

Dental Provider Educational Sessions

April 22, 2022

May 6, 2022

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Guidance for Dental Professionals: Medicaid Dental Policy Updates

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Dental CDT-2021 Code Updates

- **Deleted Procedure Code effective December 31, 2020**
 - D7960 Frenulectomy, also known as frenectomy or frenotomy, separate procedure not incidental to another procedure
- **New Procedure Codes effective January 1, 2021**
 - D7961 Buccal/labial frenectomy (frenulectomy)
 - D7962 Lingual frenectomy (frenulectomy)
 - Rate same as previously covered procedure code D7960

D7961 Buccal/Labial Frenectomy (frenulectomy)

- Document necessity (for example, impairs speech, hinders mastication, prevents seating of a denture)
- Requires current diagnostic photographic images of the proposed surgical site
- Prior approval required
- Rate same as previously covered procedure code D7960

D7962 Lingual Frenectomy (frenulectomy)

- **Document necessity (for example, impairs speech, hinders mastication, prevents seating of a denture)**
- **Requires current diagnostic photographic images of the proposed surgical site**
- **Prior approval required for age 1 and older**
- **No prior approval required for under age 1**
- **Limited to once per lifetime for lingual frenulectomy**
- **Rate same as previously covered procedure code D7960**

Dental CDT-2022 Code Updates

Revised Procedure Code effective January 1, 2022

Original

- **D9613 Infiltration of sustained release therapeutic drug, single or multiple sites**
- **Provides post-surgical regional analgesia for up to 5 days**
- **Not allowed for local anesthesia purposes**
- **Reimbursement = \$92.00 per day**

Revised

- **D9613 Infiltration of sustained release therapeutic drug, per quadrant**
- **Reimbursement = \$23.00 per quadrant**

Extended Postpartum Medicaid Coverage

Summary

- The American Rescue Plan Act of 2021 (ARPA) offered states the option to extend postpartum coverage to **12 months**
 - NC General Assembly approved the option in Session Law 2021-180 (SB 105)
- Pregnant beneficiaries receive **12 months of postpartum coverage, regardless of Medicaid eligibility group**
 - The postpartum coverage begins the date the beneficiary's pregnancy ends and will end on the last day of the month of their 12-month postpartum period
 - Medicaid for Pregnant Women (MPW) is now a full-benefit Medicaid program during pregnancy and postpartum (after childbirth)
- Effective **April 1, 2022**

Non-covered Services for Children

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

State Medicaid agencies are required to cover services, products, and procedures for Medicaid beneficiaries under 21 years of age if the service is medically necessary health care to correct or improve a defect, physical or mental illness, or a condition (health problem) identified through a screening examination (includes any evaluation by a physician or other licensed clinician).

EPSDT Services

- **Must be medical in nature**
- **Must be coverable under §1905(a) of the Social Security Act**
- **Must not be experimental or investigational**
- **Must be generally recognized as an accepted method of medical practice or treatment**
- **Must be safe**
- **Must be effective**
- **Must be the least costly treatment of equally effective choices**

Examples of EPSDT Services

- **Crown – porcelain fused to noble metal (D2752)**
- **Prefabricated porcelain/ ceramic crown – primary tooth (D2929)**
- **Interim partial denture, maxillary (D5820)**
- **Limited orthodontic treatment (D8010/D8020)**
- **Non-intravenous conscious sedation (D9248)**

Dental CDT-2022 Code Updates

- Deleted Procedure Codes effective December 31, 2021
 - D8050 Interceptive orthodontic treatment of the primary dentition
 - D8060 Interceptive orthodontic treatment of the transitional dentition
- Requesting treatment effective January 1, 2022
 - D8010 Limited orthodontic treatment of the primary dentition
 - Reimbursement = \$1,044.40 (same at D8050)
 - D8020 Limited orthodontic treatment of the transitional dentition
 - Reimbursement = \$1,162.56 (same as D8060)

Updating an Existing Prior Approval for D8050 or D8060



- Prior approval was granted in 2021 – Service rendered in 2022
- Contact the NCTracks Call Center at 800-688-6696
- Request a Prior Approval Ticket to update the procedure code
 - D8050 to D8010
 - D8060 to D8020
- A new NCTracks notification will be sent to the provider when the prior approval is updated

NC Medicaid Website [medicaid.ncdhhs.gov](https://www.medicaid.ncdhhs.gov)

NCDHHS
NC Medicaid
Division of Health Benefits

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DHHS Resumes Implementation of Medicaid Managed Care

Managed Care will now launch in North Carolina on July 1, 2021.

[Questions & Answers for Beneficiaries →](#)

MEDICAID

4A Dental Services Policy

NC Medicaid
Dental Services

Medicaid and Health Choice
Clinical Coverage Policy No.: 4A
Amended Date: January 10, 2020

5.3.3 Preventive

5.3.3.1 Dental Prophylaxis

Dental prophylaxis (D1110 or D1120) is allowed once per beneficiary per six (6) calendar month period for the same provider. (For example, a beneficiary seen for a prophylaxis on any date in January would be eligible for the next prophylaxis on any date in July.)

Dental prophylaxis (D1110 or D1120) is not allowed for an individual beneficiary on the same date of service as a periodontal procedure (D4210, D4211, D4240, D4241, D4341, D4342, D4355, or D4910).

Code	Description	PA Needed?
D1110	Prophylaxis – adult * Limited to beneficiaries 13 years and older	No
D1120	Prophylaxis – child * Limited to beneficiaries under 13 years old	No

5.3.3.2 Topical Fluoride Treatment (Office Procedure)

Topical fluoride treatment (D1206 or D1208) is allowed once per beneficiary per six (6) calendar month period for the same provider. (For example, a beneficiary seen for a topical fluoride treatment on any date in January would be eligible for the next topical fluoride treatment on any date in July.) Topical fluoride **must** be applied to **all** teeth erupted on the date of service.

