DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton/FOIA	6-24-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 100582	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Stensland Cleared 7/9/11, letter attached. ✓	[ ] Prepare reply for appropriate signature DATE DUE _____ [X] FOIA DATE DUE 7-12-11 [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Brenda James - Freedom of Information Request

From: "Harris, Deborah" <DHarris@mcnair.net>
To: "'hepfer@scdhhs.gov'" <hepfer@scdhhs.gov>, "'stensland@scdhhs.gov'" <ste...
Date: 06/24/2011 1:01 PM
Subject: Freedom of Information Request
CC: "Kirk, Ariail" <AKirk@MCNAIR.NET>
Attachments: 20110624123354323.pdf

Gentlemen:
Attached please find a Freedom of Information Request letter from Ariail B. Kirk, Esquire with Exhibit 1 attached.
Best regards,
Deborah Harris

McNair

Deborah Harris
Legal Assistant
dharris@mcnair.net | 803 753 3404 Direct

McNair Law Firm, P.A.
Columbia Office 1221 Main Street | Suite 1800 | Columbia, SC 29201
803 799 9800 Main | 803 933 1424 Fax
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MCNAIR
ATTORNEYS

Ariail Burnside Kirk

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T (803) 799-9800
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June 24, 2011

Via E-mail: stensland@scdhhs.gov and hepfer@scdhhs.gov

Richard G. Hepfer, Esquire
Deputy General Counsel
SC DHHS
1801 Main Street, 6th Floor
Columbia, SC 29201

Jeff Stensland
Office of Public Information
SC DHHS
PO Box 8206
Columbia, SC 29202-8206

Re: Freedom of Information Request

Dear Messrs. Hepfer and Stensland:

I am writing pursuant to the South Carolina Freedom of Information Act, S.C. Code Ann. §§ 30-4-10, et seq. (1976), to request copies of the following documents:

> All documents showing any correspondence or other documents showing any amounts of money paid to the United States related to the alleged $376,289.00 disallowance identified in the August 31, 2010 letter attached here as Exhibit 1.

To the extent that this request may seek any documents containing Protected Health Information ("PHI"), we request that any PHI be redacted. I will be pleased to reimburse the Department for the cost of copies of newly requested documents. Please call my office when the documents are ready, and I will send a courier to retrieve them.

Very truly yours,

Ariail Burnside Kirk

ABK:dh
Enclosure: Exhibit 1

McNair Law Firm, P. A.
1221 Main Street
Suite 1600
Columbia, SC 29201

Mailing Address
Post Office Box 11390
Columbia, SC 29211

mcnair.net

South Carolina Department of Health & Human Services

Emma Forkner • Director
Mark Sanford • Governor

August 31, 2010

CERTIFIED MAIL

Ariail Burnside Kirk
McNair Law Firm, PA
1221 Main Street, Suite 1600
Columbia, SC 29201

Provider #: ZA9690
Case #: P2644

Dear Ms. Kirk:

As part of the Program Integrity review process, we hold an informal conference with providers in order to address any questions about the review and to receive any additional information that could impact the findings. We appreciated the opportunity to meet with you and Celeste Jones along with your client, Dr. John Reese III, on July 13, 2010, to discuss the results of the Program Integrity review of Dr. Reese's Medicaid records. We also received the correspondence dated July 28, 2010, from you on Dr. Reese's behalf, and we assume that is his position regarding the Program Integrity review. We have considered information discussed during the informal conference and in your correspondence, and this letter details the outcomes of our review.

Before I respond to your response to each of the audit findings, I would like to provide some general clarification of the department's position in this case.

First and foremost, this case involves an overpayment to Dr. Reese; that is, in the most basic of terms, Dr. Reese was paid too much for the services he provided, when compared to the published Medicaid rates at that time. This overpayment was a direct result of Dr. Reese's method of filing claims for Medicaid reimbursement. All Medicaid claims are adjudicated (i.e. processed) and paid through the Medicaid Management Information System (MMIS). Payment rates are hardcoded into the system. Providers are informed of these rates, which are published in the provider manual and in provider bulletins when updates to the rates occur.

