

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**TEXAS DID NOT ENSURE THAT THE
PRIOR-AUTHORIZATION PROCESS WAS
USED TO DETERMINE THE MEDICAL
NECESSITY OF ORTHODONTIC SERVICES**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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for Audit Services

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A-06-12-00039

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

Texas did not ensure that the prior-authorization process was used to determine the medical necessity of orthodontic services under State Medicaid guidelines.

WHY WE DID THIS REVIEW

In Texas, the Health and Human Services Commission (State agency) administers the Texas Health Steps program, which provides for the early detection and treatment of dental health problems for Medicaid beneficiaries from birth through age 20. Medicaid pays for orthodontic services, but only those that are medically necessary and that have received prior authorization. The prior-authorization process is intended to determine medical necessity. Because payments for Medicaid orthodontic services in Texas have risen sharply in recent years, we have identified this area as vulnerable to fraud, waste, and abuse.

The objective of this review was to determine whether the State agency ensured that the prior-authorization process was used to determine the medical necessity of orthodontic services under State Medicaid guidelines.

BACKGROUND

The State agency contracted with the Texas Medicaid & Healthcare Partnership (TMHP) to determine the medical necessity of orthodontic services and process provider requests for prior authorizations. The prior-authorization process is intended to determine medical necessity. The orthodontic prior-authorization requests should be reviewed for medical necessity in accordance with Medicaid criteria by knowledgeable and professional medical personnel, which includes the TMHP dental director.

WHAT WE FOUND

The State agency did not ensure that the prior-authorization process was used to determine the medical necessity of orthodontic services under State Medicaid guidelines. In addition, the TMHP dental director did not follow State Medicaid policies and procedures when determining the medical necessity of orthodontic services and reviewing prior-authorization requests.

These deficiencies occurred because the State agency did not ensure (1) that TMHP properly reviewed each prior-authorization request for medical necessity and (2) that the TMHP dental director followed Medicaid policies and procedures on determining the medical necessity of orthodontic services. As a result, TMHP may have approved requests for orthodontic services that were not medically necessary. Although TMHP failed to properly use the prior-authorization process to determine the medical necessity of orthodontic services, the State agency is ultimately responsible for contractor compliance.

WHAT WE RECOMMEND

We recommend that the State agency provide proper oversight of the orthodontic prior-authorization process to ensure that:

- it is used to determine medical necessity and
- personnel making the prior-authorization decisions follow the appropriate State Medicaid policies and procedures.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency partially agreed with our findings. The State agency agreed that the orthodontic prior-authorization process was not used to determine the medical necessity of orthodontic services and that TMHP's dental director was not using Medicaid guidelines to determine medical necessity. However, the State agency disagreed that TMHP's deficiencies were due to a lack of State agency oversight. The State agency provided information on actions that it had taken to address our recommendations, including transitioning Medicaid recipients to managed care, terminating TMHP's contract, and hiring a dental director to monitor the dental program.

We maintain that TMHP's deficiencies were due to a lack of State agency oversight because the State agency is responsible for contractor compliance.

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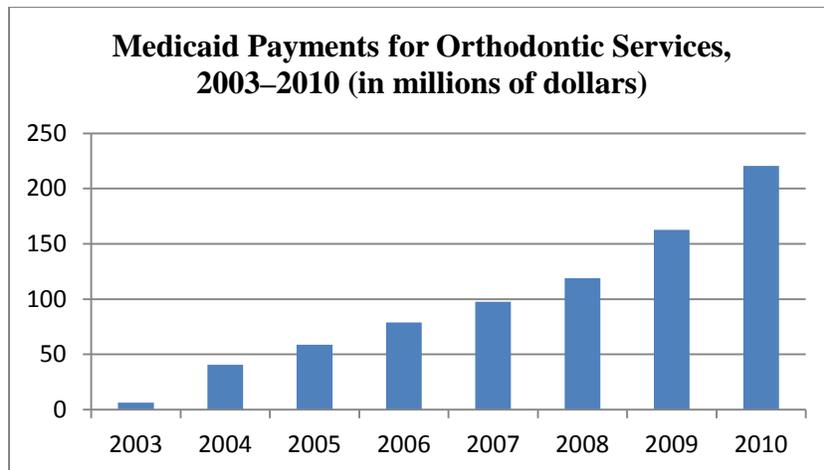
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INTRODUCTION

WHY WE DID THIS REVIEW

In Texas, the Health and Human Services Commission (State agency) administers the Texas Health Steps program, which provides for the early detection and treatment of dental health problems for Medicaid beneficiaries from birth through age 20. Medicaid pays for orthodontic services, but only those that are medically necessary and that have received prior authorization. The prior-authorization process is intended to determine medical necessity. Because payments for Medicaid orthodontic services in Texas have risen sharply in recent years, we have identified this area as vulnerable to fraud, waste, and abuse. As shown in the graph below, Texas Medicaid payments for orthodontic services rose from \$6.5 million in 2003 to \$220.5 million in 2010, an increase of more than 3,000 percent. By comparison, Texas Medicaid enrollment increased by only 33 percent during the same period.



