Audit of Dental Managed Care Organization and Fee for Service Billings

Report Number 2019-02

May 23, 2019

Utah Office of
Inspector General

Gene Cottrell
Inspector General

May 23, 2019

To: Utah Department of Health

Please see the attached report, Audit of Dental Managed Care Organization and Fee for Service Billings, Report 2019-02. An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 3 of this report.

Sincerely,

Gene Cottrell
Inspector General
Utah Office of Inspector General

cc: Justin Harding, Chief of Staff, Office of Governor Gary R. Herbert
J. Stuart Adams, President of the Utah Senate
Brad Wilson, Speaker of the Utah House of Representatives
Joseph Miner, MD, Executive Director, Utah Department of Health
Nathan Checketts, Deputy Director, Utah Department of Health, Director Medicaid and Health Financing
Emma Chacon, Utah Medicaid Division Operations Director
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EXECUTIVE SUMMARY

Medicaid is a joint state and federal government health insurance program established by Title XIX of the 1965 Social Security Act. In the State of Utah, the Utah Department of Health (DOH) is the single state agency responsible for all aspects of Utah's Medicaid state plan including administration and supervision of payment for services delivered under the plan.

The DOH contracts with two dental managed care organizations (MCOs) to provide services to pregnant adults and children eligible for the Children's Health and Evaluation Care (CHEC) program, living in the counties of Davis, Salt Lake, Utah, and Weber. The two dental MCOs receive a fixed capitated payment monthly for each recipient enrolled (enrollees) in a managed care dental plan (MCDP) regardless of treatment required. The DOH contracts with the two dental MCOs (contracts) require that providers bill the MCOs for services to enrollees covered by the MCDP. Providers may bill Medicaid directly only for services provided to enrollees, covered by the Medicaid state plan, and not covered by the MCDP. Medicaid refers to services billed directly to Medicaid as fee for service (FFS).

Audit Objectives:

- Determine whether FFS claim payments during same period of capitation payments were due and payable.
- Determine whether the DOH contracts with dental managed care contractors specify adequately the services Medicaid expects the contractors to perform by capitation.
- Determine whether the Medicaid Management Information System (MMIS) adjudication process prevents FFS payment for services covered by dental contract capitation payments.

Audit Findings:

Utah Medicaid paid FFS claims for recipients enrolled in a managed care dental plan for services covered by the MCDP and the Medicaid state plan. The improper or questionable FFS payments occurred because Utah Medicaid's MMIS edits did not prevent the FFS payments. As a result, Utah Medicaid incorrectly paid an estimated $584,777 between January 2, 2015 and June 30, 2018.

INTRODUCTION

BACKGROUND

Under the authority of Utah State Code 26-1-18, the Utah Department of Health (DOH) is designated the single state agency responsible for administration of Utah Medicaid. Portions of Utah Medicaid have operated under managed care delivery systems since 1982.[1] In September of 2013, Utah Medicaid implemented a dental managed care system to provide dental services to eligible recipients living in the counties of Davis, Salt Lake, Utah, and Weber through two managed care contractors: Delta Dental of California (Delta) and Premier Access Insurance Co. (Premier). The five-year contracts with Delta and Premier terminated on August 31, 2018—after the scope period of this audit. Utah Medicaid currently contracts with Premier and MCNA Insurance Company and Managed Care of North America Inc. (MCNA Dental). Utah Medicaid's dental managed care plans are prepaid ambulatory health plans (PAHP) authorized by 42 C.F.R. § 438.

Utah Medicaid utilizes two payment methodologies for dental services covered under the state plan: capitation and FFS. Under capitation method, Delta and Premier receive a fixed monthly capitation payment to provide specific dental services to eligible recipients. The MCOs receive prepaid capitation payments regardless of treatment required—or not required—during the month of capitation coverage.[2] Delta and Premier compensate providers for delivering contracted dental plan services. Under capitation methodology, providers submit their claims for reimbursement to Delta or Premier. Under the FFS payment method providers bill Medicaid directly for dental services covered by the state plan but not included in the MCDP.

The Utah Office of Inspector General (UOIG) initiated this audit based on observations of FFS claims paid during the dates of service for which dental capitation payments were processed.

