OFFICE OF THE NEW YORK STATE COMPTROLLER

DIVISION OF STATE GOVERNMENT ACCOUNTABILITY

Department of Health

Medicaid Payments for Excessive Dental Services

Report 2009-S-46

Thomas P. DiNapoli

Table of Contents

State of New York
Office of the State Comptroller

Division of State Government Accountability

August 16, 2010

Richard F. Daines, M.D.
Commissioner
Department of Health
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Dear Dr. Daines:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Department of Health entitled *Medicaid Payments for Excessive Dental Services*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

EXECUTIVE SUMMARY

Audit Objective

The primary objective of our audit was to determine if the Department of Health has established and implemented adequate controls to prevent Medicaid payments for excessive levels of routine dental services.

Audit Results - Summary

For the five years ended August 31, 2009, New York's Medicaid program paid about $418 million for routine dental services such as cleanings and oral evaluations. Generally, these services are not eligible for reimbursement if they exceed certain frequency limits (i.e., if they are provided to the same recipient more times than is allowed during a certain time period).

However, we found that the Department often reimburses routine dental services that exceed these frequency limits. In fact, during our five-year audit period, we identified a total of about $40 million in such reimbursements (nearly 10 percent of the total reimbursements for such services). While some of the services reimbursed by these payments may be legitimate services that were provided in good faith, other services appear highly questionable and may not have been provided at all.

For example, one dental clinic billed 79 separate oral evaluations for one recipient in a four-year period, which is 71 more than is allowed by the frequency limit of one every six months; and another recipient supposedly received 32 cleanings, between September 2005 and March 2008, from 19 different dental providers.

Claims for excessive dental services should either be denied or suspended for further review by the Department's automated claims processing system. However, we identified various weaknesses in the automated claims processing controls. We also found that Department management did not always strictly enforce some frequency limits. In addition, we determined that dental providers would be better able to comply with the frequency limits if certain enhancements were made to the Medicaid information system used by providers.

We also compared the fee schedules in New York's Medicaid dental program to the fee schedules in 15 peer states. We found that, for periodic oral evaluations and adult cleanings, New York's fees are generally higher than those in the peer states, and if New York had adjusted its fees

for these services to the averages of the other states, it could have saved more than $60 million during our five-year audit period. We recommend the Department reassess the Medicaid fees paid for routine dental services.

Our report contains six recommendations for improving controls over Medicaid payments for routine dental services and for reducing the costs of these services. In response to our draft report, Department officials indicated that they would evaluate our recommendations in relation to existing Medicaid mechanisms for managing the appropriateness of dental services, beneficiaries' needs, and the impacts on access to preventative dental care. Officials also indicated that the Office of the Medicaid Inspector General will review the overpayments identified by OSC and pursue recoveries, as priorities and resources permit.

This report, dated August 16, 2010, is available on our website at: http://www.osc.state.ny.us. Add or update your mailing list address by contacting us at: (518) 474-3271 or
Office of the State Comptroller
Division of State Government Accountability
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Introduction

Background

The Department of Health (Department) administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid eligible recipients, and generates payments to reimburse the providers for their claims. When Medicaid claims are processed by eMedNY, they are subject to various automated edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate.

The New York State Medicaid Program Dental Procedure Codes Manual (Dental Manual) describes the dental services that are eligible for reimbursement. For the five-year period ended August 31, 2009, New York's Medicaid program paid more than 5,000 dental providers about $418 million in reimbursements for routine dental services provided to 1.7 million Medicaid recipients. Such routine dental services include oral evaluations, cleanings, fluoride treatments, and scaling and root planings.

Generally, routine dental services are not eligible for reimbursement if they exceed the frequency limits specified in the Dental Manual (i.e., if they are provided to the same recipient more times than is allowed during a certain time period). For example, oral evaluations, cleanings and fluoride treatments are generally limited to once every six months, while scaling and root planing is generally limited to four different quadrants every two years. (In addition, no more than two of the four quadrants in the mouth should be scaled and root planed during a single appointment).

