

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK IMPROPERLY CLAIMED
MEDICAID REIMBURSEMENT
FOR ORTHODONTIC SERVICES TO
BENEFICIARIES IN
NEW YORK CITY**

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October 2013
A-02-11-01003

Office of Inspector General

<https://oig.hhs.gov>

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

New York State claimed at least \$7.8 million in unallowable Medicaid reimbursement for orthodontic services provided to beneficiaries in New York City.

WHY WE DID THIS REVIEW

Federal law authorizes Medicaid, which covers orthodontic services for children with severe dental conditions. Recently, in a hearing on government efforts to address Medicaid fraud, Congress noted its concerns on waste, fraud, and abuse of certain Medicaid program services, including orthodontic treatment.

The objective of this review was to determine whether the New York State Department of Health (State agency) claimed Federal Medicaid reimbursement for orthodontic services provided to beneficiaries in New York City that complied with Federal and State requirements.

BACKGROUND

In New York State, the State agency administers the Medicaid program. The New York State Medicaid Orthodontic Program (program) provides orthodontic services to Medicaid-eligible beneficiaries with severe dental defects. The State agency administers the program for the entire State except for New York City, where the local Department of Health and Mental Hygiene (DOHMH) administers the program.

DOHMH oversees three State agency-approved screening centers that evaluate beneficiaries' program eligibility. If determined to be eligible for the program, beneficiaries are approved to receive orthodontic treatment for 1-year service periods. The screening centers also conduct annual reviews to determine the need to continue treatment for additional 1-year periods.

HOW WE CONDUCTED THIS REVIEW

For calendar years 2007 through 2009, the State agency claimed Federal Medicaid reimbursement totaling approximately \$66 million for 658,612 claims for program services provided to 73,539 beneficiaries in New York City. Of these beneficiaries, we selected a simple random sample of 100 beneficiaries and reviewed corresponding claim documentation maintained by DOHMH, the assigned screening center, and the treating orthodontist (provider).

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for orthodontic services provided to beneficiaries in New York City that did not always comply with Federal and State requirements. Of the 100 beneficiaries in our random sample, the State agency properly claimed Medicaid reimbursement for 57 beneficiaries. However, for the remaining 43 beneficiaries, the State agency claimed Medicaid reimbursement for 1 or more services that were unallowable.

Specifically, the State agency claimed:

- services to 24 beneficiaries that were provided outside an approved service period,
- services to 18 beneficiaries that were not documented, and
- services to 11 beneficiaries that were not provided.

(The total exceeds 43 because we found more than 1 deficiency for services provided to 10 beneficiaries.)

On the basis of our sample results, we estimated that the State agency claimed at least \$7,780,626 in unallowable Federal reimbursement.

These deficiencies occurred because the State agency and providers did not ensure that cases were reviewed annually to determine the need for continuing care and that services were documented. Further, the State agency provided limited guidance to providers on State regulations requiring orthodontic care to be reviewed annually to determine the need for continuing care. Finally, the State agency did not (1) sufficiently educate providers regarding their responsibilities to ensure that their patients receive annual clinical reviews at screening centers and (2) maintain adequate documentation.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund \$7,780,626 to the Federal Government and
- strengthen guidance and provider education activities related to authorizing continuing treatment and maintaining adequate documentation.

DEPARTMENT OF HEALTH COMMENTS

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with either of our recommendations. Regarding our first recommendation, the State agency stated that its Office of Medicaid Inspector General would “review and recover funds as appropriate.” The State agency did not directly address our second recommendation. Rather, it described the transfer of program oversight of New York City orthodontic cases from DOHMH to the State agency as well as revisions to program regulations. These program changes occurred after the completion of our fieldwork.

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INTRODUCTION

WHY WE DID THIS REVIEW

Federal law authorizes Medicaid, which covers orthodontic services for children with severe dental conditions. Recently, in a hearing on government efforts to address Medicaid fraud, Congress noted its concerns on waste, fraud, and abuse of certain Medicaid program services, including orthodontic treatment.¹

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) claimed Federal Medicaid reimbursement for orthodontic services provided to beneficiaries in New York City that complied with Federal and State requirements.