OBJECTIVE

Our objective was to determine whether the State agency ensured that the prior-authorization process was used to determine the medical necessity of orthodontic services under State Medicaid guidelines.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Texas, the State agency administers the program.

Texas Medicaid Orthodontics

Medicaid orthodontic services must be authorized prior to treatment to determine medical necessity and are limited to severe handicapping malocclusion and related conditions as described and measured by the procedures and standards in the *Texas Medicaid Provider Procedures Manual* (Medicaid Manual).¹

Texas Medicaid & Healthcare Partnership

As of January 1, 2004, ACS State Healthcare, LLC (ACS), under contract with the State agency, assumed administration of claim processing for Texas' Medicaid program and other State health care programs. ACS contracts with a team of subcontractors called the Texas Medicaid & Healthcare Partnership (TMHP) to carry out its responsibilities. TMHP is responsible for processing Medicaid provider requests for prior authorization to perform orthodontic services. Processing these requests includes determining whether a service is medically necessary.

Texas Medicaid & Healthcare Partnership's Prior-Authorization Process

Providers send requests to perform orthodontic services to TMHP for prior authorization. The request contains an orthodontic treatment plan, x-rays, facial photographs, and a Handicapping Labio-lingual Deviation Index (HLD).² TMHP's analysts perform a clerical review of the requests to check for completeness, verify HLD scores, and review patient histories to avoid approval of duplicate services. If a prior-authorization request contains all documentation and the HLD score sheet totals at least 26 points, the analyst approves the request without review by TMHP's dental director or a determination of medical necessity. If an analyst determines that a request has an issue, such as the beneficiary is under age 12³ or the stated HLD score is less than 26 points, the analyst sends the request to TMHP's dental director for a final determination. Although the State agency's contract with TMHP requires the analysts to have some medical knowledge, they do not make medical determinations regarding a beneficiary's need for orthodontic services.

HOW WE CONDUCTED THIS REVIEW

We interviewed the State dental director, TMHP's dental director and prior-authorization director, and other officials and reviewed State laws and regulations, contracts, and State agency Office of Inspector General prior-authorization audit reports to determine whether the State agency ensured that the orthodontic prior-authorization process was used to determine medical

¹ Texas Administrative Code Title 25, part 1, § 33.71; Medicaid Manual, Children's Service Handbook, Volume 2, § 4.2.24 (2011). The Medicaid Manual allows reimbursement for procedure code D8660 (preorthodontic treatment visit) without prior authorization. Medicaid Manual, Children's Service Handbook, Volume 2, § 4.2.24.1 (2011).

² Texas Medicaid providers use the HLD to determine whether a beneficiary needs comprehensive orthodontics. The HLD lists nine conditions that the provider should consider when making a diagnosis. For each condition, a numerical score is given, and all scores are totaled at the bottom of the page.

³ The Medicaid Manual states that orthodontic services are limited to children 12 years of age or older, with some exceptions. Medicaid Manual, Children's Service Handbook, Volume 2, § 4.2.24 (2011).

necessity under Medicaid guidelines. We limited our review to TMHP's process for reviewing Medicaid provider requests for prior authorizations to perform orthodontic services. An additional report, which will include results from a medical review of a statistically valid sample of prior-authorization requests, is forthcoming.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The State agency did not ensure that the prior-authorization process was used to determine the medical necessity of orthodontic services under State Medicaid guidelines. In addition, the TMHP dental director did not follow State Medicaid policies and procedures when determining the medical necessity of orthodontic services and reviewing prior-authorization requests.

These deficiencies occurred because the State agency did not ensure (1) that TMHP properly reviewed each prior-authorization request for medical necessity and (2) that the TMHP dental director followed State Medicaid policies and procedures on determining the medical necessity of orthodontic services. As a result, TMHP may have approved requests for orthodontic services that were not medically necessary. Although TMHP failed to properly use the prior-authorization process to determine the medical necessity of orthodontic services, the State agency is ultimately responsible for contractor compliance.

