Policy on Third-Party Payor Audits, Abuse, and Fraud

Originating Council
Council on Clinical Affairs

Adopted
2014

Purpose

One of the aims of the Deficit Reduction Act[1], approved by the U.S. Congress in 2005, was to prevent Medicaid fraud and abuse through an audit process. Despite the good intentions of this law, experts predict health care providers will see more investigations, enforcement actions, and whistleblower cases, and will need to devote more resources toward compliance.[2] Pediatric dentists play a critical role in the Medicaid program, and there will be negative impact on access to care if honest providers are burdened with regulations and audits. The American Academy of Pediatric Dentistry (**AAPD**) supports efforts to eliminate Medicaid abuse. The AAPD cautions, however, against ill-informed or misguided investigations that may discourage dental provider participation in the program.[2] The AAPD is opposed to any of its dentist members committing abuse and fraud as it relates to their relationship with third party payors. Such behavior is unprofessional conduct and could result in loss of membership status in AAPD.[3] This policy is intended to help AAPD members understand the audit process, both internal and external audits.

Methods

This policy is based upon a review of current dental and medical literature, including a literature search of the PubMed® electronic database using the terms: dental audits, dental abuse and fraud, peer review, provider profiling, practice management, EPSDT; field: all; limits: within the last 10 years; human; English. Nineteen articles match these criteria. Papers for review were chosen from this list as well as references within the selected articles. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

Background

External audits are increasingly common for a full range of health care providers. AAPD members are no exception, as some of our members have experienced. If a provider requests payment from third-party payors, the claims may be subject to review by a recovery audit contractor (**RAC**), a private entity that reviews paid claims and, in some cases, earns contingency fees for improper payments it retrieves. Private and public third-party payors use audits as a mechanism to recoup over-payments, inspect for potential improper behavior, and possibly guide health care providers to control utilization and costs.[4] Notably, there can be serious financial and even criminal penalties associated with billing errors.[5]

In 2012, an estimated $19 billion, or seven percent, of the federal Medicaid funds were absorbed by improper payments, which include fraud and abuse as well as unintentional mistakes such as paper errors.[6] Improper payments totaled an estimated $11 billion, or nine percent of states' Medicaid budgets in 2010, the most recent year for which data is available.[7] Improper payments can occur when funds go to the wrong recipient, the recipient receives the incorrect amount of funds (either an underpayment or overpayment), documentation is not available to support a payment, or the recipient uses the funds in an improper manner.[6]

The AAPD recognizes the concern its members have regarding these external audits. The AAPD encourages its members to develop internal self-audit programs to address these challenges. Internal audits are used in order to preemptively detect discrepancies before the external authorities can discover them and impose penalties.[4] Given the heightened concern for compliance to avoid an external audit, internal audits have taken on importance. A compliance program generally will incorporate a credible internal audit system, which means that it must be prepared to respond to an external audit by various authorities. In addition, some pediatric dentists have discovered that an internal audit system can be developed so that it not only addresses the external audit, but also serves other quality of care and performance improvement purposes.[4]

Definitions

Abuse: "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to

ABBREVIATIONS
AAPD: American Academy Pediatric Dentistry. **EPSDT:** Early and periodic screening, diagnosis, and treatment. **MNC:** Medically Necessary care. **RAC:** Recovery audit contractor.

the Medicaid program."[8] The AAPD supports medically necessary care (**MNC**) and recognizes that dental care is medically necessary for the purpose of preventing and eliminating orofacial disease, infection, and pain, restoring the form and function of the dentition, and correcting facial disfiguration or dysfunction.[9]

Audit: "planned and documented activity performed by qualified personnel to determine by investigation, examination, or evaluation of objective evidence, the adequacy and compliance with established procedures, or applicable documents, and the effectiveness of implementation".[10] After receiving a notice of an impending audit from a third-party payor, the dentist should ascertain the type and scope of audit to be conducted.[11]

Fraud: "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person."[8]

Third party payor: "an organization other than the patient (which would be the first party) or health-care provider (also known as the second party) involved in the financing of health care services."[11]

Credentials of auditors. The Affordable Care Act required that each state Medicaid program use at least one RAC beginning in 2011.[12] Some states have started employing the RACs to aid in recovery of improper payments.[13] The AAPD strongly believes that, while audits are a part of third-party payment contracts and are necessary to protect the integrity of these programs, such audits must be completed by those who have credentials on par with the dental provider being audited. For example, pediatric dentists must be audited by a dentist who specializes in pediatric dentistry and who understands the clinical guidelines and standards of care which have been adopted and followed by their specialty. The AAPD is adamantly opposed to auditors receiving financial incentives for any money recuperated through these audits. This represents a conflict of interest.