Code	Description	PA Needed?
D1206	Topical application of fluoride varnish * Limited to beneficiaries under age 21 * Procedure code D1206 must be billed on the detail line before D0145	No
D1208	Topical application of fluoride – excluding varnish * Limited to beneficiaries under age 21	No

4B Orthodontic Services Policy

NC Medicaid
Orthodontic Services

Medicaid and Health Choice
Clinical Coverage Policy No.: 4B
Amended Date: July 1, 2020

5.3.2 Comprehensive Orthodontic Treatment

Medicaid or NCHC approval and reimbursement for comprehensive orthodontic treatment also includes any fixed or removable appliances necessary to complete the approved treatment including functional appliances (such as a Herbst appliance), palatal expanders, bite plates, holding arches, retainers, etc.

Code	Description	PA Needed?
D8070	<p>Comprehensive orthodontic treatment of the transitional dentition</p> <ul style="list-style-type: none"> * Limited to Medicaid beneficiaries under 21 years of age * Limited to NCHC beneficiaries under 19 years of age * Limited to functionally impairing malocclusions caused by an occlusal condition that exhibits a profound impact from a congenital or developmental disorder (craniofacial anomaly such as cleft lip and palate or other conditions caused by a syndrome), severe trauma, or pathology which effect the function of speech, chewing, or swallowing * Includes placement and monitoring of fixed or removable appliances such as a functional appliance necessary to initiate active treatment * Use for full banding including the placement of bands, brackets, and appliances necessary to initiate active treatment of the upper and lower arches * Once in a lifetime service * Prior approval of orthodontic services is granted for 36 months * Essential to confirm on each date of service that the beneficiary is still eligible under the same health plan (Medicaid or NCHC) in which the approval was granted in NCTracks. If the beneficiary is not eligible and the health plan is not the same as approved, no payment will be issued * Once the banding has been paid, use for the maintenance visits for comprehensive orthodontic treatment of the transitional dentition * Allowed once per calendar month (for example, a patient seen for a comprehensive orthodontic treatment of the transitional dentition visit on any date in January would be eligible for the next visit on any date in February) 	Yes

Temporary COVID Policies

- **Effective March 10, 2020**
- **Temporary Teledentistry Services (D9995, D9996, D0999, D0140, D0170)**
 - **Provider to Patient Teledentistry**
- **Temporary Expansion of Services (D1206 and D1354)**
 - **Application of fluoride varnish (D1206) for all ages and every 90 days**
 - **Application of silver diamine fluoride (D1354) for all ages and all permanent teeth**
- **Sunsetting on June 30, 2022**

NCAC Rule - Billing Medicaid Patients

10A NCAC 22J .0106 PROVIDER BILLING OF PATIENTS WHO ARE MEDICAID RECIPIENTS

(a) A provider may refuse to accept a patient as a Medicaid patient and bill the patient as a private pay patient only if the provider informs the patient that the provider will not bill Medicaid for any services or supplies but will charge the patient for all services or supplies provided. If a provider refuses to accept a patient as a Medicaid patient, the provider shall inform the patient before providing any services or supplies, except when it would delay provision of an appropriate medical screening, medical examination, or treatment as required by 42 U.S.C. 1395dd.

(b) A provider will be deemed to have accepted a patient as a Medicaid patient if the provider files a Medicaid claim for services or supplies provided to the patient. Verification of eligibility alone shall not be deemed acceptance of a patient as a Medicaid patient. A patient, or a patient's representative, must request acceptance as a Medicaid patient by:

- (1) presenting the patient's Medicaid card or presenting a Medicaid number either orally or in writing;
- (2) stating either orally or in writing that the patient has Medicaid coverage; or
- (3) requesting acceptance of Medicaid upon approval of a pending application or a review of continuing eligibility.

(c) Providers may bill a patient accepted as a Medicaid patient only in the following situations:

- (1) for allowable deductibles, co-insurance, or co-payments as specified in the Medicaid State Plan;
- (2) before the service or supply is provided, the provider has informed the patient that the patient may be billed for a service or supply that is not one covered by Medicaid regardless of the type of provider or is beyond the limits of Medicaid coverage as specified in the Medicaid State Plan or applicable clinical coverage policy promulgated pursuant to G.S. 108A-54.2(b);
- (3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services or supplies are received but has failed to supply a Medicare number as proof of coverage; or
- (4) the patient is not eligible for Medicaid as defined in the Medicaid State Plan.

(d) When a provider files a Medicaid claim for services or supplies provided to a Medicaid patient, the provider shall not bill the Medicaid patient for Medicaid services or supplies for which it receives no reimbursement from Medicaid when:

- (1) the provider failed to follow program regulations;
- (2) the Division denied the claim on the basis of a lack of medical necessity; or
- (3) the provider is attempting to bill the Medicaid patient beyond the situations stated in Paragraph (c) of this Rule.

(e) A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment, plus any authorized deductible, co-insurance, co-payment, and third party payment as payment in full for all Medicaid covered services or supplies provided, except that a provider shall not deny services or supplies to any Medicaid patient on account of the individual's inability to pay a deductible, co-insurance, or co-payment amount as specified in the Medicaid State Plan. An individual's inability to pay shall not eliminate his or her liability for the cost sharing charge. Notwithstanding anything contained in this Paragraph, a provider may pursue recovery of third party funds that are primary to Medicaid.

(f) When a provider accepts a private patient, bills the private patient personally for Medicaid services or supplies covered under Medicaid for Medicaid recipients, and the patient is later found to be retroactively eligible for Medicaid, the provider may file for reimbursement with Medicaid. Upon receipt of Medicaid reimbursement, the provider shall refund to the patient all money paid by the patient for the services or supplies covered by Medicaid with the exception of any third party payments or cost sharing amounts as described in the Medicaid State Plan.

NCAC Rule- Medicaid Payment in Full

10A NCAC 22J .0106 PROVIDER BILLING OF PATIENTS WHO ARE MEDICAID RECIPIENTS

(e) A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment plus any authorized deductible, co-insurance, co-payment and third party payment as payment in full for all Medicaid covered services provided, except that a provider may not deny services to any Medicaid patient on account of the individual's inability to pay a deductible, co-insurance or co-payment amount as specified in 10A NCAC 22C .0102. An individual's inability to pay shall not eliminate his or her liability for the cost sharing charge. Notwithstanding anything contained in this Paragraph, a provider may actively pursue recovery of third party funds that are primary to Medicaid.

