Washington State Health Care Authority

Audits and the Medicaid Dental Provider

Audits

Summary of topics:

- Why are there audits?
- Who is performing audits of Medicaid providers?
- How are providers selected for audit?
- What is to be expected during an HCA audit?
- What are the most common audit findings?
- How can adverse audit results be minimized?
- What if my practice is selected for audit?

HCA Disclaimer

- This PowerPoint is for informational purposes only and the examples provided are for illustration only.

- Nothing herein is binding on the HCA, or exempts providers from their obligation to follow all applicable laws, rules, and guidelines

Why are there audits?

1. **<u>Stewardship is the right thing to do</u>:**
   a. HCA manages billions in State and Federal Medicaid expenditures each year
   b. These are public funds to cover healthcare costs for 1.6 million citizens
   c. It is "good government" to carefully oversee the administration of public programs, just as it would be "bad government" to pay no attention at all.

Why are there audits?

2. <u>The people of Washington require them</u>:

a. 35 years ago the Legislature declared that it is "in the public interest and for the protection of the health and welfare of the residents of the state of Washington that a proper regulatory and inspection program be instituted in connection with the providing of medical, dental, and other health services to recipients of public assistance." (**RCW 74.09.200**)

a. By this declaration, the people authorize and require the HCA "*to inspect and audit all records in connection with the providing of such services.*"

Why are there audits?

3. **Federal law mandates them**:

a. Participating state agencies are required to have an investigation and detection program for discovering, preventing, reducing, and otherwise dealing with fraud and abuse that result in unnecessary costs to the Medicaid program.

a. The State Agency must:

i. Identify and investigate cases

ii. Respect legal rights and due process of law

iii. Cooperate with federal and state legal authorities responsible for the prosecution of fraud.

Why are there audits?

4. **The Feds make clear that fraud, waste & abuse will not be tolerated:**
   a. The **Deficit Reduction Act of 2005** established the Medicaid Integrity Program, thereby authorizing Medicaid Integrity Contractors—like HMS—to audit state Medicaid providers.
   a. The **Improper Payments Elimination and Recovery Act of 2010** expanded the use of recovery audits.
   a. The **Affordable Care Act of 2010** provided another $350 million for federal program integrity efforts over the next 10 years.

Who is performing audits of Medicaid providers?

***MANY* entities:**

- At any time, a provider can be audited, investigated, or otherwise visited by a number of state and federal agencies.
- Though the provider may serve Medicaid clients, not every state or federal contact or visit is a "Medicaid Audit."
- In fact, the HCA itself has performed only TWO dental audits in the last five years.
- Currently, all dental provider audits are performed by Washington State's Medicaid Integrity Contractor, HMS, which is under contract to the federal government and working in concert with the HCA.

Who is performing audits of Medicaid providers?

Others who may show up:

- **The State Auditor's Office**, usually to examine dental providers to assess how HCA is managing the Medicaid dental program.
- **Labor & Industries** may assess quality of care for injured workers.
- The **Department of Health** can review, audit, and/or suspend licenses.
- The **Department of Revenue** may want to audit a provider's taxes.
- **Medicaid Fraud Control** may visit to investigate allegations received
- **Federal Health & Human Services/Office of the Inspector General** may request records to assess State management of the Medicaid dental program

The HCA neither authorizes nor controls these activities.

Who is performing audits of Medicaid providers?

In Washington:

- No Medicaid audit has ever been performed on a dental provider by a contingency fee audit contractor
- No dental provider has ever been audited by a Medicaid Recovery Audit Contractor (RAC)
- There are currently no plans to do either.

Note: Being selected for audit is NOT an accusation of fraud.

How are providers selected for audit?

Facts regarding the likelihood of audit:

- The HCA continues to run algorithms identifying claim-specific overpayments in all programs; algorithms are data-driven, are not provider-focused, and are not considered "audits."
- The HCA itself is not currently auditing dental providers
- In the last 5 years, fewer than ½ of 1% of all Medicaid dental providers (16) have been audited—mostly by the Medicaid Integrity Contractor.
- The HCA might be able to audit **10%** of all dental providers currently known to Medicaid—given 100 years to do so.

