Audit of Medicaid's Dental Program

Audit 2015-09

June 14, 2016

Utah Office of Inspector General

STATE OF UTAH

June 14, 2016

To: Utah Department of Health

Please see the attached report, Audit of Medicaid's Dental Program, 2015-09. 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: Joseph Miner, Nate Checketts, Shari Watkins, Emma Chacon, Janica Gines, Tonya Hales, John Curless, Aaron Eliason, Darin Dennis

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EXECUTIVE SUMMARY

The audit examined all paid, fee for service dental claims with service dates in calendar year 2014, with the final claim indicator. This population was further broken down to five areas: Evaluations, periodic and comprehensive; x-rays; prophylaxis; sealants; and restorative fillings, amalgam and resin. Definitions of coverage limitations listed in the Fee Schedules and the Coverage and Reimbursement Code Lookup show limits expressed as either frequency over time or grouped by permanent vs. primary teeth or anterior vs. posterior teeth.

Audit Objectives:

- Determine if payments for services provided to the limited eligible recipient groups followed the defined limitations.
- Determine if payment amounts to providers followed applicable fee schedules with adjustments.
- Determine if the payment for services follow defined limits of frequency, application and approval.
- Determine if the payments for services demonstrate the policy of maintaining standards of high quality and reasonableness in all services.

Audit Findings:

- Finding #1: Medicaid made payments for restorative filings that conflicted with Medicaid policy.
  Evidence of duplicate billings, unbundled billings, using dental codes that do not align to number of surfaces or no surfaces listed, paid by Medicaid.

- Finding #2: Medicaid does not have a policy that limits the number of times a surface can be filled within a defined timeframe.
  Medicaid policy allows providers to receive multiple payments for fillings on the same surface on the same tooth on the same date of service.

- Finding #3: Medicaid did not close dental code D2391 single surface composite resin filling for posterior teeth.
  Resin fillings on posterior teeth allowed for single surface billings. Policy allows for payment using amalgam filling codes with spend-up agreement.

INTRODUCTION

BACKGROUND

The Utah Department of Health (DOH) Division of Medicaid and Health Financing (Medicaid) shows in the annual report for fiscal year 2014 that consolidated Medicaid expenditures totaled $44,286,100 for dental services. This represents a 2.5% of the total Medicaid expenditures. For the fiscal year 2015, the expenditures totaled $53,334,900 and 9.2% of the total expenditures. Enrolled providers in the program went from 803, in 2014 to 860 in 2015. The total of fee-for-service (FFS) reimbursements was $23,443,132 (1.78% of Medicaid expenditures) in 2014 and $21,847,060 (1.76%) in 2015. The Medicaid Dental Services Provider Manual states, "Medicaid Beneficiaries who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid." Further the manual states that, "The Division of Medicaid and Health Financing (DMHF) requires beneficiaries on the pregnant women program and on the EPSDT program, living in Davis, Salt Lake, Utah and Weber counties, to enroll in a dental plan."

Medicaid issues the Dental, Oral Maxillofacial, and Orthodontia Services provider manual (Dental Services Manual). This manual, dated January 2014 and revised July 2014, sets policy for dental coverage for Medicaid recipients. Section 1-1 General Policy, contains two statements that limit the availability of dental services to two groups. The first states: "Dental services are not a covered benefit for Traditional Medicaid beneficiaries." The second states: "Dental Services are available under the pregnant women program and under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program (also known as the Child Health Evaluation and Care (CHEC) program)." Dental services are also available to a limited third group, Traditional Medicaid beneficiaries if the Dental Services are medically necessary and the least costly alternative.

Section 1 – General Information of the Dental Services Manual cited above also states, "All services must maintain a high standard of quality and must be provided within the reasonable limits of those that are customarily available and provided to most persons in the community in accordance to Medicaid's policies and procedures."

OBJECTIVES AND SCOPE

Audit Objectives:

1. Determine if payment for services provided to the limited eligible recipient groups followed the defined limitations.
2. Determine if payment amounts to providers followed applicable fee schedules with adjustments.
3. Determine if the payment for services follow defined limits of frequency, application and approval.
4. Determine if the payment for services demonstrate the policy of maintaining standards of high quality and reasonableness in all services.

Audit Scope:

Paid FFS dental service claims with service dates in calendar year 2014.