NCAC Rule – Provide Medical Records

10A NCAC 22F .0104 PREVENTION

(a) Provider Education. The Division may at its discretion, or shall upon the request of a provider, conduct on-site educational visits to assist a provider in complying with requirements of the Medicaid Program.

(b) Provider Manuals. The Division will prepare and furnish each provider with a provider manual containing at least the following information:

- (1) amount, duration, and scope of assistance;
- (2) participation standards;
- (3) penalties;
- (4) reimbursement rules;
- (5) claims filing instructions.

(c) Prepayment Claims Review. The Division will check eligibility, duplicate payments, third party liability, and unauthorized or uncovered services by means of prepayment review, computer edits and audits, and other appropriate methods of review.

(d) Prior Approval. The Division shall require prior approval for certain specified covered services as set forth in the State Plan.

(e) Claim Forms. The Division's provider claim forms shall include the following requirements for provider participation and payment. These requirements shall be binding upon the Division and the providers:

- (1) Medicaid payment constitutes payment in full.
- (2) Charges to Medicaid recipients for the same items and services shall not be higher than for private paying patients.
- (3) The provider shall keep all records as necessary to support the services claimed for reimbursement.
- (4) The provider shall fully disclose the contents of his Medicaid financial and medical records to the Division and its agents.
- (5) Medicaid reimbursement shall only be made for medically necessary care and services.
- (6) The Division may suspend or terminate a provider for violations of Medicaid laws, regulations, policies, or guidelines.

NCAC Rule – Claims Timely Filing

10A NCAC 22B .0104 TIME LIMITATION

(a) To receive payment, claims must be filed either:

- (1) Within 365 days of the date of service for services other than inpatient hospital, home health or nursing home services; or
- (2) Within 365 days of the date of discharge for inpatient hospital services and the last date of service in the month for home health and nursing home services not to exceed the limitations as specified in 42 C.F.R. 447.45; or
- (3) Within 180 days of the Medicare or other third party payment, or within 180 days of final denial, when the date of the third party payment or denial exceeds the filing limits in Subparagraphs (1) or (2) of this Rule, if it can be shown that:
 - (A) A claim was filed with a prospective third-party payor within the filing limits in Subparagraph (1) or (2) of this Rule; and
 - (B) There was a possibility of receiving payment from the third party payor with whom the claim was filed; and
 - (C) Bona fide and timely efforts were pursued to achieve either payment or final denial of the third-party claim.

(b) Providers must file requests for payment adjustments or requests for reconsideration of a denied claim no later than 18 months after the date of payment or denial of a claim.

(c) The time limitation specified in Paragraph (a) of this Rule may be waived by the Division of Medical Assistance when a correction of an administrative error in determining eligibility, application of court order or hearing decision grants eligibility with less than 60 days for providers to submit claims for eligible dates of service, provided the claim is received for processing within 180 days after the date the county department of social services approves the eligibility.

(d) In cases where claims or adjustments were not filed within the time limitations specified in Paragraphs (a) and (b) of this Rule, and the provider shows failure to do so was beyond his control, he may request a reconsideration review by the Director of the Division of Medical Assistance. The Director of Medical Assistance is the final authority for reconsideration reviews. If the provider wishes to contest this decision, he may do so by filing a petition for a contested case hearing in conformance with G.S. 150B-23.

Medicaid Payor of Last Resort

- Beneficiaries may have a private third-party insurance in addition to Medicaid benefits
- Primary – Third Party Insurance
- Secondary – Medicare
- Last - Medicaid




Find a Dentist

Use the Dentist Locator to find a dentist in your community who sees children and accepts Medicaid and CHIP.

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Find a Dentist for Your Kid



* Required

State* ?

Benefit Plan* ?

Search by Address, ZIP Code ?

InsureKidsNow.gov
Powered by data.HRSA.gov

[FIND A DENTIST IN YOUR STATE >](#)

Dental Plan *(items with * are required)*

* State: ?

* Benefit Plan: ?

Near: ?

Within: ?

Accepts new patients: Yes No Preference ?

Additional Search Criteria

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Does your child have special health care needs? Yes No ?

Preferred Language: ?

Specialty: ?

Dentist Location: ?

County City ?

Dental Ambulatory Surgical Centers

- Four dental specific Ambulatory Surgical Centers (ASCs) in NC
- Approved by the State Health Coordinating Council, the State's Certificate of Need (CON) regulatory body, as a CON demonstration project
- First of these facilities opened in March of 2018 after receiving Medicare certification
- Locations in Raleigh, Fayetteville, Greensboro and Charlotte after Medicare certification of each facility

NC HealthConnex

- Providers that participate in a state funded Program (Medicaid, NC Health Choice or State Employees Health Plan)
- Providers must sign a participation agreement
- Providers must be prepared to share information electronically effective December 31, 2022
- Private Dentist Compatible Option - Dentrax Enterprise
- Dental Schools Compatible Option – EPIC Wisdom
- Data Aggregators (electronic dental record but not HIE compatible/\$5000 initially and \$500 yearly): Smartlink
- and Tangible
- Website: hiea.nc.gov

Contact Information

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NC Medicaid Dental and Orthodontic Services

medicaid.ncdhhs.gov/providers/programs-services/dental-and-orthodontic



Overview of the Office of Compliance and Program Integrity Investigations Unit

**Patrick O. Piggott, MSW, LCSW, DCSW, NCI, CPIP
Associate Director, Investigations Unit**

Objectives



Objectives

By the completion of this training each participant will be able to:

- **Describe at least one function of the Office of Compliance and Program Integrity (OCPI)**
- **List three reasons to refer to OCPI**
- **Identify at least one type of review conducted by OCPI**

Landscape



north carolina
medicaid

Authority

FEDERAL:

- 42 CFR 438 (Managed Care)
- 42 CFR 434 (Contracts)
- 42 CFR 455 and 456 (Program Integrity & Utilization Control)
- 45 CFR Title II, §201-250, (Health Insurance Portability and Accountability Act)

Authority

FEDERAL:

- **42 U.S.C. § 1320a-7(Exclusion Statute)**
- **42 U.S.C. § 1395nn: (Physician Self-Referral Law/Stark)**
- **42 U.S.C. § 1320a-7b(b)] (Anti-Kickback Statute)**
- **(8 U.S.C. §1347 (Health Care Fraud)**
- **31 U.S.C.§3729-3733 (False Claims Act)**

Authority

STATE:

- Medicaid State Plan & Amendments
- NCGS 51 – 1. §§1-605 through 1-618. (False Claims)
- NCGS 108A-70.10 thru 70.17 (NC False Claims Act)
- N.C.G.S. 108A-63 (North Carolina Anti-Kickback laws)
- NCGS 108C (Medicaid and Health Choice Provider Requirements)

Authority

STATE:

- 10A NCAC 22F (Program Integrity)
- Medicaid Clinical Coverage Policies
- Medicaid Provider Participation Agreement
- MCO Contract with Provider

Who are we?



Who are we?

The Office of Compliance and Program Integrity consists of:

- **Investigations Unit: Medical, Dental, Pharmacy and Durable Medical Equipment, Behavioral Health/IDD, Waiver and other home- and community-based services**
- **Compliance Operations: Vendor management, compliance monitoring, business support, communications, financial reporting & HIPAA**
- **Data Analytics Team: J-SURS, FAMS, Identity Insights & Data Warehouse**
- **Business Intake Center: Central point to receive all complaints and referrals**
- **Member Compliance: Audit county Medicaid eligibility and investigate beneficiary fraud complaints**

Mission



Mission

Protect the resources of the Division of Health Benefits by reducing or eliminating fraud, waste and abuse (FWA) by providers and beneficiaries in the NC Medicaid Program.

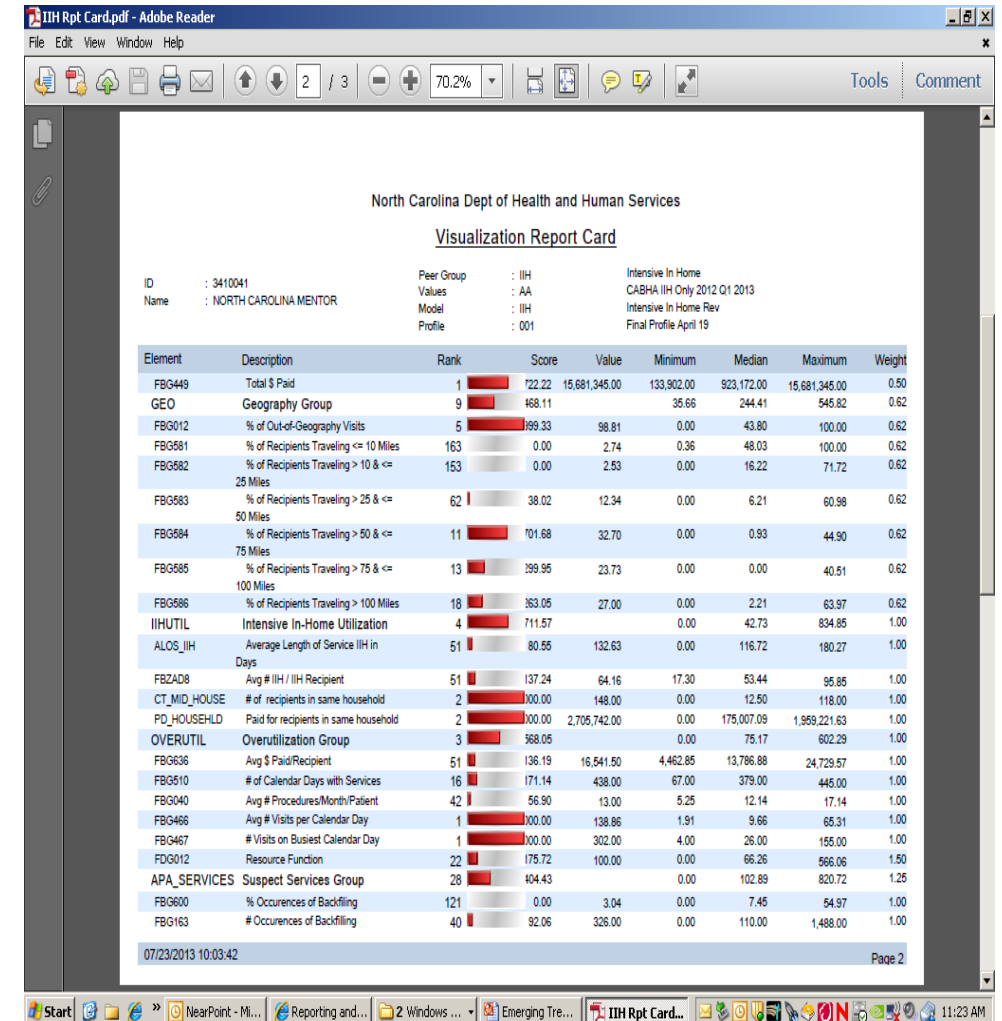
OCPI Functions



Functions

The Office of Compliance and Program Integrity, Investigation Unit functions consist of:

- Identification and Detection
- Prevention
- Investigation
- Administrative Actions
- Refer



Functions

The Office of Compliance and Program Integrity, Investigation Unit functions consist of:

- **Oversight and Monitoring of PHP SIUs**
- **Conduct Preliminary Investigations of all PHP Fraud Referrals**
- **Coordinate and Collaborate with PCCMs (FWA activities)**
- **Coordinate and Collaborate with PACE (Compliance & FWA activities)**
- **Conduct Preliminary Investigations of all complaints/referrals**

Vendors

- **Public Consulting Group (Post Payment Reviews)**
- **Health Management Services (Recovery Audit Contactor & Complaint-driven Post Payment Reviews)**
- **International Business Machine (FAMS and Data Analytics Support)**
- **Carolinas Center For Medical Excellence (Prepayment Review)**

Define Fraud, Waste and Abuse (FWA)



What is FWA?