THE STATE AGENCY DID NOT ENSURE THAT THE PRIOR-AUTHORIZATION PROCESS WAS USED TO DETERMINE MEDICAL NECESSITY

According to the State agency's contract with TMHP, prior authorization is a process used to determine the medical necessity of selected medical services. The contract requires TMHP to review the facts associated with treatments proposed by providers and make determinations regarding the medical necessity and appropriateness of care.

The State agency did not ensure that the prior-authorization process was used to determine medical necessity. The dental director was generally the only person at TMHP qualified to make a determination of medical necessity. However, based on interviews with TMHP staff, prior-authorization analysts processed all requests for prior authorization of orthodontic services without review by the dental director or another licensed dentist when the HLD score was 26 or higher and all of the relevant documents were present in the file.⁴ TMHP analysts would

⁴ This accounted for approximately 80 to 90 percent of all prior-authorization requests.

forward requests to the dental director only if the HLD score was lower than 26, the patient was under age 12, or the patient had special circumstances.⁵

The TMHP dental director stated that the prior-authorization process was “loose” and depended on providers to determine the medical necessity of treatment. TMHP’s prior-authorization director, who oversees the prior-authorization process and prior-authorization analysts, stated that, on the basis of TMHP’s interpretation of its contract and on the fact that the Medicaid Manual did not require dental molds to be submitted with the provider request for prior authorization, not every request for prior authorization had to be reviewed by a licensed dentist. She also stated that the policy change in 2007 that no longer required providers to submit dental molds was the reason the program was “out of control.” Further, she pointed out that the State agency had known since 2008⁶ that TMHP does not review x-rays for medical necessity. Thus, by automatically approving requests for prior authorization, TMHP did not appropriately research, analyze, evaluate, or ensure that all medical facts were considered and documented before determining medical necessity. This deficiency occurred because the State agency did not ensure that TMHP properly reviewed the medical necessity of each request for prior authorization.

THE STATE AGENCY DID NOT ENSURE THAT THE TEXAS MEDICAID & HEALTHCARE PARTNERSHIP DENTAL DIRECTOR FOLLOWED STATE MEDICAID POLICIES AND PROCEDURES WHEN DETERMINING MEDICAL NECESSITY

The State agency’s contract with TMHP requires that TMHP have a sufficient number of knowledgeable and professional medical personnel to process requests for prior authorization in accordance with State Medicaid policies and procedures. The contract also states that every request for prior authorization must be reviewed to determine medical necessity.

The TMHP dental director did not follow State Medicaid policies and procedures when determining the medical necessity of orthodontic services and reviewing prior-authorization requests. When we asked the dental director what Medicaid criteria he used to approve prior-authorization requests, he responded that he did not use Medicaid criteria, but rather his professional judgment. Dentists, in using their professional judgment, may treat a moderate malocclusion; however, Medicaid allows reimbursement only for severe handicapping malocclusions. The dental director made final determinations of medical necessity on only about 10 to 20 percent of orthodontic prior authorizations, and he did so without using Medicaid criteria. This deficiency occurred because the State agency did not ensure that the TMHP dental director followed Medicaid policies and procedures.

⁵ Medicaid Manual, Children’s Service Handbook, Volume 2, § 4.2.24.1 (2011).

⁶ *Performance Audit Report Texas Medicaid & Healthcare Partnership Prior Authorization Audit*, OIG Report No. 08-70-52903191-MA-03, published August 29, 2008, and *Performance Audit Report Texas Medicaid & Healthcare Partnership Prior Authorization Follow-up*, OIG Report No. 11-70-05290801-MA-03, published August 1, 2012.

EFFECT OF THESE DEFICIENCIES

As a result of these deficiencies, TMHP may have approved requests for orthodontic services that were not medically necessary.

RECOMMENDATIONS

We recommend that the State agency provide proper oversight of the orthodontic prior-authorization process to ensure that:

- it is used to determine medical necessity and
- personnel making the prior-authorization decisions follow the appropriate State Medicaid policies and procedures.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency partially agreed with our findings. The State agency agreed that the prior-authorization process was not used to determine the medical necessity of orthodontic services and that TMHP's dental director was not using Medicaid guidelines to determine medical necessity. However, the State agency disagreed that TMHP's deficiencies were due to a lack of State agency oversight. State agency officials said that they reasonably relied on TMHP's assurances that it was complying with the State agency's policies. The officials said that TMHP violated its contractual obligations and therefore "opened the door to potential fraud by unscrupulous orthodontic providers who could exploit" TMHP's "lax prior-authorization process"

The State agency provided information on actions that it had taken to address our recommendations. On March 1, 2012, the State agency transitioned the vast majority of Medicaid recipients to managed care, thereby limiting TMHP's medical necessity reviews to a small population.

