUDIT/INVESTIGATIVE RISKS

- New York Attorney General actions under the New York False Claims Act
- Whistleblower actions under the New York False Claims Act (these cases limited to private entities)
- Claims under the federal False Claims Act

OFFICE OF NY STATE COMPTROLLER (OSC) Dental Audits

- **Recent Dental Audits performed at OSC include;**
 - **Inappropriate Medicaid Payments for Dental Services Provided to Patients with Dentures 03/25/2009 with a follow up report 01/21/2011;**
 - **Medicaid Payments for Dental Consultations 09/30/2010;**
 - **Medicaid Payments for Excessive Dental Services 08/17/2010;**
 - **Inappropriate Medicaid Billings for Dental Services 09/28/2007 & 07/09/2008 with follow up reports on 07/02/2009 & 10/08/2009;**
 - **Inappropriate Medicaid Billings for Dental Sealants 11/26/2007 with a follow up report on 05/07/2009;**
 - **Inappropriate Medicaid Billings for Dental Restorations 12/27/2007 with a follow up report on 05/07/2009.**

HHS Office of Inspector General Work Plan 2011-Audit of state expenditures for dentistry

- We will review Medicaid payments for dental services to determine whether States have properly claimed the FFP.
- *(OAS; W-00-10-31135; W-00-11-31135; various reviews; expected issue date: FY 2011; work in progress)*

CORE MEDICAID REQUIREMENTS FOR ALL PROVIDERS

- (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services
- to furnish such records and information, upon request
- Bill for only services which are medically necessary and actually furnished . . ."
- Permit audits. . . .of all books and records relating to services furnished and payments received, including patient histories, case files, and patient-specific data
- Provide information in relation to any claim . . . Which is true, accurate, and complete.
- Comply with the rules, regulations, and official directives of the department."

CORE MEDICAID REQUIREMENTS FOR ALL PROVIDERS

- Dental records are a legal document that provide a main source of information about **what happened and why;**
- Dental documentation must **support the dental necessity of the service,** to what extent the service was rendered, and why it was medically justified;
- Accurate and complete documentation can ensure better care and **increase the chances of full and fair reimbursement;**
- **Dental Manual identifies the Record-Keeping Requirements** - General Policy Section page 21

MEDICAID REGULATIONS AND OFFICIAL DIRECTIVES FOR DENTAL SERVICES

- 18 NYCRR 504.3: Duties of the Provider
 - “By enrolling, the provider agrees . . .(i) to comply with the rules, regulations, and official directives of the Department.”
- Qualifications of Dentists regulation (18 NYCRR 506.1)
- Dental Care regulations(18 NYCRR Part 506.2) last amended in 1971
- What is an “official directive?”

“Official Directives”

- “Official directives”
 - **Dental Provider Manual Version 2011-1 (5/15/2011)**
www.emedny.org/ProviderManuals/Dental/PDFS/Dental_Policy_and_Procedure_Manual.pdf
 - Medicaid Updates-
http://www.health.ny.gov/health_care/medicaid/program/update/ Sample: Dental Place of Service (POS) Policy and Billing Guidance
March 2011: For dates of service on or after April 1, 2011 - requires reporting of POS; professional component for dental services performed at ambulatory surgery, emergency department and inpatient POS will be reimbursed at 65 percent of the office fee schedule amount. (Requires accurate reporting of place of service).

CORE MEDICAID REQUIREMENTS FOR ALL PROVIDERS

- The dental record should be **complete and legible**;
- The documentation of each patient encounter should include the date, the reason for the encounter, appropriate history and dental exam, review of lab and x-ray data and other ancillary services (where appropriate), an assessment , and a treatment plan;
- entries to the dental record should be dated and authenticated;
 - **Evaluations**
 - **Anesthesia**
 - **Radiographs**
 - **Testing or diagnostic service**
 - **Type of treatment**
 - **Service on other intra-oral structures**
 - **Treatment plan**
 - **Charting**
 - **Extension notes**
 - **Failed appointment notes**
 - **Communication notes**

CORE MEDICAID REQUIREMENTS

18 NYCRR 504.3 FOR ALL PROVIDERS

- Medicaid is payment in full-no balance billing
- Bill for only services which are medically necessary and actually furnished
- Bill only for services to eligible persons
- Permit audits. . . of all books and records relating to services furnished and payments received, including patient histories, case files, and patient-specific data
- Provide information in relation to any claim . . . Which is true, accurate, and complete.
- “to comply with the rules, regulations, and official directives of the department.”