FUNDING SOURCE

The Federal government and the State of Utah jointly fund Utah's Medicaid program. Funding rates are set every federal fiscal year (FFY) by the Federal Medicaid Assistance Percentage (FMAP). During the audit scope period, the Federal government's portion of the funding for eligible medical expenditures ranged from approximately 70% to 71%. The State is responsible for paying the remaining amount. On average, the Federal government paid $2.36 for every $1.00 spent by the State of Utah.

[1] "Managed Care Quality Strategy." 2015. Accessed November 6, 2018. https://docs.google.com/viewer?a=v&pid=sites&srcid=dXRhaC5nb3Z8Y3FtfGd4Ojc5NTU1MzQxZDQ4YTJlZGE.
[2] Managed Care, 42 C.F.R. § 438.2 (2017), https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-part438.pdf.

OBJECTIVES AND SCOPE

Audit Objectives:

- Determine whether fee for service (FFS) claim payments during same period of capitation payments were due and payable.
- Determine whether the Medicaid contracts with dental managed care contractors specify adequately the services Medicaid expects the contractors to perform by capitation.
- Determine whether the Medicaid Management Information System (MMIS) adjudication process prevents FFS payment for services covered by dental contract capitation payments.

Audit Scope:

The scope of the audit covered January 1, 2015 through June 30, 2018, excluding dental services provided at Indian Health Service (IHS) and Federally Qualified Health Center (FQHC) facilities.

METHODOLOGY

To carry out the audit objectives, UOIG conducted fieldwork between August and November of 2018. The early stages of UOIG's fieldwork included review of federal laws, rules, and regulations applicable to the audit objectives. UOIG also reviewed relevant portions of Utah's Medicaid state plan.

Using the Medicaid Data Warehouse, UOIG obtained FFS dental claims paid during the audit scope period. UOIG also obtained capitation payments and capitation coverage dates for Delta and Premier. From the FFS dental claim information, UOIG omitted all crossover claims and claims with a third party payment before linking the FFS dental claims and capitation payment information. To link the claims, UOIG matched the date of service on the FFS dental claims with capitation payments and coverage dates. Any FFS dental claim that did not link with a capitation payment and coverage date was not part of the final data file analyzed by UOIG.

UOIG requested and reviewed the managed care contracts in place January 1, 2015 through June 30, 2018, between Utah Medicaid and the two dental managed care contractors: Delta and Premier. To understand capitated dental managed care contracting standards, UOIG reviewed contracts executed by other states. The review of other state contracts was limited to the language used to specify services covered by the capitated payment agreement.

The following Utah Medicaid publications and online tool were part of UOIG's fieldwork review: Utah Medicaid Manual—All Providers General Information Section I; Utah Medicaid Manual—Dental, Oral Maxillofacial, and Orthodontia; Utah Medicaid Information Bulletins; and Utah Medicaid Coverage and Reimbursement Code Lookup. UOIG's review of the aforementioned publications and online tool focused on the portions applicable to the audit objectives.

Finally, UOIG conducted interviews of Utah Medicaid staff to gain an understanding of the dental claims adjudication process including pre-payment safeguards. Additional interviews explained dental services that require prior authorization and the adjudication of such claims.

We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

FINDING 1 — Utah Medicaid's System Edits Lack a Crucial Pre-payment Safeguard.

As part of the audit fieldwork, UOIG held a meeting with the Bureau of Managed Health Care (BMHC) in September of 2018 to discuss the data obtained by UOIG from the Medicaid Data Warehouse (data file) showing FFS claims paid during the dates of service for which dental capitation payments were processed. UOIG provided BMHC with a complete copy of the data file prior to the meeting. The cumulative fieldwork, including the meeting with BMHC, indicates that claims submitted to MMIS include basic information such as recipient ID, procedure performed, provider type, and date of service. Using this and other information on the claim, automated system edits determine if claims should be paid, denied, or suspended.

During the audit scope period, Utah Medicaid had automated system edits in place to safeguard claims payment. BMHC expressed in the meeting with UOIG that the edits were working as designed. However, the edits lack a critical pre-payment safeguard to detect FFS claims submitted with provider type 45 (group practice). Without the provider type 45 safeguard, Utah Medicaid incorrectly issued payments to providers for dental services covered by the managed care dental contracts. Federal law states that the single state agency "must ensure that no payment is made to a network provider other than by the MCO, PIHP,[3] or PAHP for services covered under the contract between the State and the MCO, PIHP, or PAHP."[4] In the September meeting with UOIG, BMHC indicated that new pre-payment safeguards—for provider type 45—were being developed and would be deployed immediately.

