DEPARTMENT OF HEALTH

INAPPROPRIATE MEDICAID BILLINGS FOR DENTAL RESTORATIONS

Report 2007-S-71
AUDIT OBJECTIVE

The objective of our audit was to determine whether New York State’s medical assistance program (Medicaid) made inappropriate payments for dental restoration procedures.

AUDIT RESULTS - SUMMARY

During our four year audit period ended March 31, 2007, we reviewed the Medicaid billings of five dental providers (dentists) who billed Medicaid almost $10.1 million for dental restorations (fillings). Our review of medical claims data showed these dentists appeared to be billing for an excessive amount of services. For example, these dentists often provided between 37 to 270 fillings per day, billed for 25 or more fillings per recipient during one office visit, often administered services to more than one quadrant of the mouth during an office visit, and were not properly identifying servicing providers on claims, as required by regulations.

From our detailed review we determined payments totaling $148,341 were inappropriate and potentially fraudulent. During our detailed review, we discovered several questionable practices that cause us to question the appropriateness of these dentists’ remaining claims totaling over $9.9 million billed to Medicaid for dental fillings during our audit period. For example, one dentist and his former employer did not have medical records for any of the 335 claims totaling $26,657 we sampled at his practice. Another dentist said he could complete a filling procedure in 30 seconds. The former employer of another dentist that said he terminated the dentist from his practice because the dentist was providing excessive dental services.

These improprieties occurred because dental providers did not comply with Department guidelines for billing Medicaid. In addition, the Department needs to improve its controls for detecting and preventing these types of inappropriate payments. Our report contains five recommendations to review all claims of these dentists, determine whether the services were appropriate, recover inappropriate payments and to improve controls.

We referred our findings concerning two of the dentists to the Attorney General’s Medicaid Fraud Control Unit, as these dentists were under investigation by the Attorney General. Our findings on the remaining three dentists were referred to the Office of the Medicaid Inspector General for review and investigation.

This report dated December 28, 2007, is available on our website at: http://www.osc.state.ny.us. Add or update your mailing list address by contacting us at: (518) 474-3271 or Office of the State Comptroller Division of State Government Accountability 110 State Street, 11th Floor Albany, NY 12236

BACKGROUND

During our four year audit period ended March 31, 2007, the Department of Health (Department) paid $1.2 billion for dental services to Medicaid recipients, of which $366 million was paid for dental fillings. In New York State’s Medicaid program, dentists are expected to comply with the Department’s Medicaid Dental Manual (Manual) when submitting claims for reimbursement. The Manual contains policy guidelines, prior approval guidelines, billing guidelines, fee schedules, and the codes to use for reimbursable dental procedures.
The Manual also states that quadrant dentistry should be practiced whenever practicable. In quadrant dentistry, the inside of the mouth is divided into four quadrants of eight teeth each (the upper left, lower left, upper right and lower right). Dental services usually are not administered to more than one quadrant during one office visit.

The Manual requires providers to maintain comprehensive patient dental records, which are to be available upon request. Title 18 of the New York State Codes, Rules and Regulations (18 NYCRR), Section 504.3 also requires providers to maintain records demonstrating their right to receive payment and keep, for six years from the date services were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims submitted for payment.

According to 18 NYCRR 502.2, a “group of practitioners” is defined as two or more health care providers who practice their profession at a common location. Practitioners who practice in a group setting are required to enroll as a group and comply with the requirements associated with group practices, including accurately stating the servicing provider, the provider who actually provided the medical service for which payment is sought, on all claims. The Department issues monthly publications of Medicaid updates to inform providers of changes that may affect their participation in Medicaid. The Department last updated providers about three years ago.

AUDIT FINDINGS AND RECOMMENDATIONS

Questionable Claims

During our four year audit period ended March 31, 2007, we identified six dentists who billed Medicaid for an unusually large volume of dental services. These six dentists were reimbursed over $10.4 million for dental fillings during the four year audit period. We determined, and confirmed with Department officials, the claims of one dentist, totaling $361,000, were appropriate because the services were provided to disabled recipients in a hospital setting.

We question the appropriateness of claims totaling almost $10.1 million for the remaining five dentists. These billings were questionable because the dentists submitted Medicaid claims for 37 to 270 fillings per day on numerous occasions during our audit period. In fact, we identified 151 instances where these dentists billed for 25 or more fillings per recipient during one office visit. While not yet an official policy, the Department’s Medical Review Unit considers claims for more than 24 fillings for a single patient during a single office visit excessive unless another medical condition is involved (i.e. disabled patients treated in a hospital setting). Although Department officials consider these practices excessive, they have not established specific policies or claim processing edits to monitor and mitigate where needed.