BACKGROUND

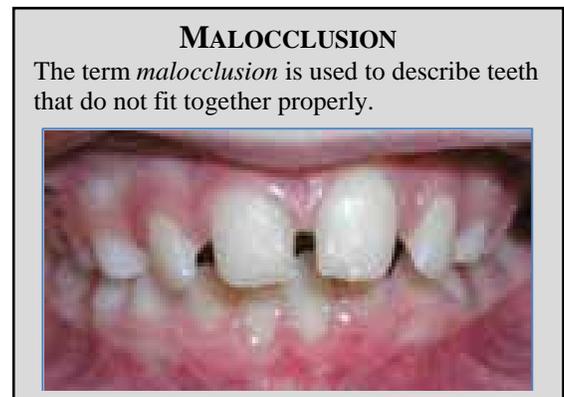
Medicaid Program

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.

In New York State, the State agency administers the Medicaid program. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

New York State's Medicaid Orthodontic Program

The New York State Medicaid Orthodontic Program provides orthodontic services to Medicaid-eligible beneficiaries with severe dental defects known as malocclusions. (See accompanying text box.) The State agency administers the program for all social services districts except New York City.²



¹ “Is Government Adequately Protecting Taxpayers from Medicaid Fraud?” Joint hearing before the Subcommittee on Health Care, District of Columbia, Census, and the National Archives; and the Subcommittee on Regulatory Affairs, Stimulus Oversight, and Government Spending of the Committee on Oversight and Government Reform, House of Representatives, 112th Congress, April 25, 2012.

² In New York State, each county is considered its own social services district, except the five counties that make up New York City, which are considered a single district.

State regulations limit program eligibility to Medicaid beneficiaries under age 21 who exhibit severe dental defects that affect oral health, function, and esthetics (i.e., malocclusions).³ In addition, State regulations authorize orthodontic care for Medicaid reimbursement by the State agency⁴ and require all cases accepted for orthodontic care to be reviewed annually for progress to determine the need for continuing care.^{5, 6}

New York City's Orthodontic Rehabilitation Program

In New York City, the Department of Health and Mental Hygiene (DOHMH) administers the Medicaid Orthodontic Program, known as the Orthodontic Rehabilitation Program (program). To determine program eligibility, Medicaid orthodontists refer beneficiaries to one of three State agency-approved screening centers overseen by DOHMH. The screening centers perform a clinical exam and, if the beneficiary is determined to be eligible for the program, DOHMH approves an initial 1-year service period. The screening centers also conduct annual reviews to determine the need to continue treatment for additional 1-year periods. According to DOHMH policies and procedures, treating orthodontists (providers) are responsible for ensuring that their patients receive an annual clinical review from the screening centers to authorize additional 1-year service periods.

HOW WE CONDUCTED THIS REVIEW

For calendar years 2007 through 2009, the State agency claimed Federal Medicaid reimbursement totaling approximately \$66 million for 658,612 claims for program services provided to 73,539 beneficiaries in New York City. Of these beneficiaries, we selected a simple random sample of 100 beneficiaries and reviewed corresponding claims documentation maintained by DOHMH, the assigned screening center, and the treating orthodontist (provider).

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, Appendix B contains details of our statistical sampling methodology, and Appendix C contains our sample results and estimates.

³ 10 NYCRR section 85.45(b) (2011).

⁴ 18 NYCRR section 506.4(a).

⁵ 18 NYCRR section 506.4(b) (2011). In 2012, the State amended section 506.4(b) and removed the annual review requirement from the regulation. New York State Register, I.D. No. HLT-32-12-00017-E (Aug. 8, 2012).

⁶ Except in some circumstances (e.g., beneficiaries with a cleft palate), orthodontic care is covered for a maximum period of 3 years of active treatment and 1 year of retention care (18 NYCRR § 506.4(c)).

FINDINGS

The State agency claimed Federal Medicaid reimbursement for orthodontic services provided to beneficiaries in New York City that did not always comply with Federal and State requirements. Of the 100 beneficiaries in our random sample, the State agency properly claimed Medicaid reimbursement for 57 beneficiaries. However, for the remaining 43 beneficiaries, the State agency claimed Medicaid reimbursement for 1 or more services that were unallowable.

