Making Compliance a Priority
Today May Save Your Practice from OMIG Tomorrow

Think of it as preventative medicine for your practice.

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While it’s doubtful that any reader of this article would dispute the benefits of recent advances in technology, the increased ease of maintaining and sorting patient information has also enabled government agencies to modernize oversight tactics. Specifically, new and improved methods of data mining are being utilized to determine where practitioners are overusing services, misrepresenting care provided or flat out billing for services that were not rendered. While historically such inquiries were made predominantly for instances of reported or discovered blatant abuse, new software with the ability to identify questionable billing patterns or unnecessary services has drastically changed the oversight game.

Medicaid as Domestic Player in Dental Compliance

The most significant player to emerge for dentists in New York State in the sampling and enforcement role is the Office of the Medicaid Inspector General (OMIG). With its newly formed Dental Fraud Unit, OMIG is not cowering around the fact that its work order today and for years to come is to target dental practices and attempt to recoup monies already paid to them or to deny monies that would be paid. To that end, in conversations with our firm, OMIG has said its enforcement actions against dental practices are likely to begin the simplest way possible: A list will be tabulated of the dental practices in New York State and OMIG will peer into each practice to make sure it is operating effectively and appropriately.

You may be wondering how OMIG can do this efficiently; the answer is, the groundwork has already been laid. For this preliminary check, OMIG will take your word for it—until information to the contrary arises. However, in order to enforce the presumption that you are operating appropriately, OMIG is now requiring that you take affirmative steps annually to prove that you are.

For dentists not familiar with OMIG, or the process referenced above, pursuant to New York law, certain persons eligible to receive reimbursement from New York State Medicaid are required to have a compliance plan that meets specified criteria and to certify adoption of that compliance plan with Medicaid.1 Of relevance to

1. New York Codes, Rules and Regulations, Title 18, Part 521.

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Harlem Week Celebrates Oral Health

ON A SUNNY WEEKEND in August, under blue canopies erected on the schoolyard outside of P.S. 175, in the Harlem section of New York City, a volunteer cadre of NYSDF dentists, Columbia dental students and Mt. Sinai Hospital residents performed oral health exams on neighborhood children and adults. By the end of the weekend, these dental professionals had screened nearly 500 people.

The event was organized by the New York State Dental Foundation and timed to coincide with New York’s annual Harlem Week Children’s Festival, a two-day, family-friendly cultural celebration that also features health and educational awareness activities. Madeline Ginzburg, president elect of the Bronx County Dental Society and a member of the NYSDF Board of Trustees, worked with Rep. Charles Rangel, Democrat of New York, to secure a place at the festival for the NYSDA screeners. She further immersed herself in the event, participating—along with other dental volunteers—in a parade down Malcolm X Boulevard and 135th Street to the schoolyard for a ribbon-cutting ceremony. The families who entered the schoolyard behind them received tubes of toothpaste, toothbrushes, coloring books, floss— courtesy of Henry Schein—and, of course, free dental screenings. Patients needing follow-up treatment were referred to local dental components for contacts with nearby dentists.

Components volunteering for the Harlem Week screening included New York County, Bronx County, Second District and Suffolk County Dental societies.
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For the majority of New York dental practices, the compliance program requirement is hard to miss. If you are one of the many practitioners who qualify as a required provider, Medicaid has dubbed you a "required provider." The compliance plan requirement for affected providers did not come without direction. OMIG has specified the areas that required providers' compliance programs must be applicable to. These are:

1. Billings.
2. Payments.
4. Governance.
5. Mandatory reporting.
6. Credentialing.
7. Other risk areas that are or should with due diligence be identified by the provider.