Additionally, the State agency notified TMHP of the termination of its contract for cause and is in the process of finalizing an agreement with another contractor until the contract can be competitively bid. In addition to the State agency's termination of the contract, the Texas Attorney General's Office filed a lawsuit against TMHP pursuant to the Texas Medicaid Fraud Prevention Act.

Finally, the State agency hired its own dental director to monitor the effectiveness of its dental and orthodontia programs.

The State agency's comments are included as Appendix B.⁷

OFFICE OF INSPECTOR GENERAL RESPONSE

We maintain that TMHP's deficiencies were due to a lack of State agency oversight because the State agency is responsible for contractor compliance.

OTHER MATTERS

THE STATE AGENCY DID NOT ENSURE THAT TEXAS MEDICAID & HEALTHCARE PARTNERSHIP'S ANALYSTS WERE MEDICALLY KNOWLEDGEABLE

The State agency's contract with TMHP requires that TMHP have a sufficient number of medically knowledgeable analysts to process requests for prior authorization.

According to TMHP officials, the analysts that TMHP hired to process prior-authorization requests for orthodontic services were not medically knowledgeable. This deficiency occurred because the contract did not define "medically knowledgeable."

STATE AGENCY COMMENTS

The State agency agreed that TMHP's analysts were not medically knowledgeable but disagreed that it was because the term "medically knowledgeable" was not defined in the contract. State agency officials said that TMHP's proposal included a "plan to employ qualified clinical personnel, such as 'registered dental assistants and dental technicians' who would use their 'medical expertise' to review prior-authorization requests for orthodontic services." The contract included similar language. Additionally, the officials said that "the lack of a contractual definition does not excuse mismanagement" by TMHP.

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree with the State agency's assertion that TMHP's proposal and the contract required qualified clinical personnel to review requests for prior authorization. However, the State agency was responsible for providing oversight of its contract with TMHP. The State agency provided no evidence that it had performed its due diligence, such as checking the analysts' credentials, in ensuring that TMHP's analysts were medically knowledgeable.

⁷ The attachments that the State agency submitted with its comments are not included.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We focused our review on determining whether the State agency ensured that the prior-authorization process was used to determine medical necessity under Medicaid guidelines. We limited our review to TMHP's process for reviewing Medicaid provider requests for prior authorizations to perform orthodontic services. An additional report, which will include results from a medical review of a statistically valid sample of prior-authorization requests, is forthcoming.

We performed our fieldwork at the State agency and TMHP offices in Austin, Texas.

METHODOLOGY

To accomplish our objective, we:

- reviewed State laws, regulations, and guidance pertaining to Texas Medicaid orthodontic services;
- reviewed the State agency's contract with TMHP for administration of claim processing for Texas' Medicaid program;
- interviewed the State dental director, TMHP's dental director and prior-authorization director, and other State agency and TMHP officials;
- reviewed the two reports on audits performed by the State agency's Office of Inspector General that are noted in footnote 6 on page 4; and
- reviewed TMHP's internal document describing the step-by-step procedures for processing prior authorizations.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATE AGENCY COMMENTS



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

May 30, 2014

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General, Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Reference Report Number A-06-12-00039

Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Texas Did Not Ensure That the Prior-Authorization Process Was Used To Determine the Medical Necessity of Orthodontic Services" from the Department of Health and Human Services Office of Inspector General. The cover letter, dated February 5, 2014, requested that HHSC provide written comments, including the status of actions taken or planned in response to report recommendations.

I appreciate the opportunity to respond. Please find the attached HHSC management response which (a) includes comments related to the content of the findings and recommendations, and (b) details actions HHSC has completed or planned.

If you have any questions or require additional information, please contact David M. Griffith, Director of HHS Risk and Compliance Management. Mr. Griffith may be reached by telephone at (512) 424-6998 or by e-mail at David.Griffith@hhsc.state.tx.us.

Sincerely,

A handwritten signature in blue ink, appearing to read "Ch. Janek, M.D.", written over a faint circular stamp.

Kyle L. Janek, M.D.