To further determine the appropriateness of dental claims submitted by the five dentists, we reviewed the dentists’ records for 1,841 claims totaling $148,341 for 47 recipients. From our review of the dentists’ records, we concluded all payments were inappropriate and potentially fraudulent because either the claims were not supported by the dentist’s medical records or not in compliance with the rules set forth in the Manual.

During our detailed review auditors discovered the following questionable practices at the five providers visited:
On 81 occasions, the five dentists administered services to more than one quadrant during one office visit for a recipient.

On 37 occasions, four of the dentists administered 25 or more fillings to one recipient during a single office visit.

One dentist and his former employer were unable to produce medical records to support the 335 claims totaling $26,657 we sampled at his practice.

One dentist stated that he can complete a filling procedure in 30 seconds. When we asked this dentist to explain the reason for the excessive amount of services he administers to recipients, he stated he provides a high quantity of services to his recipients because he is unsure when he will see them again or if their Medicaid eligibility will expire. However, our review of medical records contradicted this explanation because the medical records showed this dentist develops treatment plans for recipients. Moreover, seven of the nine sampled recipients were seen by this dentist on numerous occasions.

The former employer of one of the five dentists told us that he terminated the dentist from his practice because the dentist was providing excessive dental services.

Two dentists billed for four or more fillings on one tooth or for two types of fillings on the same surface of the same tooth.

One dentist submitted almost identical claims for eight recipients, billing for three or more surface restorations on the same 11 teeth during one office visit for each of the eight recipients. This dentist was not able to explain why these recipients’ billings were so similar.

We also identified two dental practices that were not properly identifying servicing providers on claims. At one dental practice, the dentist listed as the servicing provider on the claims stated he has four to five part-time dentists in his employ to provide dental services. We further determined that this practice’s claims did not identify these part-time dentists as the servicing providers. Another dental practice listed on its claims an orthodontist from a nearby orthodontia facility as the servicing provider. The nearby orthodontia facility is separate from the dental practice. Moreover, the dental practice is managed by a person who is not licensed to practice dentistry in New York State and is the spouse of the orthodontist. From our review of the dentists’ records, we were not able to determine who provided the services. Without proper identification of the servicing provider, the Department cannot ensure only qualified and non-sanctioned providers are providing services to Medicaid recipients.

Because of the billing patterns identified during our audit, we question the appropriateness of these five dentists’ remaining 103,964 claims totaling over $9.9 million billed to Medicaid during our audit period.

We discussed our findings with Department officials and learned the Department’s claims processing and payment system, eMedNY, has various controls to prevent the payment of inappropriate claims. For example, claims for many medical procedures will not be
approved if certain frequency thresholds are exceeded (i.e., if the same medical procedure is billed too many times on the same recipient within a certain period of time). According to Department officials, such claims are flagged for manual review by the Department. Department officials informed us that, during our audit period, they experienced a significant backlog in their manual review of flagged dental claims primarily due to staff shortages. In January 2006, to expedite payments to providers, the Department decided to pay over 32,000 backlogged dental claims without a manual review. As a result, some providers received payments for restorative services without the Department’s review for appropriateness. Department officials believe this was the cause for some of our results. We were not able to determine what percentage of the claims in question were mass adjudicated.

At the time of our audit, the Department had not established in policy a limit on the number of fillings a recipient can receive during a single office visit or established a limit on the number of fillings a provider can administer in a single day. Department officials informed us that, in July 2007, two projects were initiated to develop controls that would suspend or deny payment of dental claims where a specified number of teeth and a specified number of surfaces are restored on a single date of service.

**Recommendations**

1. Investigate and recover the $148,341 in inappropriate claims identified during the audit.

2. Review the dentists’ remaining 103,964 claims totaling over $9.9 million billed to Medicaid during our audit period to determine whether the dental restoration services were appropriate. Recover inappropriate payments where warranted.

3. Reinstruct dental providers on the requirements to appropriately identify servicing providers on Medicaid claims.

4. Routinely review Medicaid claims submitted by group providers to determine if the servicing providers were appropriately identified. Recover inappropriate payments where warranted.

5. Expedite the development and implementation of the projects to suspend or deny payment of dental claims where a specified number of teeth and a specified number of surfaces are restored on a single date of service.

