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Hello everyone and thank you for attending today's webinar, "Advancing Program Integrity for Medicaid Dental Programs: Federal, State, and Stakeholder Efforts." Before we begin, we wanted to cover a few housekeeping items. At the bottom of your audience console are multiple application widgets that you can use. You can expand each widget, as well as your slide area, by clicking on the "Maximize icon" on the top right of the widget panel or by dragging the bottom right corner of the panel or slide area.

A copy of today's slide deck and additional materials are available in the resource list widget indicated by the green folder icon at the bottom of your screens. If you have any questions for presenters during the webcast, you can click on the Q&A widget at the bottom of the console and submit your question there. We will address as many questions as possible during this session. If a fuller answer is needed or we run out of time, your question will be answered later via e-mail. We do record all questions received during the webcast.

In order to encourage collaboration among participants, we are excited to provide attendees with the opportunity to join the discussion through an open-mic format for Q&A. If you would like to participate in the forum, please dial into the audio portion of this webcast using the call-in number and access code provided during registration. When you have dialed into the teleconference, please press "5\*" on your phone to indicate that you would like to be unmuted to ask a question or contribute to the discussion. This will raise your hand in the teleconference interface.

When we open the floor for your question you will hear an operator recording indicate when your line has been unmuted. When you hear this recording, please state your name and organization before making any comments to the group. Please note, you will be placed on mute again after you have finished. You will need to press "5\*" to raise your hand after each time you would like to be unmuted. You can lower your hand by pressing the "5\*" again.

To the right of the Q&A widget is the group chat widget, which can be used to communicate with other attendees during the webcast. Please note that the Q&A widget is for communicating with presenters, while the group chat is for communicating only with your fellow audience members. If you have any technical difficulties, please click on the "Help" widget. It has a question mark icon and covers common technical issues. However, you can also submit technical questions through the Q&A widget.

Finally, an on-demand version of the webcast will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you following registration.

Now I'd like to introduce Dr. Mouden, Chief Dental Officer at CMS. Dr. Mouden, you now have the floor.

Thank you, Brice, and welcome to everybody. Good afternoon or good morning, as the case may be. Welcome to the first CMS Learning Lab of 2015, our continuing series, helping to educate especially state program people and others about issues important to Medicaid and CHIP dental program.

First of all, I want to thank, Brice, Abi, Michaela, and many others at Mathematica Policy Research, the contractors that support these webinars, as well as the Medicaid-CHIP State Dental Association that co-runs our webinars, and as you will see in a bit, also is participating today.

I'm sure you all realize the importance of program integrity as it deals with Medicaid and CHIP programs. Often we are talking about compliance for providers, but there's so much more to program integrity. I know there's been a lot of discussion about recovery audit contractors, typically known as RACs, and we don't want people to be fearful of what goes on in program integrity, because obviously the true goal of all we're doing is to get the most providers participating in our programs so that we're able to provide the optimum dental services for the beneficiaries that we serve. So the next slide, please.

Learning objectives for today are four and pretty much match our four speakers that we'll be presenting. To gain knowledge about the process and reports of the Office of Inspector General, which you will hear many times today as the OIG, the OIG evaluations on Medicaid Dental billing; to gain knowledge about the processes and implications for audits of state Medicaid programs, to gain knowledge about how a

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state can help educate providers to avoid audits and non-compliance; and finally, to gain knowledge about how stakeholders may work with state Medicaid programs to improve program integrity.

I'm going to go ahead and introduce all four speakers, and then they will, in turn, pass the baton as we move along. Our first speaker today will be John Hagg. John graduated from the University of Dayton, Dayton, Ohio, in 1989 with a BS degree in accounting. Upon graduation, he began his career with the Department of Health and Human Services Office OIG as an auditor in the Boston regional office. Later he transferred to the OIG Columbus field office, where he served as a senior auditor responsible for health-care audits. In November of '99, he was promoted to audit manager of the OIG Centers for Medicare and Medicaid audits located here in Baltimore. And since 2004, he has served as the director of Medicaid Audits and is responsible for audits of the Medicaid and CHIP programs.

In 2001, John was honored with the secretary's award for distinguished service for outstanding accomplishments and addressing concerns involving states' use of upper payment limits that threaten the stability of the Medicaid program. In 2002, he was also awarded the inspector general's bronze medal for outstanding employee of the year. Since 2002, he has received numerous awards and recognition of substantial audit contributions, as well as letters of appreciation citing excellence in audit performance.

Our next speaker will be Meridith Seife. Meridith is the deputy regional inspector general for the Department of Human Health and Human -- try that again, for the Department of Health and Human Services OIG. She investigates fraud, waste, and abuse within HHS programs. She directs research on a variety of topics, such as the quality of care within Medicare and Medicaid programs, the integrity of provider payments, and the effectiveness of public health initiatives. Before joining the OIG, Miss Seife held positions with the U.S. Government Accountability Office and the Congressional Research Service. She has a Master's Degree in public administration from the Maxwell School of Syracuse University.

Our third speaker will be Dr. Linda Altenhoff. Dr. Altenhoff is a 1984 graduate of the University of Texas Health Science Center San Antonio Dental School, with a DDS degree. She has 16 -- more than 16 years of state service, having served as a state dental director at the Department of State Health Services prior to coming to the Office of Inspector General as the chief dental officer there in 2013. She has held leadership positions within the National Oral Health Organizations, including the Medicaid CHIP State Dental Association, and the Association of State and Territorial Dental directors. Dr. Altenhoff has presented on various Medicaid and public health topics and national and state dental and oral health meetings and has been invited faculty at the CMS Medicaid Integrity Institute, speaking on dental fraud. She's co-authored a chapter on dental hygiene textbook and currently holds adjunct and associate faculty positions at the University of Texas Health Science Center in San Antonio Dental School, and the Texas A&M Health Sciences Center at Baylor.

The final speaker today will be Mary Foley. Miss Foley is the executive director of the Medicaid-CHIP State Dental Association, MSDA. She received her license to practice dental hygiene in Massachusetts more than 35 years ago. She holds a Master's degree in public health, with a concentration in epidemiology and biostatistics from the University of Massachusetts School of Public Health and Health Policy. Previously in her career, Miss Foley served as the director of Massachusetts Department of Public Health, Office of Oral health. In that role, she had oversight of all the state-funded dental public health programs, addressing surveillance, access, prevention, and education, including management of Massachusetts Community Water Fluoridation Program, expansion of the federally qualified health center, Dental Safety Net, the Tufts Developmentally Disabled Dental Program, State Oral Health Surveillance efforts, and she was a participant in the Massachusetts Special Legislative Commission on Oral Health.

