Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NORTH CAROLINA CLAIMED FEDERAL MEDICAID REIMBURSEMENT FOR DENTAL SERVICES THAT DID NOT ALWAYS COMPLY WITH FEDERAL AND STATE REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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for Audit Services

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Office of Inspector General

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EXECUTIVE SUMMARY

North Carolina claimed approximately $1 million in Federal reimbursement over 3 years for unallowable dental services provided to Medicaid for Pregnant Women program beneficiaries after the day of delivery.

WHY WE DID THIS REVIEW

Federal law authorizes Medicaid to cover dental services for eligible beneficiaries. Prior Office of Inspector General work indicated a high rate of improper payments for Medicaid dental services in some States, including North Carolina, and indicated that some dental providers may have inappropriately billed Medicaid.

The objective of this review was to determine whether the North Carolina Department of Health and Human Services (State agency) claimed Federal Medicaid reimbursement for dental services paid in Federal fiscal years 2009 through 2011 that complied with Federal and State requirements.

BACKGROUND

The Federal and State Governments jointly fund and administer the Medicaid program. In North Carolina, the State agency supervises the administration of the Medicaid program. Within the State agency, the Division of Medical Assistance administers the Medicaid program. For Federal fiscal years 2009 through 2011 (audit period), the State agency claimed dental services expenditures totaling approximately $1.05 billion ($769 million Federal share).

Dental services are defined as diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist. Necessary and essential dental services, subject to the criteria and restrictions in the State's dental clinical coverage policies, are covered for all eligible beneficiaries.

In North Carolina, pregnant women whose family income does not exceed 196 percent of the Federal poverty level qualify for certain Medicaid services under the Medicaid for Pregnant Women (MPW) program. The dental clinical coverage policies state that dental services provided to Medicaid-eligible beneficiaries under the MPW program are covered through the day of delivery.

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for dental services that did not always comply with Federal and State requirements. Our review of all claim lines for dental services provided to beneficiaries covered under the MPW program during our audit period showed that the State agency improperly claimed $1,420,940 ($1,038,735 Federal share) for dental services provided after the day of delivery.

Also, of the 100 non-MPW dental services (sample items), 96 complied with Federal and State requirements, but 4 did not.

- For two sample items, the service was not adequately documented in the treatment record.

- For two sample items, the person who provided the service was not documented in the treatment record.

The State agency's procedures for postpayment reviews were inefficient because the State agency did not identify all of the deficiencies that we found in our review of MPW claims or in our sample review.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $1,038,735 to the Federal Government for unallowable dental services provided to MPW beneficiaries after the day of delivery and

- increase postpayment reviews of dental claims, including claims for MPW beneficiaries, to help ensure the proper and efficient payment of claims and ensure compliance with Federal and State laws, regulations, and program guidance.

STATE AGENCY COMMENTS AND OUR RESPONSE

In comments on our draft report, the State agency partially agreed with our first recommendation and described corrective actions that it has taken or plans to take to address our second recommendation.

We reviewed the State agency's comments and, on the basis of followup discussions with State agency officials, agree that expenditures for certain orthodontic services provided after the day of delivery were allowable. We updated our findings and recommendations accordingly.

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INTRODUCTION

WHY WE DID THIS REVIEW

Federal law authorizes Medicaid to cover dental services for eligible beneficiaries. Prior Office of Inspector General work indicated a high rate of improper payments for Medicaid dental services in some States, including North Carolina, and indicated that some dental providers may have inappropriately billed Medicaid.[1]

OBJECTIVE

Our objective was to determine whether the North Carolina Department of Health and Human Services (State agency) claimed Federal Medicaid reimbursement for dental services paid in Federal fiscal years 2009 through 2011 that complied with Federal and State requirements.

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 program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although the State has considerable flexibility in designing and operating its program, it must comply with applicable Federal requirements.

