

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK MAY HAVE
IMPROPERLY CLAIMED
MEDICAID REIMBURSEMENT FOR
CERTAIN DENTAL SERVICES**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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for Audit Services

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A-02-16-01020

Office of Inspector General

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: November 2018

Report No. A-02-16-01020

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

Prior OIG reviews identified Medicaid dental services as vulnerable to waste, fraud, and abuse. For this review, we decided to review specific Medicaid dental claims for beneficiaries who resided in health care facilities for which dental services were incorporated into their reimbursement rate.

Our objective was to determine whether New York ensured that it did not separately claim Medicaid reimbursement for dental services provided to beneficiaries that resided in health care facilities for which dental services were incorporated into their reimbursement rate.

How OIG Did This Review

For the period January 2013 through September 2016, New York claimed Federal Medicaid reimbursement for 113,763 claims, totaling more than \$12 million (\$6 million Federal share), for dental services provided to beneficiaries residing in health care facilities. We reviewed a non-statistical sample of 30 claims to determine which types of health care facilities included dental services in their Medicaid reimbursement rate (i.e., facility rate).

We then analyzed the 113,763 claims to determine which facilities included dental services in their facility rate. This resulted in 7,650 claims associated with beneficiaries residing in nursing facilities and residential treatment centers. We did not review each claim in detail.

New York May Have Improperly Claimed Medicaid Reimbursement for Certain Dental Services

What OIG Found

New York may have separately claimed Medicaid reimbursement for dental services provided to beneficiaries residing in nursing facilities and residential treatment centers for which dental services were incorporated into their reimbursement rate. We determined that New York may have improperly claimed reimbursement for 7,650 dental services totaling \$1.3 million (\$670,000 Federal share). Of these, 712 claims, totaling \$66,000 (\$34,000 Federal share), were for Medicaid fee-for-service dental services and 6,938 claims, totaling \$1.3 million (\$635,000 Federal share), were for clinic dental services.

This occurred because New York's Medicaid claims reimbursement system did not always prevent the reimbursement of certain fee-for-service dental claims for beneficiaries residing at nursing facilities and residential treatment centers. In addition, while New York's regulations require these facilities to provide, as part of the basic service agreement, dental services to all patients, its regulations do not require clinic dental providers to seek reimbursement from the facility where the beneficiary resided even though services provided to the beneficiary may be the same as those included in the facility's rate.

What OIG Recommends and New York's Comments

We recommend that New York (1) investigate each potentially improper dental fee-for-service claim and refund up to \$34,000 to the Federal Government, as appropriate; (2) revise its Medicaid claims reimbursement system edit to ensure that fee-for-service dental claims are not reimbursed for beneficiaries residing at nursing facilities and residential treatment centers; and (3) amend its regulations and program guidelines to prohibit the Medicaid reimbursement of clinic dental claims, which may have saved as much as \$635,000 during our audit period, for services provided to beneficiaries who reside in nursing facilities and residential treatment centers.

In written comments on our draft report, New York did not indicate concurrence or nonconcurrence with our recommendations; however, it described actions that it planned to take to address them. Specifically, New York stated that it will review the identified claims and determine an appropriate course of action. New York also stated that it will correct its Medicaid claims reimbursement system edit as appropriate and confirm that its edits established to disallow duplicative billing for fee-for-service claims will also be used for clinical services.

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INTRODUCTION

WHY WE DID THIS REVIEW

Prior Office of Inspector General (OIG) reviews¹ identified Medicaid dental services as vulnerable to waste, fraud, and abuse. For this review, we decided to review specific Medicaid dental claims for beneficiaries who resided in health care facilities for which dental services were incorporated into their reimbursement rate.

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) ensured that it did not separately claim Medicaid reimbursement for dental services provided to beneficiaries that resided in health care facilities for which dental services were incorporated into their reimbursement rate.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

New York's Medicaid Dental Coverage for Beneficiaries Residing in Health Care Facilities

In New York, the State agency administers the Medicaid program. Providers can bill Medicaid on a fee-for-service (i.e., for each procedure) or clinic (i.e., for each visit) basis. The State agency processes provider claims through its Medicaid Management Information System (MMIS).

¹ Appendix B contains a list of related OIG reports.