Two types of reimbursement claims may be submitted for routine dental services: fee-for-service claims and rate-based claims. Generally, fee-for-service claims are submitted by individual practitioners, who receive a set fee for each service provided to each recipient. Generally, rate-based claims are submitted by facilities such as dental clinics, and the facilities receive a single all-inclusive fee for each recipient treated on a given day, regardless of the type or number of services actually provided to the recipient.

Medicaid is a federal program with certain minimum requirements that apply to all participating states. The states also have the authority to establish their own rules for eligibility and reimbursement in many

areas of the Medicaid program. As a result, eligibility criteria and reimbursement amounts may vary from state to state.

Audit Scope and Methodology

We audited the Department's Medicaid reimbursement practices, policies and procedures for routine dental services for the five years ended August 31, 2009. To accomplish our objective, we met with Department officials to discuss the policies and controls relating to dental services in Medicaid, and we examined the Department's relevant policies and procedures.

We also reviewed dental claim information on eMedNY and identified, for our five-year audit period, (1) the fee-for-service claims for oral evaluations, cleanings, fluoride treatments, and scaling and root planings and (2) the rate-based claims in which only one of these routines services was performed. We then analyzed these claims to determine whether the frequency limits specified in the Dental Manual had been exceeded.

We visited three dental providers that submitted comparatively higher numbers of claims for routine dental services during our audit period, ensuring that the three providers were geographically dispersed throughout New York. We reviewed their records for a judgmental sample of 45 recipients, selecting recipients with a high number of claim payments during our audit period, and examined a total of 1,029 claims for these 45 recipients.

Further, to determine whether New York's frequency limits and fee schedules were similar to those of other states' Medicaid programs, we obtained and reviewed pertinent Medicaid-related information from 15 peer states that we selected judgmentally (Alabama, California, Connecticut, Florida, Illinois, Indiana, Massachusetts, Michigan, Montana, New Jersey, North Dakota, Ohio, Texas, Vermont, and Washington). We selected these 15 states because they were either comparatively large, adjacent to New York, and/or had dental programs with certain similarities to New York's program.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal

officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials indicated that they would evaluate our recommendations in relation to existing Medicaid mechanisms for managing the appropriateness of dental services, beneficiaries' needs, and the impacts on access to preventative dental care. Officials also indicated that the Office of the Medicaid Inspector General will review the overpayments identified by OSC and pursue recoveries, as priorities and resources permit. Our rejoinders to the Department's response are included at the end of this report as State Comptroller's Comments.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Contributors to the Report

Major contributors to the report include Steven Sossei, Andrea Inman, Danielle Rancy, Arnold Blanck, Daniel Zimmerman, Earl Vincent, Brian Mason, and Dana Newhouse.

Audit Findings and Recommendations

Excessive Services and Payments

We found the Department often reimburses Medicaid claims for routine dental services that exceed the frequency limits specified in the Dental Manual. In fact, during our five-year audit period, we identified a total of about $40 million in such reimbursements. While some of the services reimbursed by these payments may be legitimate services that were provided in good faith, other services appear highly questionable and may not have been provided at all. We shared the details of our findings with the Department and the Office of the Medicaid Inspector General.

The claims for these excessive services should either have been denied or suspended for further manual review. However, they were approved and paid because of weaknesses in eMedNY's edit controls and because of a Department management decision that is inconsistent with the reimbursement guidelines in the Dental Manual. We also determined that dental providers would be better able to comply with the frequency limits if certain enhancements were made to the Medicaid information systems used by the providers.

The eMedNY control weaknesses we identified are similar to control weaknesses we identified in other recent audits of the Medicaid dental program. To prevent the continued payment of questionable Medicaid reimbursements for dental services, we urge Department officials to take the actions that are needed to establish an appropriate level of control over dental reimbursements.