METHODOLOGY

The Utah Office of Inspector General (UOIG) examined dental policies found in the Utah Medicaid provider manuals and the Medicaid Information Bulletins starting in July 2013 through July 2015. The UOIG reviewed the Medicaid fee schedules and sorted these by dental codes only and then by covered dental codes only. The fee schedules identify basic rates, coverage limitations and inclusions with defining special notes that formulate the adjudication policies.

The UOIG developed a file of all paid, fee for service dental claims with service dates within calendar year 2014 with the final claim indicator. This file indicated payments of $20,466,932 to 766 providers for 55,328 recipients. The UOIG separated the population into five subgroups: restorative fillings (both amalgam and resin), sealants, evaluations, x-rays and prophylaxis. These subgroup files constituted the working files in the audit. The total of the five subgroup file was $11,804,528.

To determine if payments for services provided to the limited eligible recipient groups followed the defined limitations the UOIG:

- Determined limitations from the provider manuals, the MIBs, the published fee schedules and the Coverage and Reimbursement Look up Tool.
- Compared the claims to the defined limits by sorting on selected fields.

To determine if payments amounts to providers followed applicable fee schedules with adjustments the UOIG:

- Reviewed Medicaid's fee schedule and calculated the increases per policy.
- Compared calculated increased rates to claims.

To determine if the payments for services follow defined limits of frequency, application and approval the UOIG:

- Determined limits of frequency, application and approval from the fee schedules and the Coverage and Reimbursement Look up Tool.
- Compared claims to limits found in fee schedules and Coverage Reimbursement Look up Tool.

To determine if the payments for services demonstrated the policy of maintaining standards of high quality and reasonableness in all services the UOIG:

- Used publication articles from the American Dental Association (ADA) to define standards.
- Compared claims to standards of high quality found in the Dental Services Provider Manual and the Coverage and Reimbursement Look up Tool.

CONCLUSIONS

1. Medicaid's payment for services provided to the limited eligible recipient groups did not follow defined limitations on 0.8% of the restorative filling claims ($35,123/$4,430,735). Evaluations, X-rays, and Prophylaxis subgroups did not show material exceptions to defined limits. Even though this was a small percentage of the total payments there was no evidence that Medicaid's payment system could edit for duplicate claim submissions or claims without surfaces listed.
2. Medicaid's payment for services provided followed the published fee schedule rates with adjustments as defined in policy.
3. Medicaid's overall payment for services provided followed defined limits of frequency and application or approval. Any deficiencies were immaterial in total.
4. Dental services provided did not demonstrate the policy of maintaining standards of high quality and reasonableness on 4.3% of sealants and restorative fillings ($240,183/$5,559,974).

FINDING 1 — Medicaid made payments for restorative fillings that conflicted with Medicaid policy

Medicaid's General Information, provider manual states, "The use of any device or strategy that may have the effect of increasing the total amount claimed or paid for any service beyond the maximum allowable amount payable for such service is not allowed. Following are examples of unacceptable billing practices:

- Duplicate billing or billing for services not provided.
- Submitting claims for services or procedures that are components of a global procedure."

Medicaid agrees to reimburse providers for services rendered to eligible recipients defined as covered in the Coverage and Reimbursement Lookup tool, criteria and limitations apply. Medicaid should not reimburse providers for services outside of defined covered Dental codes. This includes, but is not limited to, duplicate service claims. The definition of restorative filling codes, amalgam or resin, specify the number of surfaces to show for that code. The definition is specific and not intended to delineate a different number of surfaces.

The structure of the dental service billing codes for restorative fillings shows four codes in each group. The definition of these codes show one surface, two surfaces, three surfaces and four plus surfaces. The payment rates increase, but not proportionately, from one code to the next in order of surface counts (See Table 1). A Provider could increase the reimbursement by separating each surface on one claim line and using the single surface billing code (See Table 2). Claims should indicate the proper surface combination based on the surfaces restored.

Table 1: Cost per restoration for Resin Restorations.

CDT Code	Description	Payment Rate	If billed Individually	Difference
D2330	Anterior Resin Composite 1s	$45.38	$45.38	$0.00
D2331	Anterior Resin Composite 2s	$58.36	$90.76	$32.40
D2332	Anterior Resin Composite 3s	$73.92	$136.14	$62.22
D2335	Anterior Resin Composite 4+s	$79.10	$181.52	$102.42

Table 2: Method of Billing for four surface restorations.