- **FRAUD:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefits to himself or some other person.
- **WASTE:** Costs that could have been avoided without a negative impact on quality.
- **ABUSE:** Occurs when a provider practices that are inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health.



Examples



Examples of Fraud and Abuse

Managed Care:

- Falsifying Encounters
- Denial of services to beneficiaries
- Discriminating against beneficiaries due to chronic and complex conditions
- Falsification of financial solvency



Examples of Fraud and Abuse

Managed Care:

- Collusion with providers and providing kick-backs
- Conflicts of Interest
- Falsifying Reports to the State Medicaid program
- Fraudulent subcontracting



Examples of Fraud and Abuse

PROVIDER:

- A provider performs and bills for services not medically necessary
- A provider's credentials are not accurate (e.g. unlicensed to provide service)
- Provider billing for a higher level of service than what was provided such as altering the diagnosis of patient or upcoding

Examples of Fraud and Abuse

PROVIDER:

- Providing kickbacks, bribes for the Medicaid ID or soliciting client services
- Double billing
- Providing narcotic prescriptions for sale
- Billing for services not rendered



Examples of Fraud and Abuse

BENEFICIARY:

- Doctor shopping for pain medicine
- Forging prescriptions
- A non-recipient uses a recipient's card with or without the recipient's knowledge



Examples of Fraud and Abuse

BENEFICIARY:

- Misrepresenting household composition, income or resources during application process
- Selling prescription(s) filled by Medicaid
- Receiving Medicaid in NC while living in another state
- Collusion with Medicaid providers (Receiving kickbacks)

What is not fraud?

What is not fraud?

- Quality of medical service
- Length of time spent waiting to be seen by medical provider
- Refusing to provide a referral to another provider
- Refusal to release medical records

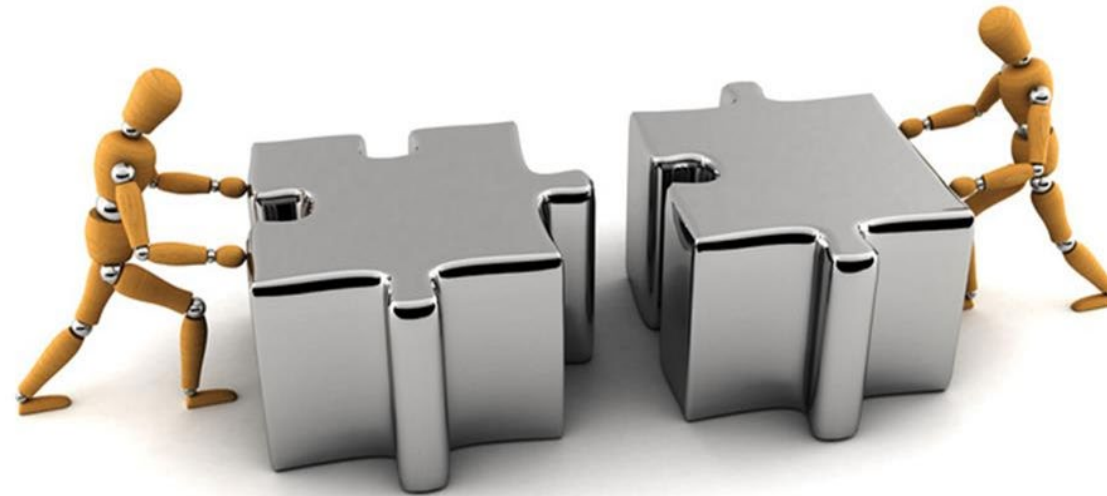
What is not fraud?

- **Complaints about DSS**
- **Aides not being paid by provider agency**
- **Appointments only available on certain days**
- **Dentures not fitting**

Conduct Reviews, Audits or Investigations

- **Self-Audits (Proactive Quality Assurance)**
- **Directed Self-Audits**
- **Post-payment Reviews**
- **Prepayment Reviews**
- **Projects/Initiatives**

Action



Actions due to FWA

PROVIDER FRAUD AND ABUSE:

- **All complaints warrant a preliminary investigation**
- **Provider investigations are handled in house or referred to the OCPI vendor**
- **Investigations may include provider and beneficiary interviews and surveys**
- **Most investigations are post-payments (after claims have been paid).**

Actions due to FWA

OCPI may take one or multiple actions:

- **Issuance No Findings Letters**
- **Warning Letters**
- **Issuance of Tentative Notice of Decisions**
 - **Overpayment**
 - **Suspension of Payments**
 - **Suspension of Provider Participation**
 - **Probation**
 - **Termination of participation**
- **Provider Lock-out**
- **Referral to Medicaid Investigations Division**

Actions due to FWA

BENEFICIARY FRAUD AND ABUSE:

- The Beneficiary Fraud Consultants conduct preliminary investigations on all allegations received on a beneficiary.
- If substantiated, complaints of suspected fraud are referred to the Program Integrity with the local county DSS for a full investigation.
- Benefits can be issued erroneously with or without intent.

Fraud can only be determined by a court of law.

Sources of Complaints

- Internal Medicaid Units
- Beneficiaries
- General Public
- Providers



Sources of Complaints

- Law Enforcement
- Office of the Secretary
- Other state and federal agencies (DSS, DHSR, DOL, CMS, OIG, etc.)



FWA Reported?



How is FWA Reported?

- Telephone
- Online [complaint form](#) on NC Medicaid website
- Emails from internal and external agencies (DSS, Clinical Policy, etc.)
- Mail
- Fax

FRAUD

Business Intake Center (BIC)



BIC

- CMS requires each state have a centralized source for which all complaints of fraud funnel. The BIC unit serves as the centralized point of contact for Program Integrity.
- The unit was mandated by the Legislature and established in 2008.
- Receive, screen and log all fraud complaints.
- Assigns inquiries or fraud complaints to the appropriate area within OCPI.



Report FWA



REPORT FWA

- Contact the NC Medicaid OCPI Business Intake Center directly at **877-362-8471**
- Complete and submit a Medicaid fraud and abuse confidential online complaint form at [medicaid.ncdhhs.gov/Medicaid Fraud and Abuse Confidential Complaint](https://www.ncdhhs.gov/Medicaid-Fraud-and-Abuse-Confidential-Complaint)

Confidentiality



Confidentiality

10A NCAC 22F .0106 CONFIDENTIALITY

All investigations by the North Carolina Department of Health Benefits concerning allegations of provider fraud, abuse, overutilization or inadequate quality of care shall be confidential, and the information contained in the files of such investigations shall be confidential.