Fee-for-Service Claims

In our review of fee-for-service claims, we found that, in approximately 361,000 claims, the services were reimbursed even though they exceeded the frequency limits specified in the Dental Manual. The providers submitting these claims were paid a total of $14 million for these apparently excessive services.

In most of these claims, the recipients supposedly received the services from more than one provider. For example, one recipient supposedly received 32 cleanings, between September 2005 and March 2008, from 19 different providers. In other claims, the recipients supposedly received the services from a single provider. For example, one dentist billed 18 cleanings (averaging about four per year) for the same recipient between October 2004 and May 2009.

When a recipient receives an excessive number of services from different providers, the excessiveness of the services is not detected by the edits in eMedNY, because the edits tracked and controlled each recipient's services only on an individual provider basis (at the time of our review). Thus, eMedNY would only detect excessive recipient services from a single provider. We recommend the Department modify the edits so that they can also detect and prevent payments for excessive services when a recipient visits multiple providers within defined time frames.

In addition, to better enable providers to comply with frequency limits when they treat recipients who have been treated by other providers, we recommend the Department make certain enhancements to an information system for Medicaid providers (such as the Medicaid Dispensing Validation System or DVS) - or establish another comparable mechanism. Providers can access the DVS to determine whether recipients have received prior authorization for medical procedures requiring such authorization. If the DVS were modified to include claims history information for recipients, dental providers could check the DVS to determine whether a recipient was in danger of exceeding a frequency limit for a certain service, and if so, schedule the appointment accordingly.

Department officials note that dentists may sometimes unknowingly exceed frequency limits when they treat recipients who have been treated by other dentists, and it would be unfair to penalize such dentists by denying payments for services that were performed in good faith. We acknowledge the difficulty for dentists in this situation, but believe the public interest would best be served if the Department made it possible for the dentists to check the recipients' claim history and avoid billing Medicaid for excessive services. (In responding to our draft report, Department officials stated that they would explore the feasibility of a system development project to convert or modify a subsystem other than DVS, to create a claims history that could be used by providers to determine if service limits have been met.)

When a recipient received an excessive number of services from the same provider, it should have been detected by the edits in eMedNY, and the claim should have been denied. However, we found that many such services were not denied, because (1) the edits were not always activated and (2) in accordance with a decision made by Department management, the edits allow recipients to have *three* oral evaluations, cleanings and fluoride treatments per year, rather than the *two* specified by the Dental Manual (i.e., once every six months). We recommend that the edits be modified to comply with the Dental Manual. (We also note that the time frames in the Dental Manual are generally consistent with the time

frames in the 15 peer states, as their Medicaid programs allow only two or fewer services per year).

After we initiated our audit fieldwork, the Department instituted several eMedNY edit controls that partially address the excessive payments we identified. For example, certain edits flag claims for excessive services on a per recipient basis (specifically, five or more periodic oral evaluations per year, five or more cleanings per year, and seven or more fluoride treatments per year).

These service levels, however, are well in excess of the Department's prescribed limits. Further, although the Department recently added these new payment controls to eMedNY, the officials had not activated them (at the time of our audit fieldwork) to deny or suspend claims for the excessive services in question. Thus, additional actions are still needed to prevent the continuation of excessive Medicaid dental payments.

Rate-Based Claims

In our review of the rate-based claims in which only one routine dental service was performed, we found that, in approximately 204,000 such claims, the services were reimbursed even though they exceeded the frequency limits specified in the Dental Manual. The providers submitting these claims were paid a total of more than $26 million for these apparently excessive services.

For example, in the four-year period ended December 31, 2008, one dental clinic billed 79 separate oral evaluations for one recipient, 71 more than was allowed by the frequency limits specified in the Dental Manual. The payments for the 71 excessive oral evaluations totaled $13,202.

These rate-based claims for excessive services were not denied or suspended for further review because eMedNY does not have sufficient edit controls that apply the frequency limits to the services detailed on the claims. In December 2008, the Department started to implement a new rate-based reimbursement methodology known as Ambulatory Patient Groups (APG). Under this new methodology, the reimbursement amounts are now based, in part, on the specific services provided, and as a result, the Department will be better able to design edits for avoiding excessive dental services on such claims.