P. O. Box 13247 • Austin, Texas 78711 • 4900 North Lamar, Austin, Texas 78751 • (512) 424-6500

SUMMARY

HHSC relied to its detriment on its third-party administrator, Xerox d/b/a Texas Medicaid & Healthcare Partnership (TMHP), to manage the Medicaid orthodontia prior authorization program (the Program) effectively and in compliance with HHSC's policy for orthodontia services. Xerox's mismanagement of the program resulted in the overpayment of orthodontia claims worth millions of dollars. When HHSC questioned Xerox's administration of the Program as part of its monitoring process, Xerox made repeated written and oral assurances that it was complying with HHSC's approved policies and procedures to determine medical necessity. HHSC trusted Xerox's representations regarding its management of the Program.

At HHSC's insistence, Xerox changed its review process in October 2011 to comply with longstanding policies and procedures approved by HHSC regarding the prior authorization of orthodontia services. HHSC's approved policies and procedures require that the Dental Director review all prior authorization requests for medical necessity. *See Attachment 1, e.g. 2005 Policies and Procedures for Dental Authorization Department.* Additionally, to ensure quality of services and to effectively monitor the Medicaid program for overutilization and fraud, HHSC moved almost all dental and orthodontic services for Medicaid recipients to managed care. As a result of the move to managed care, HHSC limited Xerox's medical necessity reviews for orthodontic services to a small population including: (1) recipients under age 21 with emergent conditions who have not yet transitioned to a Dental Managed Care Organization (DMO), (2) recipients who aged out of the program at age 21 or lost Medicaid eligibility and needed to complete orthodontic treatment, and (3) recipients who are residents of Medicaid paid facilities such as nursing homes, state-supported living centers and intermediate care facilities for persons with intellectual and developmental disabilities.

As a result of Xerox's failure to properly manage the Program, HHSC notified Xerox of termination for cause of the Medicaid Claims/Primary Care Case Management Administrative Services Agreement (the Contract)¹ on May 9, 2014. HHSC is currently in the process of finalizing an agreement with Accenture LLP, the subcontractor responsible for the maintenance and operation of the Medicaid Management Information System (MMIS), to be HHSC's prime contractor until HHSC can competitively rebid the Contract.

In addition to the termination of the Contract, the Texas Attorney General has filed a lawsuit against Xerox pursuant to the Texas Medicaid Fraud Prevention Act (TMFPA), Chapter 36 of the Texas Human Resources Code.² The lawsuit seeks to recover fraudulent Medicaid payments for orthodontic and dental services that were improperly approved by Xerox.

¹ "The Contract" unless otherwise specified refers to both Medicaid Claims/Primary Care Case Management Administrative Services Agreements between HHSC and Xerox which were effective on January 1, 2004 and on August 31, 2010, respectively.

² *State v. Xerox Corp.*, No. D-1-6V-14-000581, 2014.

FINDINGS

I.

DHHS – OIG Finding: The State agency did not ensure that the prior authorization process was used to determine medical necessity of orthodontic services.

HHSC Clarification: HHSC agrees with the Department of Health and Human Services (DHHS) Office of Inspector General's (OIG) finding that Xerox failed to use the prior authorization process to determine the medical necessity of orthodontic services. However, HHSC does not agree that Xerox's failure was from a lack of agency oversight. HHSC reasonably relied upon Xerox's assurances regarding its compliance with HHSC policies. When confronted by HHSC regarding allegations of mismanagement, Xerox convincingly misrepresented its process for making medical necessity determinations.

During the procurements of the Contract, Xerox held itself out to HHSC as an expert, both in determining medical necessity and in managing an orthodontia prior authorization program.³ Additionally, Xerox promised HHSC that it could seamlessly continue the services provided by the prior claims administrator, Electronic Data System d/b/a National Heritage Insurance Company (NHIC), including NHIC's process of using a licensed dentist to make medical necessity determinations for orthodontia services. HHSC reasonably relied to its detriment on Xerox's adamant assurances that Xerox was fulfilling its contractual obligations to ensure that all prior authorization requests were being reviewed by qualified clinical personnel and that all approved requests for orthodontic services were, in fact, medically necessary.