Summary

- Medicaid Landscape
- Authority
- Who are we?
- OCPI Mission
- OCPI Investigation Unit Functions
- Definition of FWA
- Examples of FWA
- What is not FWA?
- Actions due to FWA
- Sources of FWA
- How is FWA Reported?
- Business Intake Center
- How to Report FWA?
- Confidentiality



Contact Information

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Prepayment Claims Review for Dental Services

Robyn S. Winters, RN, AHFI, BSA
Contract Manager
Prepayment Claims Review

History & Overview of Prepay

- CCME contract with NC Division of Health Benefits Office of Compliance & Program Integrity (OCPI) since 2009
- Governed by NC General Statute 108C-7
- Audit program targeting
 - Fraud
 - Waste
 - Abuse
- Reviews claims of select providers for policy compliance PRIOR to payment



Review Team

- Following Medicaid Clinical Policy 4A &4B
- Clinical team of Registered Dental Hygienists
- Average of 31 years practical experience per team member
- Led by Janet Ellis, RDH, CPC – Dental Supervisor



108C-7 Requirements

- 20-Day Notification prior to placement on review in NCTracks
- Records Requests
 - Original upon receipt of claim
 - Final if any documents are missing
- Threshold Requirement
 - Must submit at least 50% of the pre-audit per month DLI (Detailed Line Item) average
 - Query by OCPI
 - Monitored by OCPI
- Accuracy Requirement
 - 70% of claims received by CCME in a month must pass
 - Must have $\geq 70\%$ accuracy for three consecutive months to pass
 - Six-month window
 - OCPI may initiate termination action for failure of prepayment review

Role Distinction

OCPI

- Investigate complaints & analyze providers
- Determine providers appropriate for prepay
- Determine provider's pre-audit billing threshold
- Place providers on prepayment review
- Monitor provider compliance throughout prepay
- Monitor billing threshold for each month of accuracy
- Make termination decisions
- Remove providers from prepayment review

CCME

- Receive instruction from OCPI to review providers
- Receive direction on policy requirements from OCPI
- Notify providers of placement on prepayment review
- Receive claims from NCTracks
- Request records from providers
- Evaluate for missing records prior to clinical review
- Apply clinical policy to claims billed to determine clinical compliance
- Reporting findings to OCPI

Provider Notification of Placement

Request for Medical Records

Record Indexing
& Data Extraction

Quantitative
Record Evaluation

Qualitative
Compliance
Review

Reporting to OCPI

Timelines

- **Placement on Review**
 - 20 days written notice prior to placement on review in NCTracks
- **Documents Due from Provider**
 - Five business days from the date provider receives request
 - If not picked up by 5th business day, letter marked unclaimed, and claims move to next phase
- **CCME Requesting Missing Documents**
 - 15 days from the original document due date
- **CCME Completes Clinical Reviews**
 - 20 days from the document due date

Remember:

Reviews are sent to CCME based on date you **KEY** the claim to NCTracks, not the **DATE OF SERVICE** on the claim

CCME's Request for Medical Records

- Valid email addresses matter
 - Ensure all provider information in NC Tracks is correct
- Letters are posted on the portal
 - Providers notified with email address shown in NCTracks
- DHB lists of documents will be requested
- Documents due by the 5th business day from receipt of letter
 - Not picking up a letter does not delay processing
 - If not picked up by 5th day after notification, claims move to next process with or without documents
- A missing service note will generate also a request for staff files since CCME cannot know who the rendering provider was without the service note

Submitting Documents

- **Providers know what documents apply to the claims billed**
 - A request for an “operative note, if applicable” would not apply to a claim for a periodic exam for an established patient (D0120) but it would apply to an extraction of a completely bony tooth with unusual surgical complications (D7241)
- **One copy versus 20**
- **Date specific**
 - Service notes for 2/26/2022 do not apply to a DOS billed for 4/1/2022
 - Staff licensure is valid for a one-year period. Only one copy is needed for all services rendered in that one-year period
- **Providers may upload documents to the provider portal or fax documents to CCME to the toll-free fax number**
 - Faxing and uploading are both free services to help minimize provider cost and burden
 - Bar-coded fax cover sheet **IS REQUIRED** for faxed records
 - Bar-coded fax cover sheet is **NOT** required for uploads

Denials

A claim denied by CCME is NOT a final agency decision

- Any claim **CAN** be rebilled
 - This **MAY** get the claim approved
 - This **MAY NEVER** get the claim approved



1st submission: D1110 – Prophylaxis: Adult

- Patient is 2 years old
- First submission is a claim denial

2nd submission: D1120 – Prophylaxis: Child

- Patient is **STILL** 2 years old
- Documents comply with policy
- Second submission is a claim approval



1st submission: D0270 – Bitewing single image

- No evidence of bitewing in the record
- First submission is a claim denial

2nd submission: D0270 – Bitewing single image

- No evidence of bitewing in the record
- New documents show patient never showed for appointment
- Second submission is a claim denial

Common Findings

- Illegible or missing signatures or staff names
- If providers update a document (i.e., an updated license verification) CCME will need that document
- Documents not dated may be requested again on a file since CCME cannot determine the document's effective date
- Image quality – copies of copies, copies on colored paper and poor image quality (i.e., faxing a radiographic image) may result in second request OR even a claim denial
- Many documents have clear expiration dates and will, in fact, expire. Updates to expired documents need to be submitted when updated



Contacting CCME

- CCME is here to help!
- Remember our role: Auditors not Consultants
- By phone or email
- Do NOT use PHI in unencrypted emails



Contact Information

Robyn S. Winters, RN, AHFI, BSA
Contract Manager
Prepayment Claims Review

800-682-2650 extension 6020
claimsreview@thecarolinascenter.org

Public Consulting Group (PCG) Investigations and Oversight

Mary Elizabeth Lipcsak
Operations Supervisor

Agenda

- Who is PCG?
- Introductions and Roles
- I&O Process Overview
 - BIC Intake
 - Preliminary Reviews
 - Preliminary Investigations
 - Outcomes
- Appeals
 - Requesting a Reconsideration Hearing
- Dental Data Analytic Initiatives
- Common Dental Non-Compliance Issues



Who is Public Consulting Group (PCG)

Public Consulting Group (PCG) is a leading public sector management consulting and operations improvement firm that partners with health, education, and human services agencies to improve lives.