**AUDIT SCOPE AND METHODOLOGY**

We conducted our audit in accordance with generally accepted government auditing standards. We audited the Medicaid claims submitted to the Department by six dental providers for the period April 1, 2003 through March 31, 2007 to determine whether the claims were appropriate and in compliance with the policy guidelines set forth in the Department’s Medicaid Dental Manual. To accomplish our audit objective, we met with Department officials and the Department’s Division of Medical Review and Provider Enrollment. In addition, we reviewed the Department’s Medicaid Dental Manual to understand the internal controls over claims and billings. We visited the offices of the six providers, interviewed the dentists, and reviewed a judgmental sample of their claims. Claims were judgmentally selected based on an unusually large quantity of restorative
services (fillings) provided to a recipient on one day of service.

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 to certain boards, commissions and public authorities, some of whom have minority voting rights. 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 comment. Department officials generally agreed with our recommendations and indicated actions planned or taken to implement them. We considered their comments in preparing this report. A complete copy of the Department’s response is included as Appendix A. Appendix B contains a State Comptroller’s comment which addresses matters contained in the Department’s response.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department 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 therefor.

CONTRIBUTORS TO THE REPORT

Major contributors to this report include Steven Sossei, Sheila Emminger, Ronald Pisani, Robert Mainello, Lucas McCullough, Karina Hojraj, Joe Fiore, Frank Smith, and Dr. Lee Perry, DDS.
November 28, 2007

Sheila A. Emminger, Audit Manager
Office of the State Comptroller
Division of State Services
State Audit Bureau
110 State Street, 11th Floor
Albany, New York 12236

Dear Ms. Emminger:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report on "Inappropriate Medicaid Payments for Dental Restorations" (2007-S-71).

Thank you for the opportunity to comment.

Sincerely,

Wendy E. Saunders
Chief of Staff

Enclosure
Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2007-S-71 on
“Inappropriate Medicaid Billings for Dental Restorations”

The following are the Department of Health’s (Department) comments in response to the Office of the State Comptroller’s (OSC) draft audit report 2007-S-71 on “Inappropriate Medicaid Billings for Dental Restorations.”

**Recommendation #1:**

Investigate and recover the $148,341 in inappropriate claims identified during the audit.

**Response #1:**

The Office of the Medicaid Inspector General (OMIG) will review the dental claims that the OSC has identified as inappropriate and recover overpayments where appropriate.

**Recommendation #2:**

Review the dentists’ remaining 103,964 claims totaling over $9.9 million billed to Medicaid during our audit period to determine whether the dental restoration services were appropriate. Recover inappropriate payments where warranted.

**Response #2:**

Based on the outcome of the OMIG’s review of the claims associated with Recommendation #1, a determination will be made on whether to randomly sample the $9.9 million universe of claims and to recover inappropriate payments where warranted.

**Recommendation #3:**

Reinstruct dental providers on the requirements to appropriately identify servicing providers on Medicaid claims.

**Response #3:**

The Department furnishes dental providers, upon enrollment, with written and oral instructions regarding claims submission and the requirements for group status. In addition, the Department’s Medicaid Update publications inform providers of Medicaid seminars and include contact information for providers’ questions pertaining to claims and other program areas. The December 2007 edition will include reissue of an article reinforcing the requirement to appropriately identify servicing providers on claims.
Recommendation #4:
Routinely review Medicaid claims submitted by group providers to determine if the servicing provider were appropriately identified. Recover inappropriate payments where warranted.

Response #4:
Current eMedNY processing includes edits to determine if the servicing provider is on the State Education Department's License File, is actively enrolled in Medicaid, and/or is deceased.

Recommendation #5:
Expedite the development and implementation of the projects to suspend or deny payment of dental claims where a specified number of teeth and a specified number of surfaces are restored on a single date of service.

Response #5:
The Department will develop system controls to pend (deny) claims for professional review whenever an unreasonable number of teeth and a specified number of surfaces are restored on a single day by a single provider. Edits EP 1148 (number of surfaces restorations per date of service) and EP 1149 (number of teeth restored per date of service) are currently awaiting assessment.

* See State Comptroller’s Comment, page 11
cc: Stephen Abbott
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The current eMedNY edits cited by the Department will only work properly when the servicing provider is listed on the Medicaid claims. As we stated in our report, we identified two dental practices that did not list the servicing providers on claims. According to 18 NYCRR, practitioners who practice in a group setting are required accurately state the servicing provider, the provider who actually provided the medical service for which payment is sought, on all claims. Without proper identification of the servicing provider, the Department cannot ensure only qualified and non-sanctioned providers are providing services to Medicaid recipients.