From '04 to '08, she was the Region One Head Start oral health consultant to the HRSA administration of children and families Head Start Oral Health Initiative. In '05, she was named a fellow by the HRSA Bureau of Health Professions Primary Health care Policy Fellowship. After completing that fellowship, she became the project director for improving Perinatal and Infant Oral Health, a HRSA maternal and child Health Bureau funded project. From '07 to '09, she served as the dean of the Forsyth School of Dental Hygiene at the Massachusetts College of Pharmacy and Health Sciences in Boston. Since joining the

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Medicaid-CHIP State Dental Association, Miss Foley has been instrumental in broadening stakeholder collaboration, raising awareness of oral health within HHS and CMS, annually convening a national Medicaid-CHIP Oral Health Symposium, and advancing state program policy and protocols to improve the health, health care, and costs for all Medicaid beneficiaries.

I want to thank all four of our speakers for participating today. They've put in a considerable amount of time and effort in preparation, more than just the presentations today, so with that, I will turn it over to our first speaker, John Hagg.

Thank you, Dr. Mouden. I appreciate the opportunity to be here today to be part of this webinar on Program Integrity for Medicaid Dental Programs. As Dr. Mouden said, my name is John Hagg. And I'm an audit director with the HHS Office of Inspector General. While we do have some ongoing audits involving Medicaid payments for dental services, because that work is in process and not final, I'm not at liberty today to discuss our results. Instead, then, today, I'd like to provide some background on the HHS OIG. I'd like to talk a bit about the process we go through in selecting areas to audits, and also discuss a little on how we go about conducting our work. So first some background. Next slide, please.

The primary mission of the OIG is to protect the integrity of HHS programs, as well as the health and welfare of program beneficiaries. HHS administers more than 300 programs. We have groups throughout the OIG, located throughout the country, that focus on many of these programs. The majority of our time, however, is spent focusing on Medicare and Medicaid. My focus is almost entirely on the Medicaid program, and to a lesser extent, the CHIP program as well.

The OIG is made up of five components. The first one is the Office of Investigations. This is the group that investigates fraud. The next group is the Office of Evaluation and Inspections. This group, OEI, conducts national studies of the effectiveness of HHS programs. Meridith Seife works for OEI and will be discussing some of their work in a few minutes. The third group is the Office of Counsel to the Inspector General. This is a group of attorneys that provides legal counsel for the OIG. As a side note, during our audit work, we work very closely with the attorneys to try to make sure, especially in the up-front part of our audit work, that we have a clear understanding of all of the applicable federal laws and state -- federal and state laws and regs that apply to the issue that we're auditing. The fourth group is the Office of Management and Policy. This is the group that handles the OIG budget and other human resource issues. And the last group is the Office of Audit Services. This is group I work for, and we conduct audits of the various programs that HHS administers. Next slide, please.

So I'd like to talk a little bit about who we audit. You know, obviously there are 300-plus programs administered by HHS. We have different people across the country who are involved with auditing Medicare, the Food and Drug Administration, the National Institutes of Health, et cetera. My focus is primarily on Medicaid; in my remarks today, focus on how we go about auditing the Medicaid program.

At most any given point in time, we have around 75 Medicaid audits ongoing throughout the country. There are three main groups that we audit. The first is the activities of the state Medicaid agencies themselves. This is the folks of the majority of our work, probably 80% or so. We issue, on average, around 60 reports or so each year to state Medicaid agencies.

The next group is providers. This isn't a big part of our work, but we do spend some time auditing individual Medicaid providers. If we issue 75 reports per year, maybe 10 are focused on individual providers. It's not a big part of our work. We feel like we can cover more ground on specific issues by auditing specific states, auditing claims across the states, as opposed to auditing claims at an individual specific provider. And also, there were many other groups who audit individual providers; state PI units, the Medicaid RACs, as was mentioned before, and the contractors who work for CMS's Medicaid Integrity Group. All of those groups focus on auditing providers, so we, partly because of all those groups that are out there, we spend more time auditing state agencies, as opposed to providers themselves.

The third group we audit, we also spend some time auditing CMS themselves, maybe five audit reports per year or so. We focus on areas where we believe improvement is needed, things like loopholes and

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individual rules, areas where rules -- based on audit work we know the rules aren't being followed, or areas where we believe savings could be gained if there was a change of program rules.

We usually issue the reports to CMS when we identify significant problems, and usually it's after we have done a series of reports in various states, say, anywhere from five to ten states, doing specific audit work. If we find significant problems across those states, then we'll issue reports to CMS, making recommendations on what we think can be done to help improve the area. Next slide, please.

I'd like to talk for a minute about the type of work we focus on. For this fiscal year, we have around -- in our work plan, we have around 30 Medicaid areas that we're looking into. If anybody is interested, the OIG work plan is on our website, and you can find more detail about the work plan there. Typically, when we audit states, we test for compliance with applicable rules. Some of our priority areas, when testing for compliance this year include a heavy focus on Medicaid provisions within ACA. ACA, there's new eligibility rules for Medicaid populations, there's new federal matching rates. We're going to do some work to try to make sure that those new rules are being followed.

We have a heavy focus this year on Medicaid managed care. More and more states are moving populations into managed care, and we want our audit work to follow that. We focus on Medicaid payments to various provider types; dentists, home health agencies, medical equipment companies, and schools. We have some focus on state financing mechanisms. Those are mechanisms that states use to help fund state's share of the Medicaid payments. We do some work involving areas where we believe potential cost savings could exist, or some type of program improvements, and we spent some time looking at quality-of-care-type issues. Next slide, please.

I'd like to talk a few minutes about the process we use for determining high-risk areas to audit. There's a number of bullets listed here, in no particular order. These are the types of things that we do to help determine what we believe to be high-risk areas in Medicaid. The first is analysis of provider claims data. Again, we don't audit many providers, but occasionally we'll analyze data, and if a provider stands out, for one reason or another, we may decide to conduct an audit of that individual provider. An example would be where we're looking at a claim submission from one provider and the volume of the claims leads us to think that all of the services aren't possible to be provided in a single 24-hour period. So if we see something like that, for example, we may start an audit of that provider.