Prior authorization programs ensure that only medically necessary services are approved by using a process to safeguard against fraud, waste and abuse. Xerox contractually promised that it would protect HHSC from fraud and abuse by diligently applying HHSC's policy requiring a genuine medical necessity review by qualified clinical staff with final approval by Xerox's Dental Director.⁴ HHSC included these protections in the Contract as a vendor responsibility so that HHSC could devote state resources to program and policy oversight without having to scrutinize individual orthodontia claims. Because HHSC had contracted and was paying for Xerox to administer the Program, it was unrealistic for HHSC to duplicate efforts and employ staff to monitor individual prior authorization requests. *See 2008 RFP § 8.9-Prior Authorization Contract Requirements (PACs) 1, 4, 5, 6, 12, 15, 16, 18, 20, 23, 26, 30 and 37.*

³ See 2004 Contract §2.02 and 2010 Contract §2.03.

⁴ "Dental Director" refers to the licensed dentist employed by Xerox to conduct medical necessity reviews.

Xerox made a unilateral decision to change a well-established prior authorization process without approval from HHSC and without seeking a change in, or any clarification of, its contractual obligation to provide genuine medical necessity reviews by properly-trained, medically knowledgeable clinicians. Policy and Procedures submitted to HHSC for approval indicated to HHSC that every request for prior authorization of orthodontic treatment was sent to the Xerox Dental Director for review. Additionally, Xerox's written internal work instructions (WIKIs), posted electronically for HHSC to review, indicated that all prior authorization requests, including photographs and X-rays, were reviewed by the Xerox Dental Director. See *Attachment 2, Dental Authorization WIKI dated May 18, 2011*. It was only when HHSC gave Xerox a deficiency notice for mismanagement of the Program on May 18, 2011 (Deficiency Notice) that Xerox changed its Program WIKI to reflect Xerox's actual process. The amended WIKI instructed staff, with no clinical qualifications, to approve requests for eligible Medicaid recipients if the Handicapping Labio-Lingual Deviation (HLD) Index score sheets indicated 26 points or more. See *Texas Health Steps (THSteps) Medicaid Medical Policy Manual, Orthodontic Dental Services 4.2.24*. See *PAC-4, Establish and follow State-approved policies and procedures for analyzing and researching PA determinations*.

By failing to follow the approved policies and procedures, Xerox not only violated its contractual obligations, but opened the door to potential fraud by unscrupulous orthodontic providers who could exploit Xerox's lax prior authorization process by receiving Medicaid reimbursement for orthodontic services that the providers knew, or should have known, were not medically necessary.

HHSC does not agree with the TMHP's dental director⁵ that the change in policy regarding the submission and review of dental molds⁶ was the reason for the increase in prior authorization requests. During an August 2004 Benefits Management Workgroup (BMW) meeting, Xerox's Dental Director requested a policy change to discontinue the requirement for the submission of molds. The BMW approved the request, which subsequently received HHSC's approval in 2005. The Xerox Dental Director's simultaneous request for a policy change to eliminate the requirement for supporting diagnostics, including X-rays, was denied. Contrary to the information provided by Xerox, HHSC was not aware of, nor did it approve, any change in policy to discontinue the submission of X-rays and photographs necessary to a valid prior authorization decision. Further, HHSC expected Xerox to use X-rays and photographs to determine medical necessity because their submission was a policy requirement.⁷ See *Attachment 3, Xerox's Proposal to RFP, Business Operations Plan 8.9*.

⁵ TMHP's dental director refers to the Program administrator.

⁶ Refers to plaster cast models.

⁷ "We understand that HHSC must review and approve any changes, including the addition or deletion of services that require prior authorization and the criteria used to evaluate their medical necessity and cost effectiveness." Planning and Criteria Development §8.9-9.

Although HHSC required providers to submit X-rays and photographs in order to show the medical need for the requested services, Xerox, pursuant to its arbitrary and unreasonable interpretation of the contract, implemented a system that omitted a review of any diagnostic tools. Xerox employees simply examined their paperwork for a bar code indicating that the submitted request included the required diagnostics, but they never took the diagnostics out of the packaging for examination unless the HLD Index score was less than 26 points. Regardless of whether the HLD scores met the initial 26 points threshold, Xerox's Dental Director routinely approved requests without examining any of the required diagnostic tools to determine if a service was actually medically necessary. Most importantly, HHSC was not aware (and because of Xerox's misrepresentations, could not become aware) that Xerox had unilaterally interpreted HHSC's Medicaid policy to mean that Xerox could verify medical necessity by simply seeing a 26 or more point value on the HLD score sheet.

II.

DHHS – OIG Finding: HHSC did not ensure that Xerox's Dental Director followed State Medicaid policies and procedures when determining the medical necessity of orthodontic services.

HHSC Clarification: HHSC agrees Xerox's Dental Director did not follow State Medicaid policies and procedures when determining the medical necessity of orthodontic services. However, HHSC does not agree that the failure of the Dental Director to follow policy was due to a lack of agency oversight.

