

PROGRAM RULE VIOLATIONS IN THE
MEDICAID DENTAL PROGRAM

LOUISIANA DEPARTMENT OF HEALTH



MEDICAID AUDIT UNIT
ISSUED MARCH 22, 2017

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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

March 22, 2017

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Taylor F. Barras
Speaker of the House of Representatives

Dear Senator Alario and Representative Barras:

This report provides the results of our review of payments made in the Louisiana Department of Health's (LDH) Medicaid Dental Program. During this review, we identified \$6.4 million in program rule violations that either LDH or Managed Care of North America paid. I hope this report will assist you in your legislative decision-making process.

The report contains our finding, conclusion, and recommendations. Appendix A contains LDH's response to this report. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of LDH for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/ch

MEDICAID 2017

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE



Audit Control # 80170006

Program Rule Violations in the Medicaid Dental Program Louisiana Department of Health March 2017

Introduction

The Louisiana Department of Health (LDH) administers the Medicaid program in the state of Louisiana to provide health and medical services for uninsured and medically indigent citizens. This includes the coordination of dental benefits and services for eligible individuals. On July 1, 2014, LDH moved from a fee-for-service (FFS) model, where LDH paid all claims submitted by Medicaid dental providers for each service performed, to a Prepaid Ambulatory Health Plan (PAHP).¹

Under a PAHP, LDH pays a fixed per member per month (PMPM) fee, essentially an insurance premium, to the PAHP for the administration of dental benefits, including the processing and payment of all dental claims for Medicaid recipients. LDH contracted with Managed Care of North America (MCNA) to serve as the PAHP and operate the program through June 30, 2017. MCNA is responsible for the processing and payment of all dental claims except for the Intermediate Care Facilities for the Developmentally Disabled population, which remains under the FFS model.

Medicaid dental benefits vary based on the recipient's age. Recipients under 21 years old are in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Additionally, dental benefits are divided into nine service areas, each containing specific procedures related to type of service being provided.² For example, the preventative service area contains specific procedures, like dental cleanings, that prevent or defend against dental disease. Individual procedures are identified by procedure codes, such as procedure code D1110 for an adult cleaning. The services available in this program, the number of procedures associated with the services, the number of claims, and the total amount LDH and MCNA paid for these services between July 1, 2012, and June 30, 2016 are summarized in Exhibit 1 on the following page.

¹ A Prepaid Ambulatory Health Plan (PAHP) is a non-comprehensive prepaid health plan that provides only certain outpatient services, such as dental services or outpatient behavioral health care. PAHPs provide no inpatient services and are paid on an at-risk or capitated basis.

² For full description of Medicaid Dental Procedures, including all associated procedure codes and associated rules, see http://www.lamedicaid.com/provweb1/Providermanuals/manuals/DENTAL_NEW/Dental_New.pdf

**Exhibit 1:
Medicaid EPSDT Dental Benefits and Payments
July 1, 2012 - June 30, 2016**

Service	Description	Number of Procedures	Number of Claims	Total Amount Paid
Adjunctive General Services	Miscellaneous procedures, such as palliative (emergency) treatment, anesthesia, professional visits that may be needed in addition to the services described below.	11	635,598	\$32,110,650
Diagnostic Services	Used to diagnose dental problems and include oral examinations, radiographs and oral/facial images, diagnostic casts, etc.	13*	4,413,445	113,448,881
Endodontic Therapy Services	Related to treatment of dental pulp. Includes pulp capping and root canals (endodontic therapy) on primary and permanent teeth.	12	207,037	27,067,849
Oral and Maxillofacial Surgery	Includes non-surgical extractions, surgical extractions, and other surgical procedures.	21	417,539	42,743,735
Orthodontic Services	Diagnosis, prevention, interception, guidance, and correction of bad bites. It includes appliances like braces and retainers.	7	2,104	1,501,907
Periodontal Services	Services involving the gums and tissue surrounding teeth. Services include gingivectomy and full mouth debridement.	4	4,119	438,034
Preventative Services	Cleanings and dental sealants; services to prevent or defend against the onset of disease.	9	4,208,604	114,689,287
Prosthetics	Similar to complete dentures or fixed partial denture retainers used to treat conditions associated with missing or deficient teeth.	26	1,291	460,100
Restorative Services	Related to the restoration of diseased teeth to normal form and include fillings and crowns.	23	1,974,876	169,009,520
Total		126	11,864,613	\$501,469,963