Specifically, the State agency claimed:

- services to 24 beneficiaries that were provided outside an approved service period,
- services to 18 beneficiaries that were not documented, and
- services to 11 beneficiaries that were not provided.⁷

On the basis of our sample results, we estimated that the State agency claimed at least \$7,780,626 in unallowable Federal reimbursement.

These deficiencies occurred because the State agency and providers did not ensure that cases were reviewed annually to determine the need for continuing care and that services were documented. Further, the State agency provided limited guidance to providers on State regulations requiring orthodontic care to be reviewed annually to determine the need for continuing care. Finally, the State agency did not (1) sufficiently educate providers regarding their responsibilities to ensure that their patients receive annual clinical reviews at screening centers and (2) maintain adequate documentation.

SERVICES NOT AUTHORIZED

Under Office of Management and Budget (OMB) Circular A-87, to be allowable, costs must be authorized or not prohibited under State laws or regulations.⁸ New York regulation requires that all cases accepted for orthodontic care (i.e., determined eligible for the program) be reviewed annually for progress to determine the need for continuing care.⁹ Therefore, if the annual review is not performed or furnished on an annual basis, services are not authorized under the State's regulations.

According to DOHMH policies and procedures, providers are responsible for ensuring that their patients receive annual clinical reviews at the screening centers. In letters to providers notifying them that a patient is authorized to receive treatment, DOHMH states this requirement. Further, DOHMH included a space on its "Medicaid Annual Review Request" form for the provider to

⁷ The total exceeds 43 because we found more than 1 deficiency for services provided to 10 beneficiaries.

⁸ OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, Attachment A, section C.1.c. (2 CFR Part 225, App. A, § C.1.c.).

⁹ 18 NYCRR section 506.4(b) (2011).

indicate the appropriate period for review (e.g., “2nd yr.”). Finally, according to DOHMH program guidance issued to New York City providers:

Cases must be reviewed annually. The treating orthodontist who wants to continue a Medicaid patient’s orthodontic treatment must request and ensure their Medicaid patient’s annual review by submitting a completed “Medicaid Annual Review Request” form ... to the appropriate [screening center].¹⁰

For 24 of the 100 beneficiaries in our sample, orthodontic services were provided outside of a 1-year service period approved by 1 of the screening centers. For 22 of these beneficiaries, providers billed for treatment when no annual review was performed to determine whether the beneficiary continued to need treatment (i.e., providers had not received approval from a screening center to continue services). For the remaining two beneficiaries, annual reviews were performed; however, providers submitted claims for active orthodontic care outside of an approved service period. Therefore, these services were not authorized.

These deficiencies occurred because providers did not ensure that beneficiaries were authorized by the screening centers for continued treatment after a 1-year service period. Some providers stated that they instructed beneficiaries to schedule appointments with a screening center for an annual review but did not ensure that the beneficiaries went. Others stated that they expected the screening centers to schedule appointments with beneficiaries.

SERVICES NOT DOCUMENTED

Federal and State regulations require that services claimed for Federal Medicaid reimbursement be documented.^{11, 12}

For 18 of the 100 beneficiaries in our sample, we found that the provider did not have documentation to support orthodontic services billed to Medicaid. Specifically, providers did not provide documentation of quarterly adjustments to orthodontic appliances (braces) for 11 beneficiaries and diagnostic casts, photographs, or X-rays taken for 7 other beneficiaries. This occurred because providers did not maintain documentation to support services billed for Medicaid reimbursement.

SERVICES NOT PROVIDED

CMS’s *State Medicaid Manual* specifies that Federal financial participation is available only for allowable actual expenditures made on behalf of eligible beneficiaries for covered services rendered by certified providers.¹³

¹⁰ DOHMH Physically Handicapped Children’s Program. *Orthodontic Rehabilitation Program*, March 1996 (Revised December 2010); p. 10.

¹¹ 42 CFR section 431.107; CMS, *State Medicaid Manual*, section 2500.2.A.

¹² 18 NYCRR section 515.2(b)(6).