In addition, two of the three providers in our judgmental sample of providers that submitted among the highest numbers of claims for routine dental services in our audit period were clinics that submitted rate-based claims. We visited these two providers and reviewed their records for

a judgmental sample of 30 recipients, selecting recipients with a high number of claim payments during our audit period, and we examined a total of 551 claims for these 30 recipients. We found that 41 claims lacked adequate supporting documentation for the services supposedly provided. For example, some of the claims were submitted even though the recipients' appointments were cancelled. Consequently, we question whether the services on such claims were, in fact, provided.

Program Fees

The Department establishes the fee schedules used to pay dentists for services rendered. We compared the fee schedules for New York's Medicaid dental program to the fee schedules used in the 15 peer states. We found that, for periodic oral evaluations and adult cleanings, New York's fees are generally higher than those in the peer states. If New York had adjusted its fees for oral evaluations and cleanings to the averages of the other states, it could have saved more than $60 million during our five-year audit period.

For example, New York's Medicaid program reimburses providers $58 for an adult dental cleaning. This fee is higher than the fees paid by any of the other 15 peer states, where the average fee for adult dental cleanings is $38 ($20, or 34 percent, less than in New York). In fact, in 12 of the 15 states, the fee for this service is less than $50.

During our audit period, New York's Medicaid program paid a total of more than $97 million in fee-for-service claims for adult dental cleanings. Even if New York paid a fee of only $48 for an adult cleaning (midway between the current fee and the average for the peer states), it could have saved about $16.5 million for this service alone.

In addition, New York State, like most other states, pays a higher rate for adult cleanings than for child cleanings ($58 versus $43). In New York, a provider is paid at the higher, adult cleaning rate of $58 when the recipient reaches the age of 13. In comparison, many other states pay the higher rate when the recipient reaches the age of 21. If New York State continued to pay the lower rate until the recipient reached 21, like many of the other states, it would have paid about $4.4 million less over our five-year audit period.

The New York State Social Services Law requires the Department to identify methods to contain the growth of Medicaid spending and improve the efficiency and effectiveness of existing service delivery. Therefore, we recommend that the Department reassess the fees paid for certain common dental services and determine if adjustments should be made that would help the State reduce its Medicaid costs.

Recommendations

1. Modify the eMedNY edits for periodic oral evaluations, cleanings, and fluoride treatments, paid on a fee-for-service basis, to allow payment for these services only once in a six-month period, consistent with the provisions of the Dental Manual.

2. Either modify the Medicaid Dispensing Validation System or establish a comparable mechanism to enable dental providers to determine whether recipients have met their service limits before services are performed and billed.

3. Activate eMedNY edit controls to limit services by recipient (rather than by provider).

4. Establish edits for rate-based claims for dental procedures to ensure providers are paid only at the limits set forth in the Dental Manual.

5. Review the overpayments we identified and recover the excessive amounts paid, as appropriate. As priorities and resources permit, follow up on claim payments for excessive services to determine if certain providers have abused the Medicaid program. Take actions with such providers, as appropriate.

6. Make a formal assessment of the level of the fees paid by New York's Medicaid program for routine dental services. Compare New York's fees with the fees paid in other states and determine if adjustments are justified to achieve savings by lowering fees for certain procedures, such as evaluations and cleanings.

Agency Comments

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

August 4, 2010

Steven E. Sossei, CPA
Audit Director
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Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236

Dear Mr. Sossei:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's draft audit report 2009-S-46 on "Medicaid Payments for Excessive Dental Services."

Thank you for the opportunity to comment.