Between January 1, 2015 and June 30, 2018, Utah Medicaid paid $584,777 in improper or questionable fee for service (FFS) claims for dental services covered by the dental managed care contracts. MMIS did not reject the FFS claims and as a result, payments totaling $584,777 issued directly to the dental service providers. The FFS payments made by Medicaid were for services identified in the dental managed care contracts as services covered under the MCDP.

Recommendations

UOIG recommends Utah Medicaid take action as follows:

1.1 Review questionable payments made by Medicaid to providers and determine if recovery, to the extent permitted by contract, is appropriate for dental service claims incorrectly billed to Medicaid.

1.2 Pursue recovery of improper payments, to the extent permitted by contract, made by Medicaid for contractually covered dental services that the dental managed care contractors were responsible to pay.

1.3 Proactively review existing and new system edits for accuracy and completeness in detecting and denying improper FFS claims filed for MCDP enrollees.

[3] Prepaid Inpatient Health Plan.
[4] Managed Care, 42 C.F.R. § 438.60 (2017), https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-part438.pdf.

OBSERVATION 1	Questionable Fee for Service Claims

UOIG interviews with Utah Medicaid indicate edits in place during the audit scope period included a pre-payment safeguard to detect FFS claims submitted with provider types 40 (dentist) or 95 (oral surgeon) for recipients enrolled in a managed care dental plan (MCDP). The edits are designed to automatically deny claims if 1) the recipient is enrolled in a MCDP, 2) the provider type is 40 or 95, 3) a capitation payment was made to Delta or Premier, and 4) the service is covered by the MCDP.

Utah Medicaid paid approximately $3,837 between January 2, 2015 and June 30, 2018 in questionable fee for service (FFS) claims submitted for recipients enrolled in a MCDP, with provider type 40 (dentist) or provider type 95 (oral surgeon), during a period of capitation coverage, for services covered by the dental managed care contracts (*see* Appendix 3). While these questionable FFS claims are minor in terms of taxpayer dollars potentially paid incorrectly, the questionable claims suggest that existing system edits may not always prevent payment of improper FFS claims. UOIG did not review the questionable claims submitted with provider type 40 or 95 in detail because the issue does not rise to the level of a significant or material weakness in internal controls.

Observation

Federal law requires the single state agency make no payment to a provider for service covered under the contract between the single state agency and the dental MCO.[5]

[5] Managed Care, 42 C.F.R. § 438.60 (2017), https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-part438.pdf.

OBSERVATION 2	Incomplete and Inaccurate Reference Information on Medicaid's Website

Utah Medicaid publishes the Utah Medicaid Provider Manual to give providers "basic information about Utah's Medicaid Program and other medical assistance programs administered by the Utah Department of Health."[6] Section 1 of the manual contains information relevant to all Utah Medicaid providers. Chapter 10 of Section 1 of the Utah Medicaid Provider Manual communicates information about fee for service prior authorization. The manual directs readers seeking prior authorization for a contractually covered service for a recipient enrolled in a managed care dental plan (MCDP) to "contact the MCO for instructions on requesting prior authorization."[7] A link sends readers to the Utah Medicaid website with instructions to select *Contact Us* and "scroll to the applicable MCO."[8] The *Contact Us* section lists contact information for the following MCOs:

Molina Healthcare of Utah
Healthy U
SelectHealth Community Care
Health Choice Utah
Healthy Outcomes Medical Excellence Program (HOME) program
Primary Care Network

No contact information is included for the two dental MCOs: Premier and MCNA Dental.

Utah Medicaid's website also includes a section detailing prior authorization criteria titled, *Utah Medicaid Criteria*. The first paragraph of the page directs readers to chapter 9 of Section 1 of the Utah Medicaid Provider Manual for "detailed instructions regarding the prior authorization process and procedures."[9] In fact, the detailed instructions are contained in chapter 10—not chapter 9—of the Utah Medicaid Provider Manual.