Recipient	CDT	Tooth	Surface	Cost
Recipient 1	D2330	A	F	$45.38
Recipient 1	D2330	A	O	$45.38
Recipient 1	D2330	A	L	$45.38
Recipient 1	D2330	A	M	$45.38
Recipient 2	D2335	A	FOLM	$79.10

Medicaid should not reimburse for duplicate claims or for restorative filling claims without surfaces listed.

The restorative fillings accounted for 21.65% ($4,430,735/$20,466,932) of the total claims in the dental services program. Approximately 0.8%, $35,123, of the restorative fillings payments did not comply with Medicaid policy in one of the following ways:

1. Total payments for duplicate claims for the same recipient, same surface, same tooth on the same service dates, whether the surfaces were identical or transposed (See Table 3: Hard Duplicates), $13,153;

Table 3: ***Hard Duplicates***

Recipient ID	Date of Service	CDT Code	Tooth Number	Surface	Reimbursement
Recipient 1	2/3/2014	D2140	14	O	$46.68
Recipient 1	2/3/2014	D2140	14	O	$46.68
Recipient 2	10/7/2014	D2160	13	DOB	$74.23
Recipient 2	10/7/2014	D2160	13	ODB	$74.23

2. Total payments for claims using codes with surface designations different from that defined for that code, for example: billing for single surface code and listing two surfaces, $16,453 (See Table 4: Code does not agree with surfaces);

Table 4: ***Code does not agree with surfaces***

Recipient ID	Date of Service	CDT Code	Tooth Number	Surface	Reimbursement
Recipient 1	9/4/2014	D2160	03	MO	$74.23
Recipient 2	2/24/2014	D2161	B	DO	$79.10
Recipient 3	2/10/2014	D2391	15	MODBL	$45.38
Recipient 4	12/31/2014	D2391	04	MODLB	$48.11

3. Total payments for claims not listing surfaces on the billing, $5,517 (See Table 5: No Surfaces Listed).

Table 5: ***No Surfaces Listed***

Recipient ID	Date of Service	CDT Code	Tooth Number	Surface	Reimbursement
Recipient 1	11/25/2014	D2160	28		$74.23
Recipient 2	7/14/2014	D2161	04		$83.86
Recipient 3	11/7/2014	D2332	25		$78.36
Recipient 4	1/29/2014	D2335	08		$65.92

Medicaid's claim processing system did not have sufficient edits in place to detect duplicate dental billings, dental claims that do not have surfaces listed, or dental claims with transposed surfaces. In 2014, Medicaid paid $35,123 in duplicate dental claims, dental claims without surfaces, and claims with transposed surfaces.

These types of dental claims have been referred to the UOIG to actively investigate possible duplicate dental billings, unbundled dental billings, restorative filling dental claims without surfaces listed, and claims with transposed surfaces.

Recommendations

1.1 Medicaid should not pay duplicate claims.

1.2 Medicaid should evaluate the submission of claims with incongruent code to surface correlation and not pay for claims using the wrong number of surfaces for the CDT code used.

1.3 Medicaid should establish edits to deny claims without surfaces listed when using restorative billing codes.

FINDING 2 — Medicaid does not have a policy that limits the times a surface can be filled within a defined timeframe

Many Medicaid agencies have defined limits for how often a provider can bill amalgam and resin fillings for the same tooth and same surface. One of Utah's Dental Managed Care Plans (MCP), Premier Access, limits fillings to once every 24 months, per tooth, per surface. Idaho Medicaid (DentaQuest) follows the same limitation. Wyoming Medicaid limits their fillings to once per tooth, per surface every 18 months. Other states, such as Colorado (DentaQuest) and Nevada Medicaid agencies limit their fillings to once per tooth, per surface every 36 months. Utah's other MCP, Delta Dental, does not have language that limits how often they will pay a filling per surface, per tooth. However, the commercial Delta Dental plan limits fillings to once per tooth, per surface every 24 months.

Utah Medicaid does not have limits on their filling surfaces. Medicaid paid on 2,265 claims with at least one common surface on the same tooth, on the same service date (See Table 6: Soft Duplicates).

