Section 8 - Fraud, Abuse, and Quality of Care

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Surveillance and Utilization Review Subsystem (S/URS)

Introduction

Medi-Cal Dental's Surveillance and Utilization Review (S/UR) department monitors for suspected fraud, abuse, and poor quality of care as part of its duties as the Fiscal Intermediary for the Department and California Medi-Cal Dental . In overseeing appropriate utilization in the program, the S/UR department helps Medi-Cal Dental meet its ongoing commitment to improving the quality of dental care for Medi-Cal members.

The goal of the S/UR department is to ensure providers and members are in compliance with the criteria and regulations of Medi-Cal Dental.

Under the authority of the Federal Medicaid statutes, California Welfare and Institutions Code (W & I), the, Business & Professions Code, Dental Practice Act (click here for details), and the California Code of Regulations (CCR) Title 22, and with the assistance of the California Dental Association's Guidelines for the Assessment of Clinical Quality of Professional Performance, the S/UR department reviews treatment forms, written documentation, and radiographs for recurring problems, abnormal billing activity and unusual utilization patterns. The S/UR department staff determines potential billing discrepancies, patterns of over-utilization of procedures, incomplete, substandard, and/or unnecessary treatment.

Methods of Evaluation

The S/UR department employs several different means to evaluate suspected fraud and abuse of Medi-Cal Dental, including:

- **Utilization Review Analysis**: This statistical analysis compares a provider activity with that of his or her peers within a certain range, such as geographic area or dental specialty.
- **Referrals**: The Department of Health Care Services (DHCS), Medi-Cal Dental Services Division (MDSD), works in collaboration with the Department of Justice, the Bureau of Medi-Cal Fraud & Elder Abuse and the Dental Board of California on cases of suspected fraud, abuse and poor quality of care. These agencies often refer provider names for investigation to the S/UR department. The S/UR department also receives referrals from internal sources such as Professional Review Medi-Cal dental consultants.
- **Clinical Screening Examinations**: Patients are selected by the S/UR department for examination by a Medi-Cal Dental clinical screening consultant to determine if certain procedures for which authorization is requested are medically necessary, verify if billed procedures were in fact provided, and evaluate the professional quality of the treatment that was provided.

- **Member Fraud Unit**: A part of the S/UR department, the Member Fraud unit, monitors conflicts in patient dental histories to determine if Medi-Cal identification cards are being misused or services are being billed improperly.
- **S/URS Audits**: When poor quality of care, abuse, over utilization, or fraud is suspected, the S/UR department may elect to conduct an audit of patient records, including radiographs, obtained from the provider's office to gather additional information about the provider's activity.

Possible S/URS Actions

The S/UR department will take appropriate action at the direction of the Department of Health Care Services, Medi-Cal Dental Services Division (MDSD), to address situations where poor quality of care, inappropriate billings, and/or inappropriate utilization of services are identified. Such actions may include one or more of the following:

- **Summary of Findings Letter**: When minor non-conformities to Medi-Cal Dental criteria are detected, the S/UR department will send a letter informing and educating the provider of Medi-Cal Dental criteria, including program limitations, exclusions, and special documentation requirements. The letter will also direct the provider to modify his or her performance in accordance with the criteria and standards of Medi-Cal Dental.
- **Corrective Action Letter**: When poor quality of care is identified, Medi-Cal Dental will send a letter to the provider requesting that he or she take immediate action to correct the problem within 60 days. The letter will inform the provider that if the correction is not made within 60 days, Medi-Cal Dental will take action to recover payment for the procedures in question.
- **Prior Authorization/Special Claims Review**: The Department may require providers to obtain prior authorization for certain Medi-Cal Dental procedures to protect members from unnecessary treatment. The prior authorization procedure is described in "Section 2: Program Overview" of this Handbook. The Medi-Cal Dental may place a provider on Prior Authorization (PA) review for non-emergency procedures at any time by the Director upon a determination that the provider has been rendering medically unnecessary services based upon the Program's Manual of Criteria (MOC). If prior authorization review is initiated, there are no appeal rights.

  If the S/UR department determines that a provider is billing Medi-Cal Dental by submitting improper claims, including claims which incorrectly identify or code services provided, or are for procedures that are of poor quality, or were not provided, the provider may be placed on Special Claims Review. The provider will then be required to submit pre-operative and/or post-operative radiographs and other documentation to demonstrate the quality of treatment provided and to verify that the procedure provided corresponds to the procedure billed. Utilization

control requirements are in addition to the requirements outlined in "Section 2: Program Overview" of this Handbook and may be imposed under the authority of Title 22, California Code of Regulations (CCR), Sections 51159, 51455, and 51460. If Special Claims Review is initiated, there are no appeal rights.