Observations

Utah Medicaid relies heavily on online tools and publications to communicate information and supply resources to providers. Clear, consistent, and complete information on Utah Medicaid's website supports efficient delivery of health care to Utah's most vulnerable populations. The incomplete and inaccurate information about the prior authorization process increases the risk of inefficiencies such as MCDP providers incorrectly submitting prior authorization requests to Utah Medicaid. The time and cost associated with correcting such errors is a consideration as well as potential delays to providing health care to Medicaid recipients.

[6] "Manuals." Utah Medicaid Official Publications. Accessed November 27, 2018. https://medicaid.utah.gov/manuals.
[7] "All Providers General Information Section I." Utah Medicaid Official Publications. July 2018. Accessed November 8, 2018. https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid Provider Manuals/All Providers General Information Section I/AllProvidersGeneralInfo_Section_1.pdf.
[8] Ibid.
[9] "Utah Medicaid Criteria." Prior Authorization. Accessed November 8, 2018. https://medicaid.utah.gov/utah-medicaid-criteria.

Appendix 1: Improper or questionable provider type 45 fee for service claims paid by CDT code, description, and group

The table below lists improper or questionable fee for service (FFS) paid claims for dates of service January 2, 2015 through June 30, 2018, by CDT code, description, and group for recipients enrolled in a managed care dental plan. Excluded are the following FFS claims:

- IHS and FQHC facilities, foster children, and presumptive eligibility recipients
- Claims submitted with a Medicaid issued prior authorization

The improper or questionable FFS claims submitted under provider type 45 for dates of service January 2, 2015 through June 30, 2018, total $584,777. UOIG in Finding 1 recommends Medicaid recover payments in full, to the extent permitted by contract, for all improper FFS claims.

Current Dental Terminology (CDT)			Allowed Charge
Code	**Description**	**Group**	**Total**
D0120	PERIODIC ORAL EVALUATION-ESTABLISHED PATIENT	Diagnostic Services	25,709
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED		8,330
D0150	COMPREHENSIVE ORAL EVAL-NEW OR ESTABLISHED PATIENT		19,786
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)		5,897
D0220	INTRAORAL-PERIAPICAL-FIRST FILM		12,671
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM		10,363
D0270	BITEWING-SINGLE FILM		235
D0272	BITEWINGS-TWO FILMS		20,425
D0274	BITEWINGS - FOUR FILMS		13,904
D0330	PANORAMIC FILM		15,657
D0470	DIAGNOSTIC CASTS		1,198
D1110	PROPHYLAXIS - ADULT	Preventative Services	12,353
D1120	PROPHYLAXIS - CHILD		46,986
D1206	TOPICAL FLUORIDE VARNISH;THERAPEU APPL HIGH RISK		18,323
D1208	TOPICAL APP OF FLUORIDE		2,735
D1351	SEALANT - PER TOOTH		32,790
D1510	SPACE MAINTAINER-FIXED UNILATERAL		2,295
D1515	SPACE MAINTAINER-FIXED BILATERAL		1,666
D1520	SPACE MAINTAINER-REMOVABLE UNILATERAL		99
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	Restorative Services	31,724
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT		66,669
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT		21,185
D2161	AMALGAM-FOUR OR MORE SURFACES,PRIMARY OR PERMANENT		3,651
D2330	RESIN - ONE SURFACE, ANTERIOR		4,934
D2331	RESIN - TWO SURFACES, ANTERIOR		7,432
D2332	RESIN - THREE SURFACES, ANTERIOR		10,623
D2335	RESIN-4 OR MORE SURFACE/INVOLV INCISAL ANGLE,ANTER		5,253
D2391	RESIN-BASED COMPOSITE,ONE SURFACE,POSTERIOR		6,173