Table 6: ***Soft Duplicates***

Recipient ID	Date of Service	CDT Code	Tooth Number	Surface	Reimbursement
Recipient 1	10/14/2014	D2150	04	DO	$63.23
Recipient 1	10/14/2014	D2150	04	MO	$63.23
Recipient 2	11/6/2014	D2160	03	MOD	$74.23
Recipient 2	11/6/2014	D2161	03	MODL	$83.86

Providers are billing the same surface multiple times on the same date of service. The Current Dental Terminology (CDT) manual allows providers to bill for separate fillings on the same tooth as long as the fillings are not connected. This could include multiple fillings on the same surface. Multiple states within the industry do not follow this practice. If Medicaid agencies reimburse for the same surfaces multiple times, within a short period of time, they do not promote a high standard of care.

Recommendation

2.1 Medicaid should adopt a policy that limits the payment of a single surface on a tooth to a defined timeframe.

FINDING 3 — Medicaid did not close dental code D2391 single surface composite resin filling for posterior teeth

The Medicaid Information Bulletin (MIB) 14-33, dated January 2014, closes the multiple surface composite resin filling codes D2392, D2393, D2394, effective December 31, 2013. Medicaid does not cover composite fillings on posterior teeth but the MIB states that a Medicaid recipient may choose to upgrade a covered amalgam filling to non-covered composite resin filling. The MIB goes on to state that if the provider is providing an upgraded service they should bill the covered code and charges, document that an upgraded service was provided and reference the upgrade code in the description box.

Even though Medicaid states that it did not cover composite resin fillings for posterior teeth, code D2391 (single surface composite resin fillings) was open until April 2016 while the multiple surface composite resin filling codes on posterior teeth were closed as of December 31, 2013. Medicaid denied claims for services to posterior teeth in configurations of two surface, three surface and four plus surfaces.

Medicaid's policy for use of composite resin fillings could cause confusion because Medicaid only left the single surface code open. Providers submitted claims using the open single surface code with one claim line for each surface as well as for multiple surfaces. The result is reimbursement for more money than a bundled two, three or four plus surface billing.

MIB # 16-35, effective April 2016, closes the dental code D2391 as recommended below.

Recommendation

3.1 Medicaid should close the single surface composite resin on posterior teeth code D2391 since Medicaid does not cover resin fillings on posterior teeth.

GLOSSARY OF TERMS

The first use of each term is described in the report. The glossary is included to help ensure easier reading.

Term	Description
ADA	American Dental Association
CDT	Current Dental Terminology
CHEC	Child Health Evaluation and Care
CMS	Centers for Medicare & Medicaid Services
DMHF	Division of Medicaid and Health Financing
DOH	Utah Department of Health
EPSDT	Early Periodic Screening Diagnosis and Treatment
FFS	Fee for Service
MCP	Managed Care Plan
MMIS	Medicaid Management Information System
UOIG	Utah Office of Inspector General

MANAGEMENT RESPONSE

State of Utah

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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

May 24, 2016

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 entitled *Audit of Medicaid's Dental Program* (Report 2015-09). We appreciate the effort and professionalism of you and your staff in this review. Likewise, our staff has 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. There were, however, some issues noted based upon the verbiage within the report. These issues are noted prior to our responses to the recommendations. Our response describes the actions the Department has taken and plans to take to implement the recommendations.

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 to be improved.

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 the Audit Report

Please note the following observations related to the audit report:

1. In the Conclusions section, #4 notes *Dental services provided did not demonstrate the policy of maintaining standards of high quality and reasonableness on 4.3% of sealants and restorative fillings ($240,183/$5,559,974).* There were no sealant issues noted in the report and we cannot confirm the assertion. Additionally, we understand the auditors did not obtain any medical records related to any of their findings that would support the auditors' general statement supposing the dental services provided did not demonstrate high quality and reasonableness.
2. The amount noted in Finding #1, $35,123, accounts for 0.17% of the total dental fee-for-service payments. The amounts and percentages noted in the audit were a bit confusing.
3. Finding #2 notes that "Medicaid does not have a policy…," but fails to recognize that effective April 1, 2016 we do have such a policy. This point was noted to the auditors, but appears to have been overlooked in the final version.
4. At the end of the commentary for Finding #2, the auditors again note that Medicaid policy "do[es] not promote a high standard of care," but does not support their assertion with proof of substandard care. The auditors did not obtain medical records to support this overly general statement.