Provider profiling. The AAPD is opposed to "provider profiling" and believes that dentist providers selected for audits should be chosen randomly or with compelling evidence that makes them an outlier compared to peers practicing in similar geographic areas, on similar populations of patients, and within the same specialty. Claims-based data used for provider profiling are not collected exclusively for performance assessment and, as a result, may be irrelevant or inadequate for profiling.[14] Claims data may be unable to properly and fully characterize an episode of care and may fail to reveal a patient's baseline status.[14] In addition, codes contained in claims data do not articulate "patients' compliance, their desire for care, or their socioeconomic status".[14]

Peer review as part of audit outcomes. The AAPD supports peer review as a way to offer information and support to dentists who need to review best practices regarding chart documentation, coding, and billing practices related to third party payors. This should be offered in lieu of financial penalties when an audit shows that no intent to fraud was present, but that the dentists need education to improve their practice systems. It provides practicing dentists a means to preserve their reputation and good standing in the community.[15] This model would be consistent with the peer review practices that occur when clinical decision making is in question. The intent of peer review is to resolve discrepancies between the dentists and third-party payors expeditiously, fairly, and in a confidential manner. [15]

Best practices for chart documenting, coding, and billing. The AAPD supports the education of pediatric dentistry residents, pediatric dentists, and their staff to ensure good understanding of appropriate coding and billing practices. The AAPD, therefore, supports the creation of educational resources and programs that promote best practices, which may include:

- Programming at the AAPD's Annual Session or other AAPD-sponsored continuing education course.
- Programs offered to pediatric dentistry state unit and district organizations.
- The creation of a web-based tutorial for dentists and their staff, including frequently asked questions regarding Medicaid.
- Partnering with other public/private organizations and agencies to distribute 'Medicaid Updates' that can be received via e-mail, and building open *Medicaid Compliance for the Dental Professional* webinars offered jointly by AAPD and Centers for Medicare and Medicaid Services (**CMS**)[16].
- The development of a third party payor submission compliance program.

Medicaid policies that conflict with AAPD clinical practice guidelines. The AAPD is opposed to Medicaid programs that have policies which are in direct conflict with AAPD clinical practice guidelines and are of detriment to patient care. In several states, children are not receiving appropriate dental treatment covered by Early and Periodic Screening, Diagnosis, and Treatment (**EPSDT**) because there is a refusal to reimburse providers for EPSDT-covered dental services.[17] It is in the best interest of the public to have EPSDT dental periodicity schedules readily available on the Internet. Such availability would also improve compliance by health care professionals and EPSDT staff members with federal EPDST requirements.[17]

In addition, according to CMS, "federal law also requires that states inform all families about EPSDT coverage."[18] The AAPD recommends that this requirement be followed to enable caregivers to seek necessary dental treatment for their children.

Policy statement

Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfiguration or dysfunction. MNC is based upon current preventive and therapeutic practice guidelines formulated by professional organizations with recognized clinical expertise. Expected benefits of MNC outweigh potential risks of treatment or no treatment. Early detection and management of oral conditions can improve a child's oral health, general health and well-being, school readiness, and self-esteem. Early recognition, prevention, and intervention could result in savings of health care dollars for individuals, community health care programs, and third party payors. Because a child's risk for developing dental disease can change over time, continual professional reevaluation and preventive maintenance are essential for good oral health. Value of services is an important consideration, and all stakeholders should recognize that cost-effective care is not necessarily the least expensive treatment.[9]

The AAPD:

- Encourages it members and all third-party payors to support efforts to eliminate Medicaid abuse.
- Opposes any of its dentist members committing abuse and fraud as it relates to their relationship with third-party payors.
- Recognizes the concern its members have regarding these external audits.
- Encourages its members to develop internal self-audit programs to address these challenges.
- Strongly believes that, while audits are a part of third-party payment contracts and are necessary to protect the integrity of these programs, such audits must be completed by those who have credentials on par with the dental provider being audited.
- Adamantly opposes auditors receiving financial incentives for any money recuperated through audits.
- Opposes provider profiling and believes that dentist providers selected for audits should be chosen randomly or with compelling evidence that makes them an outlier as compared to their peers who practice in similar geographic areas, on similar populations of patients, and within the same specialty.
- supports peer review in lieu of financial penalties when an audit shows that no intent to fraud was present, as a way to offer information and support to dentists who need to re-acquaint themselves on best practices regarding chart documentation, coding, and billing practices relating to third-party payors.
- Supports the education of pediatric dentistry residents, pediatric dentists, and their staff to ensure a good understanding of appropriate coding and billing practices.
- Supports the creation of educational resources and programs that promote appropriate coding and billing practices.
- Opposes Medicaid programs that have policies in direct conflict with AAPD clinical practice guidelines and are of detriment to patient care.
- Endorses the enforcement of the "federal law that requires that states inform all families about EPSDT coverage"[18] to enable caregivers to seek necessary dental treatment for their children.