- **Recovery of Payment**: Recovery for paid procedures may be obtained by withholding the amount to be reimbursed from a provider's future Medi-Cal Dental payments. Recovery may occur when a post-operative clinical screening exam or post payment review identifies any discrepancies in the billing or delivery of those services and/or for failure to complete a noticed corrective action.
- **Removal From Referral List**: If a provider's performance is deemed below the standard of professional care for a particular course of treatment, the provider may be subject to removal from the Medi-Cal dental provider referral list.
- **Other Agency Referral**: When S/URS investigations disclose a situation that may require criminal prosecution or action beyond the jurisdiction of Medi-Cal Dental, the matter will be referred to the Department of Health Care Services, MDSD, for possible referral to the Department of Justice, Bureau of Medi-Cal Fraud & Elder Abuse and/or the Dental Board of California. Referrals to these agencies may result in further investigation, prosecution, and suspension of the provider's license to practice.
- **Suspension from Medi-Cal Dental**: Non-compliance with corrective action and/or continued and persistent substandard care, fraud, and/or abuse as well as violation of any Medi-Cal statute, rule or regulation relating to the provision of health care services under the California Medical Assistance Program can lead to suspension of a provider's participation in Medi-Cal Dental.

Help Stop Fraud

Providers can help stop fraud and abuse in Medi-Cal Dental. If providers or members of the provider's staff are aware of any suspicious or fraudulent activity, send information to:

Medi-Cal Dental
Surveillance & Utilization Review
Department
PO Box 13898
Sacramento, CA 95853-4898

Please include the name of the person reporting the incident, the phone number, the provider's name, the location of his/her office, and an explanation of the incident. **Anonymity will be maintained upon request**. Because of the confidential nature of investigations, individuals will not be notified of the outcome of any case. All referrals

are appreciated and will contribute significantly to the ongoing efforts of detecting, halting, and preventing fraud and abuse in Medi-Cal Dental.

Statutes and Regulations

Pertaining to Providers

This section details certain State statutes and regulations that are binding on Medi-Cal dental providers, their designated agents, all public and private agencies and/or individuals that are engaged in planning, providing, or securing Medi-Cal Dental services for or on the behalf of recipients or applicants.

Confidentiality

The W & I Code, Section 10850 provides that names, addresses, and all other information concerning circumstances of any applicant or recipient of Medi-Cal dental services for whom, or about whom, information is obtained shall be considered confidential and shall be safeguarded. Both the release and possession of confidential information in violation of this statute are misdemeanors.

Record Keeping Criteria

Through its audit process, the S/UR department has found many areas to be deficient in the documentation of treatment for Medi-Cal dental members. Lack of proper documentation may result in an unfavorable audit and potential recovery of payments. It is also important to note that all documentation on Treatment Authorization Requests (TARs) and claims must be consistent with and supported by documentation in the record of treatment.

Providers should carefully review the full text of regulations regarding the keeping and availability of records.

Title 22, California Code of Regulations (CCR), Section 51476. (a) states:

Each provider shall keep, maintain, and have readily retrievable, such records as are necessary to fully disclose the type and extent of services provided to a Medi-Cal member. Required records shall be made at or near the time at which the service is rendered. Such records shall include, but not be limited to the following:

(1.)Billings.
(2.)Treatment authorization requests.
(3.)All medical records, service reports, and orders prescribing treatment plans.
(4.)Records of medications, drugs, assistive devices, or appliances prescribed, ordered for, or furnished to members.
(5.)Copies of original purchase invoices for medication, appliances, assistive devices, written requests for laboratory testing and all reports of test results, and drugs ordered for or supplied to members.

(6.)Copies of all remittance advices which accompany reimbursement to providers for services or supplies provided to members.
(7.)Identification of the person rendering services. Records of each service rendered by nonphysician medical practitioners (as defined in California Code of Regulations (CCR), Title 22, Section 51170) shall include the signature of the nonphysician medical practitioner and the countersignature of the supervising physician.

Title 22, California Code of Regulations (CCR), Section 51476. (d) states:

Every practitioner who issues prescriptions for Medi-Cal members shall maintain, as part of the patient's chart, records which contain the following for each prescription:

(1.)Name of the patient.
(2.)Date prescribed.
(3.)Name, strength, and quantity of the item prescribed.
(4.)Directions for use.

Title 22, California Code of Regulations (CCR), Section 51476. (g) states:

A provider shall make available, during regular business hours, all pertinent financial books and all records concerning the provision of health care services to a Medi-Cal member, and all records required to be made and retained by this section, to any duly authorized representative of the Department acting in the scope and course of employment including, but not limited to, employees of the Attorney General, Medi-Cal Fraud Unit duly authorized and acting within the scope and course of their employment. Failure to produce records may result in sanctions, audit adjustments, or recovery of overpayments, in accordance with California Code of Regulations (CCR), Title 22, Section 51458.1.