PCG is a contractor of the Division of Health Benefits, Office of Compliance and Program Integrity, PCG is authorized to conduct post-payment Provider audits and investigations in accordance with Subchapter 22F of Title 10A of the NC Administrative Code and Parts 455, 456, and 457 of Title 42 of the Code of Federal Regulations.



PCG Provider Investigation and Oversight Team



Jay Peck, MBA
Associate Manager



Angela Bridges, LCSW, CCM, CPHQ
*Healthcare Compliance Investigator
Supervisor*



Mary Elizabeth Lipcsak, MBA
Operations Supervisor



Mary Jane Plowman, RN
*Healthcare Compliance Investigator
Supervisor*

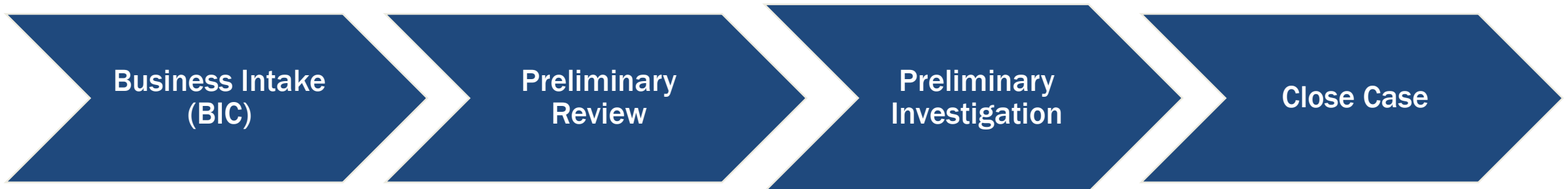


Deborah Cade BSN, RN-BC, CCM, CPHQ
*Healthcare Compliance Investigator
Manager*



Ann Powers, RDH
Healthcare Compliance Investigator

PCG Investigation and Oversight Process



Business Intake Center (BIC)

OCPI's BIC processes complaints, referrals, or allegations from general public

Incidents are vetted in the BIC

The incident is then entered into PCG's Case Tracking Management System. Those entries auto-generate a case tracking number

A PCG Investigative Analyst opens the case file within 48 hours of the referral

All incidents received through the BIC are subject to a preliminary review

Preliminary Reviews

The Preliminary Review is conducted by a PCG Healthcare Compliance Investigative Analyst to validate allegations received by the BIC and to establish whether there is sufficient basis to warrant a full investigation. As outlined in 10A NCAC 22F .0202, the preliminary review continues until it is determined:

- Whether there are sufficient findings to warrant a preliminary investigation;
- Whether there is sufficient evidence to warrant referring the case for civil and/or criminal fraud action;
- Whether there is insufficient evidence to support the allegation(s) and the case may be closed.



Preliminary Review

PCG Healthcare Compliance Investigative Analyst will:

- Review complaint or referral
- Contact stakeholders and beneficiaries
- Review billing claims data and provider history
- Summarize findings and recommend preliminary investigation, referral to another agency or close the case.



Preliminary Investigation

If the findings of the Preliminary Review substantiate a complaint, or if additional documentation is needed to make the determination, the Healthcare Compliance Investigator assigned to the complaint proceeds with a Preliminary Investigation in accordance with the parameters of 42 CFR 455, 10A NCAC.



Preliminary Investigation

PCG Healthcare Compliance Investigator will:

- Prepare for the investigation
- Review the complaint or referral
- Request provider medical records via certified mail
- Review provider records for compliance with Medicaid policy and licensing rules



Solutions that Matter
www.publicconsultinggroup.com

Certified Mail: _____ Date: _____

Provider Name _____ NPI: _____
Address _____
State _____
Zip _____

RE: PI Case # _____
Healthcare Compliance Investigator: _____

Subject: Medicaid Records Request

Dear Provider:

In accordance with Parts 455 and 456 of Title 42 of the Code of Federal Regulations, Chapter 108C of the North Carolina General Statutes, and Subchapter 22F of Title 10A of the North Carolina Administrative Code and, the North Carolina Division of Health Benefits (DHB) Office of Compliance and Program Integrity Section or its authorized agent is conducting a post payment review of Medicaid paid claims submitted by your agency for dates of service from **XX/XX/XXXX to XX/XX/XXXX**.

DHB is authorized by Section 1902(a) 27 of the Social Security Act and 42 CFR § 431.107 to access patient medical records for the purposes directly related to the administration of the Medicaid program. In addition, when applying for Medicaid benefits, each beneficiary signs a release which authorizes access to his/her Medicaid records by appropriate regulatory authorities. Therefore, no special recipient permission is necessary for release of records to DHB or its authorized agents.

Federal regulations, 10A NCAC Subchapter 22F, and provider agreements with DHB require the provider to maintain all clinical and financial records for a period of five (5) years. Such records shall be subject to audit and review by federal and state representatives.

If the DHB Office of Compliance and Program Integrity Section or authorized representative determines your agency failed to substantially comply with requirements of state and federal law or regulations or the Department has received a credible allegation of fraud concerning your agency, the results of this audit may be extrapolated in accordance with N.C Session Law 2011-399, N.C.G.S §108C-5, 10A NCAC 22F .0606, and guidance from the Centers for Medicare and Medicaid Services (CMS).

Please note that DHB contracts with Public Consulting Group (PCG) to provide provider oversight and investigations of incidents involving Medicaid reimbursed services. PCG is required to investigate all incidents which may have jeopardized the integrity of the Medicaid program to determine what, if any, actions are needed to be taken by DHB.