References

1. U.S. Congress. Deficit Reduction Act of 2005. Pub. No. 109-171, 120 Stat. 119, Feb 8, 2006. U.S. Government Printing Office. Available at: "http://www.gpo.gov/fdsys/pkg/BILLS-109s1932enr/pdf/BILLS-109s1932enr.pdf". Accessed March 15, 2014.
2. Litch CS. The government's Medicaid fraud tools: Good reason to stay out of trouble and strategies to preempt trouble. American Academy of Pediatric Dentistry. Chicago, Ill.; 2007. Available at: "http://www.aapd.org/assets/1/7/2935.pdf". Accessed March 15, 2014.
3. American Academy of Pediatric Dentistry. Constitution and Bylaws of the American Academy of Pediatric Dentistry. Available at: "http://www.aapd.org/assets/1/7/constitutionBylaws.pdf". Accessed March 15, 2014.
4. Jose DE, DeVault K. Payor audits: Preparation, response, and opportunities. Feb 2010. Available at: "http://www.healthlawyers.org/Events/Programs/Materials/Documents/PHY10/jose.pdf". Accessed March 15, 2014.
5. U.S. Dept of Justice. The Federal False Claims Act, A Primer. Available at: "http://www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Primer.pdf". Accessed March 15, 2014.
6. U.S. Dept of Health and Human Services. Payment Accuracy Report. Available at: "http://www.paymentaccuracy.gov/programs/medicaid". Accessed March 15, 2014.
7. Centers for Medicare and Medicaid Services. Medicaid Improper Payment Report: FY 2010 Executive Summary. Available at: "http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/downloads/2010_long_version.pdf". Accessed March 15, 2014.
8. National Archives and Records Administration. Code of Federal Regulations, Title 42: Public Health Part 455, Program Integrity: Medicaid. U.S. Government Printing Office. Available at: "http://www.ecfr.gov/cgi-bin/text-idx?SID". Browse, Title 42- Public Health, Vol. 4, Chapter IV, Browse Parts 455, Definition 455.2. Accessed March 15, 2014.
9. American Academy of Pediatric Dentistry. Definition of medically necessary care. Pediatr Dent 2014;35(special issue):15.
10. Project Auditors, LLC. Auditor Dictionary: Audit. Available at: "http://www.projectauditors.com/Dictionary2/1.8/index.php/term/,62555c9cae53606f68555ca75a.xhtml". Accessed March 15, 2014.

11. Oberman SJ. Dental practice audits. Dental Tribune International. November 12, 2010. Available at: "http://www.dental-tribune.com/articles/specialities/practice_management/3413_dental_practice_audits.html". Accessed March 15, 2014.
12. U.S. Congress. The Patient Protection and the Affordable Care Act. , Pub. L. No. 111-148, 124 Stat. 119, Mar 23, 2010. U.S. Government Printing Office. Available at: "http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf". Accessed March 15, 2014.
13. U.S. Dept for Health and Human Services Centers for Medicare and Medicaid Services. Medicaid Integrity Program, New Jersey Comprehensive Program Integrity Review, June 2012. Available at: "http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/NJfy12.pdf". Accessed March 15, 2014.
14. Charvet H. The problem with physician profiling: What have we learned? Quill and Scope 2002;2:43-7. Available at: "http://www.nymc.edu/Clubs/quill_and_scope/volume2/charvet.pdf". Accessed March 15, 2014.
15. American Dental Association. How the dental peer review system works and what you expect from it. American Dental Association, Chicago, Ill. Available at: "http://www.ada.org/~/media/ADA/Member%20Center/FIles/peer_review_overview.ashx". Accessed August 7, 2014.
16. Mouden LD, U.S. Dept for Health and Human Services Centers for Medicare and Medicaid Services, American Academy of Pediatric Dentistry. Medical Compliance for the Dental Professional. Webinar offered by American Academy of Pediatric Dentistry and Centers for Medicare and Medicaid Services, 2013. American Academy of Pediatric Dentistry, Chicago, Ill. Available at: "http://www.aapd.org/assets/1/7/MedicaidComplianceWebinar2013.pdf". Accessed March 15, 2014.
17. Hom JM, Lee JY, Silverman J, Casamassino PS. State Medicaid early and periodic screening, diagnosis, and treatment guidelines adherence to professionally recommended best oral health practices. J Am Dent Assoc 2013;144(3):297-305.
18. U.S. Dept for Health and Human Services Centers for Medicare and Medicaid Services. Guide to children's dental health care in Medicaid. Washington: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services: 2004. Available at: "http://www.medicaid.gov/Medicaid-CHIP-Program-information/By-Topics/Benefits/Downloads/Child-Dental-Guide.pdf". Accessed March 15, 2014.