We audit areas -- we look at areas of significant dollar increase. A few years back we saw a few individual states that had a dramatic increase in claims for personal care services, so we started a series of audits involving personal care across those states. Let's see. We look at areas identified during prior audit work. Sometimes during the course of an audit, some information comes to our attention that looks problematic. It leads us to think there's a problem in this specific area, but it's not really part of the scope of our current work, so we'll finish our current audit. We'll come back later and do some survey work of this other potentially problematic area, and depending on how that survey work turns out, we may start a full-scope audit of that new area.

Sometimes we're mandated to conduct audits by statutes, in those cases we always follow the law and conduct the work that's requested. We get requests from various group; congress, OMB, the Department CMS. We have a lot of discussions with those groups, and as issues come up, if we're requested to look at a specific area, if we have the resources and it makes sense within the current framework of the work that we have ongoing, we try to fulfill that request. As I mentioned previously, we look at changes in existing laws like the changes that came about in ACA. And we follow up on prior audit recommendations. You know, a lot of times if we have significant recommendations from past years, we try to do some follow-up work to see whether or not our recommendations have been implemented and program improvement has happened. Next slide, please.

And the last point I want to cover is just the process for conducting audits, what does it look like? What does the process look like when we conduct a garden-variety audit? First, it starts with selecting a high-risk area. I talked about that on the prior slide, in the various bullets that were on that slide. Once we have a high-risk area, you know, in most cases, not always, but in most cases we're auditing the state agency,

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so we're trying to pick a state or states that we want to look at the specific issue. We're trying to look for states that stand out for one reason or another.

Once we have an issue and a state selected, we send an audit notification letter to the state, letting them know of our intention to audit the state for the specific type program, say it's dental claims or home health or medical equipment, or something like that. Next, we set our objectives, our scope, and our methodology. Our objective would be something like we're trying to determine whether or not the state agency made claims to this provider type and that the payments made followed all the applicable federal and state rules.

Our scope defines the period of time we're looking at, usually a year or two or three, and within that period of time, we're trying to put a dollar figure to the amount of claims that were made during that period of time. And the methods are the steps we take to help fulfill our objectives. We have an entrance conference with the auditee. We let them know what we're planning on doing, and then we move into our data collection analysis phase. Now this is the most time-consuming part of the audit for sure. We don't always use the fiscal sampling, but in many cases we do. When we use that sampling, we set up a universe of all the claims that were paid during that period. We draw a random sample of claims from that universe. We test the sample of claims for compliance with the applicable federal and state rules. Sometimes we find errors that are significant. Sometimes we don't find many errors at all. At that point, then, once we draw our conclusions, we have an exit conference with the auditee. We let them know up front what we're finding. When they receive the draft report, there really shouldn't be any surprises in the draft. We want to talk at the exit conference about everything we were finding.

We issue the draft report to the auditee; the state in this case. The state is given a chance to provide written comments on our draft reports. If any new information comes out during the exit conference or in the auditee's written comments, we take that new information into -- we look at that new information and we adjust our final report as needed, and then we issue a final report to the state that includes our recommendations on things that we think need to be done. The auditee comments are included as an appendix in the audit reports, so in case anybody wants to see what the comments were, they can see those comments as an appendix.

Once the final report is issued, we're not the action official on this. CMS would be the action official for our recommendations. CMS, they have to decide whether they agree or don't agree with our recommendations. If they agree -- and most times they do, sometimes they don't, but if they agree, then they're responsible for taking action with the state in making sure that the recommendations are implemented. Of course if the state disagrees with the recommendations, they have appeal rights that are open to them.

That's a very quick run through, from start to finish in very broad strokes of how we go about auditing. We do have a few ongoing audits of Medicaid dental claims. Those audit reports should be issued very soon, probably within the next month or so. Sorry if I ran through that very fast. Just trying to stay within the allotted time. That concludes my presentation. My colleague, Meridith Seife, will be the next speaker.

All right, thank you. And thank you, John, and thank you so much for the opportunity to speak with you today and to participate in this webinar. Like John, I'm also with the Office of Inspector General, but I'm within the Office of Evaluations and Inspections. The core mission of my office is to conduct evaluations of HHS programs from a broad issue-based perspective. I was asked to speak with you today about our series of studies evaluating Medicaid pediatric dental services. Next slide, please. And actually, next slide after that as well.

So why are we looking at Medicaid dental services? Well, as I'm sure many of you know, in recent years, there have been a number of high-profile cases where certain dentists and dental chains were found to have engaged in some extremely abusive dental practices. Although such cases represent an extremely small number of bad actors, they can have truly devastating effects on children. Dentists have been found guilty of routinely extracting healthy teeth, performing unnecessary pulpomies, or putting stainless steel crowns on teeth that didn't need them. Obviously our primary concern is that no kid should ever have to

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endure unnecessary treatment, or that treatment that doesn't meet basic standards of care. But this can also have a significant impact on taxpayers as well.

The primary goal of our evaluations was to use Medicaid claims data in a way that could accurately identify dental providers who exhibited patterns of questionable billing. We're doing this currently in four states. In 2014 we issued reports on providers in New York, Louisiana, and Indiana. And our California report will be issued early this year. Although we were somewhat limited in doing these studies in only a few selected states, we hope that these reports will serve as a model for how other states can use their Medicaid data to identify potentially problematic providers in their Medicaid programs, and, hopefully, to target their resources more effectively in looking at those providers.

Although I'm primarily going to be talking about our questionable billing studies today, I should also note that we're simultaneously working on an evaluation that looks at children's access to dental care in these states. Next slide, please.

So I've already referenced, a few times, this idea of questionable billing, but I haven't really defined what it means. It's based on a type of analysis that the OID has done in other parts of Medicare and Medicaid, but this is the first time we've applied such an analysis to dental services. What is it? It's really just a method of determining certain billing patterns that are significantly different from one's peers.

We base these analyses on certain key measures that we developed in consultation with numerous experts. We spoke with law enforcement officials who specialized in working dental fraud cases. We also spoke with dental experts in state Medicaid agencies and CMS. We also received a tremendous amount of help from experts within the AAPD and that ADA.

Once we developed these measures, we then analyzed Medicaid's claim data in each state to identify extreme outliers or questionable billers, as we referred to them in our report. Specifically, we use these measures to identify providers who received extremely high payments per child, provided an extremely large number of services per day, provided an extremely large number of services per child per visit, and/or provided certain selected services, such as pulpotomies and extractions, to an extremely high proportion of children. Next slide, please.

Just to give you a sense of what those outliers look like, here is an example of a questionable billing analysis on average Medicaid payments per child by individual dentists. As you see, the vast majority of dentists are clustered around the median and mean amount, with an average payment of about \$200 per visit. But, of course, way out towards the left, you start seeing outliers that are very different from that amount. For example, you can see that one outlier was paid over \$1,100 per visit on average. Next slide, please.

