

April 3, 2014

Marilyn Tavenner  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Ave., SW  
Washington, DC 20201

Dear Administrator Tavenner:

We are writing today to express concern over aspects of the Recovery Audit Contractor (RAC) program affecting Medicaid programs as provided for in the Patient Protection and Affordable Care Act (ACA). Program integrity in Medicaid is a priority for all stakeholders, including practitioners and taxpayers who provide the funds for these programs. The American Dental Association (ADA) expects all of our members to adhere to the ADA “Code of Ethics”, which include three important principles pertinent to Medicaid program integrity: nonmaleficence, beneficence and veracity.<sup>1</sup> The ADA supports best practices by federal and state governments that ensure wise spending of finite dental dollars in each state and includes appropriate utilization management practices, such as valid statistical sampling and extrapolation.

As you are aware, the Medicare RAC audit program has experienced a number of problems. It has come to our attention that the Medicaid RAC program, as expanded under the ACA, is negatively impacting providers and the patients they serve in at least one state. If properly and timely addressed with some guidance from the Centers for Medicare and Medicaid Services (CMS), we believe well informed and knowledgeable stakeholders, including the ADA, could establish best practices that would assist federal regulators and all states implement a fair, transparent Medicaid RAC audit program and avoid some of the problems currently facing the Medicare RAC program.

According to a June 15, 2013, communication from Dr. Kristina Lake Harriman, clinical director of the Community Dental Center in Waterville, Maine, a Medicaid RAC audit conducted on her facility felt “arbitrary and a bit unfair.” The factors that contributed to this conclusion were that the errors found in the audit were due, in part, to a combination of computer errors<sup>2</sup> that were subsequently fixed and the use of the extrapolation method that

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<sup>1</sup> ADA Code of Ethics includes: Section 2 – Principle: nonmaleficence (“do no harm”). Section 3 – Principle: Beneficence (“do good”). Section 5: Principle: Veracity (“truthfulness”).

<sup>2</sup> The clinic encountered a software problem during the claims submission process. The software used by the clinic requires the selection of a primary provider for each patient record created. For subsequent visits the primary provider was auto-selected regardless of which provider was seen and the problem occurred during the claim batch despite the appropriate provider’s name being documented in the patient file. Claims affected by this error were considered overpayments to the clinic by Maine’s Medicaid program.

converted a \$186 overpayment for toothbrush cleanings to a \$23,856 fine. Contributing to the sense of unfairness is the fact that practitioners are subject to a three-year look back rule for overpayments based on an audit of less than 1 percent of the claims submitted, while those same practitioners are limited to a case-by-case review of underpayments that must be submitted within 120 days of remittance. The \$23,856 fine is a serious financial burden on this non-profit center where 78 percent of its patients are Medicaid-eligible and where there was no intent to defraud the government.

Dr. Michael Dowling of Falmouth Pediatric Dentistry in Falmouth, Maine, testified before Maine's Joint Standing Committee on Health and Human Services regarding his facility's Medicaid RAC audit experience. He stressed that both practitioners and the Medicaid program made clerical errors, but the sampling of claims reviewed were skewed toward claims where practitioner error was most likely to be found. As a result, the subsequent extrapolation to all claims overstates the number of errors, resulting in a fine that is unwarranted.

Dr. Dowling also testified that to be fair, charts for the audit should be randomly chosen; that a licensed dentist from the state should review claims to ensure the treatment provided meets the proper standard of care; and that in the absence of fraud, clerical errors should be used as an occasion to educate rather than penalize the provider. State regulations regarding Medicaid administration vary widely across the country, and occasionally actually conflict with accepted private dental plan administration standards in the use of dental codes. Practitioners are at a severe disadvantage when they are held accountable for in depth knowledge of regulations that are not easily accessible, and sometimes, in contradiction to the vast majority of their dental practice management processes, including credentialing and claims submissions.

In a January 8, 2014, letter from Mr. Herbert Downs, the director of the Maine audit, to the Maine Dental Association, Mr. Downs indicated that he reached out to the CMS Medicaid Integrity liaison for Maine. Following the recommendations from the CMS official, no repayments will be sought for the computer errors described above. Also, a Maine dentist (in lieu of an out-of-state hygienist) will be used to review certain clinical records.

The above actions taken by the Maine Department of Health and Human Services with valuable input from CMS was an appropriate response to specific legitimate concerns raised by Maine dentists and the Maine Dental Association. But more needs to be done to ensure a fair, transparent Medicaid RAC audit process across *all* states.

Fraud is a problem that wastes limited resources available for Medicaid programs across the country. The dentists reviewed indicated that they knew they were likely to be audited based on the volume of Medicaid patients seen in their practices. They simply request a process that is fair, transparent and can be a learning experience, as opposed to a process that appears to simply penalize providers in a "pay and chase" system. At the end of the day, the dentists affected indicate they enjoy treating children in their community, but they

would appreciate more education on what the program expectations are with respect to billing and recordkeeping. ADA stands ready to assist in this education.

We request that CMS:

- examine the Medicaid RAC programs that have been implemented across the states and assess the impact such audits have had on providers enrolled in the program and subsequent patient access to services;
- compile a list of state education and outreach efforts on Medicaid RAC audits to determine the depth of provider education needed to function well within the Medicaid program;
- issue guidelines to help ensure such education takes place consistent with the final rule on Medicaid RAC programs, published September 16, 2011, requiring states to provide education and outreach to providers; and
- issue guidelines to establish a uniformly fair, transparent process concerning how and when extrapolation should be used to determine fines and to recommend the use of an in-state dentist to review clinical records where appropriate.

Ensuring participating providers are educated about the expectations and requirements of participation (beyond a notification that the Medicaid provider manual has been updated) would go a long way to help increase the awareness of all providers. This includes those currently enrolled as Medicaid providers as well as those expressing interest in participating in the future. With enrollment numbers increasing on a regular basis, now is the time to make changes to Medicaid participation to ensure that adequate numbers of providers are available to serve this underserved population.

Thank you for your prompt assistance in this matter. Please feel free to contact Ms. Janice Kupiec in the ADA's Washington, D.C. office at (202) 789-5177 or [kupieci@ada.org](mailto:kupieci@ada.org) should you have any questions.

Sincerely,



Charles H. Norman, D.D.S.  
President



Kathleen T. O'Loughlin, D.M.D., M.P.H.  
Executive Director

CHN: KTO: jk