Sincerely,

James W. Clyne, Jr.
Executive Deputy Commissioner

Enclosure

cc: James Sheehan
Robert W. Reed
Donna Frescatore
Diane Christensen
Nicholas Meister
Stephen Abbott
Jayanth Kumar
Ron Farrell
Mary Elwell
Irene Myron
Lynn Oliver

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2009-S-46 on
"Medicaid Payments for Excessive Dental Services"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2009-S-46 on "Medicaid Payments for Excessive Dental Services."

Recommendation #1:

Modify the eMedNY edits for periodic oral evaluations, cleanings, and fluoride treatments, paid on a fee for service basis, to allow payment for these services only once in a six-month period, consistent with the provisions of the Dental Manual.

Response #1:

The Department believes that the current edit settings are appropriate and professionally sound. While the Dental Provider Manual states that preventive services may be provided twice per year (i.e., every 180 days), the frequency edits are set at 150 days to allow latitude for scheduling appointments to ensure that essential preventive services including examinations, cleanings and fluoride treatments are not restricted. Prevention has been determined to be more beneficial and cost effective than treating the diseases that otherwise result without preventive care, as confirmed by both the Center for Medicare and Medicaid Services and the Academic Pediatric Association.

* Comment 1

Recommendation #2:

Either modify the Medicaid Dispensing Validation System or establish a comparable mechanism to enable dental providers to determine whether recipients have met their service limits before services are performed and billed.

Recommendation #3:

Activate eMedNY edit controls to limit services by recipient (rather than by provider).

Responses #2 and #3:

While the Dispensing Validation System (DVS) is currently utilized by providers to obtain prior authorization for certain procedures, the Department believes that implementing DVS modifications to enable prior authorization for preventive dental services would create an administrative burden for providers and possibly act as a deterrent to necessary preventative care. Furthermore, from a strictly technical standpoint, before eMedNY edit controls to limit services by beneficiary rather than provider can be activated, a process to permit providers access to beneficiaries' treatment history would first need to be developed and implemented.

* See State Comptroller's Comments, page 23.

The Department will further evaluate these OSC recommendations before determining the appropriate course of action, particularly considering that it already maintains several mechanisms for managing the appropriateness of dental services and the fact that several of the overpayments identified by OSC are the result of the beneficiaries changing dentists during the five-year audit period. Changing dental providers is the beneficiaries' right and, when limited in occurrence, is neither abusive nor excessive. If warranted, the Department will explore the feasibility of a system development project to convert or modify a subsystem other than DVS, such as ePACES, for the purpose of creating a claims history that could be utilized by providers to determine if service limits have been met.

* Comment 2

It is additionally relevant to note that in February 2009 and in April 2010, to curb potentially inappropriate activity by providers and/or beneficiaries, the Department implemented additional edits and set them to report on questionable patterns. The Department also developed a new query that is run monthly and utilizes the Data Warehouse to identify excessive utilization for specific procedures such as those identified in this audit. The results are used to make referrals to the Office of the Medicaid Inspector General (OMIG) for provider investigation and recoupment and beneficiary inclusion in the Recipient Restriction Program.

* Comment 3

Recommendation #4:

Establish edits for rate-based claims for dental procedures to ensure providers are paid only at the limits set forth in the Dental Manual.

Response #4:

The Department will evaluate establishing edits for rate-based claims for dental procedures, taking into consideration the potential impact on access to essential preventative dental services.

Recommendation #5:

Review the overpayments we identified and recover the excessive amounts paid, as appropriate. As priorities and resources permit, follow up on claim payments for excessive services to determine if certain providers have abused the Medicaid program. Take actions with such providers, as appropriate.

Response #5:

The OMIG will review the overpayments identified by OSC and pursue appropriate recoveries as priorities and resources permit. However, it is relevant to note that OSC's overpayment calculation does not reflect current edit settings which potentially allow for a third examination, cleaning and fluoride treatment (children only) annually. In addition, the fee-for-service overpayments identified by OSC include payments for 9,150 clients of the Office for People with Developmental Disabilities (OPDD; formerly OMRDD). The Department questions whether these claims should have been included in the OSC review, as the dental needs of this population may not be representative of a mainstream population. Applying the present edit settings and

* Comment 4

* See State Comptroller's Comments, page 23.

eliminating the claims for the OPDD clients reduces the $14.0 million in overpayments estimated by the OSC to $1.4 million.