How are providers selected for audit?

Referral or Allegation:

- The HCA receives a statement regarding a provider
- Source: from an employee, another agency, within HCA
- There is no choice: HCA is obligated to follow-up
- Staff will examine data and may request 10-15 charts

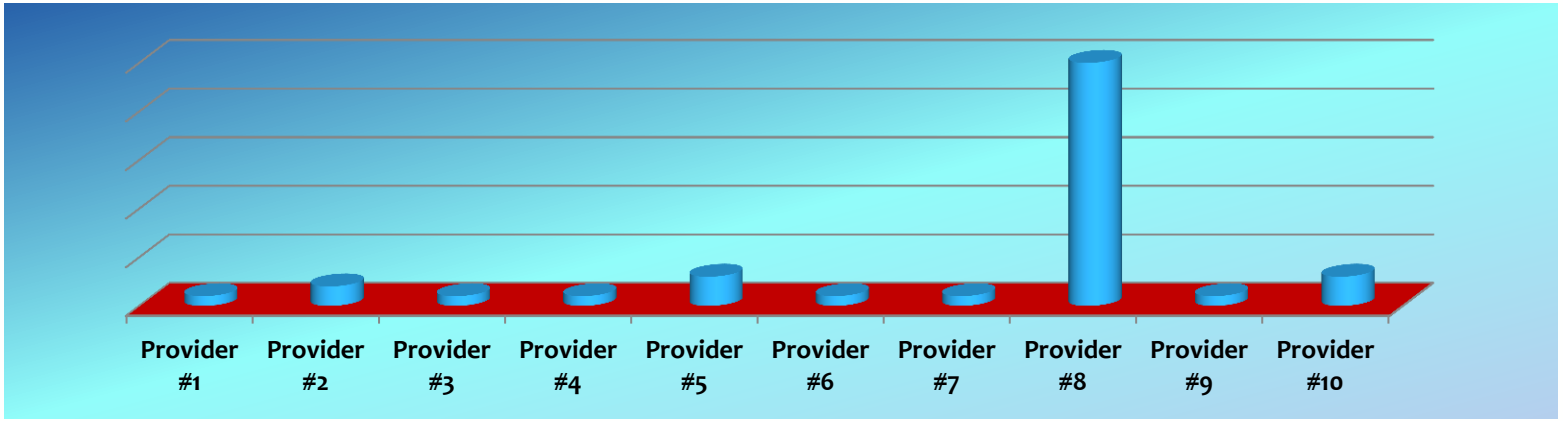
Data Mining:

- The usage of a code or code set is examined for ALL dental providers, identifying those billing atypically—the ”outliers”
- Charts are usually requested—when reviewed, they either confirm or disprove what the data appear to indicate

How are providers selected for audit?

Example #1:

- A provider ("Provider #8") decides to bill for surgical extractions every time, because "Medicaid doesn't pay enough" otherwise.
- When HCA mines data pertaining to surgical extractions across all dental providers, #8 will be the one inviting an audit.