New York covers dental services for beneficiaries residing in some health care facilities.² Specifically, residential health care facilities³ and Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs) negotiate their Medicaid reimbursement rate and the services covered under that rate, which may include dental services, with the State agency. For the purposes of this report, we refer to these facilities as health care facilities.

Medicaid beneficiaries residing in health care facilities may choose to have dental services provided by dentists whose offices are not affiliated with the facility where they reside. In most instances, outside dental providers are required to directly bill the health care facility—not the State agency.^{4,5}

HOW WE CONDUCTED THIS REVIEW

For the period January 1, 2013, through September 30, 2016 (audit period), the State agency claimed Federal Medicaid reimbursement for 113,763 claims, totaling \$12,317,630 (\$6,156,984 Federal share), for dental services provided to beneficiaries residing in health care facilities. We reviewed a non-statistical sample of 30 dental claims to gain an understanding of the State agency's claims process and to determine which types of health care facilities included dental services in their Medicaid reimbursement rate (i.e., facility rate).

We then analyzed the 113,763 Medicaid dental claims to determine which claims may be in error and eliminated claims associated with health care facilities that did not include dental services in their facility rate or claims for services not covered by the rate. This resulted in 7,650 claims associated with beneficiaries residing in nursing facilities and residential treatment centers. We did not review each claim in detail.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

² Certain health care facilities are required to provide, as part of the basic service agreement, Medicaid dental services to all beneficiaries residing at their facility (Title 10, Section 415.17 of the New York Compilation of Codes, Rules, & Regulations (NYCRR)). In addition, New York's State Medicaid plan states that dental costs are included in the facilities' rates (Attachment 4.19-D, Part I, Subpart 86-2, "Residential Health Care Facilities").

³ There are eight basic types of residential health care facilities in New York: nursing facilities, residential treatment centers, hospices, long-term day cares, assisted living facilities, diagnostic and treatment facilities, hospital-based outpatient facilities, and mental health day treatment centers.

⁴ State agency memo 87-67, dated August 5, 1987.

⁵ State agency's *New York State Medicaid Dental Policies and Procedures Code Manual* dated January 1, 2013.

Appendix A contains the details of our audit scope and methodology.

FINDING

New York may have separately claimed Medicaid reimbursement for dental services provided to beneficiaries residing in nursing facilities and residential treatment centers that included dental services in their reimbursement rate.⁶ We determined that the State agency may have improperly claimed reimbursement for 7,650 dental services totaling \$1,336,282 (\$669,007 Federal share). Of these, 712 claims, totaling \$65,562 (\$33,996 Federal share), were for Medicaid fee-for-service dental services and 6,938 claims, totaling \$1,270,720 (\$635,011 Federal share), were for clinic dental services.

This occurred because the State agency's MMIS did not always prevent the reimbursement of certain fee-for-service dental claims for beneficiaries residing at nursing facilities and residential treatment centers. In addition, while the State agency's regulations require these facilities to provide, as part of the basic service agreement, dental services to all patients, its regulations do not require clinic dental providers to seek reimbursement from the facility where the beneficiary resided. Therefore, dental providers that bill on a clinic basis are not restricted from directly billing the Medicaid program, even though services provided to the beneficiary may be the same as those included in the health care facility's rate.

NEW YORK MAY HAVE IMPROPERLY CLAIMED MEDICAID REIMBURSEMENT FOR DENTAL SERVICES FOR BENEFICIARIES RESIDING AT NURSING FACILITIES AND RESIDENTIAL TREATMENT CENTERS

Fee-for-Service Claims

Health care facilities are required to provide, as part of the basic service agreement, dental services to all patients.⁷ In addition, the State agency instructed the facilities that they are responsible for providing and reimbursing all dental services and that dental providers should not submit fee-for-service dental claims directly to Medicaid.⁸ Rather, they should seek reimbursement from the facility where the beneficiary resided. (These services are covered in the facility rate.) Further, in its Medicaid dental provider manual, the State agency stated that

⁶ While we were able to determine that these facilities included dental services in their reimbursement rate, we did not review each claim in detail. Therefore, there may have been instances for which separately claiming Medicaid reimbursement for these dental services would have been appropriate.

⁷ 10 NYCRR § 415.17. The regulation does not apply to ICF-DDs.

