# Audit of Medicaid's Dental Managed Care Plans

Report Number 2016-07

September 29, 2017

Utah Office of
Inspector General

**Gene Cottrell**
Inspector General

September 29, 2017

To: Utah Department of Health

Please see the attached report, Audit of Medicaid's Dental Managed Care Plans, Report Number 2016-07. An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 2 of this report.

Sincerely,

Gene Cottrell
Inspector General
Utah Office of Inspector General

cc: Joseph Miner, Nathan Checketts, Shari Watkins, Emma Chacon, Janica Gines, Tonya Hales, Aaron Eliason, Melanie Henderson

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# EXECUTIVE SUMMARY

The Utah Medicaid Program does not offer dental services as part of the traditional covered services. However, under the Pregnant Women, and Early and Periodic Screening Diagnosis and Treatment (EPSDT) program, pregnant women and EPSDT qualifying children can receive dental services. For the eligible recipients in Salt Lake, Davis, Weber and Utah counties, these recipients must choose one of the two Dental Managed Care Plans (MCP) for dental services. Contracts with these two plans, Delta Dental Services (Delta) and Premier Access Dental Services (Premier), provide the services. There is very limited fee for service (FFS) dental services for these two groups in the four listed counties. The only FFS services are those carved out of the MCP.

These two plans have contracts between Utah Department of Health (DOH) and the two individual MCP. These two contracts govern the administration of the Dental MCP. The contract provisions require several specific events to take place including the reporting of certain things to the department. No concise list exists but the Utah Office of Inspector General (UOIG) formed a list from the contracts to request documentation from the two plans. This list is not inclusive, but satisfies the objectives of the audit.

The plans provided all of the documentation requested. Medicaid Bureau of Managed Health Care (BMHC) provided almost all of the requested documentation.

Audit Objectives:

- Determine if the Medicaid Dental Managed Care Plans are paying for duplicate claims.
- Determine if the Medicaid Dental Managed Care Plan are meeting national coding standards.
- Determine if the Medicaid Dental Managed Care Plans are providing the High Standard of Care as defined in the contract.
- Determine if the Medicaid Dental Managed Care Plan are complying with the coverage clauses in the contract.
- Determine if the Medicaid Dental Managed Care Plan complies with the reporting guidelines defined in the contracts.

Audit Findings:

- Finding # 1: MCP paid for duplicate Claims under the guidelines in Provider Manual.
- Finding # 2: Medicaid did not produce accurate Income Statements for scope period.

# INTRODUCTION

## BACKGROUND

In September 2013, Medicaid entered into contracts with two Dental MCPs, Delta Dental Insurance Company and Premier Access Insurance Company. The intent was to cover eligible Medicaid recipients that fit into two groups, pregnant women and EPSDT qualifying children residing in the four Utah counties, Salt Lake, Weber, Davis and Utah. The contracts between Medicaid and the MCPs specify in paragraph 1.4 of Attachment B – Traditional, updated July 2014, that eligible recipients must reside in the Service Area defined as the four counties on the Wasatch Front; Salt Lake, Weber, Davis, and Utah. These two groups of recipients received benefits from Medicaid under the FFS Traditional Medicaid benefits prior to this change. The MCPs function like the defined Managed Care Organizations (MCO). Medicaid notifies the MCP of eligible recipients in each of the four counties in Utah. The MCP take this notice and enrolls those designated to be on their plan. The MCP contracts with providers who are enrolled Medicaid providers to provide services to the enrolled recipients of the MCPs. Medicaid sends a premium to the plans based on the number of enrolled recipients regardless of claims. The MCPs pay for claims submitted by the providers enrolled by the plan to provide the services. The MCPs publish provider manuals for the contract providers. These provider manuals give direction to the providers about policies and guidelines for limits on procedures. Medicaid provides a Companion Guide Provider Claims Form with Instructions. The providers would send claims to the MCPs under the contracts for payment. The MCPs would adjudicate these claims using the limits and policies for coverage published in the Provider Manual. The MCPs would then submit information to Medicaid in the form of encounter data used for reporting and future calculation of premium changes.