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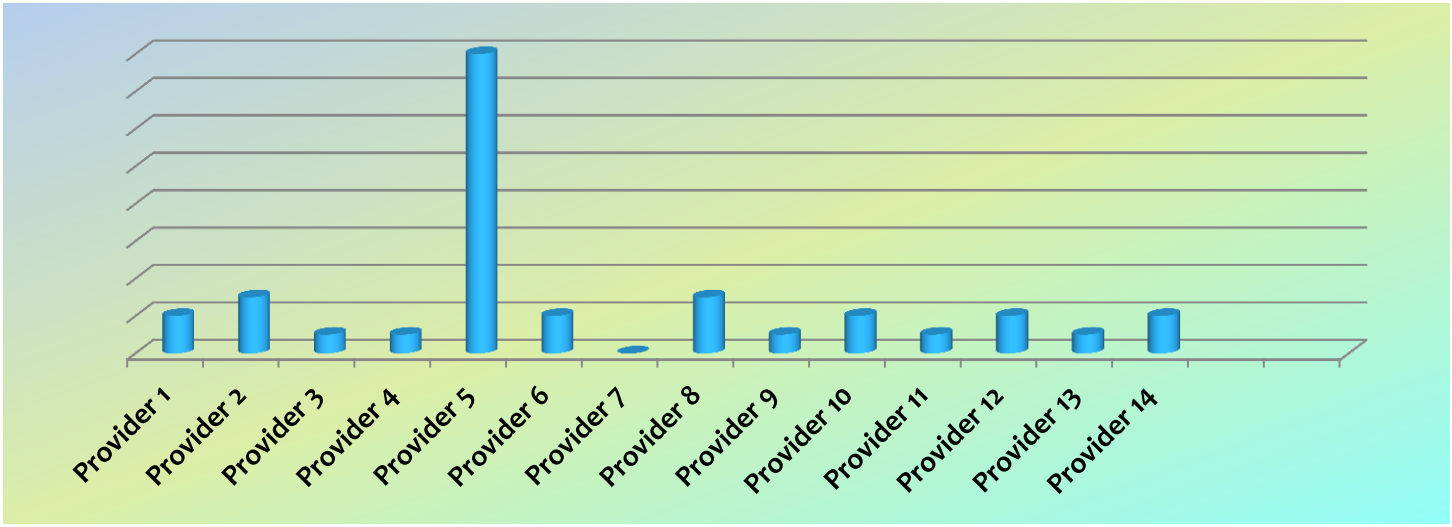
How are providers selected for audit?

Example #2:

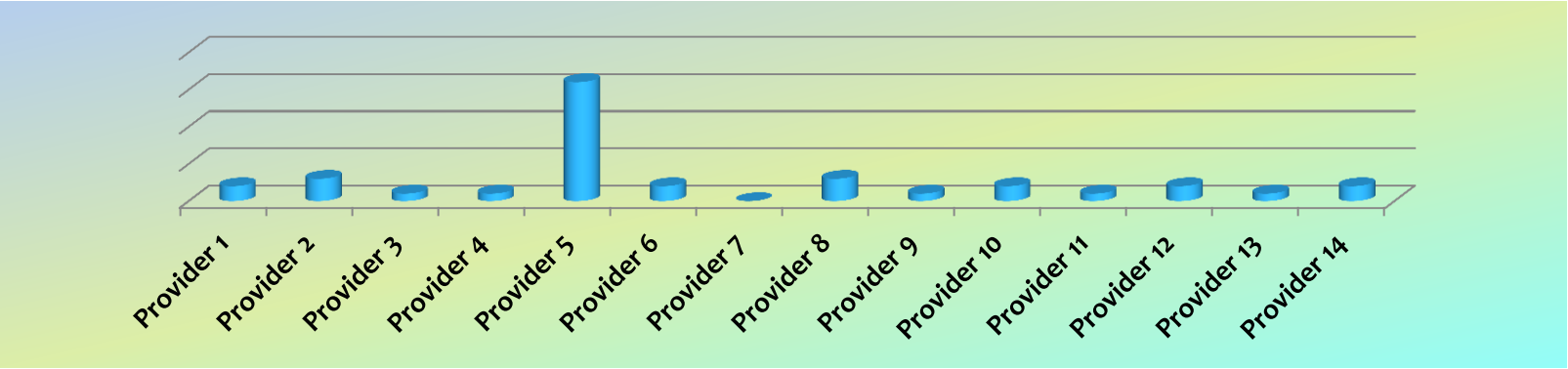
- Medicaid pays for stainless steel crowns for some teeth when decay is evident on 3 or more surfaces, or for a tooth with a pulpotomy.
- If Provider #5 is instead billing for many stainless steel crowns as a preventative measure, that provider will likely be selected for audit.



How are providers selected for audit?

Example #3:

- Also with regard to stainless steel crowns:
  - ✓ A provider (#5) performs *many* pulpotomies, not because they're medically necessary but because Medicaid will pay for a stainless steel crown on a tooth that has undergone a pulpotomy.
  - ✓ A data query easily identifies a provider who—*every time*—bills both a pulpotomy and a stainless steel crown for the same tooth.