Providers of Medicaid services submit claims to the State to receive reimbursement. The State processes and pays the claims. The Federal Government pays its share of the State's Medicaid expenditures based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. The amount of Federal reimbursement is known as the Federal share. During Federal fiscal years 2009 through 2011 (audit period), the FMAP in North Carolina ranged from 64.71 percent to 75.59 percent.[2]

In North Carolina, the State agency supervises the administration of the Medicaid program. Within the State agency, the Division of Medical Assistance (DMA) administers the Medicaid program. For the audit period, the State agency claimed dental services expenditures totaling approximately $1.05 billion ($769 million Federal share).

[1] Appendix A contains a list of related Office of Inspector General reports.

[2] Section 5001 of the American Recovery and Reinvestment Act of 2009 provided temporary increases in the FMAP rates from October 1, 2008, through June 30, 2011. Additionally, certain dental expenditures qualified for reimbursement at an enhanced FMAP rate.

Dental services are defined as diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist. These services include treatment of (1) the teeth and associated structures of the oral cavity and (2) disease, injury, or impairment, which may affect a beneficiary's oral or general health.[3]

North Carolina's Dental Program

North Carolina's dental program (the program) is managed by DMA's dental program office. The program's mission is to ensure efficient delivery of quality oral health care services to Medicaid beneficiaries. The dental program office establishes policies and procedures with which dental providers must comply to receive reimbursement for services provided to Medicaid beneficiaries.

The program covers necessary and essential dental services for all eligible Medicaid beneficiaries, subject to the criteria and restrictions in the State's dental clinical coverage policies. Generally, only procedures listed in the dental clinical coverage policies are covered,[4] including routine dental examinations and screenings, emergency dental services, x rays, periodontal services, complete and partial dentures with relining, endodontic therapy, surgery, and orthodontics.[5]

In North Carolina, pregnant women whose family income does not exceed 196 percent of the Federal poverty level qualify for certain Medicaid services under the Medicaid for Pregnant Women (MPW) program. The dental clinical coverage policies state that dental services provided to Medicaid-eligible beneficiaries under the MPW program are covered through the day of delivery.

HOW WE CONDUCTED THIS REVIEW

For our audit period, the State agency claimed dental service expenditures totaling approximately $1.05 billion ($769 million Federal share). From the claimed expenditures, we identified and audited all 139,518 claim lines, totaling $9.6 million ($7 million Federal share), in dental services provided to beneficiaries with MPW coverage. We also created a sampling frame[6] that consisted of 17,506,116 claim lines totaling $908,055,171 ($664,459,534 Federal share), from which we selected a simple random sample of 100 claim lines (sample items) and reviewed supporting documentation maintained by dental providers. We excluded the remaining expenditures from our review.

[3] 42 CFR § 440.100(a).

[4] 10A NCAC § 22O.0204(a), recodified as 10A NCAC § 25H.0204(a) effective May 1, 2012.

[5] North Carolina Medicaid State Plan, Attachment 3.1-A.1, 10(a), (c), (d), and (f).

[6] We excluded from the sampling frame all claim lines for dental services provided to MPW beneficiaries.

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 contains relevant Federal and State requirements, Appendix C contains the details of our scope and methodology, and Appendix D contains the details of our sample design and methodology.

FINDINGS

The State agency claimed Federal Medicaid reimbursement for dental services that did not always comply with Federal and State requirements. Our review of all claim lines for dental services provided to beneficiaries covered under the MPW program during our audit period showed that the State agency improperly claimed $1,420,940 ($1,038,735 Federal share) for dental services provided after the day of delivery.

Also, of the 100 non-MPW dental services sample items, 96 complied with Federal and State requirements, but 4 did not.

- For two sample items, the service was not adequately documented in the treatment record.

- For two sample items, the person who provided the service was not documented in the treatment record.

The State agency's procedures for postpayment reviews were inefficient because the State did not identify all of the deficiencies that we found in our review of MPW claims or in our sample review.

DENTAL SERVICES PROVIDED TO MEDICAID FOR PREGNANT WOMEN PROGRAM BENEFICIARIES AFTER THE DAY OF DELIVERY

State agency expenditures are unallowable for Federal reimbursement if the expenditures are unauthorized or prohibited under State or local laws or regulations.[7] The program covers necessary and essential dental services for all eligible Medicaid beneficiaries, subject to the criteria and restrictions in the dental clinical coverage policy.[8] The coverage policy states that

[7] 2 CFR part 225, Appendix A, section C.1.c.