Preliminary Investigation

Dental Medical Records Requested

Per 21 NCAC 16T .0101 Record Content, a dentist shall maintain complete treatment records on all patients for a period of at least 10 years.

- Copy of Patient Medical History/Patient Registration Documents
- Copy of Informed Consent for Treatment
- Copy of Treatment Plan
- Copy of Clinical/Operative Notes
- Copy of Anesthesia Records (including monitoring)
- Copy of Laboratory Reports if applicable
- Dental Prosthetic Laboratory Work Orders
- Diagnostic quality copy of radiographic images to substantiate services rendered labeled and dated
- Copy of Patient Ledger/Accounts Receivable
- Copy of Prior Approval for services that require Prior Approval
- Electronic Recordkeeping Policies if applicable
- Referral Forms
- Documentation of trainings/certificates of dental auxiliaries involved in anesthesia monitoring
- Copy of signed Medicaid Card

** please do not fax X-rays*

Preliminary Investigation

PCG Healthcare Compliance Investigator will:

- Document findings and deficiencies
- Refer to other agencies as necessary



Outcomes

In accordance with 42 CFR 455.16, there are several possible outcomes for cases PCG investigates:

- PCG closes the case because of insufficient evidence to support the allegations of noncompliance with Clinical Policy, fraud, waste, or abuse.
- PCG substantiates the complaint and resolves the issue, which may include, but is not limited to:
 - Issue a Tentative Notice of Decision (TND)
 - Send a warning letter to the Provider, giving notice that continuation of the activity in question will result in further action
 - Issuing a Corrective Action Plan (CAP) requirement
 - Refer the Provider to DHB with the recommendation of suspension or termination from participation in the Medicaid program;
 - Refer the Provider to Office of Compliance Program Integrity for MID referral if there is a credible allegation of fraud
 - Recommend other sanctions

Tentative Notice of Decision

All notifications are sent by the Healthcare Compliance Investigator via certified mail to the correspondence address listed in NCTracks

- Informs Provider of identified findings and tentative recoupment, requires staff to complete the Medicaid or NC Health Choice Training and requires the Provider to complete a corrective action plan
- You may request a reconsideration review of this tentative decision in accordance with 10A NCAC 22F.0402. The request for reconsideration review must be submitted within thirty (30) working (business) days of receipt of the TND



Appeals

Request for Reconsideration Hearing (included in TND)

- Your request must be received by the DHHS Hearing Office within thirty (30 working business) days from the receipt of the TND
- You may submit additional documentation that was not submitted with the original audit
- You may call the Hearing Office if you have any questions about the reconsideration 919-814-0090
- If you disagree with the Department's decision you may file a petition for a contested case hearing with the Office of Administrative Hearings (OAH) in accordance with G.S. § 150B-23. You have sixty (60) calendar days from the date that this Tentative Decision becomes final (or from the date of receipt of the reconsideration review decision if you request a reconsideration review) to file a contested case petition with the Office of Administrative Hearings in accordance with N.C.G.S. §150B-23.

REQUEST FOR RECONSIDERATION

TO: Hearing Office
Department of Health and Human Services
2501 Main Service Center
Raleigh, North Carolina 27601
Facsimile 919 709-2001

Dear Chief Hearing Officer:

I hereby request the following type of reconsideration review of the employment identified:

_____ Page (Additional information about my concern is attached)

_____ Personal (by scheduled telephone conference call)

_____ Personal (I understand this will be held in Raleigh)

Signed: _____

Date: _____

Telephone: _____

REMEMBER: The request must be received by the DHHS Hearing Office within thirty (30) working business days from the receipt of the Tentative Notice of Overpayment. Please submit a copy of the decision and notice of overpayment with your reconsideration request. If you are unable to submit documentation as necessary, please have the documents in 10 pages or less. If you have any questions about the reconsideration, please call the Hearing Office at 919 814-0090.

NOTE: The assessment of penalty and interest begins thirty (30) days from the date the employment becomes final.

R.E. _____ FCC
Provider Name: _____ XXXXX
NPI Number: _____ XXXXX
Hearing Office Case Number: _____ XXXXX
Overpayment Amount: _____ XXXXX
Date of Notice of Overpayment: _____ XXXXX

*** IMPORTANT: The Hearing Office must receive your request by 5pm on the date it is due.

Data Analytic Initiatives

PCG and OCPI collaboratively conduct data analytic initiatives to identify either policy violations or detect fraud, waste and abuse. We do this by modeling data around specific scenarios or conducting statistical analyses to identify providers

Dental Data Analytic Projects

Dental Comprehensive One Initiative (SFY 17)

Background: The purpose of the Comprehensive Dental Provider initiative was to ensure that four main areas of Medicaid billing were compliant with Medicaid regulations. The Comprehensive Dental Provider Review includes targeted reviews of several procedure codes that have been discovered to have high incidence of billing patterns not permitted by Clinical Policy.

Dental Comprehensive Two Initiative (SFY19)

Background: The Comprehensive Dental Provider Review includes targeted reviews of several procedure codes with high incidence of billing patterns not permitted by Clinical Policy.

Dental Initiative: Protective Restorations, Incision and Drainage, Sutures (Pending SFY 22)

Background: To investigate dental providers for compliance with NC Medicaid Dental Services Medicaid and Health Choice Clinical Coverage Policy No. 4A Amended Dates: October 1, 2015, March 15, 2019, January 10, 2020

Common Dental Non-Compliance Issues

- Omitting complete medical records
- Documents not labeled with date of service and/or name of Medicaid Beneficiary
- Documents not signed by Provider
- Rendering Provider of Services contradictory to Rendering Provider on claims
- Services not deemed as Medical Necessity
- Non-Compliant report of Limited Exams, Emergency Exams and Palliative Exams
- Additional billing or upcoding procedure codes
- Discrepancy in the rendered dates of service versus the claim dates of service
- Monitoring of anesthesia not recorded
- Non-Compliant with limitations within Clinical Policy
- Services not rendered
- General Nomenclature

Contact Information

Mary Elizabeth Lipcsak
Public Consulting Group, Operations Supervisor

Post Payment Claims Review

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(919) 576-2231



Questions?