So, before I get into what we found, I do want to make just a few brief points about our methodology. One of the biggest challenges in conducting this type of an analysis is to be sure that you're comparing similar peer groups. Obviously you don't want to compare a general dentist in private practice with an oral surgeon working in a hospital setting. So, first, we separated out general dentists from other selected specialties. And once we grouped each peer group appropriately, we then established key thresholds for each of the measures I noted on the previous slide.

These thresholds were established using a statistical method that's known as the "Tukey method." For the more statistically inclined among you, it basically calculates values that are greater than the 75th percentile plus three times its interquartile range. For those of you that are not statistically inclined, it's simply a way of identifying really, really extreme outliers. It also does this in a way that takes in the overall distribution into account. It means that you will not just be taking the top ten billers on a particular measure, it has to be significantly different from the norm. As a result, in a number of cases, we found no outliers at all for a specific measure.

I should emphasize that this analysis does not confirm that a particular provider is engaging in fraudulent or abusive practices. Some providers may be billing extremely large amounts for perfectly legitimate

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reasons. Our position is simply that these providers are significantly different enough from the norm that it warrants further scrutiny. Next slide, please.

So, using those measures, we identified a number of dental providers with questionable billing in each of the states we looked at. In total, we identified 151 providers with questionable billing, and Medicaid paid these providers over \$56 million for pediatric dental services in 2012. We also found that a significant proportion of these questionable billers were concentrated in certain dental chains. As many of you know, systemic problems within specific chains is a concern to many policymakers. In the three states we've reviewed so far, between one-third to more than half of the questionable billers worked for certain dental chains. Many of these chains had been previously investigated for providing services that were medically unnecessary or that failed to meet professionally recognized standards of care. Next slide, please.

So it's probably most instructive to give you some more details about some of the billing practices we found among these providers. In New York, for example, one dentist averaged 16 procedures per child, compared with a statewide average of five. Another dentist extracted the teeth of 76% of children he treated, compared with a statewide average of just 10%. In Louisiana we identified three dentists who provided an average of 146 or more services per day, compared to an average of 27 services for other dentists in the state. Next slide, please.

We also identified dentists who performed an unusually high number of pulpotomies. For example, one dentist provided pulpotomies to 19% of the children that he served, compared to an average of only 3% of other dentists in the state. Another dentist provided 13 pulpotomies during the same visit to a 3-year-old child. In Indiana we identified a dentist who averaged over a thousand dollars in Medicaid payments per child, compared with an average payment of only \$254 for other dentists in the state. We also identified four dentists who provided extremely large amounts of behavior management, which includes the use of papoose boards and other restraints. These four dentists billed for behavior management for more than half of the children they served. And, again, this is compared to a statewide average of only 5%. Next slide, please.

So to sum up, these findings do raise concern that certain providers may be billing for services that are not medically necessary or were never provided. It also raises concerns about the quality of care provided to Medicaid children. A concentration of questionable billers within specific chains also raises concerns. You know, again, just to reiterate, although some of this billing may be legitimate, providers who billed for extremely large amounts of services do warrant further scrutiny. Next slide.

So what do we recommend to the states? You know, first we recommended that states increase their monitoring of dental providers to identify patterns of questionable billing. We really encourage these states to proactively use claims data to both identify billing patterns that are highly unusual, as well as to target the state's resources to conduct necessary follow up. We also recommended that states take a closer look at certain dental chains, specifically those that have a high concentration of providers with questionable billing.

Also, since several of the states we reviewed were moving towards the managed care model for their dental services, we recommended that states work to ensure that they will continue to have adequate safeguards to monitor providers under their new managed care systems. Finally, we recommended that states take appropriate action with the dental providers that we identified in these reports. Next slide, please.

So that's a brief overview of our findings and recommendations. I certainly look forward to answering any questions that you might have at the completion of all the presentations. But for now, I'll turn it over to Dr. Altenhoff who will talk about her state's efforts in educating providers about compliance.

Thank you, Meridith. Appreciate the information you've provided, as well as what John has provided. With that, I want to share with you all the experience that we've had here in Texas. But I want to, first of all, thank CMS and MSDA for sponsoring today's webinar and giving us this opportunity to share this information with you. Next slide, please.

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Proving fraud, waste, and abuse in health-care services, especially those funded through state and federal tax dollars, is one of the many tasks that offices of inspector generals have been assigned. In speaking with dentists, their staff members, and legal representatives from across the U.S., I often hear the admission of "I didn't know what I was doing wasn't right," or "How's the dentist and provider supposed to know this? Where is this information available?" or even, "Is it really -- it's just an administrative error, what's the big deal?" Well it is a big deal, and providing opportunities for health-care providers and their staff members to learn and understand what their role is in preventing and possibly identifying health-care fraud, waste, and abuse is critical. The earlier this information can be provided the better. Therefore, Texas OIG has developed and is cultivating opportunities to speak with current, potential, and academic dental team members. It's especially important to be inclusive of all dental team members so that there's a shared understanding of the information conveyed and their responsibilities. We've been able to establish working relationships with organized dentistry and dental hygiene, including the state components of the American Dental Association, Academy of General Dentistry, the American Academy of Pediatric Dentistry, and the American Dental Hygienist Association. We've also worked closely with the Oral Health Coalition, with our schools of dentistry, both for undergraduate and post-doctoral candidates, and with our dental hygiene programs across the state. Next slide, please.

Some of the things that we'd like to cover during our presentations is to raise the awareness among attendees of the public perception about health care fraud, waste, and abuse that's available through various media outlets. And typically the presentations that we give are anywhere from 50 minutes, so just under an hour, to the longest so far has been a three-hour presentation. These do include excerpts from various media outlets covering health care fraud stories. And to address the questions posed regarding where this information is found, we talk about the various online resources available to health-care professionals, including the State Licensing Board, the Medicaid Rules and Provider Reference Manuals, but we also discuss nationally developed professional guidelines, including those around ethics and professional standards, as well as clinical and professional guidelines, and on the slide you see some of the references that we have, including the American Dental Association's Ethics and Code of Professional Conduct, which was updated in 2012, and their Dental Records documentation that was provided in 2010. We also have the American Academy of Pediatric Dentistry's oral health policies and clinical guidelines, which serves as a great resource not only for the practicing dentists and their staff to be aware that this resource is out there and available, but also as we are conducting any of our audits, we use those as reference materials as well. And then, of course, to reinforce the issue around ethics and the professional standards that we as health-care providers are being held to, we also bring up and recognize the American College of Dentist Ethics handbook for dentists. Next slide, please.