Current Dental Terminology (CDT)			Allowed Charge
Code	**Description**	**Group**	**Total**
D2920	RECEMENT CROWN	Restorative Services continued	34
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH		51,149
D2931	PREFABRICAT STAINLESS STEEL CROWN-PERMANENT TOOTH		5,617
D2950	CORE BUILD-UP INCL ANY PINS		4,403
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN		1,631
D3220	THERAPEUTIC PULPOTOMY,(EXCL FINAL RESTOR)APPL MEDI	Endodontic Services	10,492
D3310	ROOT CANAL THERAPY,ANTERIOR(EXCLUD FINAL RESTOR)		3,446
D3320	ROOT CANAL THERAPY,BICUSPID(EXCLUD FINAL RESTORAT)		3,722
D3330	ROOT CANAL THERAPY,MOLAR(EXCLUD FINAL RESTORATION)		9,443
D4355	FULL MOUTH DEBRIDE COMPREHENSIVE EVAL & DIAGNOSIS	Periodontics	1,439
D5410	DENTURES ADJUST CMPLT MAXIL	Prosthodontic Removable	166
D5932	OBTURATOR PROSTHESIS, DEFINITIVE	Maxillofacial Prosthetics	5,493
D7111	EXTRACTION,CORONAL REMNANTS-DECIDUOUS TOOTH	Oral and Maxillofacial Surgery Services	2,109
D7140	EXTRACTION,ERUPTED TOOTH OR EXPOSED ROOT		23,091
D7210	SURG REMOVAL ERUPTED TOOTH REQ ELEV FLAP,BONE RMVL		8,451
D7220	IMPACT TOOTH REMOV SOFT TISS		4,475
D7230	REMOVAL OF IMPACTED TOOTH--PARTIALLY BONY		6,167
D7240	REMOVAL OF IMPACTED TOOTH--COMPLETELY BONY		20,690
D7280	EXPOSURE OF UNERUPTED TOOTH		68
D7286	BIOPSY OF ORAL TISSUE - SOFT		85
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM		96
D7960	FRENULECTOMY/FRENECTOMY		279
D8692	REPLACEMENT OF LOST OR BROKEN RETAINER	Orthodontic Services	345
D9110	PALLIATIVE(EMER)TRTMNT DENTL PAIN-MINOR PROCEDURE	Adjunctive General Services	90
D9220	DEEP SEDATION/GENERAL ANESTHESIA-FIRST 30 MINUTES		305
D9221	DEEP SEDATION/GENERAL ANESTHESIA-EA ADD 15 MINUTES		115
D9222	DEEP ANEST, 1ST 15 MIN		413
D9223	GENERAL ANESTHESIA EACH 15M		790
D9239	IV MOD SEDATION, 1ST 15 MIN		84
D9243	IV SEDATION EACH 15M		467
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION		4,897
D9310	CONSULTATION(DIAG SRVC BY DENTIST O/T TREAT PRACT)		797
D9420	HOSPITAL CALL		4,775
D9440	OFFICE VISIT-AFTER REGULARLY SCHEDULED HOURS		87
	Grand Total		**$584,777**

Appendix 2: Improper or questionable provider type 45 fee for service claims paid by aid category and description.

The table below lists improper or questionable fee for service (FFS) paid claims for dates of service January 2, 2015 through June 30, 2018, by aid category and description for recipients enrolled in a managed care dental plan. Excluded are the following FFS claims:

- IHS and FQHC facilities, foster children, and presumptive eligibility recipients
- Claims submitted with a Medicaid prior authorization number

The improper or questionable FFS claims submitted under provider type 45 for dates of service January 2, 2015 through June 30, 2018, total $584,777. Utah Medicaid should have denied the improper claims and instructed the providers to bill the appropriate dental MCO.

Code	Description	Allowed Charge
A1A	Subsidized adoption Medicaid, Title IV-E	10,450
A55	Family Medicaid, Child, 12-month transitional earned income increase	18,283
A69	Child Medicaid, 0 to 1, born to a mom on Medicaid	3,584
A80	Child Medicaid, ages 6 through 18	306,169
A81	Child Medicaid, ages 0 through 5	132,061
A82	Pregnant Woman Medicaid - 139% FPL	78,754
AE1	Disabled Medicaid, SSI	17,322
AF1	Disabled Medicaid, Disabled Adult Child age 18 or older	77
AUT	Autism Waiver	102
B33	Disabled Medicaid, income less than or equal to 100% FPL	417
B6	Disabled Medicaid, not on SSI	2,914
B91	Subsidized adoption Medicaid, non-IVE	2,827
C72	Family Medicaid, Child, spenddown $0	201
QD2	Community Supports Waiver and QMB, Disabled	132
QE1	Disabled Medicaid and QMB, SSI	337
TD4	Tech Dependent Waiver, Child	23
WD2	Community Supports Waiver, Disabled, income less than or equal to 300% FBR	9,852
WD4	Community Supports Waiver, Child, income less than or equal to 300% FBR	1,272
	Grand Total	**$584,777**

Appendix 3: Questionable fee for service claims paid for Provider Types 40 and 95, by CDT code description and group.