CORE PROFESSIONAL REQUIREMENTS FOR ALL DENTISTS

- “There is one course of conduct which in each and every profession is known as a matter of common knowledge to be improper and unprofessional. That is conduct by which, after a professional man has been licensed by the State, he enters into a partnership in his professional work with a layman, by the terms of which he divides with the latter, on a percentage basis, payments made by client or patient for professional services rendered.”
- *Bell v. Board of Regents* 65 N.E.2d 184 (Ct. App., 1945).
- 18 NYCRR 515.2 (b) (5) Bribes and kickbacks-prohibits “offering or paying, either directly or indirectly, whether in cash or in kind, . . . In return for referring a client” (or) “recommending” a provider

PRE-PAYMENT REVIEW PROJECTS

- Nancy DelPrado
- Focus
- Provider interaction
- Closing letters
- Potential Consequences

Statewide Dental Match

- Patricia Branson
 - Audit process

Statewide Dental Match

- **The OMIG initiated a review of Medicaid payments for dental services paid between January 1, 2006 through December 31, 2009, which looked at:**
 - Inappropriate billing for edentulous patients;
 - Inappropriate billing after complete upper or lower dentures;
 - Partial upper dentures billed after complete upper dentures;
 - Partial lower dentures billed after complete lower dentures;
 - Dental services billed fee for service for recipients in skilled nursing facilities;
 - Rebase, reline or repair within the six months of post delivery care for dentures;
 - Consultation procedure billed with no referring provider information;
 - Consultation procedure billed where the billing provider matches the referring provider;
 - Single surface restoration claims with surface codes "I" and "O" or "F" and "B" for the same patient, same tooth, same surface, same provider/group within three years.

Statewide Dental Match

- **“Draft Audit Reports” are issued, what to expect next?**
 - **Assigned staff handle all provider phone calls.**
- **Final Audit Report or Final Closing Letter;**
- **Result Communicated to provider;**
- **Agreement or Appeal.**

Dental Providers CVRs and Enrollment Onsite Visits

- Credential verification Reviews (CVR's) are periodic onsite visits of a providers place of business to ensure overall compliance with Medicaid regulations. These visits are conducted by the Medicaid Program and the Office of the Medicaid Inspector general (OMIG).
- CVR's assess such areas as;
 - Provider and staff identification and credentialing
 - Physical attributes of the place of business
 - Recordkeeping protocols and procedures regarding Medicaid claiming
- Every effort is made to conduct these visits in a professional and non-obtrusive manner.
- Investigators conducting these reviews will have a **letter of introduction signed by the Office of the Medicaid Inspector General and a photo identification card.**
- Enrollment onsite visits may also occur for providers applying to open a new group practice or location in the Medicaid Program.
- If you have any questions regarding a CVR or onsite visit you may call OMIG at 1-518-402-1837.

OTHER ISSUES

- “Roster billing”
- Card swipe
- Deceased patients

OTHER RISKS IN MEDICAID PROGRAM FOR PROVIDERS

- Risks can be avoided and managed with basic business processes

RISK #1: Using Excluded Persons to Provide Services Reimbursable by Medicaid

- See OMIG's Exclusion Webinar on our website at http://www.omig.ny.gov/data/images/stories/Webinar/6-8-10_exclusion_webinar_final.ppt

Program Exclusions

- Statute
- Regulation
- Federal OIG Guidance
- Federal CMS Guidance
- State Guidance Mandated by CMS
- Condition of NY provider enrollment or NY state contract
- Virtually no case law (criminal, civil, or administrative) on extent and effect of exclusion

CMS EXCLUSION REGULATION

- “No payment will be made by Medicare, Medicaid or any of the other federal health care programs for any item or service furnished by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion.” 42 CFR 1001.1901 (b)
- Focus is not on the relationship but on the **payment.**

PROGRAM EXCLUSION

- Federal authority and requirement on providers
 - No claims based on work of excluded persons
 - No “billing through”
- Federal authority and mandate on state Medicaid programs
 - No state Medicaid claims to CMS based on work of excluded persons

THE NEW YORK STATE EXCLUSION REGULATION

- **18 NYCRR 515.5** Sanctions effect: (a)
No payments will be made to or on behalf of any person for the medical care, services or supplies furnished by or under the supervision of the person during a period of exclusion or in violation of any condition of participation in the program.