One other aspect, which we've used on several occasions, is the Medicaid Compliance for Dental Professionals video, which has been made available through the Centers for Medicare and Medicaid Services. This is a 56-minute video clip that goes into the importance of compliance and having a compliance program, and we used this to, again, help to educate and reinforce. But this is something that is an expectation if they are involved in providing services to the Medicaid population, but also just to, again, raise the awareness that this is an important component of their day-to-day practices.

We provide information to the attendees with regards to other resources that are available to them, including rules associated with professional licensure and Medicaid services. Since those are being constantly evolved, we encourage the dental team members to sign up for notifications from our secretary of state's office so that, again, we can address the questions as to, well, where do we find this information. We also encourage by receiving those notices about rules, pending rule changes and such, gives them an opportunity to participate in the public comments segments that are offered during those rule development processes. And to be able to stay abreast of any of these potential or pending changes that may affect their business models. Again, referencing the American Dental Association, the Academy of General Dentistry, and the American Academy of Pediatric Dentistry, and the valuable information that can be found within those websites. Next slide, please.

During the various presentations, I reinforced the importance of providing professionally appropriate health-care services to the population that the providers have chosen to serve. One of the most popular



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aspects of the presentations, other than the video clip that I referenced earlier, has been the redacted examples of non-compliance that I found during the dental record reviews that I've conducted. I've reached out to the dental faculty at the three schools of dentistry here in Texas because I feel that it's important, even for them to understand how what they have taught and are supporting within the academic environment, how that is being implemented when they go out into the real world of dental practice. So maintaining those good record-keeping skills and good clinical skills are important for those graduates, whether they are finishing up their initial post-doctoral dental school environment or if they are in a post-doctoral program as well.

We also, during the presentations, really tried to engage the attendees by offering them some examples and questioning them as to how they perceive what is being shown on screen. So if we'll go to the next slide, I'll show you some of those examples that we share. So the panoramic image that's in the upper left of the slide shows extensive dental treatment that was provided on this patient when he was 15 years of age, in which all the services that you see on that, which includes root canal therapy and crowns, was all done on a single visit, and the work was done within three months prior to this X-ray having been taken.

So in showing this, it shows that here, within a very short period of time, there's already failure of the services that were provided, but the services provided did not meet standard of care, as established within the dental profession, and that created some long-lasting trauma for this particular patient. The X-ray on the upper right, I ask and pose the question is this a bite wing or a periapical X-ray, and typically I get the response that, yes, is a periapical X-ray, which is there to show the full tooth, the roots of the tooth and the supporting structure. However, this particular X-ray, along with three others, were billed out as bite wing X-rays. The example of the documentation in the lower left of this slide is from a record that I reviewed, and it points out not only that there's inadequate documentation of the services that were provided but there's also a misuse of the dental procedure codes that were billed, which may be either due to a lack of understanding of the appropriate use or possibly an intentional miscoding of the services performed.

And then on the lower right, this is an example that was sent to our office by a dentist who had been seeing this child. The child was seen by a different practice, had been solicited to come to that practice, and then the mother, being dissatisfied, came back to the original dentist, and the photographs and X-rays demonstrate teeth in which services were billed and paid, and yet the services were not rendered, and it's an obvious indication that there was no medical necessity for the services that were billed out. The only saving grace on this was that this child was not subjected to unnecessary treatment, but as taxpayer, we were subjected to having paid for services that weren't rendered.

So, in closing, one of the things is that it's critical that program directors and managers coordinate and/or facilitate and encourage contractors and state program staff to take an active role in reaching out to health-care providers, organizations in academic institutions to identify opportunities to engage in sharing information about fraud, waste, and abuse, and the importance of efforts to change the perception that Medicaid and other health-care payer resources are a blank check or an unlimited credit card that they are entitled to overindulge with. And with that, I'm going to pass it on to Mary Foley.

Thank you, Linda. Good afternoon. The title of my presentation is "Collaborating with State Medicaid Programs to Improve Program Integrity." As most of you are aware, the Medicaid-CHIP State Dental Association is a national membership organization representing all state Medicaid and CHIP dental programs. Our work serves to improve Medicaid dental program administration through infrastructure and capacity, through collaboration with Medicaid dental program stakeholders.

Program administrators and their stakeholders have been particularly interested in this topic for many of the reasons you just heard about. Two years ago, at the MSDA annual symposium during the open forum, participants raised serious concerns about the practices of state agencies and their audit contractors. In particular were the concerns of dentist providers who were being audited for no apparent reason. During the meeting, we, MSDA agreed to convene a program integrity summit and invite a group of expert stakeholders to open the conversation to better explore the issues and potential solutions.

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Today I'm going to share with you efforts that have taken place at the national level since the symposium. Next slide, please.

In February of 2014, was the convening of Medicaid and CHIP Oral Health Integrity Summit. We invited a group of national, federal, and state stakeholder representatives to discuss the issues associated with Medicaid dental program integrity. The meeting was held in Washington, D.C. and as you can see from this slide, representatives from the state Medicaid dental programs included Kentucky, Texas, Tennessee, and Oklahoma, along with the Texas Office of the Inspector General and the Tennessee Medicaid Program Integrity Unit. Federal representatives were invited from CMS, both at the Center for Medicaid and CHIP Services, as well as the Center for Program Integrity.

We had HRSA representatives, a representative from the Office of the Inspector General, the U.S. District Attorney's Office, and the SDI. Representatives from the payer community included DentaQuest, Delta Dental of South Dakota, Delta Dental Plan Association, and the National Association of Dental plans. And then, of course, representatives from national, professional leadership organizations, representatives from the Medicaid-CHIP State Dental Association, the American Dental Association, the American Academy of Pediatric Dentistry, and then, of course, there were policymakers in attendance as well. And just so you know, we worked closely with several state Medicaid PI experts, including David Weeks from Tennessee, and Dr. James Gilchrist who were both instrumental in guiding us in the preparation for this meeting. Next slide, please.

The charge for the summit was to open a dialogue among policymakers and stakeholders who share an interest in maintaining the program integrity of Medicaid, CHIP, and Title V programs to ensure the administration and delivery of quality, cost-effective oral health-care services to their beneficiaries. Next slide, please.

The purpose of the summit was to specifically identify and explore emerging program integrity issues affecting all stakeholders of Medicaid and CHIP oral health programs. To gain consensus on general strategies to address these issues and to develop a strategy for policy recommendations to advance program integrity for all key stakeholders. Next slide, please.