The table below lists questionable FFS paid claims for dates of service January 2, 2015 through June 30, 2018, by current dental terminology (CDT) code, description, and group for recipients enrolled in a managed care dental plan. Excluded are FFS claims for IHS and FQHC facilities, foster children, and presumptive eligibility recipients. FFS claims submitted with a prior authorization number issued by Utah Medicaid are not included in the table. The questionable FFS claims submitted with provider types 40 and 95 for dates of service January 2, 2015 through June 30, 2018, total $3,837.

Code	Description	Group	Provider Type		Allowed Charge
			40	95	
D0120	PERIODIC ORAL EVALUATION-ESTABLISHED PATIENT	Diagnostic Services	44		44
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED		28		28
D0150	COMPREHENSIVE ORAL EVAL-NEW OR ESTABLISHED PATIENT		177	35	212
D0220	INTRAORAL-PERIAPICAL-FIRST FILM		69		69
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM		42		42
D0272	BITEWINGS-TWO FILMS		44		44
D0274	BITEWINGS - FOUR FILMS		106		106
D0330	PANORAMIC FILM		63	63	126
D1110	PROPHYLAXIS - ADULT	Preventative Services	49		49
D1120	PROPHYLAXIS - CHILD		186		186
D1206	TOPICAL FLUORIDE VARNISH;THERAPEU APPL HIGH RISK		420		420
D1351	SEALANT - PER TOOTH		117		117
D1510	SPACE MAINTAINER-FIXED UNILATERAL		122		122
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	Restorative Services	55		55
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT		283		283
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH		221		221
D2950	CORE BUILD-UP INCL ANY PINS		169		169
D3220	THERAPEUTIC PULPOTOMY,(EXCL FINAL RESTOR) APPL MEDI	Endodontic Services	37		37
D3320	ROOT CANAL THERAPY,BICUSPID(EXCLUD FINAL RESTORAT)		293		293
D3330	ROOT CANAL THERAPY,MOLAR(EXCLUD FINAL RESTORATION)		346		346
D7140	EXTRACTION,ERUPTED TOOTH OR EXPOSED ROOT	Oral and Maxillofacial Surgery	142		142
D7960	FRENULECTOMY/FRENECTOMY		610		610

Code	Description	Group	Provider Type		Allowed Charge
			40	95	
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	Adjunctive General Services	116		116
	Grand Total		**3,739**	**98**	**$3,837**

GLOSSARY OF TERMS

Term	Description
BMHC	Bureau of Managed Health Care
CDT	Current Dental Terminology
CHEC	Children's Health and Evaluation Care
DOH	Utah Department of Health
FFS	Fee for Service
FFY	Federal Fiscal Year
FMAP	Federal Medicaid Assistance Percentage
FQHC	Federally Qualified Health Center
HOME	Healthy Outcomes Medical Excellence Program
IHS	Indian Health Service
MCDP	Managed Care Dental Plan
MCNA	Managed Care of North America
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
PIHP	Prepaid Inpatient Health Plan
PAHP	Prepaid Ambulatory Health Plan
UOIG	Utah Office of Inspector General

MANAGEMENT RESPONSE

State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

JOSEPH K. MINER, MD, MSPH, FACPM
Executive Director

Division of Medicaid and Health Financing

NATE CHECKETTS
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

April 26, 2019

Gene Cottrell
Inspector General
Office of the Inspector General of Medicaid Services
P.O. Box 14103
Salt Lake City, Utah 84114

Dear Mr. Cottrell:

Thank you for the opportunity to respond to the audit titled *Audit of Dental Managed Care Organization and Fee for Service Billings* (Report 2019-02). We appreciate the effort and professionalism of you and your staff in this review. Likewise, our staff spent time collecting information for your review, answering questions, and planning changes to improve the program. We believe that the results of our combined efforts will make a better, more efficient program.