* LDH has 13 procedure codes listed in its provider manual for Diagnostic Services under fee-for-service. However, MCNA has one additional procedure code listed for Diagnostic Services in its provider manual.

Source: Prepared by legislative auditor's staff using LDH data.

Medicaid recipients aged 21 and over are only covered in the Adult Denture Program, which includes an examination, x-rays (if in conjunction with the construction of a Medicaid-authorized denture), dentures, denture relines, and denture repairs. For this audit, we focused our testing on the EPSDT program. The purpose of our analysis was:

To identify claims that violated program rules in the Medicaid Dental Benefits Program between July 1, 2012, and June 30, 2016.

Appendix A contains LDH's response to this report, and Appendix B details our scope and methodology.

Review of Medicaid Dental Program Rules

Overall, we found approximately \$6.4 million in payments that violated program rules in the Medicaid Dental Program between July 1, 2012, and June 30, 2016.

We obtained and analyzed all payments made by LDH and MCNA for participants in the Medicaid Dental Benefits Program (Dental Program) to determine if any payments violated the program rules established in the Dental Services Provider Manuals. The Provider Manuals include the following types of program rules:³

1. Rules based on the age of the recipient;
2. Rules based on the specific tooth, tooth surface, or oral-cavity where the procedure was performed;
3. Rules that outlined a specific time between services;
4. Rules that specified if a procedure cannot be billed in conjunction with another procedure or must be billed in conjunction with another procedure;
5. Rules that specified where (e.g., hospital, outpatient clinic, office setting) the procedure must be performed;
6. Rules that required prior authorization for a procedure;
7. Rules related to the fee the provider is paid by Medicaid or MCNA;⁴ and
8. Rules that require specific information to be part of the clinical or treatment record.⁵

We found that between July 1, 2012, and June 30, 2016, LDH paid \$5,747,446 for 88,586 claims in FFS, and MCNA paid \$684,365 to providers for 18,456 claims that violated program rules. Examples of some rule violations are:

- **Procedure code D0120 (*Periodic Oral Examination*)**. A diagnostic service only covered for members 3 to 20 years of age. For this rule, we found \$153,237 in FFS payments for 5,682 claims where the recipient was under 3 years of age or over 20 years of age and received the examination.
- **Procedure code D2332 (*Resin-based composite, three surfaces, anterior*)**. A restorative service that requires prior authorization if the service is performed on

³ Procedures may have multiple program rules associated with them. For example, procedure code D0120 Periodic Oral Examination (established patient) has both age and time between services requirements.

⁴ We did not test this rule type, as fees are being evaluated as part of a separate project.

⁵ We did not test this rule type because it involves file reviews at the provider level. We did, however, evaluate procedure code D9110 that requires certain information to be included in the patient's record. We tested the data to determine if the information was included in the claim data.

certain teeth. For this rule, we found \$1,737,179 in FFS payments for 15,678 claims that did not have prior authorization indicated in the data.

- **Procedure code D3330 (*Root Canal-Molar, excluding final restoration*)**. An endodontic service that always requires prior authorization. For this rule, we found \$9,007 in MCNA payments for 19 claims that did not have prior authorization indicated in the data.

Exhibit 2 summarizes the amount of payments and the number of claims that violated program rules in our scope.