⁸ State agency memo 87-67, dated August 5, 1987.

payment for certain services to beneficiaries residing in health care facilities will not be made on a fee-for-service basis.⁹

We found that the State agency may have improperly claimed reimbursement for 712 fee-for-service dental claims, totaling \$65,562 (\$33,996 Federal share), for dental services provided to beneficiaries residing in nursing facilities and residential treatment centers for which dental services were incorporated into the facility rate.

The potential improper payments may have occurred because a system edit in the State agency's MMIS did not always prevent the claims from being paid. In addition, the services associated with these payments may have already been covered as part of a facility rate.

Clinic Claims

Health care facilities are required to provide, as part of the basic service agreement, dental services to all patients. However, unlike its requirements for fee-for-service claims, the State agency does not require clinic dental providers to seek Medicaid reimbursement from the facility where the beneficiary resided. Rather, clinic dental providers can directly bill the Medicaid program.

We found that the State agency may have improperly claimed reimbursement for 6,938 clinic dental claims, totaling \$1,270,720 (\$635,011 Federal share), for dental services provided to beneficiaries residing in nursing facilities and residential treatment centers for which dental services were incorporated into the facility rate.

Unlike its requirements for dental providers that bill on a fee-for-service basis, the State agency has not published regulations in the NYCRR or issued program guidelines to require dental providers that bill on a clinic basis to seek reimbursement from the facility where the beneficiary resided. Therefore, dental providers that bill on a clinic basis are not restricted from directly billing the Medicaid program, even though services provided to the beneficiary may be the same as those included in the health care facility's rate.

⁹ State agency's *New York State Medicaid Dental Policies and Procedures Code Manual* dated January 1, 2013.

RECOMMENDATIONS

We recommend that the State agency:

- investigate each potentially improper dental fee-for-service claim and refund up to \$33,996 to the Federal Government, as appropriate;
- revise the MMIS system edit to ensure that fee-for-service dental claims are not reimbursed for beneficiaries residing in nursing facilities and residential treatment centers; and
- amend the NYCRR and State agency program guidelines to prohibit the separate Medicaid reimbursement of clinic dental claims, which may have saved as much as \$635,011 during our audit period, for services provided to beneficiaries who reside in nursing facilities and residential treatment centers.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations; however, it described actions that it planned to take to address them. Specifically, the State agency stated that its Office of the Medicaid Inspector General will review the identified claims and determine an appropriate course of action. The State agency also stated that it will correct its MMIS system edit as appropriate and confirm that its edits established to disallow duplicative billing for fee-for-service claims will also be used for clinical services.

We commend the State agency for taking appropriate corrective actions in response to our recommendations. We note, however, that we did not review the effectiveness of these proposed corrective actions.

The State agency's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 113,763 Medicaid dental claims, totaling \$12,317,630 (\$6,156,984 Federal share), that the State agency claimed for reimbursement for services provided during the audit period. We reviewed a non-statistical sample of 30 dental claims to gain an understanding of the State agency's claims process and to determine which types of facilities included dental services in their Medicaid reimbursement rate (i.e. facility rate). We then analyzed the 113,763 Medicaid dental claims to determine which claims may be in error and eliminated claims associated with health care facilities that did not include dental services in their facility rate or claims for services not covered by the rate. This resulted in 7,650 claims associated with beneficiaries residing in nursing facilities and residential treatment centers. We did not review each claim in detail.

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the MMIS for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims data in the MMIS to the State agency's claim for reimbursement on the CMS-64, Quarterly Medicaid Statement of Expenditures for the Medicaid Program.

We did not assess the State agency's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our audit objective.

We performed our fieldwork at the State agency's offices and the MMIS fiscal agent.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency officials to gain an understanding of New York's coverage of Medicaid dental services;
- obtained from New York's MMIS, a sampling frame of 113,763 Medicaid dental claims for services provided to beneficiaries residing in residential health care facilities and ICF-DDs totaling \$12,317,630 (\$6,156,984 Federal share) for the period January 1, 2013, to September 30, 2016;
- reviewed a non-statistical sample of 30 dental claims (22 claims for beneficiaries residing at residential healthcare facilities and 8 claims for beneficiaries at ICF-DDs) from the sample frame, totaling \$3,952 (\$1,976 Federal share), to gain an understanding of

the claims process and to determine which type of facilities included dental services in their Medicaid reimbursement rate (facility rate);