We concur with the recommendations in this report. The Department of Health is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Nate Checketts

Nate Checketts
Deputy Director, Department of Health
Division Director, Medicaid and Health Financing

UTAH DEPARTMENT OF HEALTH

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Response to Recommendations

Finding 1: Utah Medicaid's System Edits Lack a Crucial Pre-payment Safeguard

Recommendation 1.1

> *UOIG recommends Utah Medicaid take action as follows: Review questionable payments made by Medicaid to providers and determine if recovery, to the extent permitted by contract, is appropriate for dental service claims incorrectly billed to Medicaid.*

Department Response:

The Department concurs with this recommendation. BMHC will review questionable fee for service payments made by Medicaid to providers when the Medicaid member is enrolled in a Medicaid managed care dental plan and determine if recovery of the fee for service payment is needed, to the extent permitted by contract. BMHC will work with BMO and the OIG to ensure appropriate action is taken on incorrectly paid claims.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: 1/1/2020

Recommendation 1.2

> *UOIG recommends Utah Medicaid take action as follows: Pursue recovery of improper payments, to the extent permitted by contract, made by Medicaid for contractually covered dental services that the dental managed care contractors were responsible to pay.*

Department Response:

The Department concurs with this recommendation. The Department will work with the Office of Attorney General to recover payments made by Medicaid that should have been billed and reimbursed to providers by a Medicaid managed care dental plan, to the extent permitted by contract.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: 1/1/2020

Recommendation 1.3

> *UOIG recommends Utah Medicaid take action as follows: Proactively review existing and new system edits for accuracy and completeness in detecting and denying improper FFS claims filed for MCDP enrollees.*

Department Response:

The Department concurs with this recommendation. The Department identified the cause of improper claims payment and submitted a DOT to correct the issues. BMHC is actively working with BMO and DTS on this DOT. The DOT will be implemented in production upon completion of testing. The Department will also carefully review and test new system edits for dental fee for service claims submitted to Medicaid for Medicaid members enrolled in a Medicaid managed care dental plan.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: 7/1/2019

Observation 1 – Questionable Fee for Service Claims

Utah Medicaid paid approximately $3,837 between January 2, 2015 and June 30, 2018 in questionable fee for service (FFS) claims submitted for recipients enrolled in a MCDP, with provider type 40 (dentist) or provider type 95 (oral surgeon), during a period of capitation coverage, for services covered by the dental managed care contracts (see Appendix 3). While these questionable FFS claims are minor in terms of taxpayer dollars potentially paid incorrectly, the questionable claims suggest that existing system edits may not always prevent payment of improper FFS claims.

Federal law requires the single state agency make no payment to a provider for service covered under the contract between the single state agency and the dental MCO.

Department Response:

The Department agrees that claims were paid incorrectly to provider type 40 and 95. The Department identified errors in our edit logic that allowed for claims payment of certain CDT codes regardless of provider type. The Department amended the edit logic to remove those CDT codes, previously included in the bypass logic and paid by Utah Medicaid. As stated in the above recommendations, these claims will be recovered, to the extent allowed by contract and law.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: 1/1/2020

Observation 2 – Incomplete and Inaccurate Reference Information on Medicaid's Website

Utah Medicaid relies heavily on online tools and publications to communicate information and supply resources to providers. Clear, consistent, and complete information on Utah Medicaid's website supports efficient delivery of health care to Utah's most vulnerable populations. The incomplete and inaccurate information about the prior authorization process increases the risk of inefficiencies such as MCDP providers incorrectly submitting prior authorization requests to Utah Medicaid. The time

and cost associated with correcting such errors is a consideration as well as potential delays to providing health care to Medicaid recipients.

Department Response:

The Department will update the Medicaid website adding the managed care dental plans to the contact list of managed care entities and correcting the chapter reference error on the Medicaid website. In addition to the web page referred to in the audit, providers are instructed in policy to call the Access Now line or access the web based Eligibility Look Up tool to verify Medicaid eligibility and enrollment in any managed care plans.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: 01/01/2020

EVALUATION OF MANAGEMENT RESPONSE

The Department of Health (Department) concurs with the findings and recommendations of this report. In each response, the Department designates a responsible person to implement changes within a specified deadline. In some instances, the Department has already taken steps to implement the corrective action. The Department's response is appropriate to address each of the findings, observations, and recommendations. We will review the adequacy of the Department's corrective actions following the implementation deadlines provided in the Department's response.

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

UTAH OIG CONTACT

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UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General of Medicaid Services, on behalf of the Utah Taxpayer, will comprehensively review Medicaid policies, programs, contracts and services in order to identify root problems contributing to fraud, waste, and abuse within the system and make recommendations for improvement to Medicaid management and the provider community.

ADDRESS

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