In the contracts effected between Utah Medicaid and the MCPs in section 13.2 titled Report Requirements and specifically in paragraph 13.2.2 (A) (2) defines the timing and frequency of reporting monthly income statements with other specific detail. The contract reads; "(2) Income statements for the prior month, including, but not limited to the following: enrollment totals, revenue, and paid medical and pharmacy costs. The due date for this report is the last day of the month. For example February's income statement will be due March 31."

## OBJECTIVES AND SCOPE

Audit Objectives:

- Determine if the Medicaid Dental Managed Care Plans are paying for duplicate claims.
- Determine if the Medicaid Dental Managed Care Plans are meeting national coding standards.
- Determine if the Medicaid Dental Managed Care Plans are providing the High Standard of Care as defined in the contract.
- Determine if the Medicaid Dental Managed Care Plans are complying with the coverage clauses in the contract.

- Determine if the Medicaid Dental Managed Care Plans complies with the reporting guidelines defined in the contracts.

Audit Scope:

- Scope is Calendar Year (CY) 2015

## METHODOLOGY

To determine if the Medicaid Dental MCPs are paying for duplicate claims the UOIG:

- Developed a list of documentation to request from both BMHC and the contracted MCP.
- Requested the documentation including the encounter data from Medicaid and the paid claims detail from the MCP. Scott Ellis delivered the encounter data to the UOIG.
- Sorted the Paid Claims by Current Dental Terminology (CDT) codes within recipient ID.
- Created paid claim files for six related procedure groups; Exams, Prophylaxis, Sealants, X-ray, Restorative Fillings and Root Canals.
- Created Pivot tables for each of these files identifying different limits that applied to that unique group.
- Identified questionable claims that appeared to fail based on the published limits of time and frequency.

To determine if the Medicaid Dental MCPs are meeting national coding standards the UOIG:

- Reviewed the use of CDT codes in the paid claim file sorted by CDT codes against the published covered codes from the contract.
- Identified claims that were not fulfilling the requirements.

To determine if the Medicaid Dental MCPs are providing the High Standard of Care as defined in the contract the UOIG:

- Created Pivot table showing claims by CDT code within recipient by service date.
- Reviewed dates of service for same CDT code within recipient to identify same treatments paid within short time period.
- Identified claims with short time periods between same services, for same recipient.

To determine if the Medicaid Dental MCPs are complying with the coverage clauses in the contract the UOIG:

- Identified a small sample of the recipients from the paid claims file to test in the Medicaid Management Information System (MMIS) for address.
- Identified whether the address listed fit the county designation in the recipient overview screen.
- Identified any addresses that did not fit the criteria.
- Compared the recipients in the paid claim file with the numbers reported in the encounter data.
- Noted the differences and calculated error rates.

To determine if the Medicaid Dental MCPs complies with the reporting guidelines defined in the contracts the UOIG:

- Used the list of documents requested to compare with what the contract lists as reporting requirements.
- Compare the items received with the list.

- Identify the areas that are deficient and report these back to the MCP and BMHC.
- Compared the number of enrollees reported by the MCP to the numbers shown on the Income Statement and noted differences.

| FINDING 1 | MCP paid for duplicate Claims under the guidelines in Provider Manual. |
|---|---|

Per the terms of the contract between Medicaid and the MCP, in the section 18.1.8 titled Policy, Rules, and Regulations, paragraph (A) we read: "The Contractor shall be aware of, comply with, and be bound by the State Plan, the Department's policies and procedures in Provider Manuals and Medicaid Information Bulletins, and shall ensure that the Contractor and its Participating Providers comply with the policies and procedures in effect at the time when services are rendered". The MCP publishes a provider manual for the contract providers in compliance with this directive. This manual lists each CDT code covered by the MCP with guidelines on number and frequency of covered services. The contracts specify that the CDT codes follow the Medicaid Coverage and Reimbursement Look up Tool for coverage.