In addition, a required provider's compliance program must include the following elements:

1. Written policies and procedures that describe compliance expectations; provide guidance to employees and others on dealing with potential compliance issues; identify how to communicate compliance issues to appropriate compliance personnel; and describe how potential compliance problems are investigated and resolved.
2. Designate an employee vested with responsibility for the day-to-day operation of the compliance program.
3. Provide for compliance training and education of all practice staff.
4. Dictate the proper communication lines to allow compliance issues to be reported (including anonymous and confidential good faith reporting) as they are identified.
5. Set forth disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for:
   a. failing to report suspected problems;
   b. participating in non-compliant behavior; or
   c. encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior.
6. Designate a system for routine identification of compliance risk areas specific to dentistry for self-evaluation of such risk areas, including, but not limited to, internal audits and as appropriate, external audits, credentialing of providers and persons associated with providers, mandatory reporting, governance and quality-of-care of medical assistance program beneficiaries.
7. Detail a system for responding to compliance issues as they are raised, such as: responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the Office of Medicaid Inspector General; and refunding overpayments.
8. Provide a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to,

The term "substantial portion" of business operations is the key to understanding the broad reach of the compliance plan requirement. The statute offers the following encompassing definition for "substantial portion," which will be discussed at greater length below.

"(1) when a person, provider or affiliate claims or orders, or has claimed or has ordered, or should be reasonably expected to claim or order at least five hundred thousand dollars ($500,000) in any consecutive twelve-month period from the medical assistance program;

"(2) when a person, provider or affiliate receives or has received, or should be reasonably expected to receive at least five hundred thousand dollars ($500,000) in any consecutive twelve-month period directly or indirectly from the medical assistance program; or

"(3) when a person, provider or affiliate who submits or has submitted claims for care, services, or supplies to the medical assistance program on behalf of another person or persons in the aggregate of at least five hundred thousand dollars ($500,000) in any consecutive twelve-month period."

According to the OMIG enrollment office, the $500,000 precipice in the substantial portion definition section applies to practitioners who receive over $500,000 of reimbursement from straight Medicaid or any managed care Medicaid plan (Medicaid HMO). The rationale behind incorporating Medicaid HMO monies is that Medicaid funds every managed care Medicaid plan; so even though services are "administered" by the managed care company, reimbursement comes from Medicaid and, therefore, Medicaid has an interest and connection to the funds.

Another important element of the substantial portion definition that deserves highlighting is that Medicaid includes the cost of services ordered by a dentist (just ordered, not actually paid to that practitioner) in the $500,000 calculation. The ordering element of the substantial portion definition applies to the ordering of any of the following, as well as additional services: dentures, DME, lab work, radiology and home care services.

When taking into consideration the two factors referenced above, that the $500,000 precipice includes straight Medicaid and Medicaid HMO monies and that the amount of "ordered" services, not just monies received by a practice are included in the tally, the conclusion that in all likelihood the majority of New York dental practices will fall within Medicaid's compliance program requirement is hard to miss. If you are one of the many practitioners who qualify as requiring a compliance plan, Medicaid has dubbed you a "required provider."
reporting potential issues, investigating issues, self-
evaluations, audits and remedial actions, and report-
ing to appropriate officials as required by law.5

While the elements listed may seem overwel-
ing, in all likelihood, your practice has some form of
procedures, no matter how basic, established for each
of the above. The difficulty that arises now is taking
the steps to adopt a written compliance program that
explicitly covers all of the listed elements. This is not
as laborious a process as you may think, so long as you
are working with the right healthcare attorney. In
creating your compliance program, the appropriate
balance must be met between incorporating the needs
and intricacies of your practice and the requirements
established by OMIG.

**OMIG Knows**

One of the first questions I receive
from clients with regard to compli-
ance is, who is going to know if I
don't bother to comply? The answer
is, OMIG will know, because OMIG
is checking. In fact, OMIG does not
have to look further than its own
database, because required providers
are responsible for certifying to
OMIG each December that they
have adopted and have in place a
compliance program that meets
OMIG's requirements.6 To simplify
the process, OMIG has made certifi-
cation available on its website (www.
omig.ny.gov).

Should the commissioner of
health or the Medicaid inspector gen-
eral find that a required provider does
not have a satisfactory compliance
program,7 or no program at all, appli-
cable law states that "the required
provider may be subject to any sanc-
tions or penalties permitted by federal
or state laws and regulations, includ-
ing revocation of the provider's agree-
ment to participate in the medical
assistance program."8 Unfortunately,
if you are a required provider, it is not
anticipated that should it be discov-
ered that your practice does not have
a compliance program, your troubles
with OMIG would stop. OMIG has
intimated that it will be using the
compliance program requirement as a
window into practices. Failing to cer-
tify that you have a compliance pro-
gram would be equivalent to allowing
your window to have cracks and dirt
accumulation, indicating a messy
interior with the potential for addi-
tional noncompliance.