[8] 10A NCAC § 22O.0204(a), recodified as 10A NCAC § 25H.0204(a), effective May 1, 2012.

dental services provided to Medicaid-eligible beneficiaries under the MPW program are covered through the day of delivery.[9,10]

For the audit period, the State agency claimed reimbursement for 139,518 claim lines totaling $9,597,955 ($7,020,502 Federal share) for dental services provided to beneficiaries covered under the MPW program. Using data matching procedures, we identified claims for services that were provided after the day the beneficiary had delivered. Of the 139,518 claim lines, 23,943 totaling $1,626,665 ($1,190,717 Federal share) were unallowable because they were for services provided to MPW program beneficiaries after the day of delivery.

Before our review, however, the State agency had identified certain claims that were provided after the day of delivery and performed postpayment reviews of some of these claims. Specifically, the State agency had already recouped $205,725 ($151,982 Federal share) associated with 2,580 of the 23,943 unallowable items through its postpayment reviews. The State agency had already refunded the Federal share of the recouped amount to the Federal Government. Taking these refunds into account, the State agency improperly claimed $1,420,940 ($1,038,735 Federal share) for dental services provided to MPW beneficiaries after the day of delivery.

SOME DENTAL SERVICES LACKED REQUIRED SUPPORTING DOCUMENTATION

Federal law and regulations require that Medicaid providers keep any records necessary to disclose the extent of services the providers furnish to beneficiaries.[11] Medicaid expenditures are allowable for Federal financial participation (FFP) only to the extent that, when the State agency files a claim, adequate supporting documentation in readily reviewable form is available to verify that the claim met all applicable Federal requirements.[12] Supporting documentation includes, as a minimum, the following: "date of service, name of recipient, Medicaid identification number, name of provider agency and person providing the service, nature, extent, or units of service, and the place of service."[13]

State law requires that Medicaid providers maintain all Medicaid financial, medical, or other records necessary to fully disclose the nature and extent of services furnished to Medicaid

[9] Division of Medical Assistance Clinical Coverage Policies 4A, section 2.2, and 4B, section 2.2. Clinical Coverage Policy 4B, section 5.2.1, allows payment for periodic orthodontic treatment visits regardless of eligibility when orthodontic banding was approved and paid. After April 1, 2010, MPW beneficiaries were not eligible for orthodontic dental services. Coverage Policy 4A, section 2.2, was moved to Coverage Policy 4A, section 2.4, effective March 1, 2013.

[10] Delivery day is the date delivery occurred or the date the pregnancy was terminated for reasons other than delivery (i.e., abortion or miscarriage).

[11] Social Security Act § 1902(a)(27)(A); 42 CFR § 431.107(b)(1).

[12] CMS, State Medicaid Manual § 2497.1.

[13] CMS, State Medicaid Manual § 2500.2.A.

beneficiaries and claimed for reimbursement. These records must be retained for at least 5 years from the date of service, unless a longer retention period is required by applicable Federal or State law, regulations, or agreements.[14]

For 4 of the 100 sample items, the providers were unable to provide adequate evidence to show that they had complied with these requirements.

Services Not Adequately Documented

For two sample items, the dental service was not adequately documented in the patient treatment record.

One provider received payment for dental x rays but could not produce the x-ray film. The provider stated that it had experienced problems with its electronic health record system properly attaching x-ray films to the patient treatment record.

For the second sample item, the provider received payment for a fluoride treatment that was not documented in the patient's record. The provider stated that the fluoride treatment was provided as part of a comprehensive exam. However, comprehensive exams and fluoride treatments are individual services that have separate billing codes for which the provider billed and received separate payments.

Person Who Provided the Service Not Documented

For two sample items, the provider did not document the person providing the service in the patient treatment record. Neither provider required the person who performed the service to sign or otherwise indicate that they provided the service. In the absence of evidence in the record, we requested any documentation, such as production reports, appointment schedules, or dated prescriptions, that would indicate that a dentist was in the office on the date of service. In both cases, the providers could provide no such evidence.