When the UOIG requested the paid claims for the CY 2015 from the MCPs, the size of the files exceeded the limitations to attach to emails. The MCPs separated the files into smaller groups and sent them to the UOIG. The UOIG took the paid claim files requested from the MCPs and created one working file for each plan. The UOIG sorted this working file by CDT codes. Then isolated six areas of concern; Exams, Prophylaxis, Sealants, X-rays, Restorative Fillings, and Root Canals. We treated each area separate from the others in six specific files or worksheets.

We reviewed the limits and frequency policies for each CDT code related to the six groups. We then sorted the files by CDT code within recipient and service date. We compared the limits and frequency designations published in the provider handbooks from each MCP with the sorted claims by CDT codes. We created pivot tables for each worksheet and used that for analysis. The UOIG found that:

> In the case of exams multiple failures of the limits appeared. Delta listed limits of four per calendar year per provider for codes D0120 and D0140. Limits for code D0150 shows one per provider and can replace either the D0120 or D0140 in the four per calendar year per provider. Additional limit of one D0120, D0140 or D0150 per day. In the Delta exam file incidents of 25 paid recipient billings with 5 exams in 2015, 15 paid recipient billings with 6 exams in 2015, 3 paid recipient billings with 7 exams in 2015 and 4 paid recipient billings with 8 exams in 2015. In the Premier exam file, only code D0150 showed failures of 14 incidents with multiple paid recipient billings for code D0150 in 2015. This constitutes duplicate billings and payments for exams.
>
> In the case of prophylaxis, the CDT codes for children and adults showed different limitations. Delta listed the limits for code D1110 as 2 per calendar year with age range 16-20. Delta listed billings for D1110 of which 10 showed paid billings for recipients greater than 2 per year. Also 21 of the 427 billings using the adult code, D1110 for recipients listing ages younger than 16 showed as paid. Delta also listed the code D1120 showing a limit of 4 per calendar year. No incidents of paid claims greater than 4 per year. However, Delta listed 647 billings for recipients listing ages greater than 15 years with 112 showing some amount paid. Premier listed the same limits and had 12 incidents showing paid billings for recipients greater than 2 per year. Also of the 1,752 billings for recipients listing ages less than 16 years, 1,513

incidents of billings for recipients listing ages less than 16 years, of which all paid some amount. Premier also listed the limits using the D1120, children code, with a limit of 4 per year. 45 Incidents of billings greater than 4 per year paid. Additional Premier showed 1,668 billings using the children codes for recipients who listed an age great than 16. Of this number of claims, 1,442 showed some amount paid.

In looking at the sealant files, Delta listed the limits for code D1351 as 1st and 2nd molar and premolar (bicuspids) once every two years. The UOIG found 11 incidents of billings listing primary teeth codes with 62 incidents of billings for children under 6 years of age. Delta showed 12 incidents of paid billings for teeth other than molars and bicuspids. Premier listed the limits for code D1351 as 1st and 2nd permanent molar and premolars (bicuspids) once every two years. Premier did not show any paid billings for primary teeth codes but showed 221 billings for permanent teeth on recipients listed younger than 6 years of age. Premier showed 2 incidents of paid billings for permanent teeth other than molars and bicuspids. With our limited scope no determination made of frequency other than every two years due to not having historical data.

In looking at the x-ray files, we find the limits between the plans vary. Delta lists the limits for the entire group rather than code by code. So applying the limits to specific billings raises interpretation concerns. The limits listed show that any periapical, billed along with a complete series, will be considered part of the complete series. Panoramic and full series x-rays shall not be taken more frequent than once every two years. X-rays submitted in conjunction with a root canal will be considered part of and included in the fee for the root canal. Delta showed 6 incidents of complete series x-ray billings paid on the same service date with billings for periapical x-rays. Delta showed 5 incidents of complete series billings 2 times in a year. Delta showed 146 incidents of Panoramic x-rays billed and paid more frequent than every 2 years. Premier showed limits specific to CDT codes and so the interpretation of the limits did not cause the same concerns. Premier showed limits on the complete series code as once every two years, limited to age 6 and older, and no periapicals billed and paid along with the complete series. The periapical code limits show any periapical billed with a complete series code will be considered part of the complete series. Premier also lists that any periapical billed as part of a root canal will be considered part of the root canal fee. Premier limits all bite wing x-rays to 2 times per year regardless of number of films. Premier showed 39 paid claims out of 44 billed using complete series codes for recipients under 6 years of age. Premier also showed 158 billings paid for bitewing x-rays more frequent than 2 times per year. Premier showed 32 incidents of panoramic billings paid more frequent than every 2 years.