Welfare & Institutions Code, Section 14124.1. states:

Each provider, as defined in Section 14043.1, of health care services rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, shall keep and maintain records of each such service rendered, the member or person to whom rendered, the date the service was rendered, and such additional information as the department may by regulation require. Records herein required to be kept and maintained shall be retained by the provider for a period of ten years from the date the service was rendered.

NOTE: Examples of appropriate documentation to be placed in the services rendered portion of the patient chart include, but are not limited to:

- Type and dosage of local anesthetic;
- Type and dosage of vasoconstrictor;
- Number of carpules used;

- When local anesthetic is not used for procedures which normally call for local anesthetic, but is not used;
- Original radiographs and photographs must be included;
- Specific treatment and materials placed for restorative services;
- Specific service provided for topical fluoride application;
- Written documentation explaining emergency services;
- The extent and complexity of a surgical extraction; and
- Specific documentation for medical necessity, observations and clinical findings, the specific treatment rendered, and medications or drugs used during periodontal procedures.

Identification in Patient Record

Medi-Cal Dental will not pay for services unless the rendering provider is actively enrolled in Medi-Cal Dental at the time of treatment. Treatment of Medi-Cal dental patients by un-enrolled providers is not covered and will be subject to recovery of payments made.

Business and Professions Code, Section 1683. states:

(a.)Every dentist, dental health professional, or other licensed health professional who performs a service on a patient in a dental office shall identify himself or herself in the patient record by signing his or her name, or an identification number and initials, next to the service performed and shall date those treatment entries in the record. Any person licensed under this chapter who owns, operates, or manages a dental office shall ensure compliance with this requirement.

(b.)Repeated violations of this section constitute unprofessional conduct.

NOTE: Billing providers MUST ensure that all their rendering providers are enrolled in Medi-Cal Dental prior to treating Medi-Cal patients. Payments made to billing providers for services performed by unenrolled rendering providers are not covered and will be subject to recovery.

Cause for Recovery

Amounts paid for services provided to Medi-Cal members shall be audited by the department in the manner and form prescribed by the department. The department shall maintain adequate controls to ensure responsibility and accountability for the expenditure of federal and state funds. Overpayments may be recovered when the department discovers information that indicates the provider may have engaged in practices that have resulted in over reimbursement.

Welfare and Institutions Code Title 22, Section 51458.1. states:

(a.)The Department shall recover overpayments to providers including, but not limited to, payments determined to be:

(1.)In excess of program payment ceilings or allowable costs.

(2.)In excess of the amounts usually charged by a provider.

(3.)For services not documented in the provider's records, or for services where the provider's documentation justifies only a lower level of payment.

(4.)Based upon false or incorrect claims or cost reports from providers.

(5.)For services deemed to have been excessive, medically unnecessary or inappropriate.

(6.)For services prescribed, ordered or rendered by persons who did not meet the standards for participation in the Medi-Cal program at the time the services were prescribed, ordered or rendered.

(7.)For services not covered by the program.

(8.)For services to persons not eligible for program coverage when the services were provided.

(9.)For Medi-Cal covered services already paid for by the member, but not yet refunded, or for services already reimbursed by the Department or other coverage.

(10.) For services that should have been billed to other coverage.

(11.) For services not ordered or prescribed, when an order or prescription is required.

(12.) For services not authorized, when a treatment authorization request is required.

(13.) In violation of any other Medi-Cal regulation where overpayment has occurred.

(14.) The provisions of Sections 51488. and 51488.1. shall prevail in circumstances that conflict with this section.

Special Permits

Providers who administer general anesthesia and/or intravenous conscious sedation/ analgesia shall have valid anesthesia permits with the California Dental Board. Provision of these services is not a benefit of the program when provided by persons not holding the appropriate permit and payment is subject to recovery.

Utilization of Nurse Anesthetist

Providers who utilize the services of Nurse Anesthetists in a dental office must also hold the appropriate permit.

Business and Professions Code, Section 2827. states:

The utilization of a nurse anesthetist to provide anesthesia services in an acute care

facility shall be approved by the acute care facility administration and the appropriate committee, and at the discretion of the physician or dentist.

If a general anesthetic agent is administered in a dental office, the dentist shall hold a permit authorized by Section 1646.

Deep Sedation/General Anesthesia (D9222 and D9223)

Deep Sedation/General anesthesia is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.

Business and Professions Code, Section 1646.1. states:

(a.)No dentist shall administer or order the administration of general anesthesia on an outpatient basis for dental patients unless the dentist either possesses a current license in good standing to practice dentistry in this state and holds a valid general anesthesia permit issued by the board or possesses a current permit under Section 1638 or 1640 and holds a valid general anesthesia permit issued by the board.