STATE AGENCY PROCEDURES FOR POSTPAYMENT REVIEWS WERE INEFFICIENT

Federal law requires a State to have procedures for postpayment reviews that ensure the proper and efficient payment of claims.[15] The State agency's procedures for postpayment reviews were inefficient because it did not identify all of the deficiencies we found either in our review of MPW claims or in our sample review.

In regard to MPW claims, the State agency had no claim-processing edits to identify and deny claims for dental services provided after the day of delivery. According to State agency officials, providers have up to a year to submit inpatient claims for childbirth. Therefore, an edit would

[14] 10A NCAC 22F.0107.

[15] Social Security Act § 1902(a)(37)(B).

not detect dental claims for services provided after the day of delivery until a childbirth claim was processed. Because of the ineffectiveness of an edit, the State agency's DMA Program Integrity (PI) instead identified MPW claims with services provided after the day of delivery and performed postpayment reviews of some of these claims.[16] However, the DMA PI only recouped about 11 percent of the unallowable items associated with these MPW claims (2,580 of 24,294). State agency officials said they did not review all of these claims because of limited resources.

The DMA PI also conducted postpayment reviews of dental claims for payment accuracy and for evidence of fraud and abuse. However, during our audit period, DMA PI conducted only 173 postpayment reviews of providers, covering approximately $1.03 million in Medicaid reimbursements, or less than 0.1 percent of the approximately $1.05 billion in total Medicaid dental expenditures statewide.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,038,735 to the Federal Government for unallowable dental services provided to MPW beneficiaries after the day of delivery and

- increase postpayment reviews of dental claims, including claims for MPW beneficiaries, to help ensure the proper and efficient payment of claims and ensure compliance with Federal and State laws, regulations, and program guidance.

OTHER MATTERS

DMA had an Interagency Memorandum of Agreement (MOA) with the State agency's Division of Public Health (DPH) to provide public health dental field activities and technical assistance to enhance and maximize access to dental and other oral health services for Medicaid beneficiaries. These activities included providing preventive dental services, such as dental sealants and mouth rinses; oral health education; oral assessments; referrals; and followup services. The activities were targeted primarily at school-aged children. Under the MOA, DPH also provided inservice and continuing education training to State and local health department personnel who provided dental services.

The MOA limited Federal reimbursement of expenditures to $1,147,986 each State fiscal year.[17] However, for the 3 State fiscal years that ended during our audit period, DPH received $559,341 in FFP in excess of the MOA's yearly limitation on Federal reimbursement. DPH and DMA were jointly responsible for monitoring compliance with the MOA requirements. However,

[16] DMA PI periodically reviewed paid claim data for all services provided to MPW beneficiaries and compared dates of service for dental claims with certain gynecological claims to identify dental services provided after the day of delivery. DMA PI then conducted postpayment reviews of some of the dental claims it identified.

[17] North Carolina's State fiscal year is July 1 through June 30.

according to DPH officials, no one was specifically tasked with ensuring compliance with the Federal reimbursement limitation. Although the Federal Government does not have the authority to enforce the requirements of the MOA between the State agency and DPH, we are bringing this matter to the State agency's attention.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

State Agency Comments

In comments on our draft report, the State agency partially agreed with our first recommendation and described corrective actions it has taken or plans to take to address our second recommendation. Specifically, the State agency stated that it has increased postpayment reviews of dental claims, implemented procedures to identify and recoup overpayments for MPW dental claims on a quarterly basis, and conducted provider education regarding services that are reimbursable under the MPW eligibility category and the documentation required in dental records.

In comments on our first recommendation, to refund $1,072,410 for unallowable dental services provided to MPW beneficiaries, the State agency acknowledged that it had made overpayments but stated that the amount of the recommended refund was incorrect. Specifically, the State agency stated that expenditures of $37,956 for certain orthodontic services were allowable under its coverage policy.