The UOIG found that the use of x-rays in conjunction with root canal procedures did not follow the guidelines of incorporating the x-ray billing globally into the root canal procedure. Delta showed 63 incidents of paid billings for anterior permanent teeth along with other x-ray codes, 69 incidents of paid billings for bicuspid root canals with other x-ray codes, and 172 incidents of paid billings for molar root canals with other x-ray codes. Premier showed 54 incidents of paid billings for anterior root canal codes billed with other x-ray codes, 38 incidents of paid billings for bicuspid root canal codes billed with other x-ray codes, and 203 incidents of paid billings for molar root canal codes with other x-ray codes.

The restorative fillings found in the working file as a separate tab. The limits listed in the two plan's provider manuals are different in approach and scope. Delta lists the limits for Amalgam restorative codes only as "Routine amalgam fillings on posterior teeth are covered. Composite resin restorations on anterior teeth and posterior teeth are covered." Delta shows the limit for Resin fillings on anterior teeth as "Limited to primary, permanent anterior teeth." Delta listed the single surface composite resin code as a covered charge with no guidelines. Delta did not list the 2, 3 and 4 plus surface codes for Composite Resin fillings. Delta did not list the tooth surface in the paid claims files. The UOIG found that in the Delta file there were incidents of 31 paid claims with the same tooth, with different dates and different codes within the year. The UOIG also found 15 incidents of the same tooth, same date and different codes within the year. The UOIG found 5 incidents of the same tooth, different dates but the same codes within the year. The UOIG found 7,492 paid claims using the 2 surface Composite Resin on Posterior teeth code. The UOIG found incidents of 1,153 paid claims using the 3 surface Composite Resin on Posterior teeth code. The UOIG found incidents of 138 paid claims using the 4 plus surface Composite Resin on Posterior teeth code. Premier listed the limits for the Amalgam restorative codes as, "Limited to once every two years, per tooth, per surface. If more than one filling is applied on the same tooth/same date of service, use the appropriate restorative code for 2, 3, or four or more surfaces." Premier listed the limits for the Resin on Anterior Teeth limits as, "Limited to once every two years, per tooth, per surface. If more than one filling is applied on the same tooth/same date of service, use the appropriate restorative code for 2, 3, 4 or more surfaces." Premier listed the limits for the Composite Resin on Posterior teeth codes as, "Resin-based composites on posterior teeth are NOT covered under the Medicaid program. Please refer to the "Dental Spend Ups section of this Provider Manual. If the Spend Up provisions are followed, these procedures may be submitted to Premier and an allowance will be made for the amount of the corresponding amalgam restoration." The UOIG found incidents of 25 paid claims for the same tooth, different dates, using different codes. The UOIG found 69 incidents of paid claims using the same tooth, same service date, and same code. The UOIG found 33 incidents of paid claims using same tooth, same service date but different codes. The UOIG found 16 incidents of paid claims using same tooth, different service dates, and same code. The UOIG found 11,172 paid claims using the 2 surface Composite Resin on Posterior Teeth code. The UOIG found 1,630 paid claims using the 3 surface Composite Resin of Posterior Teeth code. The UOIG found incidents of 127 paid claims using the 4 or more surface Composite Resin on Posterior Teeth code.

## Recommendations

1.1 MCPs should reevaluate the published limitations from their Provider Handbooks and integrate the necessary checks and balances so the claims submitted by providers do not pay if there is a violation of the limits of number or frequency.