Throughout the term of its contract with HHSC, the prior vendor, NHIC, employed a licensed dentist to perform medical necessity reviews of orthodontia prior authorization requests for services. During the transition of the contract from NHIC to Xerox, NHIC provided Xerox with details of its review process, and Xerox worked closely with NHIC to ensure the smooth transition of all business operations as well as acquire a clear understanding of all policies and processes. *See Attachment 4, Medical Affairs 12-03-03 Delivery of Inventory Sign-Off Form-NHIC Department Manuals for Dental Authorizations and Attachment 5, Texas Medicaid & Healthcare Partnership Prior Authorization Work Group, June 16, 2003 Meeting Minutes.*

Further, the Xerox Dental Director had a first-hand opportunity to observe NHIC's process for dental and orthodontia medical necessity reviews, and he was well aware of HHSC's approved methodology, including the requirement for an examination of the dental records and of all the required diagnostic tools and photographs. Even though Xerox had a duty to ensure its employees complied with HHSC's Orthodontia Program policy, Xerox failed to meet its obligation because it directed, condoned and profited from the Dental Director's mismanagement of the Program. Xerox's misconduct permitted providers to submit prior authorizations requests they knew would be approved even though the services were not medically necessary. Subsequent to Xerox's implementation of its unapproved process for prior authorization, and in

response to the 2008 HHSC OIG audit of the Program, HHSC sent a written inquiry on May 15, 2009 to Xerox regarding its management of the Program. In its response to HHSC, Xerox vigorously claimed that its administration of the Program was based on HHSC's medical policy guidelines and on the dental policy and procedures approved by HHSC. Xerox claimed that the Dental Director reviewed requests for services that did not meet medical policy criteria. HHSC relied on Xerox's convincing oral and written assurances that it was administering the Program in compliance with HHSC's policies. It was only later through an exhaustive investigation in conjunction with the Texas Office of the Attorney General that HHSC was able to determine that Xerox's mismanagement of the Program resulted in substantial fraud by dishonest providers. *See Attachment 6, Memorandum to Billy Millwee from Rick Pope, dated May 13, 2009.*

III.

DHHS – OIG Other Matters: HHSC did not ensure that Xerox's prior authorization analysts were medically knowledgeable.

HHSC Clarification: HHSC reasonably relied on Xerox's assurances that it was meeting its contractual obligations to use only qualified, medically knowledgeable personnel to review prior authorization requests.

By making specific pledges in its Proposal to the Request for Proposal (RFP), Xerox contractually promised HHSC to have a sufficient number of medically knowledgeable analysts to process prior authorization requests. The Contract obligated Xerox to employ "...qualified clinical personnel" who were to "...use their medical expertise and HHSC-approved criteria to evaluate the medical necessity and cost-effectiveness of requested services." The Contract also obligated Xerox to use "... registered nurses, licensed vocational nurses, licensed clinical social workers, registered dental assistants, and dental technicians to provide timely and accurate review of PA requests in accordance with the RFP's performance requirements." Moreover, the clinical staff was to have access "...to staff physicians and medical consultants as needed to resolve questionable requests." *See Attachment 3, Xerox's Proposal to RFP, Business Operations Plan § 8.9.5.* As a result of Xerox's responses to HHSC's inquiries regarding the competency of the Program's staff, HHSC believed Xerox's claim that Xerox's employees were qualified and appropriately trained to conduct medical necessity reviews in a manner that met the Contract's requirements including high professional standards.

HHSC disagrees with Xerox's assertion that its failure to employ qualified medical personnel was because the Contract did not define the term "medically knowledgeable." *See PAC 37, Provide and maintain a sufficient number of knowledgeable and professional medical personnel to perform the PA function, in accordance with State-approved processes and procedures.* Xerox's own proposal to HHSC includes its plan to employ qualified clinical personnel, such as "registered dental assistants and dental technicians" who would use their "medical expertise," to review prior authorization requests for orthodontic services. Further, the Contract required

clinical personnel have access to staff physicians and medical consultants for an additional review if needed. Given the essential purpose of the Program and the terms of the contract requiring clinical staffing, the term “medically knowledgeable” should be given its ordinary meaning. The lack of a contractual definition does not excuse mismanagement by Xerox. *See Attachment 3.*