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

Office of Inspector General Response

In response to the State agency's comments that expenditures of $37,956 for certain orthodontic services provided after the day of delivery were allowable under its coverage policy, we agree that there was an exception for periodic orthodontic treatment visits. The DMA Orthodontic Clinical Coverage Policy 4B, section 2.2, states that dental services provided to Medicaid-eligible beneficiaries under the MPW program are covered through the day of delivery. However, section 5.2.1 of the policy states that, when the State agency has approved and paid for orthodontic banding, Medicaid will continue to pay for periodic orthodontic treatment visits regardless of eligibility.

In discussions with State agency officials regarding their comments, the officials stated that the removal of orthodontic appliances and construction and placement of retainers were also allowable regardless of eligibility when orthodontic banding has been approved and paid. Although this is not specifically stated in the policy, we agree that these services were allowable.

Additionally, during our discussions, the State agency acknowledged that in its comments it incorrectly reported the expenditures for these allowable services. We computed, and the State agency agreed, that the expenditures for these allowable services totaled $46,249 ($33,675 Federal share). We updated our findings and recommendations accordingly.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Texas Did Not Ensure That the Prior-Authorization Process Was Used To Determine the Medical Necessity of Orthodontic Services	A-06-12-00039	8/2014
Questionable Billing for Medicaid Pediatric Dental Services in Louisiana	OEI-02-14-00120	8/2014
Questionable Billing for Medicaid Pediatric Dental Services in New York	OEI-02-12-00330	3/2014
New York Improperly Claimed Medicaid Reimbursement for Orthodontic Services to Beneficiaries in New York City	A-02-11-01003	10/2013
Improper Payments for Medicaid Pediatric Dental Services	OEI-04-04-00210	9/2007

APPENDIX B: FEDERAL AND STATE REQUIREMENTS FOR DENTAL SERVICES

Social Security Act § 1902(a)(27)

> (27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees
>
> (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan ….

Social Security Act § 1902(a)(37)(B)

> (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program

2 CFR part 225, Appendix A, Section C.1.c

> 1. *Factors affecting allowability of costs*. To be allowable under Federal awards, costs must meet the following general criteria:
>
> c. Be authorized or not prohibited under State or local laws or regulations.

42 CFR § 431.107(b)

> (b) *Agreements*. A State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to:
>
> (1) Keep any records necessary to disclose the extent of services the provider furnishes to recipients.

42 CFR § 440.100(a)

> (a) "Dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including treatment of—
>
> (1) The teeth and associated structures of the oral cavity; and
>
> (2) Disease, injury, or impairment that may affect the oral or general health of the beneficiary.

CMS State Medicaid Manual § 2497.1

> Statement of Policy. Federal financial participation (FFP) is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.

CMS State Medicaid Manual § 2500.2(A)

> Report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed. Your supporting documentation includes as a minimum the following: date of service, name of recipient, Medicaid identification number, name of provider agency and person providing the service, nature, extent, or units of service, and the place of service.

10A NCAC 22F.0107

> All Title XIX providers shall keep and maintain all Medicaid financial, medical, or other records necessary to fully disclose the nature and extent of services furnished to Medicaid recipients and claimed for reimbursement. These records shall be retained for a period of not less than five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations or agreements.

10A NCAC 25H.0204(a)

> Necessary and essential dental services, subject to the criteria and restrictions in the North Carolina Dental Manual are covered for all eligible Medicaid recipients. Only the procedures listed in the North Carolina Dental Manual are generally covered under the North Carolina Dental Program.

North Carolina Medicaid State Plan, Attachment 3.1-A.1, 10

> (a) Routine dental examinations and screening tests are covered for adults and EPSDT recipients, which include adults and children in nursing facilities.
>
> (c) The services requiring prior approval are: complete dentures, partial dentures, complete and partial denture relines, orthodontic services, periodontal services, elective root canal therapy, and complex or extensive oral maxillo-facial surgical procedures. Emergency services are exempt from prior approval. The Division of Medical Assistance will have the responsibility of prior authorization of dental services.

(d) Endodontic treatment is covered for anterior teeth only.

(f) Payment for full mouth x-ray series is allowed only once every five (5) years.