1.2 For the current billing year, the MCP should use the checks and balances from recommendation 1.1 to recover payments made to providers that should not have been paid reducing the total service cost to the plan.

## FINDING 2 — Medicaid did not produce accurate Income Statements for scope period.

In the contracts effected between Utah Medicaid and the MCPs in section 13.2 titled Report Requirements and specifically in paragraph 13.2.2 (A) (2) defines the timing and frequency of reporting monthly income statements with other specific detail. Specifically the contract requires reporting Income statements for the prior month, including, but not limited to the following: enrollment totals, revenue, and paid medical and pharmacy costs.

When asked to provide the twelve Income Statement reports as described, Medicaid failed to produce one Income Statement for each of the MCP because the MCPs did not submit the missing income statement packets to Medicaid. After notification of this failure, Medicaid requested and received the missing Income Statement reports. Medicaid then reported them to the UOIG. Medicaid has implemented a system to notify the MCP if the income statement packet fails to arrive by the due date.

Part of the reported Income Statement package included a worksheet showing the enrolled recipients for the month. The documentation in the income statement package from Delta failed to agree with the enrollee numbers shown on the enrollment data from the MCP. Premier only showed the one missing packet that failed to agree because no data reported.

**Recommendation**

2.1 Medicaid should reconcile the Income Statement enrollee numbers with the enrollment data sent by the MCPs when reporting the income statement data.

# GLOSSARY OF TERMS

| Term | Description |
|---|---|
| BMHC | Bureau of Managed Health Care |
| CDT | Current Dental Terminology |
| CY | Calendar Year |
| Delta | Delta Dental Insurance Company |
| DOH | Utah Department of Health |
| EPSDT | Early and Periodic Screening and Diagnostic Treatment |
| FFS | Fee For Service |
| MCP | Managed Care Plan |
| MCO | Managed Care Organization |
| MMIS | Medicaid Management Information System |
| Premier | Premier Access Insurance Company |
| 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*

October 31, 2017

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 Managed Care Plans* (Report 2016-07). 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. Our response describes the actions the Department 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 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*

Recommendation 1.1

*MCPs should reevaluate the published limitations from their Provider Handbooks and integrate the necessary checks and balances so the claims submitted by providers do not pay if there is a violation of the limits of number or frequency.*

Department response:

We concur with this recommendation. The Department will ask the Managed Care Plans (MCPs) to review the limitation issues identified by the OIG in this audit report and report back to the Department on what systems corrections, edits, or other action they intend to take to ensure that the benefit limitations are appropriately accounted for.

*Contact: Julie Ewing, Bureau Director, Bureau of Managed Health Care, 801 538-9125*
*Implementation Date: 2/1/2018*

Recommendation 1.2

*For the current billing year, the MCP should use the checks and balances from recommendation 1.1 to recover payments made to providers that should not have been paid reducing the total service cost to the plan.*

Department response:

We concur with this recommendation. The Department will request that the MCPs use the detail provided to the MCP by the OIG to identify any claims that were incorrectly paid to the provider. The Department will ask the MCP to reverse the encounters on any claims that were inappropriately paid.

*Contact: Julie Ewing, Bureau Director, Bureau of Managed Health Care, 801 538-9125*
*Implementation Date: 2/1/18*

Recommendation 2.1

*Medicaid should reconcile the Income Statement enrollee numbers with the enrollment data sent by the MCPs when reporting the income statement data.*

Department response:

We concur with this recommendation. The Department will develop a policy and procedure in which the Department will review the MCP enrollment data and ensure that the data is correctly reflected on the MCP's financial statements.

*Contact: Julie Ewing, Bureau Director, Bureau of Managed Health Care, 801 538-9125*
*Implementation Date: 2/1/18*

# EVALUATION OF MANAGEMENT RESPONSE

The Utah Division of Medicaid and Health Financing has issued a Management Response. They concur with the recommendations for each finding and have appointed a responsible person to correct each recommendation. They have identified a date for completion. The response is adequate.

# UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

**UTAH OIG CONTACT**

David P. Stoddard, CIGA
Auditor

Neil Erickson
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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