(b.)No dentist shall order the administration of general anesthesia unless the dentist is physically within the dental office at the time of the administration.

(c.)A general anesthesia permit shall expire on the date provided in Section 1715 which next occurs after its issuance, unless it is renewed as provided in this article.

(d.)This article does not apply to the administration of local anesthesia or to conscious-patient sedation.

Business and Professions Code, Section 1646.7. states:

(a.)A violation of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, license, or both, or the dentist may be reprimanded or placed on probation.

(b.)A violation of any provision of this article or Section 1682 is grounds for suspension or revocation of the physician's and surgeon's permit issued pursuant to this article by the Dental Board of California. The exclusive enforcement authority against a physician and surgeon by the Dental Board of California shall be to suspend or revoke the permit issued pursuant to this article. The Dental Board of California shall refer a violation of this article by a physician and surgeon to the Medical Board of California for its consideration as unprofessional conduct and further action, if deemed necessary by the Medical Board of California, pursuant to Chapter 5 (commencing with Section 2000). A suspension or revocation of a physician and surgeon's permit by the Dental Board of California pursuant to this article shall not constitute a disciplinary

proceeding or action for any purpose except to permit the initiation of an investigation or disciplinary action by the Medical Board of California as authorized by Section 2220.5.

(c.) The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the Dental Board of California shall have all the powers granted therein.

Intravenous Moderate (Conscious) Sedation/Analgesia (Conscious Sedation) (D9239 and D9243)

Intravenous conscious sedation/analgesia (Conscious Sedation) is a medically controlled state of depressed consciousness that retains the patient's ability to maintain independently and continuously an airway, protective reflexes, and the ability to respond appropriately to stimulation or verbal commands. It includes intravenous (IV) administration of sedative and/or analgesic agent(s) and appropriate monitoring.

"Intravenous Conscious Sedation/Analgesia" (Conscious Sedation) does not include the administration of oral medications or the administration of a mixture of nitrous oxide and oxygen, whether administered alone or in combination with each other.

Business and Professions Code, Section 1647.2. states:

(a.) No dentist shall administer or order the administration of conscious sedation on an outpatient basis for dental patients unless one of the following conditions is met:

(1.) The dentist possesses a current license in good standing to practice dentistry in California and either holds a valid general anesthesia permit or obtains a permit issued by the board authorizing the dentist to administer conscious sedation.

(2.) The dentist possesses a current permit under Section 1638 or 1640 and either holds a valid anesthesia permit or obtains a permit issued by the board authorizing the dentist to administer conscious sedation.

(b.) A conscious sedation permit shall expire on the date specified in Section 1715 which next occurs after its issuance, unless it is renewed as provided in this article.

(c.) This article shall not apply to the administration of local anesthesia or to general anesthesia.

(d.) A dentist who orders the administration of conscious sedation shall be physically present in the treatment facility while the patient is sedated.

Business and Professions Code, Section 1647.9. states:

A violation of any provision of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, license, or both, or the dentist may be reprimanded or placed on probation. The proceedings under this section

shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

Non-intravenous Conscious Sedation (Oral Conscious Sedation) (D9248)

Non-intravenous conscious sedation (Oral Conscious Sedation) is a medically controlled state of depressed consciousness that retains the patient's ability to maintain independently and continuously an airway, protective reflexes, and the ability to respond appropriately to stimulation or verbal commands. It includes administration of sedative and/or analgesic agent(s) orally, by patch and by intramuscular or subcutaneous injection with appropriate monitoring.

The drugs and techniques used in oral conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from painful stimuli would not be considered to be in a state of oral conscious sedation.

For very young or handicapped individuals, incapable of the usually expected verbal response, a minimally depressed level of consciousness should be maintained.

"Minor patient" means a dental patient under the age of 13 years.

"Certification" means the issuance of a certificate to a dentist licensed by the board who provides the board with his or her name, and the location where the administration of oral conscious sedation will occur, and fulfills the requirements specified in Sections 1647.12. and 1647.13.

Business and Professions Code, Section 1647.11. states:

(a.)Notwithstanding subdivision (a) of Section 1647.2, a dentist may not administer oral conscious sedation on an outpatient basis to a minor patient unless one of the following conditions is met:

(1.)The dentist possesses a current license in good standing to practice dentistry in California and either holds a valid general anesthesia permit, conscious sedation permit, or has been certified by the board, pursuant to Section 1647.12, to administer oral sedation to minor patients.

(2.)The dentist possesses a current permit issued under Section 1638 or 1640 and either holds a valid general anesthesia permit, or conscious sedation permit, or possesses a certificate as a provider of oral conscious sedation to minor patients in compliance with, and pursuant to, this article.