The claims in question that were submitted by Dr. Reese involved multiple restorations to the same tooth during a single patient encounter. The pricing logic (i.e., payment rules) incorporated in the MMIS assigns a bundled rate when multiple amalgam and resin fillings are applied to the same tooth, at the same time, but on different surfaces of the tooth. Therefore, a one-surface filling receives the full rate for a single surface; however, if a second filling is placed on the same tooth at the same time, the rate paid is not double the single surface rate but is a bundled rate – the full, one-surface rate plus a lesser payment for the second filling on another surface of the same tooth. Dr. Reese, however, circumvented these pricing rules by splitting a single patient encounter between two separate claims when he did two or more restorations on a single tooth. Our policy and rules involving multiple restorations are discussed further in Finding #1.

Second, your contention that "the Department's March 2005 implementation to the editing system to automatically bundle single-surface restorations violated Dr. Reese's due process right" indicates a lack of understanding of the Medicaid program. First, SCDHHS, as the single

Division of Program Integrity
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EXHIBIT
tabbies
1

State Medicaid agency, has authority under state and federal law to administer the Medicaid program. This authority includes setting payments for services, which must be consistent with efficiency, economy, and quality of care (42 CFR447.203). The payment rates in effect from January 1, 2005, through October 1, 2008, were published in the 2000 Medicaid manual, and are enclosed for your review. The changes were made to the MMIS in order to automatically apply the correct rate that was already established in the policy manual. SCDHHS is only required to issue a public notice to providers when "significant changes to its methods and standards for setting payment rates for services" is proposed. (42 CFR 447.205).

Third, please be aware the Program Integrity reviews look for waste, overpayments, excessive or improper payments, and abuse of the Medicaid program. Upon suspicion of fraud, SCDHHS must refer the case to the Medicaid Fraud Control Unit in the State Attorney General's Office. This is the process that Program Integrity followed in regards to Dr. Reese. Your contention that "there is absolutely no evidence of a fraudulent act" is not relevant to this case. As noted, the review in question is an overpayment case. It is also clearly abuse of the Medicaid program, which is defined as: "Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result 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 care" (42 CFR§ 455.2). Our final determinations of the findings from this review are as follows:

Finding #1: Unbundling, resulting in a total of 8,620 disallowed claims, totaling $374,684.00, (see Discrepancy Key G).

G2. Different claim forms were used to bill for filling restorations applied to different surfaces of the same tooth on the same date of service, resulting in 8,620 disallowed claims. Our review of claims data for the period of January 1, 2005, to June 30, 2008, found eight thousand six hundred twenty (8,620) instances of two or more restorations that were separately billed when a multiple surface restoration was performed. As noted above, the use of multiple claim forms caused the "unbundling" of services that are supposed to be combined under a single payment and resulted in excess payment to Dental Access, and constitutes abuse of the Medicaid program. Program policy directs providers to bill multiple restorations on the same tooth on the same date of service so that it will be combined (bundled) by SCDHHS and reimbursed at the combined surface rate. By using two separate claim forms, SCDHHS' claims processing system was unable to combine the surfaces to pay the Medicaid rate.
Disallowance: $374,684.00

Resolution #1: As discussed in our meeting and illustrated on the spreadsheet example of actual claims submitted by Dental Access, Dr. Reese billed multiple filling restorations on the same tooth for the same date of service and patient using separate claim forms. This caused MMIS to apply the full, one surface rate to both fillings. If Dr. Reese had submitted this same information but on a single claim, the MMIS would have applied the pricing logic and paid at the bundled, correct rate. Because Dr. Reese split the restorations for the same patient encounter and tooth among two or more individual claims, the MMIS was unable to apply the correct price, and thus Dr. Reese was overpaid.

The SC Medicaid Dental Provider Manual, dated January 1, 2000, in the second example outlined under "Restorative Service", on page 400-4 instructs providers how multiple tooth surfaces should be combined to be billed. "Example #2: · MOB and DOBL must be combined and billed as MODBL." This is just one example of multiple surface combinations, and it applies regardless of whether there is a "single restoration covering multiple surfaces of a tooth" or whether there are "multiple restorations (i.e. fillings that are not contiguous) on multiple surfaces of the same tooth." There is no difference in policy or pricing methodology between the two and your assertion of this is incorrect.