Response to Recommendations

Recommendation 1.1

Medicaid should not pay duplicate claims.

Department response:

We concur with this recommendation.

To enforce industry standard rules and guidelines and provide more consistent and logical dental claim processing, effective April 1, 2016, Utah Medicaid, along with Verisk, implemented improved technology in software editing to assess and evaluate the coding of dental claims. This was announced in MIB article number 16-30.

Based on these April 2016 claims adjudication updates, we believe that this recommendation has already been implemented.

Additionally, on March 16, 2015, the agency asked the UOIG to perform post-payment review of this type of issue and recover any overpayments. To date, we have not received any updates on the referral.

Contact: John Curless, Director, Bureau of Coverage & Reimbursement Policy, 801-538-6149
Implementation Date: April 1, 2016

Recommendation 1.2

Medicaid should evaluate the submission of claims with incongruent code to surface correlation and not pay for claims using the wrong number of surfaces for the CDT code used.

Department response:

We concur with this recommendation.

To enforce industry standard rules and guidelines and provide more consistent and logical dental claim processing, effective April 1, 2016, Utah Medicaid, along with Verisk, implemented improved technology in software editing to assess and evaluate the coding of dental claims. This was announced in MIB article number 16-30.

Based on these April 2016 claims adjudication updates, we believe that this recommendation has already been implemented.

Additionally, on March 16, 2015, the agency asked the UOIG to perform post-payment review of this type of issue and recover any overpayments. To date, we have not received any updates on the referral.

Contact: John Curless, Director, Bureau of Coverage & Reimbursement Policy, 801-538-6149
Implementation Date: April 1, 2016

Recommendation 1.3

Medicaid should establish edits to deny claims without surfaces listed when using restorative billing codes.

Department response:

We concur with this recommendation.

To enforce industry standard rules and guidelines and provide more consistent and logical dental claim processing, effective April 1, 2016, Utah Medicaid, along with Verisk, implemented improved technology in software editing to assess and evaluate the coding of dental claims. This was announced in MIB article number 16-30.

Based on these April 2016 claims adjudication updates, we believe that this recommendation has already been implemented.

Additionally, on March 16, 2015, the agency asked the UOIG to perform post-payment review of this type of issue and recover any overpayments. To date, we have not received any updates on the referral.

Contact: John Curless, Director, Bureau of Coverage & Reimbursement Policy, 801-538-6149
Implementation Date: April 1, 2016

Recommendation 2.1

Medicaid should adopt a policy that limits the payment of a single surface on a tooth to a defined timeframe.

Department response:

We concur with this recommendation.

Effective April 1, 2016, Utah Medicaid, adopted a policy that limits restorations to once every 24 months, per tooth, per surface. Refer to MIB article number 16-35.

To enforce industry standard rules and guidelines and provide more consistent and logical dental claim processing, effective April 1, 2016, Utah Medicaid, along with Verisk, implemented improved technology in software editing to assess and evaluate the coding of dental claims.

Based on these April 2016 policy and claims adjudication updates, we believe that this recommendation has already been implemented.

As an aside, UOIG did not provide any publications to support its claim that the agency's policy was not in line with a high standard of care, nor did they provide a definition of high standard of care.

Please note that the agency's change in policy was reviewed and implemented prior to receiving this recommendation in conjunction with conversion to a new claims editing system through Verisk.

Contact: John Curless, Director, Bureau of Coverage & Reimbursement Policy, 801-538-6149
Implementation Date: April 1, 2016

Recommendation 3.1

Medicaid should close the single surface composite resin on posterior teeth code D2391 since Medicaid does not cover resin fillings on posterior teeth.

Department response:

We concur with this recommendation.

As noted in the audit finding, this was implemented effective April 2016 as announced in MIB article number 16-35.

Contact: John Curless, Director, Bureau of Coverage & Reimbursement Policy, 801-538-6149
Implementation Date: April 1, 2016

EVALUATION OF MANAGEMENT RESPONSE

Medicaid's response is adequate in that it designates a responsible person to implement all recommendations within an appropriate timeframe.

However, there are some items from Medicaid's management response that requires comments from the Utah OIG.