(b.)Certification as a provider of oral conscious sedation to minor patients expires at the same time the license or permit of the dentist expires unless renewed at the same time the dentist's license or permit is renewed after its issuance, unless certification is renewed as provided in this article.

(c.)This article shall not apply to the administration of local anesthesia or a mixture of nitrous oxide and oxygen or to the administration, dispensing, or prescription of postoperative medications.

Business and Professions Code, Section 1647.14. states:

(a.)A physical evaluation and medical history shall be taken before the administration of, oral conscious sedation to a minor. Any dentist who administers, or orders the administration of, oral conscious sedation to a minor shall maintain records of the physical evaluation, medical history, and oral conscious sedation procedures used as required by the board regulations.

(b.)A dentist who administers, or who orders the administration of, oral conscious sedation for a minor patient shall be physically present in the treatment facility while the patient is sedated and shall be present until discharge of the patient from the facility.

(c.)The drugs and techniques used in oral conscious sedation to minors shall have a margin of safety wide enough to render unintended loss of consciousness unlikely.

Business and Professions Code, Section 1647.17. states:

A violation of any provision of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, certificate, license, or all three, or the dentist may be reprimanded or placed on probation. The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part I of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

<u>Oral Conscious Sedation for Adult Use</u>

As used in this article, the following terms have the following meanings:

(d.)Adult patient" means a dental patient 13 years of age or older.

(e.)Certification" means the issuance of a certificate to a dentist licensed by the board who provides the board with his or her name and the location at which the administration of oral conscious sedation will occur, and fulfills the requirements specified in Sections 1647.12. and 1647.13.

(f.) Oral conscious sedation" means a minimally depressed level of consciousness produced by oral medication that retains the patient's ability to maintain independently and continuously an airway and respond appropriately to physical stimulation or verbal command. "Oral conscious sedation" does not include dosages less than or equal to the single maximum recommended dose that can be prescribed for home use.

(1.)The drugs and techniques used in oral conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from

painful stimuli would not be considered to be in a state of oral conscious sedation.

(2.)For the handicapped individual, incapable of the usually expected verbal response, a minimally depressed level of consciousness for that individual should be maintained.

Business and Professions Code, Section 1647.19. states:

(a.)Notwithstanding subdivision (a) of Section 1647.2, a dentist may not administer oral conscious sedation on an outpatient basis to an adult patient unless the dentist possesses a current license in good standing to practice dentistry in California, and one of the following conditions is met:

(1.)The dentist holds a valid general anesthesia permit, holds a conscious sedation permit, has been certified by the board, pursuant to Section 1647.20, to administer oral sedation to adult patients, or has been certified by the board, pursuant to Section 1647.12, to administer oral conscious sedation to minor patients.

(2.)The dentist possesses a current permit issued under Section 1638 or 1640 and either holds a valid general anesthesia permit, or conscious sedation permit, or possesses a certificate as a provider of oral conscious sedation to adult patients in compliance with, and pursuant to, this article.

(b.)Certification as a provider of oral conscious sedation to adult patients expires at the same time the license or permit of the dentist expires unless renewed at the same time the dentist's license or permit is renewed after its issuance, unless certification is renewed as provided in this article.

(c.)This article shall not apply to the administration of local anesthesia or a mixture of nitrous oxide and oxygen, or to the administration, dispensing, or prescription of postoperative medications.

Billing Medi-Cal Dental

Billing for Benefits Provided

Title 22, California Code of Regulations (CCR), Section 51470. (a) states:

A provider shall not bill or submit a claim to the Department or a fiscal intermediary for Medi-Cal benefits not provided to a Medi-Cal member.

Title 22, California Code of Regulations (CCR), Section 51470. (d) states:

A provider shall not bill or submit a claim to the Department or a fiscal intermediary for Medi-Cal covered benefits provided to a Medi-Cal member:

(1.)For which the provider has received and retained payment.

(2.)Which do not meet the requirements of Department regulations.

Sub-Standard Services

Title 22, California Code of Regulations (CCR), Section 51472. states:

No provider shall render to a Medi-Cal member health care services which are below or less than the standard of acceptable quality.

Excessive Services

Title 22, California Code of Regulations (CCR), Section 51473. states:

No provider shall render to any Medi-Cal member, or submit a claim for reimbursement for, any health care service or services clearly in excess of accepted standards of practice.

Business and Professions Code, Section 1685. states:

In addition to other acts constituting unprofessional conduct under this chapter, it is unprofessional conduct for a person licensed under this chapter to require, either directly or through an office policy, or knowingly permit the delivery of dental care that discourages necessary treatment or permits clearly excessive treatment, incompetent treatment, grossly negligent treatment, repeated negligent acts, or unnecessary treatment, as determined by the standard of practice in the community.