- eliminated from our sampling frame:
 - dental claims associated with beneficiaries at ICF-DDs because the State agency's Medicaid billing requirements did not apply to these facility types;
 - dental claims associated with beneficiaries at six types of residential health care facilities because these facilities did not include dental services in their facility rate (hospices, long-term day cares, assisted living facilities, diagnostic and treatment centers, hospital-based outpatient facilities, and mental health day treatment centers);
 - dental claims that were billed on the date of admission or discharge from the residential health care facility;
 - dental claims for orthodontic and other specialty procedures not included in the facility rate;
- determined that the remaining 7,650 dental claims in our sampling frame, totaling \$1,336,282 (\$669,007 Federal share) were comprised of 712 fee-for service claims, totaling \$65,562 (\$33,996 Federal share) and 6,938 clinic claims totaling \$1,270,720 (\$635,011 Federal share) for beneficiaries residing in nursing facilities and residential treatment centers, for which dental services were incorporated into the facility rate;
- discussed the results of the review with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>New York Claimed Medicaid Reimbursement for Unallowable Dental Services Billed by a Dentist Based in Queens</i>	<u>A-02-13-01034</u>	1/26/2017
<i>New York Claimed Medicaid Reimbursement for Unallowable Dental Services Billed by a Dentist Based in Westchester County</i>	<u>A-02-13-01033</u>	1/26/2017
<i>New York Claimed Medicaid Reimbursement for Unallowable Dental Services Billed by a Dentist Based in New York City</i>	<u>A-02-13-01032</u>	10/28/2016
<i>Washington State Claimed Unallowable Federal Medicaid Reimbursement for Some Dental Services</i>	<u>A-09-13-02041</u>	5/24/2016
<i>Most Children With Medicaid in Four States Are Not Receiving Required Dental Services</i>	<u>OEI-02-14-00490</u>	1/20/2016
<i>Texas Paid Millions for Unallowable Medicaid Orthodontic Services</i>	<u>A-06-11-00048</u>	6/3/2015
<i>Questionable Billing for Medicaid Pediatric Dental Services in California</i>	<u>OEI-02-14-00480</u>	5/15/2015
<i>North Carolina Claimed Federal Medicaid Reimbursement for Dental Services That Did Not Always Comply With Federal and State Requirements</i>	<u>A-04-13-04014</u>	3/26/2015

APPENDIX C: STATE AGENCY COMMENTS



Department
of Health

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Executive Deputy Commissioner

October 23, 2018

Ms. Brenda Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
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New York, New York 10278

Ref. No: A-02-16-01020

Dear Ms. Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-16-01020 entitled, "New York May Have Improperly Claimed Medicaid Reimbursement for Certain Dental Services."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner
Donna Frescatore
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**New York State Department of Health Comments on the
Department of Health and Human Services
Office of Inspector General Draft Audit Report A-02-16-01020
Entitled “New York May Have Improperly Claimed Medicaid
Reimbursement for Certain Dental Services”**

The following are the New York State Department of Health’s (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-16-01020 entitled, “New York May Have Improperly Claimed Medicaid Reimbursement for Certain Dental Services.”

Recommendation #1:

Investigate each potentially improper dental fee-for-service claim and refund up to \$33,996 to the Federal Government, as appropriate.

Response #1

The Office of the Medicaid Inspector General (OMIG) will review the identified claims, and determine an appropriate course of action.

Recommendation #2:

Revise the MMIS system edit to ensure that fee-for-service dental claims are not reimbursed for beneficiaries residing in nursing facilities and residential treatment centers.

Response #2

The eMedNY system edit will be researched and corrections made as appropriate to ensure that dental practitioner services included in the nursing home rate are not reimbursed for nursing home patients.

Recommendation #3:

Amend the NYCRR and State agency program guidelines to prohibit the separate Medicaid reimbursement of clinic dental claims, which may have saved as much as \$635,011 during our audit period, for services provided to beneficiaries who reside in nursing facilities and residential treatment centers.

Response #3

The Department will review the identified concerns relating to clinical billing overlapping with nursing home billing, and confirm that the edits established to disallow duplicative billing for fee-for-service will also be used for comparable clinical services.