Contrary to its contractual requirement, Xerox used clerical staff – which Xerox represented as “Dental Specialists” – to review prior authorization requests in place of registered dental assistants or dental technicians. The Contract expressly limits clerical staff to non-clinical tasks such as verifying the Medicaid eligibility of recipients and ensuring that the dental service providers were eligible to receive Medicaid reimbursement for properly approved services. *See Attachment 3.*

When confronted by HHSC regarding the qualifications of its Program staff, Xerox asserted that it was using appropriately trained staff and that requests for services that did not meet medical policy criteria were sent to the Dental Director for review. HHSC relied on Xerox's oral and written assurances that the Program was administered in compliance with HHSC's policies. *See Attachments 1, 3 and 6.*

Although virtually all Medicaid recipients that qualify for orthodontia services are now enrolled in managed care, HHSC's stringent requirements for medical necessity still apply to the recipients who remain in the fee-for-service Medicaid program, and the fee-for-service providers must still submit prior authorization requests for orthodontia services to Xerox for approval. As a result of the contractual Notice of Deficiency that HHSC sent to Xerox, all prior authorization requests must be reviewed by qualified dentists to determine medical necessity. In addition, qualified dentists must review all diagnostic tools including dental molds when assessing the requests. The medical necessity determinations are further subject to retrospective reviews by HHSC's Dental Director. As previously noted, HHSC terminated the Contract with Xerox for cause and is transitioning Xerox's contractual responsibilities to Accenture as the prime contractor until HHSC can competitively rebid the Contract. Accenture is scheduled to take over Xerox's business operations effective August 1, 2014.

RECOMMENDATIONS

Detailed responses to each of the recommendations included in the report follow.

DHHS – OIG Recommendation: *We recommend that the State Agency provide proper oversight of the orthodontic prior authorization process to ensure that it is used to determine medical necessity.*

HHSC Response: HHSC is providing proper oversight of the orthodontic prior authorization process to ensure that the process is properly used to determine if orthodontic services are

medically necessary. HHSC's Notice of Deficiency resulted in a change in Xerox's management of the Program. As of October 1, 2011, all prior authorization requests are reviewed by a qualified dentist.

Additionally, on March 1, 2012, HHSC transitioned the vast majority of its Medicaid recipients to a managed care system.⁸ Currently, Xerox only reviews prior authorization requests for a small population of recipients. As a result of the change, Xerox did not conduct any new orthodontic prior authorization approvals between February 1, 2013 and December 30, 2013. HHSC also hired its own Dental Director to perform retrospective reviews and monitor the effectiveness of its dental and orthodontia programs.

Actions Planned: HHSC will continue to monitor the Program as contractual responsibilities are transitioned from Xerox to Accenture. HHSC also plans to complete retrospective reviews of the Program.

Responsible Person: Associate Commissioner for Medicaid and CHIP

DHHS – OIG Recommendation: *We recommend that the State Agency provide proper oversight of the orthodontic prior authorization process to ensure that personnel making the prior authorization decisions follow the appropriate State Medicaid policies and procedures.*

HHSC Response: HHSC is providing proper oversight of the orthodontic prior authorization process to ensure that appropriate personnel are making medical necessity determinations for orthodontic services.

Xerox is reviewing few prior authorization requests for orthodontia services because almost all Medicaid recipients eligible for orthodontia services are now in managed care. Additionally, Xerox has changed the management of its Program to comply with the Contract and HHSC's policy, and all prior authorization requests are now being reviewed by a qualified dentist. Further, HHSC hired its own Dental Director to monitor the Program.

Actions Planned: HHSC will continue to monitor the Program as contractual responsibilities are transitioned from Xerox to Accenture. HHSC also plans to complete retrospective reviews of the Program.

Responsible Person: Associate Commissioner for Medicaid and CHIP

⁸ Paid Medicaid Orthodontia Services cost \$126,713,664 (state and federal funds) in SFY 2012. After the transition to managed care, the Paid Medicaid Orthodontia Services cost \$43,742,651 (state and federal funds) in SFY 2013.

ATTACHMENTS

1. 2005 Policies and Procedures for Dental Authorization Department
2. Dental Authorization WIKI dated May 18, 2011
3. Xerox's 2002 Proposal to RFP, Business Operations Plan § 8.9
4. Medical Affairs 12-03-03 Delivery of Inventory Sign-Off Form-NHIC Department Manuals for Dental Authorizations received by Xerox on December 11, 2003
5. Texas Medicaid & Healthcare Partnership Prior Authorization Work Group, June 16, 2003 Meeting Minutes
6. Memorandum to Billy Millwee from Rick Pope, dated May 13, 2009