Should your practice appear on
OMIG’s radar as a potentially non-
compliant practice, you run the risk
of being targeted by OMIG for a
retrospective review of claims or being
placed on prepayment review, which
is a process that requires that you
send in patient records prior to receiv-
ing reimbursement for any services.

**Benefits of Compliance**

In addition to staying off of OMIG's radar, there are
benefits to OMIG's compliance plan requirement
that are immediate and rewarding, which is why man-
datory compliance can be a good thing.

A few ways you are protecting your practice
through compliance are:

1. **Identifying Red Flags.** Designating in your policy poten-
tial red flags that your practice will make an effort
to identify during your billing process, not after.

2. **Designating Lines of Communication.** Your com-
pliance program will also set forth appropriate lines
of communication to report compliance issues.

Often, employees will cover up mistakes, rational-

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5. Id.
6. 18 NYCRR § 521.3.
7. 18 NYCRR § 521.4.
8. Id.

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Ed Department Waives Fees for Dentists Needing to Replace Storm-Damaged Documents

THE NEW YORK STATE EDUCATION DEPARTMENT has been directed by Gov. Andrew Cuomo to temporarily suspend fees it ordinarily charges to replace license and/or registration documents lost as a result recent flooding and damage in designated disaster-area counties. Until further notice, the fees charged by the Education Department’s Division of Professional Licensing Services for issuing duplicate license parchments and registration certificates are suspended for the replacement of documents lost as a result the disaster.

All requests for copies of any document or record on file with the DPLS should indicate the document to be replaced was the result of Hurricane Irene and subsequent storms. To replace a lost or destroyed license parchment, write or call: Office of the Professions, Division of Professional Licensing, Records & Archives Unit, State Education Building, 2nd Floor, 89 Washington Ave., Albany, NY 12234-1000; (518) 474-3817, ext. 380.

To replace a damaged, lost or destroyed registration certificate, contact the Registration Unit by e-mailing them at opregnfee@mail.nysed.gov or calling (518) 474-3817, ext. 410, or writing them at the address above.

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izing that they may be in more trouble for identifying them than not.

3. Detailing Repercussions for Perpetuating Noncompliance. Your compliance plan should explicitly state that covering up noncompliance may result in potential termination from employment. Further, an effective compliance program should establish a chain of command for responding to and dealing with noncompliance.

4. Requiring Training. Your compliance plan will be a place to keep track of required training and education for those conducting billing services at the practice, as well as to track changes in billing and coding requirements for each third-party payor.

5. Holding Your Staff Accountable for Documentation Requirements. Your compliance program should clearly indicate that any practitioner of your practice will be held accountable for failing to take appropriate X-rays during patient care and that any practitioner who fails to abide by applicable requirements will be responsible for the repercussions.

It’s worth noting that many practitioners report an increase in their reimbursement upon adopting a compliance plan. Because their staff has a written policy to follow when performing billing, practitioners find that fewer errors are occurring and the result is increased reimbursement.

CONCLUSION

A compliance plan is a preventative measure you implement to keep your practice in top shape to avert potential problems in the future by mitigating billing errors and protecting the integrity of the practice’s documentation and operations. In that regard, it’s not unlike the advice dentists give to their patients daily: preventative medicine pays.

Ms. Kirschenbaum manages Kirschenbaum & Kirschenbaum’s healthcare department, which specializes in representing healthcare practitioners in regulatory compliance, audit defense, licensure and transactional matters. She is a member of the New York State Dental Association Legal Services Panel. Should you require assistance acquiring and implementing a Medicaid compliant program, she can be reached at Jennifer@Kirschenbaum.com or (516) 747-6700. Or visit the firm online at www.nyhealthcareattorneys.com to view compliance plan options.