What is to be expected during an HCA audit?

A Standard Process:

- Receipt of an "Intent to Audit" letter explaining the process
- Phone conversations to arrange logistics for an on-site visit
- An "Entrance Conference" to establish expectations
- Ongoing conversations during record/chart reviews
- An "Exit Conference" to discuss audit results to date
- Draft and Final Reports
- Possible assessment of an overpayment amount
- Dispute and Appeal rights are guaranteed by law

What are the most common audit findings?

1. **Unbundling of Procedures:** Billing a global procedure as multiple component parts, resulting in additional revenue
2. **Upcoding**:
   a. Billing a higher cost procedure than the one performed.
   b. Example: Chart indicates no complications but higher level is billed.
3. **Exceeding Program Limits**:
   a. Example: Billing more oral evaluations than allowable in a year.
   b. Example: Billing additional evaluations for siblings on the same day.
4. **Uncovered Services**:
   a. Service not covered but billed using covered service code
   b. Example: Service not performed by a licensed dental hygienist.

What are the most common audit findings?

5. **Insufficient Documentation:**
   a. No documentation of the procedure
   b. Nothing in the chart to support the specific services billed

This is the most common of all findings during dental audits.
Think like an auditor and always remember:
"If it's not documented, IT DIDN'T HAPPEN!"

What are the most common audit findings?

Three Examples of *Sufficient* Documentation:

1. Periodontal Scaling and Root Planing (D4341)
   a. **Criteria**: 182-535-1050 & 1088 WAC
   b. **Provider Guides** state that the chart must contain:
      i. X-Ray evidence of periodontal disease and subgingival calculus
      ii. Complete periodontal charting and diagnosis of periodontal disease.
   c. **Documentation Required**:
      i. Authenticated chart note that it was performed
      ii. PSRP performed within the scope of practice of the dental professional
      iii. Periodontal charting must be complete, per WAC
      iv. Definitive diagnosis of periodontal disease
      v. X-Ray evidence.

What are the most common audit findings?

2. ABCD Enhanced: Oral Health Education (D9999)
   a. **Criteria**: 182-535-1245 WAC—billing requires all of the following:
      i. Lift the Lip training
      ii. Oral hygiene training
      iii. Risk assessment for childhood caries
      iv. Dietary counseling
      v. Discussion of Fluoride supplements
   b. **Documentation Required**:
      i. All services are documented, with the duration of the education visit.
      ii. A note of "OHI" does not meet the requirement, and does not contribute to a comprehensive, understandable, and sharable dental record for the client.
      iii. ALL elements that constitute the enhanced payment must be present in the chart or the related payment is subject to recoupment.

What are the most common audit findings?

3. ABCD Enhanced: Behavior Management (D9920)
   a. **Criteria**: 182-535-1245, 1050, & 1098 WAC
      Definition: "Using assistance of one additional dental professional staff to manage behavior of a client to facilitate the delivery of dental treatment."
   b. **Provider Guides**:
      "Documentation supporting the medical necessity of the billed procedure code must be in the client's record."
   c. **Documentation Required**:
      i. What kind of behavior must be managed, or, why was it medically necessary?
      ii. What kind of behavior management technique was employed?
      iii. The name/identification of the additional dental professional who assisted

How can adverse audit results be minimized?

Suggestions:

1. Know how the CDT defines the code
2. Follow documentation guidelines in WAC and Provider Guides
3. Document only what's performed, bill only what's documented
4. As a practice, keep current with any changes to coverage
5. Always remember:

"***If it's not documented, it didn't happen***."

What if my practice is selected for audit?

Suggestions:

1. Know who is auditing you—what agency and their purpose
2. Ask questions, ask for updates, stay apprised of developments
3. Cooperate, be helpful
4. Get clear regarding the audit process after on-site activities
5. If you still have questions, consult with the HCA Office of Program Integrity:
   - **PHONE**: 360-725-1257
   - **EMAIL**: **programintegrity@hca.wa.gov**
   - **ONLINE**: **http://www.hca.wa.gov/medicaid/pi/Pages/index.aspx**

Questions?