Medicaid beneficiaries are the center of the Medicaid program universe. This slide was presented by Dr. James Gilchrist at our PI Summit, and I share it with all of you today to reemphasize that Medicaid beneficiaries are the primary focal point that all Medicaid programs are responsible for. That said, it should be noted that program administrators are held accountable for taxpayer dollars as they are used to fund their programs. Next slide, please.

In the next couple of slides, I'm going to briefly explain the approach we took during the summit. I'm going to highlight the new knowledge that was gained and discuss the recommendations that came forth. Recalling who was at the table, everyone agrees that managing Medicaid program integrity is a complex task in this day and age. There are a variety of federal and state agencies that have authority in this platform. That is why MSDA invited, in addition to the Medicaid dental program administrators, the various federal agencies who share that authority, again, the OIG, the FBI, and two of the centers within CMS. But the roles and responsibilities associated with managing the program integrity at the program level have changed. What traditionally was exclusively managed by the state, may now, in part, be managed by external contractors.

You heard Dr. Mouden state earlier of RAC auditors. RAC stands for Recovery Audit Contractors. These contractors have the responsibility of identifying potential abusers. What is particularly interesting, and confusing to many, is the fact that different RACs may use different protocols for how they undertake their work. So there's no quick or dirty manual that we can use or read to understand how these practices and protocols are implemented. It's very complex. We are most definitely in the age of accountability, and with advances in technology comes the ability to monitor provider behavior and billing practices, unlike in the past, as we heard earlier today. This technology is what allows for improved detection of provider treatment norms and, thus, the extreme outliers, and those are the concerns of many. However, what was most striking at the summit to the Medicaid providers was the confusion due to multiple authorities and

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the use external contractors and what independent and integrated roles they play. So there is that complexity and that's just the way the system is made up at this point. Next slide, please.

There are recommendations at this point that I would like to go forth with you, and the first is a recommendation for the federal agencies. The group made recommendations that federal agencies need to and should collaborate, communicate, coordinate, and cooperate with other partnering federal and state programs more readily. To establish transparent policies to the degree possible and protocols to the degree possible to support all efforts, to collaborate with MSDA, the American Dental Association, and the American Academy of Pediatric Dentistry, along with other provider organizations, and to provide education and technical assistance to help those involved understand federal law and regulations. Next slide, please.

The recommendations to the state programs were, again, to collaborate, communicate, coordinate, and cooperate with other federal programs, as well as other in-state programs, to establish transparency in policies and protocols, to collaborate with MSDA, ADA, and ADT, and state provider organizations to gain input and share information for new regulation policies and practices, and to assist in the education of providers and, of course, beneficiaries as well. Next slide, please.

There were recommendation also to payers and other contractors, and it was recommended that payers who are working and doing the roles of traditional Medicaid programs would have done but they follow the same recommendations that were made for the state, and also, to maintain a positive attitude throughout the practice and remember that here in the United States we are innocent until proven guilty. Next slide, please.

Recommendations for provider organizations included the provision of education to members in all aspects of personal integrity and medical necessity. It was recommended that these organizations share audit practices by all federal and state agencies that affect dental provider service delivery, to share audit practices by federal and state contractors and to develop risk management programs for member dentists; to develop a model guideline for dental medical use necessity for use by states establishing and updating benefit payment policies; to participate in state regulatory meetings to provide input and guidance in Medicaid policy development; and finally, to send representatives to participate on state Medicaid program integrity advisory committees. Next slide, please.

The group had recommendations for dental providers as well, and those recommendations included the recommendations that dental providers read the provider manuals, that these manuals serve as contracts, and when a dentist signs up to becomes part of a network, a Medicaid network, they are signing a contract. And that when you read those contracts, dental providers should identify differences in policies, benefits, and payments across plans and contract agreements, even within the same state. This should gain understanding of rules and regulations regarding prior approval and acquaint billing staff with program integrity and medical necessity policies by state and by plans, as some dental provider may work in more than one state. Next slide, please.

There were further recommendations as well for dental providers, and those included to bill only those services eligible for payment by the plan, to document reasons for all treatment and billing practices, to provide evidence or be prepared to provide evidence for medically necessary services, and to participate in state regulatory meetings, to provide input and guidance in Medicaid policy development. Next slide, please.

There were finally recommendations for the Medicaid-CHIP State Dental Association, and that was to monitor federal and state program integrity legislation and regulation; to monitor state medically necessary policies and protocols across the U.S.; to identify variability in state policies' to identify variability and policies across plans' to identify the roles and responsibilities of various state and federal authorities; and to publish annual national reports to the best degree possible. Next slide, please.

In closing, the group identified next steps, and those steps are to release this report that comes from the summit, and I will share with you that that report is expected to be available by the 2015 symposium

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which is going to take place this June in Washington, D.C. And basically for stakeholders need to continue this conversation, to continue monitoring and continue education of all involved. Thank you very much, and I'd like to now turn this platform back over to Dr. Mouden. Thank you again.

Well, I want to give a special thanks to all of our speakers. I can't imagine how much effort it's taken to put this webinar together, especially considering the fact that we were working on it over the Holidays. All four of you did a wonderful job, and I certainly appreciate your time and effort.

Before I forget, I want to remind people that both Dr. Altenhoff and Mary Foley have agreed to be available for further consultation to up to three states. If you would like to schedule some time with them to talk further about their efforts and activities, please just send me an e-mail. Contact me, and we will be happy to set that up.

So we're going to move into the Q&A session, what we call our office hours that we can have as much as 30 minutes time if needed. And so for a little explanation, I'd like to turn it back to Brice.

Thank you, Dr. Mouden. So this concludes the presentation portion of the webcast for today. We will be opening the floor up for questions at this point, but before we do so, for those of you that need to leave, CMS does request that you submit your feedback on this webinar using the survey widget located in the widget menu at the bottom of your event console. If you are unable to provide your feedback at this time, you can view the on-demand recording of the event and access the survey widget there. Again, the on-demand recording will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you following registration.

Additionally, this webinar will be posted on the CMS website in approximately three weeks. Any future topics or discussion points can also be shared with the team by e-mail at [macqualityta@cms.hhs.gov](mailto:macqualityta@cms.hhs.gov). Thank you. Next slide.