Division of Medical Assistance Dental Clinical Coverage Policy 4A, Section 2.2

"For pregnant Medicaid-eligible recipients with a pink Medicaid identification card, dental services as described in this policy are covered through the day of delivery."

Division of Medical Assistance Orthodontic Clinical Coverage Policy 4B, Section 2.2

"For pregnant Medicaid-eligible recipients with a pink Medicaid identification card, dental services as described in this policy are covered through the day of delivery."

Division of Medical Assistance Orthodontic Clinical Coverage Policy 4B, Section 5.2.1

"Periodic orthodontic treatment visit (as part of contract) … if the case is approved and the banding is paid, Medicaid will continue to pay for monthly maintenance visits regardless of eligibility."

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

We identified and audited 139,518 claim lines totaling $9,597,955 ($7,020,502 Federal share) for dental services provided to beneficiaries with MPW coverage that the State agency paid during the audit period and claimed for reimbursement. Our review also covered 17,506,116 Medicaid paid claim lines, totaling $908,055,171 ($664,459,534 Federal share), for dental services that the State agency paid during the audit period and for which it claimed Federal Medicaid reimbursement. We obtained Medicaid claim data from the North Carolina Medicaid Management Information System (MMIS).

We limited our review of internal controls to those related to our objective. We conducted fieldwork at the State agency's offices in Raleigh, North Carolina, provider offices throughout North Carolina, and one provider office in Tennessee from May 2013 through April 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and policies and the State plan;
- held discussions with State agency officials to gain an understanding of the program;
- held discussions with the Medicaid fiscal agent officials to gain an understanding of the claim-processing edits applicable to dental claims;
- reconciled dental services expenditures reported on the CMS-64 to the State's accounting records;
- reviewed claim lines for services provided to beneficiaries with MPW program coverage that included:
    - performing data match procedures and identifying claims for services that were provided after the day the MPW beneficiary had delivered;
    - determining whether the State agency, through postpayment reviews, had identified and recouped any of these overpayments; and
    - verifying that the Federal share of overpayments for services provided to MPW beneficiaries that the State agency previously recouped was refunded to the Federal Government;

- created a sampling frame of 17,506,116 paid claim lines of dental services that were submitted by dental providers[18] (Appendix D);

- selected a random sample of 100 claim lines for which we:

    - interviewed the associated provider to gain an understanding of how the provider documented services rendered and

    - reviewed provider documentation supporting the sample item, including patient medical records, billing and payment records, licenses, and other records as necessary; and

- discussed the results of our audit 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.

[18] We excluded certain claims and reviewed claims for MPW program beneficiaries separately (Appendix D).

APPENDIX D: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of Medicaid paid claim lines for dental services that the State agency paid during our audit period for which it claimed Federal Medicaid reimbursement.

SAMPLING FRAME

The State agency provided us with a database of Medicaid claim lines with a dental procedure code that it paid during our audit period from the North Carolina MMIS. The database contained 19,381,160 claim lines totaling $1,090,548,261. In addition to the claim lines for services provided to beneficiaries with MPW coverage, we removed the following claim lines from the database:

- zero paid claim lines;
- refund and negative adjustment claim lines, and the associated claim lines;
- claim lines for services provided under the State's Medicaid Children's Health Insurance and Refugee Medical Assistance programs;
- claim lines for services provided by physicians or in a hospital outpatient setting, and Medicare crossover dental claim lines;
- claim lines for partial dentures and certain orthodontic procedures; and
- claim lines for services over $206.

The resulting sampling frame consisted of 17,506,116 paid claim lines totaling $908,055,171 ($664,459,534 Federal share) that the State agency paid during our audit period for dental services.

SAMPLING UNIT

The sampling unit was a dental service claim line.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claim lines.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

APPENDIX E: STATE AGENCY COMMENTS

North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

December 22, 2014

Lori S. Pilcher, Regional Inspector
General for Audit Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3t41
Atlanta, GA 30303

Re: Report Number: A-04-13-04014

Dear Ms. Pilcher:

We have reviewed the draft report, entitled *North Carolina Claimed Federal Medicaid Reimbursement for Dental Services That Did Not Always Comply With Federal and State Requirements,* summarizing the Department of Health and Human Services' Office of Inspector General's (OIG) Findings and Recommendations based on its review of claimed dental service expenditures totaling approximately $1.05 billion ($769 million Federal share) for the period of Federal fiscal years 2009 through 2011.