Prohibition of Rebate, Refund, or Discount

Title 22, California Code of Regulations (CCR), Section 51478. states:

No provider shall offer, give, furnish, or deliver any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care service to any Medi-Cal member. No provider shall solicit, request, accept, or receive, any rebate, refund, commission, preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care service to any Medi-Cal member.

Billing for Suspended Provider

Title 22, California Code of Regulations (CCR), Section 51484. states:

No provider shall bill or submit a claim for or on behalf of any provider who has been suspended from participation in the California Medical Assistance Program, for any services rendered in whole or in part by any such suspended provider during the term of such suspension.

Submission of False Information

Title 22, California Code of Regulations (CCR), Section 51485. states:

No provider shall submit or cause to be submitted any false or misleading statement of material fact when complying with departmental regulations, or in connection with any claim for reimbursement, or any request for authorization of services.

Overpayment Recovery

Medi-Cal Dental collects overpayments identified through an audit or examination, or any portion thereof from any provider. A provider may appeal the collection of overpayments under this section pursuant to procedures established in Article 5.3 (commencing with Section 14170). Overpayments collected under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings if the findings are against the provider. Overpayments will be returned to a provider with interest if findings are in favor of the provider.

Title 22, California Code of Regulations (CCR), Section 51470. states:

(a.)When it is established upon audit that an overpayment has been made to a provider, the Department shall begin liquidation of any overpayment to a provider 60 days after issuance of the first Statement of Accountability or demand for repayment. The demand for repayment or Statement of Accountability shall be issued no later than 60 days after the issuance of the audit or examination report establishing such overpayment. The overpayment shall be recovered by any of the following methods:

(1.)Lump sum payment by the provider.

(2.)Offset against current payments due to the provider.

(3.)A repayment agreement executed between the provider and the Department.

(4.)Any other method of recovery available to and deemed appropriate by the Director.

(b.)An offset against current payments shall continue until one of the following occurs:

(1.)The overpayment is recovered.

(2.)The Department enters into an agreement with the provider for repayment of overpayment.

(3.)The Department determines, as a result of proceedings under this article, that there is no overpayment.

(c.)The provider shall pay interest at the rate of seven percent per annum on any unrecovered overpayment in all cases where the statement of account status was issued before June 28, 1981. In all other cases, the provider shall pay interest as provided by Welfare and Institutions Code Section 14171(f).

(d.)Nothing in this section shall prohibit a provider from repaying all or a part of the disputed overpayment without prejudice to his right to a hearing under this article.

(e.)Any recovered overpayment that is subsequently determined to have been erroneously collected shall be promptly refunded to the provider, together with

interest computed at the legal rate of seven percent per annum from the date of such liquidation or 60 days after issuance of the audit or examination findings, whichever is later. The provisions of this paragraph shall apply only to those overpayments determined by audit reports issued after April 6, 1976 and before June 28, 1981. In all other cases, interest shall be paid in accordance with the provisions of Sections 14171(e) and 14172.5, Welfare and Institutions Code.

(f.) (As used in this section, "Statement of Account Status" also includes statement of accountability or demand for repayment.

Civil Money Penalties

Title 22, California Code of Regulations (CCR), Section 51485.1 states:

(a.)The Director may assess civil money penalties against a person or provider ("provider") pursuant to Welfare and Institutions Code Section 14123.2 after a determination that the provider knows or has reason to know that items or services:

(1.)Were not provided as claimed,

(2.)Are not reimbursable under the Medi-Cal Program as provided in subsection (d), or

(3.)Were claimed in violation of an agreement with the State.

(b.)The Director's determination of whether a provider "knows or has reason to know" that items or services were not provided, are not reimbursable, or were claimed in violation of an agreement with the State (hereafter "improperly claimed"), shall be based on the following standards:

(1.)Knows: The provider is aware of a high probability of the existence of the fact that items or services were improperly claimed, or

(2.)Has reason to know: The provider has information from which a reasonable person in that position would infer that items or services were improperly claimed.

(c.)The Director's determination of whether the provider knows or has reason to know that items or services were "not provided as claimed" shall be based on information available pursuant to Section 51476.

(d.)The Director shall determine whether or not the provider knows or has reason to know that claimed items or services are "not reimbursable under the Med-Cal Program" in the following instances:

(1.)The provider has been suspended from participation in the Program,

(2.)The claimed items or services are substantially in excess of patient needs as de fined in Section 51303(a),

(3.)The items or services are deficient in quality compared with professionally re cognized standards of health care (See Section 51472),

(4.)The provider has demonstrated a pattern of abusive overbilling to the Medi-Cal Program. Evidence of such overbilling shall include, but not be limited to:

(A.) Medi-Cal Dental audit adjustments repeated in two or more fiscal years except if there is a pending appeal where these adjustments are still at issue,

(B.) Repeated submission of improperly coded or identified claims. Evidence of such overbilling shall not include repeated submission of claims which have been denied payment previously, even though such payment denial was not contested.