RISK #2: Failing to Refund Identified Overpayments to the Medicaid Program- ACA § 6402

- *"(d) REPORTING AND RETURNING OF OVERPAYMENTS—*
- *"(1) IN GENERAL — If a person has received an overpayment, the person shall—*
- *"(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and*
- *"(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment . . .*

ACA § 6402 and False Claims Act

- Failure to report, refund, and explain overpayments within 60 days of identification can give rise to a claim of “knowing” failure to repay under the False Claims Act
- See OMIG Webinar:
http://www.omig.ny.gov/data/images/stories/Webinar/7-14-10_ppaca_webinar.ppt

RETURNING OVERPAYMENTS IN NEW YORK TO THE MEDICAID PROGRAM

- **Report and return the overpayment *to the State* at the correct address**
- **In New York, Medicaid overpayments should be returned, reported, and explained to OMIG**
- **OMIG's correct address:**
 - **Office of the Medicaid Inspector General**
 - **800 North Pearl Street**
 - **Albany, New York 12204**
- **May also use DOH adjustment process for multiple funders through Brad Hutton (BJH08@Health.State.NY.US)**

VOIDS AND SMALL OVERPAYMENTS

- **Providers may use void process through CSC (the eMedNY claims system) for smaller or routine claims. A void is submitted to negate a previously paid claim based upon a billing error or late reimbursement by a primary carrier.**
- **Overpayments of smaller or routine claims which cannot be attributed to billing error or late reimbursement by a primary carrier should be reported to CSC in writing. These should include known mistakes in CSC or DOH billing and payment programs.**
- **eMedNY call center: 1-800-343-9000, M – F, 7:30 am – 6:00 pm; email: HIPAADESK3@csc.com**
- **See <http://www.emedny.org/provider> manuals for instructions on submission of voids.**
- **NYEIS System also can be used to initiate report and refund process**

WHAT IS AN "OVERPAYMENT"?

- "(B) OVERPAYMENT—The term "overpayment" means any **funds** that a **person** receives or retains under title XVIII (Medicare) or XIX (Medicaid) to which the person, after applicable reconciliation, is **not entitled** under such title"
- "**funds**" not "**benefit**"

WHO MUST RETURN THE OVERPAYMENT?

- A “person” (which includes corporations and partnerships) who has “received” or “retained” the overpayment
- Focus on “receipt”; payment need not come directly from Medicaid; if “person” “retains” overpayment due the program, violation occurs
- “person” includes a an individual program provider or subcontractor

WHEN MUST AN OVERPAYMENT BE RETURNED?

- ACA § 6402(d)(2)
- An overpayment must be reported and returned . . .by the later of -
 - (A) the date which is 60 days after the date on which the overpayment was **identified**; or
 - (B) the date on which any corresponding cost report is due, if applicable

WHEN IS AN OVERPAYMENT “IDENTIFIED”?

- “identified” for an organization means that the fact of an overpayment, not the amount of the overpayment has been identified. (e.g., patient was dead at time service was allegedly rendered, APG claim includes service not rendered, charge master had code crosswalk error)
- Compare with language from CMS proposed 42 CFR 401.310 overpayment regulation 67 FR 3665 (1/25/02 draft later withdrawn)
 - “If a provider, supplier, or individual identifies a Medicare payment received in excess of amounts payable under the Medicare statute and regulations, the provider, supplier, or individual must, within 60 days of identifying or learning of the excess payment, return the overpayment to the appropriate intermediary or carrier.”

WHEN IS AN OVERPAYMENT “IDENTIFIED”?

- Employee or contractor identifies overpayment in hotline call or email
- Patient advises that service not received
- OMIG sends letter re deceased patient, unlicensed or excluded employee or ordering physician
- *Qui tam* or government lawsuit allegations
- Criminal indictment or information

DOCUMENTING GOOD FAITH EFFORT TO IDENTIFY OVERPAYMENTS

- Create a record to demonstrate to the government that your organization collected or attempted to address allegations of overpayments
 - Develop standard form to document employee's internal disclosure
 - Document interviews
 - Document evidence and means to determine if credible
 - Record employees involved in deliberations and decisions

SOME REASONS FOR OVERPAYMENTS

- Duplicate payments of the same service(s).
- Incorrect provider payee.
- Services not actually rendered.

MORE REASONS FOR OVERPAYMENTS

- Failure to refund credit balances
- Excluded ordering or servicing person
- Patient deceased
- Servicing person lacked required license or certification (see 18 NYCRR 506.1, Qualifications of Dentists)
- Billing system error

GOVERNMENT IS USING DATA TO DETECT OVERPAYMENTS

- EXCLUDED PERSONS
- DECEASED OR TRANSITIONED ENROLLEES
- DECEASED PROVIDERS
- CREDIT BALANCES
- WHAT IS GO-BACK OBLIGATION WHEN PROVIDER IS PUT ON NOTICE THAT SYSTEMS ARE DEFICIENT?

OMIG SELF DISCLOSURE FORM FROM WWW.OMIG.NY.GOV

- You must provide written, detailed information about your self disclosure. This must include a description of the facts and circumstances surrounding the possible fraud, waste, abuse, or inappropriate payment(s), the period involved, the person(s) involved, the legal and program authorities implicated, and the estimated fiscal impact. (Please refer to the OMIG self-disclosure guidance for additional information.)