So to pose a question to the presenters, please click on the Q&A widget at the bottom of your screen or use the open Q&A box to submit your question there. And please note that your questions can only be seen by our presentation team and are not viewable by other attendees. Today we are going to have an open mic forum to foster better participation and a more spontaneous approach to the discussion. Before we go to open mic, we'd like to outline the code of conduct.

If you would like to ask a question or contribute to the discussion, please make sure you're connected to the teleconference line listed on this slide. Once connected, please press "5\*" on your phone to indicate that you would like to have your line unmuted. We request that everyone be respectful and post questions to the topic at hand. And be mindful of the fact that, given the limited time, others would probably have questions as well.

If you have asked a question and wish to follow up with additional questions on a different topic, you could choose to do so after others have had an opportunity to ask questions. Callers are requested to engage in conversation by offering information and experiences and restrict opinions to where it is encouraging a fruitful discussion. Please note that with such a large audience you might hear something you disagree with, and we caution that your responses be respectful and amicable. The moderators reserve the right to conclude a conversation or mute a caller who is found to be disruptive. We hope this format would present a more collaborative environment and respect your cooperation in making it successful. Dr. Mountain, back to you.

Okay, thank you, Brice. Some very specific instructions. I will answer one of the questions that's come on the Q&A before we start. If you are listening to this by the computer and not by telephone, you'll need to type in your question. You will not be able to ask it on the phone. We do have some questions that have already come in, so we're going to try and work through some of that. One of the first questions was about whether there is a web link or contact for the CMS-provided compliance webinar presentation. If you will drop me an e-mail in the contact list -- matter of fact, can we go ahead and go to that contact list

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slide. You can contact me and I will provide you with the link to the CMS webinar that Dr. Altenhoff mentioned.

Somebody has asked why we can't provide dentists with specific language about medical necessity. First thing to understand is medical necessity is defined by the states, not by CMS. And for information about specific medical necessity requirements, I would suggest you talk to your state program. Somebody else has asked if there is a list of, I guess what they would call approved abbreviations for use in documentation. I do not know of any such list of approved abbreviations. What I would suggest to providers is, if you're going to use abbreviations in your patient charting, and of course we all do, I would suggest to you that you keep a list within your own office of any abbreviations you might use. While something like an MOA for a medial occlusal amalgam, might be pretty universally understood. Just because you know what the abbreviation is, does not mean that somebody who might be looking at your charts later on would understand, so that's a good time to have a glossary.

Excuse me, I'm reading through a question here. Somebody's asking about whether program integrity and audit activities are all retrospective, what we commonly call "pay and chase," and asking what if any use of prepayment claim review do the presenters use or recommend? I'm going to first ask Dr. Altenhoff if she has a response to that.

Thank you, Dr. Mouden. At this point in time, within the state of Texas, there are the dental managed care organizations that are supporting our dental services, do have the opportunity and are implementing on a case-by-case basis some prepayment review, so it is up to -- it would be up to the individual state programs and/or in collaboration with their dental managed care organization if they are in a managed care environment or with their claims administrator to make that determination and to do some prepayment review. It may be more on a per code basis or a provider basis versus uniformly across the board.

Okay, thank you. Somebody has asked if we can spend a little time describing RAC audits and what providers should do. It's a long complicated answer, so I'll try and just touch some high points. First of all, the process of RAC audits is required in federal statute. What providers need to know is, first of all, whether you're working with Medicaid, CHIP, or any private insurance program, people are looking at your claims. Now what that means is these days is that a computer system may be doing -- using various algorithms looking at claims data. So people are interested in what's being claimed and the money that's being expended, no matter what program you're involved in.

A RAC auditor can, based on such an algorithm, actually be in a dental office, do a random sample of charting, and based on that analysis, can recommend that there be a long list of things, including further education for providers, recoupment of funds, or other more onerous activities that might follow. So, again, RAC auditing is something that is rather complicated. It's something that providers should not be afraid of, because all you need do is provide proper documentation, do the best services for the patient, and a RAC audit would not be a complication to your practice.

Oh, okay, I didn't catch it before, but apparently Meridith's name is spelled incorrectly. So I know it's M-e-r-i-d-i-t-h. It is correct in the contact information.

Somebody's asking if there's a requirement that each state office of inspector general, that's at the state level, have a chief dental officer. I do not know of any such requirement. Obviously having somebody with dental expertise in that office would be an advantage, but I don't know of any requirement that that person be a dentist. Brice, do we have questions that have come in by the phone? Not yet, Dr. Mouden, but just to remind everyone, during the teleconference you can raise your hand to be unmuted by pressing "5\*" on your telephone key pad.

Someone has asked if there are other national forums that state Medicaid programs can participate in that actively consider matters of program integrity specific to dental services? I would suggest that the MSDA National Symposium, it's an annual event, has had this as a topic more than once, and obviously suggested topics for the symposium for future years, obviously not 2015, which is already in the planning,

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would be appropriate for MSDA, and, of course, all the folks that work in state Medicaid and CHIP dental programs are part of MSDA.

Somebody's asking what's the relationship between the federal OIG and the state OIG? I'll ask John Hagg if he can answer that.

Yeah, sure. I mean one is federal and one's state. You know, we, as far as the relationship goes, I mean we, on a limited basis I guess, we at the federal level try to work with the other state OIGs, where our work overlaps, so we try to do that. But, you know, if it's about the differences between the groups, you know, the federal OIGs are federally run, and the state OIGs are part of the state government.

Okay, thank you. Someone has asked in all caps, so I hope you're not yelling at me. It says, "What steps are being taken to address these issues with the dental providers?" Several steps. First of all, the American Academy of Pediatric Dentistry has sponsored a series of webinars on compliance. I believe we did three of them last year, and we are in the planning stages for probably three more this year. The AAPD has sponsored these. We've been able to provide the input from CMS, and now we are working on the next series of webinars that would also include a pediatric dentist currently in practice.

One of the outcomes from the MSDA program integrity summit was an idea that CMS and the ADA would work together to provide some kind of information specific to dentists working in Medicaid and CHIP. One of the complications to that is that because Medicaid and CHIP are federal state partnerships, many of the decisions made in those programs are state decisions, and it would be impossible to provide; one, manual that would apply in every state. Those of you in practice settings are familiar with OSHA requirements. OSHA is a federal program relating to employees and staff. There are federal regulations that apply in every state, but we cannot say the same thing about the full breadth and width of Medicaid programs, because so many of the statutory and regulatory considerations are state and not federal.

The question is, "Can you discuss any efforts underway to examine children's access to dental care through Medicaid and CHIP?" Meredith, I think you alluded to your next report. Would you address that, please?