Exhibit 2				
Dental Program Rule Violations by Type of Service				
July 1, 2012 - June 30, 2016				
Service Type	FFS		MCNA	
	Violation Amount	Number of Claims	Violation Amount	Number of Claims
Adjunctive	\$417,259	3,989	\$32,851	769
Diagnostic	968,189	35,159	457,578	15,249
Endodontic	0	0	20,082	65
Oral Surgery	5,656	40	36,108	209
Orthodontic	0	0	1,069	2
Periodontal	408	4	1,332	13
Preventative	146,759	6,095	28,916	1,003
Prosthetics	190	2	505	3
Restorative	4,208,985	43,299	105,924	1,143
Subtotals	\$5,747,446	88,586	\$684,365	18,456
Total Claims	107,042			
Total Violation Amount	\$6,431,811			
Source: Prepared by legislative auditor's staff using LDH data.				

According to LDH, under fee-for-service these payments could have occurred because provider manuals were not updated to account for changes to program rules that were decided upon within the department. According to MCNA, violations under the PAHP could be the result of claims being denied internally yet being submitted to LDH as approved. This inconsistency means that LDH cannot effectively oversee the Dental Program, as it cannot identify in its own data if any of the violating claims were denied by MCNA. Furthermore, while these claims should have \$0 for payments, approved claims are used by the department's actuary to determine utilization for the program. This means that denied claims could be used when the actuary calculates the PMPM that the department pays MCNA for administering the Dental Program.

In addition to program violations, we found the following issues with LDH's oversight of the Dental Program:

- **We identified \$3,433,234 for 59,239 FFS claims that may have violated the Adjunctive General rule for procedure code D9110.** This code requires a tooth or area of the mouth (oral cavity) be indicated in the patient's treatment record when this procedure is performed. While LDH stated this rule does not require providers to submit the tooth or oral cavity with the claim and only requires that information be included in the patient record at the dental office, we found 62% of the claims for this procedure did not include the tooth or oral cavity in the data. Without the information in the data and without validating the information exists in the patient's treatment record, LDH does not know if these claims are in violation of program rules. According to LDH, the department has reviewed this procedure as part of individual dental case reviews, but no comprehensive review of D9110 has been done.
- **We identified \$1,071 for 14 claims that violated program rules that were processed and paid as a result of management overrides made by LDH in the fee-for-service program.** While LDH was able to provide documentation detailing the override, there is no indicator of it in claims data. Without an indicator of the management overrides in the claims data, LDH cannot efficiently monitor the dental program for violations of program rules because it is unclear which violated claims should be allowed.
- **We identified \$1,047,242 for 9,989 claims that violated program rules that were processed and paid as a result of management or administrative overrides made by MCNA in the PAHP program.** While LDH was able to request documentation from MCNA detailing which claims were overridden, there is no indicator of the override in claims data. Additionally, LDH did not have the documentation for these overrides internally. Without an indicator in the data of the overrides and without documentation to justify the override, LDH cannot efficiently oversee the dental program as it cannot determine internally which claims are actually in violation of program rules.

Based on the results of our review, LDH needs to strengthen its oversight of the Dental Program, including its process for identifying and preventing payments that violate program rules.

Recommendation 1: LDH should ensure that provider manuals are updated as it changes the program rules.

Recommendation 2: LDH should work with MCNA to identify claims that MCNA considers denied yet still appear as approved in LDH data. Additionally, LDH should ensure that claims are properly submitted and identified as denied in its system so they are not used in the rate-setting process.

Recommendation 3: LDH should consider adding a data field that indicates if an override (such as management or clinical review) was performed to allow payment for the claim.

Recommendation 4: LDH should begin the process of investigating the rule violations identified in this report and recovering those payments, as appropriate.

Recommendation 5: LDH should evaluate and strengthen its process for identifying and preventing rule violations in the Dental Program.

Summary of Management's Response: LDH outlined corrective actions for each of these recommendations. See Appendix A for LDH's full response.