Page 400-5 of the Medicaid Dental Manual shows the reimbursement rates for fillings that were in effect during the period of this review. The published rates clearly show that a one-surface filling will be reimbursed at $58.00 and a two-surface filling will reimburse for $75.00 (obviously not double the one surface rate).

In addition, the Medicaid Dental Manual instructs providers to "use one claim form for each patient". For example, on tooth #30 an occlusal (O) filling of resin material and a separate buccal (B) filling of resin material should have been billed as it was performed; one claim line would contain #30 O (D2391) and the next line would contain #30 B (D2391). The two surfaces would have been combined by the MMIS and paid at the two-surface filling rate. As each electronic claim form contains 99 lines to list each treatment performed for a date of service, there is no need for another claim form unless the amount of work exceeded the 99 claim lines. We do not see any evidence of Dental Access performing in excess of 99 procedures for a beneficiary on a given day: thus, no need for an additional claim form.

The up-dated Medicaid Dental Manual, dated March 15, 2008, page 4-9, re-states the policy that "multiple restorations on the same tooth on the same date of service will be combined by SCDHHS and reimbursed at a combined surface rate." Refer to the Medicaid Dental Manual, dated January 1, 2000, pages 300-3, 400-4, and 400-5.

The original disallowance of $374,684.00 remains.

Finding #2: Medically Unnecessary Services: The medical/dental necessity for the treatment or services was not documented in the treatment record as required by SCDHHS program policies for a total of fifty-one (51) disallowed claims, totaling $1,377.00 (see Discrepancy Key A).

A.3. We reviewed claims information for all sealants billed by Dr. Reese from January 1, 2005, through January 31, 2008. There were thirty (30) instances of billing for sealants in excess of Medicaid frequency limits. Also, we noted nineteen (19) instances of billing for a sealant on a beneficiary either over or under the age limit as established by South Carolina Medicaid Policy. Policy allows for sealants to be placed on children between the ages of 6-15, once every three years, on first and second permanent molars. Claims for services in excess of policy limits are non-covered, and therefore this resulted in an overpayment by Medicaid. Refer to the Medicaid Dental Manuals, dated January 1, 2000, page 400-3, and March 15, 2008, page 4-8. In addition, refer to the Medicaid Bulletins dated October 9, 2000, and January 1, 2009.

Disallowance: $1,315.00

Resolution: While we recognize that CMS and the American Academy of Pediatric Dentistry (AAPD) has specific recommendations in regards to sealants, SCDHHS very clearly states in the Medicaid Dental Manual that sealants be placed on children between the ages of 6-15, once every three years, on first and second permanent molars. SCDHHS does not tell providers how to practice dentistry but does establish rules and guidelines for coverage limitations and reimbursement. Refer to the Medicaid Dental Manuals, dated January 1, 2000, page 400-3, and March 15, 2008, page 4-8. In addition, refer to the Medicaid Bulletins dated October 9, 2000, and January 1, 2009.

A.13. A servicing provider (P. McBrayer) employed by Dental Access, was rendering services outside her scope of practice, resulting in two (2) disallowed claims. The treatment record for one patient indicated that two teeth, billed as extraction of coronal remnants-deciduous tooth (D7111), were actually removed when the hygienist was flossing during the course of the prophy. Section 40-15-70 of the South Carolina Code of Laws on the practice of dentistry, subpart c states that "a person is practicing dentistry who: ... shall extract teeth". Claims filed by an individual practicing outside his or her scope of practice are considered improper and an unnecessary cost to the Medicaid program. Refer to South Carolina Medicaid Dental Manuals dated January 1, 2000, page 100-8 and March 15, 2008, page 1-1.
Disallowance: $62.00

Resolution: The Dental Access' documentation reviewed by Program Integrity, was signed by P. McBrayer, and stated that "#I and S were ext while flossing." Therefore, Ms. McBrayer documented in the treatment record that the teeth were extracted (ext is almost always used as shorthand for extraction) while flossing. The flossing session is in her scope of practice; however, since it was billed and documented as extractions, we had to infer that she extracted the teeth, thus operating outside the scope of hygiene practice. If the baby teeth were so loose as to come out while flossing, then this should not have been billed as an extraction but considered incidental to the flossing, and not a separately billable service.