RISK #3: Failing to Maintain an “Effective” Compliance Program as Required by 18 NYCRR 521 (if billing over \$500,000 per year)

- See OMIG Webinar: Evaluating Effectiveness of Compliance Programs
- http://www.omig.ny.gov/data/images/stories/Webinar/compliance_webinar_11-17-10.ppt

Maintaining an “Effective” Compliance Program

- 18 NYCRR 521
- Requires an 8 step effective compliance program
- Requires an annual certification by December 31 of each year
- Applies to both governments and providers (directly or indirectly)

RISK #4: Failing to Maintain and Produce Records Demonstrating Actual Performance of a Reimbursable Service

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Risk #5: Failing to Supervise Service Bureaus or Billing Companies Submitting Claims or Receiving Payment

- See OMIG Webinar-Third Party Billing in the Medicaid program
- http://www.omig.ny.gov/data/images/stories/Webinar/1-12-11_third_party_billing_final.ppt

Duty to Supervise Service Bureaus or Billing Companies Submitting Claims or Receiving Payment

- Who is responsible if the billing company makes a mistake?
- the person or entity on behalf of whom the claim is submitted.

Questions for Health Care Providers About Third-Party Billers

- If any non-employee submits your claims, checks enrollment, or obtains authorizations, have you received a written representation that the person or entity has a records preservation policy consistent with EMEDNY-414601 (i.e., six years from the date of claims submission) for material and data your organization submits, and 10 NYCRR 69-4.26 requirements (to age 21 for educational records)?

"Compliance Program Guidance for Third-Party Medical Billing Companies," 63 FR 70138-70152 (December 18, 1998)

- billing for items or services not actually documented;
- unbundling and upcoding of claims;
- computer software programs that encourage billing personnel to enter data in fields indicating services were rendered though not actually performed or documented;
- knowing misuse of provider identification numbers which results in improper billing in violation of rules governing reassignment of benefits;
- billing company incentives that violate the anti-kickback statute;
- percentage billing arrangements.

New York State Regulation- Required enrollment

- “Persons submitting claims, verifying client eligibility, . . . Except those persons employed by providers enrolled in the medical assistance program, must enroll in the medical assistance program. . . ” 18 NYCRR 504.9
- Is your billing company enrolled?

What can you do to have a positive experience as a Medicaid participating provider?

- Know the policies, rules and regulations of the Medicaid program.
- Make sure that your staff knows the policies, rules and regulations of the Medicaid program;
- Stay current through *Medicaid Update* newsletters and the eMedNY Web site, www.eMedNY.org;
- Develop treatment plans that are comprehensive and all-encompassing in scope;
- Ensure that radiographs are appropriate and of good diagnostic quality;
- Make sure that each recipient has up-to-date, accurate, full-mouth charting of the dentition which correlates with the radiographs and treatment plans;
- When billing for something unusual or more frequently than the norm, bill with an explanation or documentation;
- If you have billing or policy questions, call the dental unit at the Office of Health Insurance Programs (OHIP) prior to billing for clarification, [1-800-342-3005](tel:1-800-342-3005) or [1-518-474-3575](tel:1-518-474-3575) (menu option #2)

FREE STUFF FROM OMIG

- OMIG website - www.OMIG.ny.gov
- Mandatory compliance program-hospitals, managed care, all providers over \$500,000/year
- Over 1500 provider audit reports, detailing findings in specific industry
- 66-page work plan issued 4/20/09 - shared with other states and CMS, OIG (new one coming in July, 2010)
- Listserv (put your name in, get emailed updates)
- New York excluded provider list
- Follow us on Twitter: NYSOMIG

Contact Information

- Important contact numbers and websites for questions and information;
 - **New York State Office of the Medicaid Inspector General (OMIG)**
 - www.OMIG.state.ny.us
 - To Report Medicaid Fraud call – 1-877-873-7283
 - Medicaid Helpline call – 1-800-541-2831
 - OMIG Dental Unit, Questions about CVRs, dental audits, dental matches, or prepayment claim reviews, call – 1-518-402-1837
 - **New York State Fiscal Agent, Computer Sciences Corporation (CSC)**
 - Medicaid provider manuals and online Links www.eMedNY.org
 - For CSC contacts general@emedny.org
 - Inquiries about claim submission process and eligibility issues call 1-800-343-9000
 - **New York State Department of Health (OHIP)**
 - www.health.state.ny.us
 - OHIP Dental Pended Claims/Prior Approval Unit, inquiries about dental policy, dental pended claims or prior approvals call - 1-800-342-3005 (menu option #2) or 1-518-474-3575 (Menu option #2)