1. We issued an announcement letter to Medicaid on April 6, 2015. The scope period for the audit was calendar year 2014. We conducted a meeting with Medicaid to explain our report findings on December 10, 2015. We had a meeting with Medicaid to discuss the draft report on March 31, 2016. By the time Medicaid released the April 2016 MIB, which took action to correct the findings, they had four months since we reported the findings to them to take action. Although Medicaid has taken management action on many of the recommendations in the report the UOIG felt it was appropriate to document the findings and recommendations in the audit report.

2. Medicaid's response states, "…the auditors again note that Medicaid policy 'do[es] not promote a high standard of care,' but does not support their assertion with proof of substandard care. The auditors did not obtain medical records to support this overly general statement." To define what is termed "…a high standard of care," the UOIG referred to several documents to establish a high standard of care. Medicaid's General Information section of the dental provider manual states, "All services must maintain a high standard of quality and must be provided within the reasonable limits of those that are customarily available and provided to most persons in the community in accordance to Medicaid's policies and procedures." We used Medicaid's Dental, Oral Maxillofacial, and Orthodontia Services provider manual, Utah's Managed Care Plan contracts (Delta Dental and Premier Access), and publications from Medicaid agencies in other states to define a high quality of care. Medicaid's definitions of high quality are very vague and leave the definition up to interpretation. Medicaid paid claims on restorative fillings and sealants that had multiple problems with surface designations and timelines (most were reported in the audit report but some were referred to Medicaid in management meetings). The UOIG felt that by incorrectly paying these claims and by not having defined limits that Medicaid was not promoting a high standard of care.

3. The management response also states that the percentages listed in the report are confusing. Medicaid stated that, "…$35,123, accounts for 0.17% of the total dental fee-for-service payments." When calculating percentages we used the test population as the denominator. For example, the report says, "Medicaid's payment… did not follow defined limitations on 0.8% of the restorative filling claims ($35,123/$4,430,735)." We determined that it was appropriate to use $4,430,735 as the denominator because that was the total amount of FFS payments on fillings. We did not test everything in the dental universe so we did not make conclusions based on the whole universe of dental claims.

We followed this methodology throughout the report when reporting percentages which is why we stated percentages as a percentage of the tested subgroups.

4. Regarding recommendation 2.1. The April 2016 MIB contains the following language under section 16-35 Dental Policy Updates: Restorative – "The following codes are allowed one every two years, per tooth, per surface." The MIB then lists amalgam and resin based fillings that the policy applies to. We did not close the recommendation because we have not seen evidence that Medicaid will be able to adjudicate claims according to this policy or what Medicaid will do with claims that do not meet the criteria. For example, if a provider bills code D2150 (Amalgam, two surfaces) on January 1 listing surfaces OD then bills the same D2150 code on March 1 for the same tooth but lists surfaces MO will Medicaid combine the claim to D2160 (Amalgam, three surfaces), will it only pay the M surface as a single surface, or will it reject the claim entirely? Once Medicaid updates their policy to show how these claims will be adjudicated and shows that their system, or a third-party system, is capable of editing and adjudicating these claims according to policy we will close the recommendation.
   Recommendation 3.1 of the report was much easier to implement. According to the MIB, Medicaid closed the dental code that had been left open. Since Medicaid has shown that they are able to close codes and adjudicate according to the code being closed we noted that the recommendation has been implemented.

5. Medicaid referenced that on March 16, 2015 they asked the UOIG to perform post-payment review on multiple issues identified in this report. The UOIG is an independent state agency. We are charged with providing oversight of Medicaid. We accept referrals from Medicaid along with other agencies and from other sources. We also have a Memorandum of Understanding (MOU) with Medicaid. Under the current MOU, the UOIG conducts specified post-payment reviews, but dental reviews and other requested post-payment reviews are not listed in the MOU, so those are treated the same as other referrals. The UOIG does not report to Medicaid. Medicaid did not disagree with any of the findings or recommendations of the report. Medicaid should ensure that payments are correct on the front end and not rely on post-payment review and the recovery process to correct claims. Referring issues to the UOIG will be helpful in recovering amounts that were paid inappropriately, but Medicaid is ultimately responsible to ensure that payments are made correctly.

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

UTAH OIG CONTACT

David P. Stoddard
Auditor

Kevin Anderson
Audit Manager

UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General will enhance the integrity of the Utah State Medicaid program by preventing fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting a high quality of patient care.

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