Recommendation #6:

Make a formal assessment of the level of the fees paid by New York's Medicaid program for routine dental services. Compare New York's fees with the fees paid in other states and determine if adjustments are justified to achieve savings by lowering fees for certain procedures, such as evaluations and cleanings.

Response #6:

The Department will evaluate the levels of reimbursements for routine dental services in context to the New York State Medicaid Program, beneficiary needs, appropriate access to care, usual and customary dental fees in New York State and the already existing shortage of dentists willing to participate in the Medicaid program. While lowered reimbursement can achieve savings, it can also be a barrier to access by negatively affecting provider participation, thereby violating State and Federal requirements. In fact, this was the premise of the 2000 dental lawsuit against the New York State Medicaid Program. Such concerns must be considered when determining reimbursement levels and comparing reimbursement levels to that of other states.

* Comment 5

The Department issued a report in March 2010 entitled, "Increasing the Supply of Dentists, Midwives, Physician Assistants, and Nurse Practitioners in Underserved Areas Through Doctors Across New York Physician Loan Repayment Program Incentives." According to the report there has been an overall decline in the number of active dentists; there is a shortage of dentists in underserved areas; and dentists have high levels of educational debt and substantial financial burdens establishing a dental practice.

Furthermore, a Pew Center on the States report entitled, "The Cost of Delay: State Dental Policies Fail One in Five Children" noted that although New York Medicaid reimburses dentists at a level that exceeds the national average, it falls short of the national average for the percentage of Medicaid-enrolled children receiving care, serving only about 34 percent of those children in 2007.

* See State Comptroller's Comments, page 23.

State Comptroller's Comments

1. Our report does not question the benefit of preventative services. Moreover, we acknowledge that preventative services can be more cost effective than treating diseases that might otherwise result without preventative care. Nonetheless, the Department has established formal limitations on the amounts of preventative services that recipients can receive, in part to ensure that limited public funding is used prudently. As documented in our report, certain recipients received well in excess of the prescribed amounts of dental services. Moreover, we identified nearly $40 million in Medicaid payments for excessive levels of services. Given the State's current fiscal crisis, we maintain that the Department should take the steps necessary to ensure that Medicaid no longer pays for excessive levels of dental care.

2. Our report does not challenge beneficiaries' rights to change dentists. Moreover, given the results of our audit, we maintain that the development of a subsystem that could be used by providers to determine if service limits have been met is now warranted.

3. We acknowledge the Department's recent efforts to establish eMedNY edit controls to detect payments for excessive levels of services. However, as stated in our report, the Department's reports on questionable billing patterns address only service levels that are well beyond the prescribed standard limits (which are generally two services per year). Specifically, Department reports note when recipients receive five or more periodic oral evaluations per year, five or more cleanings per year, and seven or more fluoride treatments per year. Consequently, the effectiveness of these controls is limited.

4. We acknowledge that there may be unique, case-by-case instances in which recipients with disabilities require services beyond the normal limits. However, our analysis showed multiple instances of billings for certain OPDD clients that were well in excess of the limits. For example, Medicaid paid more than $7,900 in routine dental services in a single year for one OPDD recipient. Moreover, if Department officials conclude that OPDD recipients require more than the standard levels of preventative dental care, they should amend the formal Medicaid guidance on this matter.

5. We commend the Department for efforts to evaluate reimbursement levels in the Medicaid dental program. We also acknowledge that lower reimbursement fees could possibly have a negative impact on provider participation. Nonetheless, Department officials advised us that material increases in fee rates, made pursuant to the lawsuit in 2000, did not appreciably increase the number of participating dental providers. Thus, we believe that the impacts of any prospective fee changes (increases or decreases) are questionable and would have to be formally assessed by the Department.