Absolutely. So we have a study that we expect to be out probably mid 2015 that looks specifically at access to care within all of our states. You know, obviously we think the program integrity angle is incredibly important, but we also want to balance that message by recognizing how important it is to ensure that there's adequate access. So with those studies we're sort of able to provide some additional information that may not be captured on the regular reporting that states do to CMS in terms of how many kids are being served and what types of services the children are receiving. Again, I can't speak about the specifics of that, but you should be able to find that on our website sometime this year, later this year.

Okay, thank you, Meredith. Somebody has asked a question about NCQA and managed care organizations. I do not have an answer about why NCQA does not have dental standards, but if you drop me an e-mail, I'll see if I can forward that on to somebody that can give us a better answer.

Somebody is asking if FQHC is federally qualified health centers that are paid using a prospective payment system included in program integrity efforts of the OIG or CMS for maximizing payments by billing, scheduling for services over multiple days? I'm not exactly sure what the questioner is asking Dr. Altenhoff, do you have any information about what you do with FQHCs billing in Texas?

Yes. Thank you for forwarding that to me. I will say that I'm aware that the dental managed care organizations, both DentiQuest and MCNA, are here, working here within Texas, have been looking at FQHCs and their billing practice and what has been commonly referred to as training of dental service. So they are included in the process, and as the first line of looking at that is the obligation of the dental managed care organizations, if they do not get resolution or see recurrence of that, once training has been done, then that would be referred to the Office of Inspector General, and we would then follow up with it.

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Okay, thank you. A questioner has asked, "What is CMS's position about records that are manipulated or altered while under review? First of all, I would suggest that nobody alter patient records. If a correction needs to be made, the age-old way to do that is to make a notation today and say in relation to treatment note of such and such a day, that's incorrect, and the correction is. Please don't anybody ever alter or erase their records. Either John or Meridith, do you have any information? I'm not quite sure what the questioner is asking about, manipulated or altered records?"

Well I'm not sure exactly either. But, you know, if, during the course of audit work, we saw records that we thought had been altered, we would be having a pretty quick conversation with the agents in our office of Investigations, you know, just about potential fraud implications. You know, any time we see records being altered, you know, we talk to our investigators right away.

Dr. Mouden, this is Linda Altenhoff. I will say that in the reviews that I've conducted here in Texas, I've not only found altered documentation within handwritten records but evidence of it electronic dental records as well, and it raises a red flag and creates a high level of concern about what all is going on within that particular practice.

Thank you. And the advice is don't alter your records. Somebody has asked, "How can dental providers within managed care plans be audited when they are not fee for service?" Meridith, do you have a response to that?

Absolutely. You know, one of the ongoing concerns in a lot of the OIG's reports has been that in a number of cases the encounter data that you get within managed care programs is not as reliable as what you might get in fee for service. There have been some steps taken to try to improve that within states, MIIS systems, which I think would make for easier auditing. That being said, I think that certainly from the federal OIG perspective, we certainly are able to audit claims that are coming, both from managed care providers, as well as fee for service providers. And for RAC audits and other audits, it might be going within the state, they certainly can audit managed care providers as well. John, did you want to add anything to that?

No. I mean I think you're right on. I mean, you know, the first hook is going to be the managed care organization itself trying to oversee what the providers are doing. That's the first part. You know, obviously at the federal level, yes, we can get into not only auditing managed care organizations, but also the providers within those plans as well.

Okay, the next questioner has asked, "Have any states worked with their dental societies to develop Medicaid education series for which dentists can obtain free continuing education? If so, which states, and whom could we contact to discuss their experiences?" Well obviously Dr. Altenhoff has shared how they have worked with the TDA and others about what's going on. Beyond that, I don't know about other states that have similar programs. No, I correct that. I do know that Connecticut has worked with their Dental Society. I would suggest that if you need information you contact both your state Medicaid and CHIP agency, and your state dental society.

Ah, somebody has asked, "What are the qualifications to be an auditor for dental records in other states?"

I don't know who the question was referred to. Maybe it was to Dr. Altenhoff. I do know that there are audit staff in many states that do not have specific dental expertise, but as Meridith was explaining, many times audits are not so much about what's done clinically or the quality of clinical practice, as much as what shows up as outliers in the billing process. John?

Yeah, you know, I would say the qualifications to be an auditor are the same for dental reviews or any type of other review that we perform. You need to have an accounting background, a financial background. If we get into situations where -- and we're always trying to compare what's happened to what the specific applicable rules are. If we get into a situation where medical judgment is needed, then we turn to a medical professional, a dentist, a doctor, whoever we need to make that determination. We don't make that medical determination looking at records on our own.

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Somebody has asked, "FQHCs included in here for their dental services" -- well let me try and rephrase what's been written here. "Are FQHCs included in here for dental services, or are they under medical practices only?" Well, Linda, I'll let you try that first.

Lynn, can you restate the question for me?

They want to know if FQHCs are included here for dental services or if they are, I guess, audited under medical practices only? I'm not quite sure about the question.

At least within the State of Texas, FQHC are subject to audit from both dental, as well as medical services that have been provided. There are very few FQHCs within our state and probably within any state in which it's exclusively dental. So if there is unusual billing practices that have been identified through data mining that are associated with medical services provided by an FQHC, then that would be looked at as well.

Okay, thank you. Next question, "Have there been any audits of the use of caries risk assessment codes?" First of all, the risk assessment codes were just included in the CDT as of January of 2014. That would be the D0601, -602, and -603. As far as I know, there are only a couple of states that have benefits paying for those codes, so I don't know that any audit has been done specific to those codes, especially since they're brand new.

Oh, somebody is asking if dentists used in audits, if they're required to be licensed in the state of audit? I don't know that there's any requirement. John or Meridith?

Yeah, I'm not sure if there is a requirement or not. Obviously we're conducting our audit work. We've relied heavily on either experts from the state or from CMS to help provide that dental expertise that's needed. I'm not sure of the specific license requirements though.

Okay, we've actually come to the end of the list of questions. I'll wait just another minute or so to see if anything else comes in. Obviously a huge topic that we have tried to condense into 90 minutes, so I appreciate everybody having stuck with us for so long. I'm not seeing any more questions, so with that, I believe we can close it out for today.

I, again, want to thank the folks at Mathematica, our co-branders from the Medicaid-CHIP state dental association, and all four of our speakers for giving us their time, and to all of the attendees for being with us. Again, you can contact us if you need further information, as the contact list was shown, the entire presentation and transcript will be available in a few weeks on the CMS website. So thank you very much.