The following represents the North Carolina Department of Health and Human Services (State agency) response and corrective action plan to the Findings and Recommendations set forth in the draft report.

FINDINGS

The State agency claimed Federal Medicaid reimbursement for dental services that did not always comply with Federal and State requirements. Our review of all claim lines for dental services provided to beneficiaries covered under the [Medicaid for Pregnant Women] MPW program during our audit period showed that the State agency improperly claimed $1,467,189 ($1,072,410 Federal share) for dental services provided after the day of delivery.

Also, of the 100 non-MPW dental services sample items, 96 complied with Federal and State requirements, but 4 did not.

- *For two sample items, the service was not adequately documented in the treatment record.*
- *For two sample items, the person who provided the service was not documented in the treatment record.*

The State agency's procedures for postpayment reviews were inefficient because the State did not identify all of the deficiencies that we found in our review of MPW claims or in our sample review.

RECOMMENDATIONS

We recommend that the State agency:

- *refund $1,072,410 to the Federal Government for unallowable dental services provided to MPW beneficiaries after the day of delivery and*

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- *increase postpayment reviews of dental claims, including claims for MPW beneficiaries, to help ensure the proper and efficient payment of claims and ensure compliance with Federal and State laws, regulations, and program guidance.*

DHHS Response: The State agency acknowledges that certain claim lines were paid for dental services provided to Medicaid for Pregnant Women (MPW) beneficiaries after the day of delivery; however, it has determined that the refund amount identified by the OIG auditors is incorrect. Based on the State agency's review of the OIG Auditors' final worksheets, it was determined that some of the expenses identified as unallowable included Orthodontic services. Expenses in the amount $37,955.90 were allowable for orthodontic services provided to MPW beneficiaries after the day of delivery in accordance with the Division of Medical Assistance (DMA) Clinical Coverage No. 4B Orthodontic Services, Section 5 dated May 1, 2007 – March 12, 2012. Accordingly, the State agency respectfully requests that the Federal share of these expenses for orthodontic services be excluded from the refund amount stated in the draft audit report.

The State agency has increased post payment reviews of dental claims. Protocols have been implemented to ensure proper and efficient payment of dental claims in adherence to Federal and State laws, regulations, and program guidance. The following processes will occur:

- DMA's Program Integrity (PI) section will perform procedures to verify the unallowable MPW dental claims identified during the OIG's audit and initiate recoupment of the overpayments from providers. For dates of service subsequent to the audit period and on-going, PI will perform procedures on a quarterly basis to identify overpayments and issue recoupment letters to providers accordingly.

- DMA previously conducted provider education regarding services that are reimbursable under the MPW eligibility category. In addition, it will continue to include articles on the MPW program in Medicaid Bulletins for provider education as well as publish future Bulletin articles in various dental periodicals.

DMA will also provide dental provider education regarding the need to maintain radiographic images as part of their dental records (including at the time of converting to an electronic health record system), separately documenting in the patient's record each service for which a separate billing code will be submitted, and documenting the person providing the service in the patient record (even in an office where the dentist is the solo practitioner).

We greatly appreciate the professionalism of your review staff and the analysis and recommendations provided in your draft report. If you need any additional information, please contact Mary R. Johnson at (919) 855-3738.

Sincerely,

s/Aldona Z. Wos, M.D./

Aldona Z. Wos, M.D.

AZW:mrj

cc: Robin Cummings, Deputy Secretary/Division Director
Matt McKillip, Senior Policy Advisor
Emery E. Milliken, General Counsel
Rod Davis, Chief Financial Officer
Laketha M. Miller, Controller
Chet Spruill, Director, Office of Internal Audit
Monica Hughes, Branch Head, Audit Resolution & Monitoring