(e.)The Director's determination of whether the provider knows or has reason to know that items or services were "claimed in violation of an agreement with the State" shall be based on the terms of the written agreement, and on other relevant evidence as that term is defined in Section 51037(e)(1). The Director shall consider only material violations which go to the merits of the agreement as distinguished from those which affect only form.

(f.) A civil money penalty shall be no more than three times the amount claimed by the provider for each item or service. It shall be within the Director's discretion to assess a lower penalty. In setting the amount of the penalty, the Director may consider evidence of mitigating circumstances submitted by the provider. Examples of such evidence include, but are not limited to:

(1.)Clerical error.

(2.)Good faith mistake.

(3.)Reliance on official publications.

(4.)Prior record of properly submitted claims.

(g.)An assessment of civil money penalties shall be effective upon the 60th calendar day after the date that the Department serves notice to the provider of the determination. Such notice shall be in writing and shall include grounds for the determination.

(h.)A provider shall have the right to appeal the determination by filing a request for hearing pursuant to Section 51022. The effective date of the assessment shall be deferred until this request is rejected or a final administrative decision is adopted.

(i.) Upon the effective date of assessment, the Director shall collect the civil money penalty in accordance with the procedures set forth in Sections 14115.5 and 14172 of the Welfare and Institutions Code and Section 51047.

(j.) Interest shall accrue on any unpaid balance of a civil money penalty from the effective date of assessment, at the rate specified in Section 14172(a) of the Welfare and Institutions Code.

(k.)Civil money penalty appeal hearings shall be conducted pursuant to the procedural guidelines set forth in Section 51016 et seq. (Title 22, CAC, Article 1.5).

(l.) Assessment of civil money penalties pursuant to Welfare and Institutions Code Section 14123.2 shall not operate to bar imposition of any other applicable penalty provisions, such as those contained in Welfare and Institutions Code Section 14171.5.

Utilization Controls

Title 22, California Code of Regulations (CCR), Section 51159 states:

Utilization controls that may be applied to services set forth in this chapter include:

(a.)Prior authorization, which is approval in advance of the rendering of service of the medical necessity and program coverage of the requested services, by a Department of Health consultant or PCCM plan. In determining what services shall be subject to prior authorization, the Director shall consider factors which include, but are not limited to:

(1.)Whether the services to be controlled are generally considered to be elective procedures.

(2.)Whether other physician procedures not subject to prior authorization are sufficient in scope and number to afford members reasonable access to necessary health care services.

(3.)The level of program payment for procedures.

(4.)The cost effectiveness of applying prior authorization as a utilization control.

(b.)Postservice prepayment audit, which is review for medical necessity and program coverage after service was rendered but before payment is made. Payment may be withheld or reduced if the service rendered was inappropriate.

(c.)Postservice postpayment audit, which is review for medical necessity and program coverage after service was rendered and the claim paid. The department may take appropriate steps to recover payments made if subsequent investigation uncovers evidence that the claim should not have been paid.

(d.)Limitation on number of services, which means certain services may be restricted as to number within a specified time frame.

Prior Authorization

Title 22, California Code of Regulations (CCR), Section 51455 states:

(a.)Any provider may be subjected to a requirement of prior authorization for all or certain specified services to be rendered under the California Medical Assistance Program, by written notice served on such provider from the Director or a carrier. The requirement for prior authorization may be imposed on such provider by the Director upon a determination that the provider has been rendering unnecessary services to a Medi-Cal member.

(b.)As used in this regulation, "unnecessary services" includes but is not limited to any of the following which exceed customary and usual practices in terms of frequency, quantity, propriety, or length of treatment:

(1.)Office, home, or inpatient visits.

(2.)Furnishing, prescribing, or ordering drugs, appliances, services, hospital, skilled nursing facility or intermediate care facility admissions.

(c.)The written notice of requirement for prior authorization shall state the nature, type, and extent of the services determined by the director to have been unnecessary and shall also state which services shall be subject to prior authorization and the duration that such prior authorization shall remain in force."

Special Claims Review

Title 22, California Code of Regulations (CCR), Section 51460 states:

(a.)The Department may place any provider on special claims review for specific or all services provided. The special claims review may be performed by the Department, or by the fiscal intermediary under direction of the Department. Special claims review may be imposed on a provider upon a determination that the provider has submitted improper claims, including claims which incorrectly identify, or code services provided.

(b.)A provider, while on special claims review, shall furnish any material requested by the Department in order to substantiate specific or all claims subject to special claims review.