APPENDIX A: MANAGEMENT'S RESPONSE



State of Louisiana

Department of Health
Bureau of Health Services Financing

March 22, 2017

Daryl G. Purpera, CPA, CFE
Louisiana Legislative Auditor
Post Office Box 94397
P.O. Box 94397
Baton Rouge, LA 70804-9397

Re: Program Rule Violations in the Medicaid EPSDT Dental Program

Dear Mr. Purpera,

Thank you for the opportunity to respond to the findings of your Medicaid Audit Unit report on **Rule Violations in the Medicaid EPSDT Dental Program**. The Louisiana Department of Health (LDH) recognizes its responsibility to provide effective oversight of the Dental Program, which includes strengthening processes to identify and prevent payments that violate program rules. In response to the recommendations in the referenced audit report, LDH offers the following corrective action:

Recommendation 1: LDH should ensure that provider manuals are updated as it changes the program rules.

Corrective Action: LDH is currently reviewing both the Dental Services Manual and Managed Care North America (MCNA) Provider Handbook to ensure all policy is up to date and requirements are clearly explained. The estimated completion of the project is June 30, 2017. In addition, LDH will create a tracking process to ensure that, going forward, timely updates are made to the above referenced manuals when program rules are changed.

Recommendation 2: LDH should work with MCNA to identify claims that MCNA considers denied, yet still appear as approved in LDH data. Additionally, LDH should ensure that claims are properly submitted and identified as denied in its system so they are not used in the rate setting process.

Corrective Action: LDH will work with MCNA to identify claims that MCNA considers denied and ensure that claims are properly submitted and identified as denied in the system. However, the denied claims in question in this report were submitted as paid at zero, so those had no impact on rate setting.

Recommendation 3: LDH should consider adding a field in the data that indicates if an override (such as management or clinical review) was performed to allow payment for the claim.

Corrective Action: For fee-for-service payments, which include only Medicaid ICF/DD recipients, the field currently exists for manual LDH approvals. To correct this deficiency with MCNA, a systems change will be made to use the third and fourth positions of the Plan ICN to indicate Administrative Management Review and Clinical Review. Details are being finalized and the Systems Companion Guide will be updated with instructions on how to submit these codes in the MCNA Plan ICN value. The change is expected to be completed by June 30, 2017.

Recommendation 4: LDH should begin the process of investigating the rule violations identified in this report and recovering those payments as appropriate.

Corrective Action: LDH and MCNA will review the final findings provided by LLA and make a recommendation for payment recoupment where appropriate.

Recommendation 5: LDH should evaluate and strengthen its process for identifying and preventing rule violations in the Dental Benefits Program.

Corrective Action: LDH will evaluate the current process for preventing rule violations and identify areas for improvement.

The above corrective action plans are anticipated to be corrected by the dates indicated. You may contact Brandon Bueche, Dental Program Manager, at 225-384-0460 or via e-mail at brandon.bueche@la.gov with any questions about the proposed actions related to these findings.

Sincerely,



Jen Steele
Medicaid Director

JS/bb

cc: Rebekah E. Gee, Secretary
W. Jeff Reynolds, Undersecretary

APPENDIX B: SCOPE AND METHODOLOGY

The objective of our work was:

To identify claims that violated program rules in the Medicaid Dental Benefits Program between July 1, 2012, and June 30, 2016.

The scope of our project was significantly less than that required by *Government Auditing Standards*. However, we believe the evidence obtained provides a reasonable basis for our findings and conclusions. To conduct this analysis, we performed the following steps:

- Obtained an electronic copy of Medicaid claims paid in the Dental Program from Molina Health Solutions, LDH's fiscal intermediary.
- Obtained Medicaid Dental Program rules from LDH website.
- Used software (e.g., SQL, ACL, Excel) to compare paid claims based on procedure codes outlined in the Dental Provider Manual to identify situations where a recipient had claims that violated the rules outlined in the manual.
- Provided results to LDH officials for further investigation throughout the project in order to validate our findings and conclusions.