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## **State Audit Background**

On January 13, 2004, Missouri State Auditor Claire McCaskill issued a report outlining inadequate monitoring of the state's Medicaid managed care program, formerly known as MC+, and now called MoHealthNet.[1] The report stated: "DMS did not ensure dental procedures with mandated codes were paid at least the Medicaid rate when funding was appropriated for this purpose. This situation occurred because the division did not adequately monitor operations of the health plans..."[2] The footnote accompanying the previous statement in the report states that "dental procedures with mandated codes required reimbursement at the Medicaid rate, effective January 1, 2002." "Underpayments occurred because the division did not monitor mandated rate compliance." [3]

The Department of Social Services was given the opportunity to respond to the audit findings. DSS states: "[B]eginning January 2003, the MC+ managed care contracts require certain codes to have the fee schedule reflect a mandated level and not the payment resulting from the global budget reimbursement methodology so as not to unintentionally lower the overall reimbursement to participating dentists. DSS/DMS will monitor compliance with this contract amendment." [4]

## Current Status

However, after extensive research, neither statutory nor regulatory language gives DSS authority to create a distinction between mandated and non-mandated codes.[5] Steve Renne, former Interim Director of the MO Department of Social Services, stated in correspondence[6]: "In the managed care contracts with health plans, codes considered mandated are those in which the health plan must reimburse the provider at the fee-for-service Medicaid fee schedule amount. Non-mandated code reimbursement may be subject to global budget analysis. The mandated codes are only those which were affected by a rate increase enacted by the General Assembly in FY 2002. Since the General Assembly stated that the increase in dental rates must be passed on to the provider through the managed care program as well as the fee-for-service program, *the mandated codes were included in the managed care contracts....*[non-mandated] were not included in the FY 2002 rate increase." [author's italics]

Thus, it appears DSS, in applying the rate increases from FY02, was trying to figure out a way to get the MCOs to "pass on the increases." MoHealthNet managed care plans and their dental subcontractors have been providing reimbursement according to the Medicaid fee schedule for *mandated*

codes since that time. However, dentists currently report that one subcontractor is paying *non*

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*mandated*

codes at 50% or less of the state Medicaid fee schedule as fee-for-service (used global method up to 2007), and another is subjecting non-mandated codes to global budget accounting methods. Additionally, there is concern that the July 1, 2008 appropriations increases are not being currently applied to all reimbursement rates.

There are a number of ***non-mandated codes*** that are basics in the oral health care of children. Examples include: (CDT code is in parentheses)

- Initial Comprehensive Oral Exam (150)
- Child prophylaxis (1120)
- X-rays (220 and 230)

These codes are reasonable dental practice standards for children's care, whether considered

screenings, diagnostic, or corrective treatment.

Managed Care Practice

A way the managed care subcontractors utilize the mandated/non-mandated dichotomy to their advantage is by “rejecting” claims in the mandated category and requiring the dentist to resubmit the claims under non-mandated codes, thus providing a lower payout (reimbursement). For example, a dentist may submit a claim for a series of seven (7) x-rays as a 2-bitewing x-ray (272) and as five (5) additional periapical single x-rays (one 220 and four 230’s), thus utilizing the state-designated mandated code 272. This following table is an example of an actual November 2007 payout (Table 1), comparing an actual state payout with a managed care subcontractor payout:

Code

State Payout

MCO/DBA Payout

272 – two-bitewing

11.00

11.00

220 – first periapical

7.50

1.35

230 – additional periapical

5.00

0.75

230 – additional periapical

5.00

0.75

230 – additional periapical

5.00

0.75

230 – additional periapical

5.00

0.75

**TOTAL**

**\$38.50**

**\$15.35**

Missouri state reimbursement is known to be approximately 50% or less of a dentist's UCR. Even when the dentist attempts to maximize their ability to cover costs, the MCO/DBA reimbursement ***is less than 50% of the state reimbursement.***

However, the managed care plans utilize *non-mandated* codes by requiring the dentist to resubmit the claim using non-mandated codes. In the above example, a DBA required the dentist to resubmit the claim as one 4-bitewing and 3 additional periapicals, with payout as follows (Table 2):

Code

MCO/DBA Payout

274 – four-bitewing

5.40

220 – first periapical

1.35

230 – additional periapical

0.75

230 – additional periapical

0.75

**TOTAL**

**\$8.15**

Since the state reimbursement calculation is the same under this claim (\$38.50), the total payout using the non-mandated codes is significantly \$30 less than state payment (21% of state payout), and **\$7.20 less than when the dentist uses the mandated code**. In other words, a dentist submitted a request for payment (\$15.35) using the codes listed in Table 1, but was asked to resubmit using non-mandated codes in Table 2, resulting in a lower payout (\$8.15).

## Recommendations

MO-DSS/MoHealthNet should ensure that codes do not have any distinction between mandated and non-mandated. The distinction is arbitrary and provides loopholes for the MCOs to decrease overall payouts to dentists. As outlined in House Bill 2011 (the Social Services/Medicaid Appropriation bill) for State Fiscal Year 2009:

There is appropriated out of the State Treasury, to be expended only as provided in Article IV, Section 28 of the Constitution of Missouri, for the purpose of funding each department, division, agency, and program enumerated in each section for the item or items stated, and provided that no funds shall be spent on health care delivered by any managed care company ***unless the Department of Social Services has received assurance in writing from such managed care company that any physician or dental rate increase contained herein shall be passed on to the physicians or dentists providing such health care, and for no other purpose whatsoever***

chargeable to the fund designated for the period beginning July 1, 2008 and ending June 30, 2009...[author's emphasis]

The Legislature clearly intended for DSS to monitor compliance of the MOHealthNet MCO's and their subcontractors in passing on increases in fees. DSS should issue a directive that the MCO's fee schedules be no lower than the Medicaid fee schedule for any codes.

Other works on dental care by Joe Squillace:

*Dental Coding in Missouri Medicaid Raises Access Concerns* (2007). Available on the National Health Law Program website: [www.healthlaw.org](http://www.healthlaw.org)

Citizens for Missouri's Children. (July 2003). *Dental Care Counts: Decay in the Heartland – A Crisis for Kansas City Children*.

Citizens for Missouri's Children. (June 2000). *Dental Care Counts: Medicaid Dental Services in Decay – A Crisis for St. Louis Children* .

Citizens for Missouri's Children. (April 2000). *Oral Health Care Availability and Access: A Crisis for Missouri's Children* .



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[1] Report No. 2004-01

[2] Page 3.

[3] Page 6, paragraph 1.

[4] Page 14, number 1 under subheading Department of Social Services Comments

[5] This includes state statutes (Revised Statutes of Missouri), state regulations (Code of State Regulations) and the DMS Provider Manual – Dental.

[6] Letter from Steve Renne to Joe Squillace, 1-25-07.