(c.)The Department shall provide written notice to any provider placed on special claims review. The written notice shall include the following:

(1.)Services determined to have been improperly billed by the provider.

(2.)Services subject to special claims review.

(3.)Documentation to be submitted with all claims subject to special claims review.

(4.)Instructions for submission of claims subject to special claims review."

Administrative Hearings

Provider Audit Hearing

Title 22, California Code of Regulations (CCR), Section 51017 states:

A provider may request a hearing under the provisions of this article to examine any disputed audit or examination finding which results in an adjustment to Medi-Cal program reimbursement or reimbursement rates by submitting a Statement of Disputed Issues to the Department in accordance with Section 51022.

Request for Hearing

Title 22, California Code of Regulations (CCR), Section 51022 states:

(a.)An institutional provider may request a hearing for any disputed audit or examination finding as follows:

(1.)A written request shall be filed with the Department within 60 calendar days of the receipt of the written notice of the audit or examination findings.

(2.)This request may be amended at any time during the 60-calendar day period.

(b.)A Non-institutional provider may request a hearing on any disputed audit or examination finding as follows:

(1.)A written request shall be filed with the Department within 30 calendar days of the receipt of the audit or examination finding.

(2.)This request may be amended at any time during the 30-calendar day period.

(c.)All late requests by either Institutional or Non-institutional providers shall be denied, and the audit or examination findings deemed final unless the provider establishes in writing good cause for late filing within 15 calendar days of being notified of the untimeliness of its request.

(d.)The request shall be known as "Statement of Disputed Issues." It shall be in writing, signed by the provider or the authorized agent, and shall state the address of the provider and of the agent, if any agent has been designated. A provider or the agent shall specify the name and address of the individual authorized on behalf of the provider to receive any and all documents, including the final decision of the Director, relating to proceedings conducted pursuant to this article. The Statement of Disputed Issues need not be formal, but it shall be specific as to each issue as are in dispute, setting forth the provider's contentions as to those issues and the estimated amount each issue involves. The information specified in subsection (e) shall also be included. If the hearing officer determines that a Statement of Disputed Issues fails to state the specific grounds upon which objection to the specific item is based, the provider or the agent shall be notified that it does not comply with the requirement of this regulation, and the reasons, therefore.

(1.)An Institutional provider shall be granted 30 calendar days after the date of the mailing of the notice of deficiency to the provider within which to file an amended Statement of Disputed Issues.

(2.)A Non-institutional provider shall be granted 15 calendar days after the date of mailing of the notice of deficiency within which to file an amended Statement of Disputed Issues.

(3.) If within the time permitted in (1) or (2) above, the Institutional or Non-institutional provider, respectively, or the agent fails to amend its appeal as notified, the appeal as to those issues shall be rejected.

(e.) The request shall also specify whether the provider does or does not wish that an informal level of review among the parties be held, together with the reasons, therefore. Either party may request, or the hearing officer may order, that a telephone conference call be initiated among the parties for discussion of the advisability of conducting an informal level of review. The hearing officer shall decide whether an informal level of review would be appropriate and notify the parties of this decision in writing.

Member Fraud

Sharing of Medi-Cal Cards

Welfare & Institutions Code, Section 14026 states:

(a.) It is a misdemeanor for a Medi-Cal member to furnish, give, or lend his Medi-Cal card or labels to any person other than a provider of service as required under Medi-Cal regulations.

(b.) It is a misdemeanor for any person to use a Medi-Cal card other than the one which was issued to him or her to obtain health care services. This subdivision shall not apply to the use of a Medi-Cal card of a family member by another family member if the person using the card is, in fact, eligible under this chapter.

(c.) This section shall not apply to any peace officer while investigating Medi-Cal fraud or other crimes in performance of his official duties or to any person working under the peace officer's immediate direction, supervision, or instruction when such peace officer has been issued a Medi-Cal card pursuant to Section 14026.5.

Provider Assistance for Medi-Cal Fraud

Members suspected of abusing Medi-Cal Dental should be reported to the appropriate authorities. To help deter fraud, providers should be aware of the following:

- Individuals who are not residents of California.
- Individuals who give, lend, or furnish their Medi-Cal cards to any person other than a Medi-Cal provider.

Note: This example does not apply to family members presenting a card on behalf of a Medi-Cal eligible recipient to obtain services for that recipient (for example, a relative picking up a prescription for the recipient).

- Any attempt to obtain a prescription or controlled substance through misrepresentation or concealment.

- Individuals suspected of trying to obtain prescriptions to support their drug habit or for resale.
- Individuals who fail to report that they have other health coverage.
- Individuals who appear to have assets that would make them ineligible for Medi-Cal.

The Statewide Medi-Cal Fraud and Abuse Hotline for reporting recipients or providers is
(800) 822-6222.