Finding #3: No documentation: The treatment record and/or key components of the treatment record were missing resulting in one (1) disallowed claim, totaling $53.00 (see Discrepancy Key B).

B.2. An entry for a sedative filling (D2940) was not written in the treatment record resulting in one (1) disallowed claim. Program policy requires that a complete patient clinical record be maintained for Medicaid patients. Documentation is required in order to substantiate what services were actually performed, to reflect the extent of services, and establish the medical necessity of the billings to Medicaid. When there is no documentation to support the services billed it results in an improper claim and an unnecessary cost to the Medicaid program. Refer to the Medicaid Dental Manuals, dated January 1, 2000, page 200-2 and March 15, 2008, page 2-11.
Disallowance: $53.00

Resolution #3: This finding was not contested and the original disallowance of $53.00 remains.

Finding #4: Inappropriate combination of services billed resulted in three (3) disallowed claims, totaling $175.00 (see Discrepancy Key H).

H.3. A sedative filling was billed with a pulpotomy resulting in three (3) disallowed claims. The Medicaid Manual expressly states that therapeutic pulpotomy (D3220) and sedative filling (D2940) cannot be billed together. The sedative filling is a temporary restoration to relieve pain. The inappropriate billings have resulted in a Medicaid overpayment to you. Refer to the South Carolina Medicaid Dental Manuals, dated January 1, 2000, page 400-6 and March 15, 2008, page 4-11.
Disallowance: $175.00

Resolution #4: This finding was not contested and the original disallowance of $175.00 remains.

General Issues

- It was noted that Dr. Reese's office places a large number of sedative fillings (D2940) with documentation indicating food impaction and sensitivity. These reasons alone are not enough to document the medical necessity for sedative fillings. According to the South Carolina Medicaid Dental Manual dated January 1, 2000, page 400-6, "sedative fillings should be used as a temporary restoration to relieve pain." Payment is contingent upon medical necessity within program guidelines and supported by justifying documentation. Documentation will consist of a complete and accurate treatment record and accountability of other special services. Refer to the South Carolina Medicaid Dental Manuals dated January 1, 2000, page 200-2 and March 15, 2008, page 2-11.

  Discussion: As discussed during the informal conference, food impaction is not sufficient reason to bill sedative filling. We discussed sensitivity in relation to the Medicaid Dental Manual which states that "a sedative filling: temporary restoration intended to relieve pain." Sensitivity implies that the problem is uncomfortable but well tolerated. Pain implies such a degree that is not tolerated and needs an intervention. For example, one may have teeth sensitive to cold so one may avoid ice in drinks and ice cream but would not require a sedative filling on each sensitive area. The Manual also instructs providers on documenting medical necessity. The Manual states "The dental provider's treatment record on each beneficiary must substantiate the need for services, including all findings and information supporting medical necessity and detailing all treatment provided." To provide justification of medical necessity, a provider would need to notate the appropriate symptoms. An example would be #J is painful to cold when eating ice cream, #3 is painful to hot and cold, #30 is very painful to cold and percussion and contains deep decay. We would expect that the following billing be a permanent treatment performed to the tooth to alleviate the pain and not an additional billing for a sedative filling.

  To further clarify, the Manual states that "The Medical treatment record is a legal

document, and it must contain the patient's chief complaint, diagnosis, and documentation of services performed." Refer to South Carolina Medicaid Dental Manuals, dated January 1, 2000, page 200-2 and March 15, 2008, page 2-11.