¹³ CMS, *State Medicaid Manual*, section 2497.1.

For 11 of the 100 beneficiaries in our sample, the provider claimed orthodontic services that were not provided. Specifically, for six beneficiaries, providers claimed Medicaid reimbursement for quarterly adjustments to braces that had already been removed or had not yet been inserted. For five other beneficiaries, the provider claimed orthodontic services even though the beneficiary missed their office appointment. This occurred because the providers did not ensure that only claims for actual services provided were submitted for Medicaid reimbursement.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$7,780,626 to the Federal Government and
- strengthen guidance and provider education activities related to authorizing continuing treatment and maintaining adequate documentation.

DEPARTMENT OF HEALTH COMMENTS

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with either of our recommendations. Regarding our first recommendation, the State agency stated that its Office of Medicaid Inspector General would “review and recover funds as appropriate.” The State agency did not directly address our second recommendation. Rather, it described the transfer of program oversight of New York City orthodontic cases from DOHMH to the State agency as well as revisions to program regulations.¹⁴ For example, all new orthodontia cases in both New York City and throughout the State are included in the State’s Medicaid managed care benefit package.

The State agency’s comments appear in their entirety as Appendix D.

¹⁴ Effective October 1, 2012, DOHMH ceased operating the New York City program. As of this date, the oversight of all New York City orthodontic cases was transferred to the State agency’s Office of Health Insurance Programs. This transition occurred after the completion of our fieldwork.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 658,612 claims for orthodontic services, totaling \$131,819,708 (\$65,910,208 Federal share), provided to 73,539 beneficiaries in New York City during calendar years 2007 through 2009.

We did not assess the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the MMIS file for our audit period, but we did not assess the completeness of the file.

We conducted our audit from November 2010 to July 2012 and performed our fieldwork at the State agency's offices in Albany, New York; the MMIS fiscal agent in Rensselaer, New York; DOHMH's offices in New York, New York; and at 3 screening centers and 50 orthodontic providers throughout the New York City metropolitan area.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with State agency officials to gain an understanding of the Medicaid Orthodontic Program;
- held discussions with DOHMH officials to gain an understanding of the agency's policies and procedures related to its administration of the Orthodontic Rehabilitation Program;
- ran computer programming applications at the MMIS fiscal agent that identified a sampling frame of 73,539 beneficiaries in New York City¹⁵ for whom the State agency was reimbursed for orthodontic services totaling \$131,819,708 (\$65,910,208 Federal share);
- selected a simple random sample of 100 beneficiaries¹⁶ from the sampling frame of 73,539 beneficiaries, and, for the 100 beneficiaries:
 - interviewed the associated provider to gain an understanding of how the provider billed orthodontic services to the Medicaid program and

¹⁵ We used beneficiaries' residence addresses on the MMIS to identify those located in the five counties that make up New York City.

¹⁶ We reviewed all claims during calendar years 2007 through 2009 for each beneficiary in our sample.

- reviewed corresponding claims documentation maintained by DOHMH, the assigned screening center, and the provider, including notes on whether the beneficiary missed their appointment; and
- estimated the unallowable Federal Medicaid reimbursement in the population of 73,539 beneficiaries.

See Appendix B for the details of our statistical sampling methodology and Appendix C for our sample results and estimates.

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: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicaid beneficiaries in New York City (Medicaid beneficiaries) who received orthodontic services during our January 1, 2007, through December 31, 2009, audit period.

SAMPLING FRAME

The sampling frame was an Excel file containing 73,539 Medicaid beneficiaries who received orthodontic services totaling \$131,819,708 (\$65,910,208 Federal share). The Medicaid claims were extracted from the claim file maintained at the MMIS fiscal agent.