Discussion: In reviewing Dr. Reese's Medicaid claims, it was noted that he billed sedative fillings in combination with root canals. His medical documentation did not indicate the need for a sedative filling on the same date of service and in the same tooth as the root canal. A sedative filling is described in the CDT as a "temporary restoration intended to relieve pain;" however, root canal therapy removes the nerve completely from the tooth thus relieving the pain. We do not see the necessity for the sedative filling to relieve pain and calm the nerve of the tooth if the nerve has been completely removed. There was no additional documentation to support the billing; therefore, criteria for medical necessity was not met. While we recognize that the Medicaid Dental Manual does not specifically forbid the combination billing of root canal with sedative filling, it is an accepted practice standard to apply a temporary filling to the "hole" that is left following a root canal therapy until the patient returns for the final restoration. SCDHHS expects a temporary filling, of any material, to be included in the root canal fee. This should not have been separately billed. Refer to South Carolina Medicaid Dental Manuals, dated January 1, 2000, page 200-2 and March 15, 2008, page 2-11. Refer to the 2007-2008 Code of Dental Terminology, page 15.

- Some services performed by associate dentists were billed under your individual Medicaid Provider identification number. All claims billed to Medicaid must have the name and individual provider number of the actual servicing provider on the claim form in order to appropriately bill for services.

Discussion: As your response indicates, this issue has been resolved by your client. However, should this occur again we may need to open a new investigation to ensure that the correct servicing provider ID number is submitted on the claim and that state and federal payment rules are not circumvented.

Conclusion: There is no change in the original disallowance previously cited in the May 6, 2010 letter. The total disallowance remains at $376,289.00. We have considered all of the factors in determining the sanction of recoupment, pursuant to State Regulations 126-401 and 126-402. We have determined that these funds must be repaid to SCDHHS based on the following factors pursuant to State Regulations 126-401 and 126-402. These factors are:

(a) Seriousness of the offense – The deliberate use of separate claim forms to bill for filling restorations applied to different surfaces of the same tooth on the same date of service circumvented Medicaid payment rules, resulting in an overpayment and abuse of the Medicaid program. In addition, failure to develop and maintain sufficient documentation to support the medical necessity or justification for services provided is non-compliant with basic Medicaid requirements that services provided must be medically necessary. Refer to South Carolina Medicaid Dental Manuals, dated January 1, 2000, page 200-2, 400-4 and March 15, 2008, pages 1-11, 2-11, and page 4-9.

(b) Extent of violations – From January 1, 2005, through June 30, 2008, Dr. Reese split multi-surface restorations performed during a single patient encounter between two or

more claims. This billing practice circumvented MMIS pricing logic and caused excess payments. The fact that this practice influenced the payment for ***8,620*** claims indicates more than an inadvertent or occasional billing error. Dr. Reese should have been aware that he was receiving payments in excess of the published rates, since the remittance advice he would have received with each Medicaid payment clearly shows the amount he was paid.

(c) History of prior violations – This is the first Program Integrity (PI) review of Dr. Reese's practice. However, as an enrolled Medicaid provider, his Provider Enrollment agreement certifies that as a condition of participation and payment, he understands and agrees that all services rendered and claims submitted shall be in compliance with all applicable federal and state laws and regulations and in accordance with SCDHHS policies, procedures, and Medicaid provider manuals.

(d) Prior imposition of sanctions – SCDHHS has imposed no prior sanctions on Dental Access, Carolina. However, Dr. Reese has been furnished with South Carolina Medicaid Dental Manuals that explain in detail the proper procedures for billing Medicaid and the expectations that Medicaid has of its providers regarding the manner in which records should be retained. Dr. Reese has the benefit of a provider representative within the Medicaid agency to whom he can address any questions concerning procedures and billing, and other opportunities for provider education and information regarding Medicaid billing requirements. In fact, the dental service provider representative had cautioned Dr. Reese in the past about the billing practices that were the subject of this review.

(e) Provider failure to obey program rules and policies as specified in the appropriate Provider Manual or other official notices – As noted in our findings, there were multiple instances of failure to follow the requirements established SCDHHS.

Medicaid program policy is developed so that providers can know what the requirements for billing services are in order to establish medical necessity and to reflect the extent of the service performed. They are also developed so that services will be reimbursed in accordance with sound medical and business practices. When these requirements are met, they are in compliance with standards set forth by Federal code for participation and reimbursement by the state Medicaid agency. When these conditions for billing are not met, they result in overpayments to the provider for services that are not substantiated by documentation, do not establish medical necessity and do not indicate the extent of the service performed. Ultimately, they result in unnecessary costs to the Medicaid program, which is prohibited by Federal Code and fits the definition of abuse.

If you believe that SCDHHS is in error of its findings, you have the right to an evidentiary hearing with the Division of Appeals and Hearings in accordance with the South Carolina Code of Laws R. 126-150. Within thirty (30) calendar days of receipt of this letter, your written request, a copy of the letter dated May 6, 2010, the findings being appealed, and a copy of this letter should be sent to Mr. Robert French, Division of Appeals and Hearings, Department of Health and Human Services, Post Office Box 8206, Columbia, South Carolina 29202-8206. Questions related to the appeal may also be directed to Mr. French at (803) 898-2600 or 800-

763-9087. You will be invoiced for the overpayment within 30 days. Upon receipt of the invoice, you may contact the Department of Accounting Operations to make payment arrangements or request your future payments be debited. The contact information for the Department of Accounting Operations will be on the invoice.

If you have any questions concerning the review, please call Tresa Martin, RDH at (803) 898-2615.

Sincerely,

Valerie S. Pack, Department Head
Department of Medical & Ancillary Service Review
Division of Program Integrity

VSP:tem

NOTE: The Federal and State authority for this review and recovery of the improper payments can be found at Reg. 126.401 et seq. Code of Laws of South Carolina 1076 as amended. – Administrative Sanctions against Medicaid Providers; 42 CFR 433.300 et seq. - Refunding of Federal Share of Medicaid Overpayments to Provider; See also 42 CFR Part 431.107 – Required Provider Agreement; 455 - Program Integrity, and 456 – Utilization Control.

Log # 582 + 586

South Carolina Department of
Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

July 19, 2011

M. Elizabeth Crum, Esquire
McNair Law Firm, PA
1221 Main Street, Suite 1500
Columbia, SC 29201

Dear Ms. Crum:

Your Freedom of Information Act requests dated June 24, 2011 and June 30, 2011 have been reviewed. As requested, we are sending information to you incrementally to enable you and your client to begin review. The responses are as follows:

Related to the June 24, 2011 letter:

1. For 4th quarter 2006 and 1st quarter 2007 the MHN data was compared to MCO data rather than fee-for –service data. All other quarters were compared to MCO data. A recalculation using fee-for-service data for the 4th quarter 2006 and 1st quarter 2007 would be extremely difficult, if not impossible, to recalculate. SCDHHS has provided spreadsheets showing the re-calculations previously and has attached the spreadsheets supporting the original calculations.

2. The eligibility file provided on May 12, 2011, was from the same source as the file used to perform the recalculation. SCDHHS hereby provides the extract of Community Health Solutions (CHSA) data from the actual file used to perform the calculation. It is available in the file named SCS.zip on the ftp server named sftp.chsamerica.com that we have used for the exchange of this data in the past.

3. The claims file provided on May 9, 2011, was from the same source as the file used to perform the recalculation. SCDHHS hereby provides the extract of CHSA data from the actual file used to perform the calculation. It is available in the file named SCS.zip on the ftp server named sftp.chsamerica.com that we have used for the exchange of this data in the past.

4. SCDHHS confirms the Claim amount shown on a spread sheet for any given month is based on the claims' Date of Service not the pay date.

5. Attached please find a copy of two pdf documents that were provided to Kyle Moll by Roy Hess on June 28, 2011. Also, please find a document which contains the list of changes to the methodology.

6. Please see response to #5 above.

9. Attached please find the explanation related to the kicker payments.

Related to the June 30, 2011 letter:

1. Programmatic changes made to MCOs during the period of 2006 through 2009 may be found in the rate books for the MCOs. The rate books are being compiled and will be provided when available. Attached please find spreadsheets showing the MCO rate history and a spreadsheet which provides a history of many of the changes made in the managed care program during the time period in question.

2. Please see response to #1 above.

3. Please see response to #1 above.

4. Please see response to #1 above.

We are continuing to compile the data you requested in the June 28th letter for items 7 and 8. Once all is compiled, we will notify you of it availability as well as the cost for reproducing all of the requested data.

I hope this information is helpful to you. Please contact me if there are any questions.

Sincerely,

Deirdra T. Singleton
General Counsel

DTS/h

Attachments