SAMPLE UNIT

The sample unit was a Medicaid beneficiary who received orthodontic services for which the State agency claimed Federal Medicaid reimbursement. One Medicaid beneficiary may have had multiple orthodontic services claimed for reimbursement.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 Medicaid beneficiaries.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the 73,539 Medicaid beneficiaries. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the unallowable Federal reimbursement paid. We used the lower limit of the 90-percent confidence level to estimate the overpayment associated with the unallowable claims.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results: Federal Share Amounts

Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Beneficiaries With Unallowable Claims	Value of Unallowable Claims
73,539	\$65,910,208	100	\$90,255	43	\$14,829

Estimated Value of Unallowable Costs
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$10,904,731
Lower limit	7,780,626
Upper limit	14,028,836

APPENDIX D: DEPARTMENT OF HEALTH COMMENTS



Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

August 15, 2013

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-11-01003

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the U.S. Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-11-01003 entitled, "New York Improperly Claimed Medicaid Reimbursement for Orthodontic Services to Beneficiaries in New York City."

Thank you for the opportunity to comment.

Sincerely,

Michael J. Nazarko

Michael J. Nazarko
Deputy Commissioner
for Administration

enclosure

cc: Jason Helgerson
James C. Cox
Diane Christensen
Lori Conway
Ronald Farrell
OHIP Audit BML

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**New York State Department of Health
Comments on the
U.S. Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-11-01003 entitled,
“New York State Improperly Claimed Medicaid
Reimbursement for Orthodontic Services
To Beneficiaries in New York City”**

The following are the New York State Department of Health’s (Department) comments in response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-11-01003 entitled, “New York State Improperly Claimed Medicaid Reimbursement for Orthodontic Services To Beneficiaries in New York City.”

Recommendation #1:

Refund \$7,780,626 to the Federal Government.

Response #1:

The Office of the Medicaid Inspector General (OMIG) will review and recover funds as appropriate.

Recommendation #2:

Strengthen guidance and provider education activities related to authorizing continuing treatment and maintaining adequate documentation.

Response #2:

The Department would like to offer additional and clarifying information in response to the OIG’s draft report. The report states that providers were not adequately informed of the annual review requirement for continuing orthodontic treatment. However, OIG also acknowledges that the New York City Department of Health and Mental Hygiene’s (NYC DOHMH) Orthodontic Review Program (ORP) stressed the annual review requirement through their individualized case treatment approval letters to providers and in their own educational materials. The Department reviewed 13 of the OIG’s “disallowed cases.” All offices reviewed confirmed that they knew annual reviews were necessary. Also, the Department enforced this requirement through the review of outlier orthodontic treatment claims during the audit period.

While orthodontist providers did understand that the annual review was required under State regulations, some orthodontists failed to ensure that it was completed in a timely manner by a screening center per the policies, rules and regulations of the Department at the time. When potential violations come to the attention of the Department, under 18 NYCRR (including Sections 515, 517, 518, 519 and 521) appropriate procedures and actions are taken. Factors considered are the nature of the violations, adverse impact on recipients, amount of damages to the program, mitigating circumstances, and the previous record of the provider. Therefore, under State regulations, violations of the annual review procedures and requirements as administered

by the ORP do not render the ongoing orthodontic treatment services automatically non-reimbursable under the 10 NYCRR regulations being applied by the OIG.

The orthodontic regulations were revised in 2012 to allow flexibility in adopting current standards of practice on an ongoing basis and to reflect the centralization over many years of the program management from local districts to the Department. The annual review of active treatment continues to be required, per the Department's Dental Provider Manual. The Department now has the authority to require a more frequent review if needed. For the NYC cases begun prior to October 2012, the Department is requiring and reviewing documentation of progress for annual approval of continuing treatment.

The administration of the Medicaid orthodontic benefit in New York State has changed significantly as a result of Medicaid Redesign Team initiatives. Specifically, effective October 1, 2012, orthodontia is included in the Medicaid managed care benefit package for all new cases statewide. In addition, as of October 1, 2012, all existing orthodontic cases statewide and any new fee for service cases are being managed by the Department's Office of Health Insurance Programs in Albany. The NYC DOHMH ceased operation of its ORP at the time of this transition. The vast majority of children are enrolled in a Medicaid managed care plan and so their orthodontic benefit is administered and services authorized by the plans through their provider networks.

In summary, through the move to managed care, assumption and centralization in Albany of existing NYC cases, updated provider manual and other provider education materials, the Department has strengthened oversight, guidance and provider education activities regarding continuing orthodontic treatment.