The Dangers of Billing Payors for the Services of a Non-Credentialed Dentist / Non-Participating Dentist

(August 17, 2019): Over the last year, we have seen a significant increase in the number of Medicaid and private insurance audits of dental claims. A common trigger for these audits included instances in which a practice improperly billed for the services of a non-credentialed dentist while using the identification number of a credentialed provider. When we discussed this billing audit issue with our dental clients, many were surprised to learn that this practice was improper. Unfortunately, billing for services performed by another dentist using your National Provider Identifier (NPI) can result in a wide range of adverse actions against you and your practice. This article examines this issue and discusses the potential fallout of engaging in this type of conduct.

I. What is "Credentialing" and Why is it Important?

The credentialing processes utilized by insurance companies serve as a payor's first line of defense and are intended to protect patients, help ensure the quality of care being provided, and safeguard the financial integrity of the insurance plan. The Joint Commission describes "Credentialing" as:

> ***"[t]he process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization. Credentials are documented evidence of licensure, education, training, experience, or other qualifications."***[1]

It is important to keep in mind that the specific credentialing requirements and procedures used vary from one payor to another. For example, dentists who wish to enroll in their State Medicaid Program are typically required to complete multiple credentialing applications.

- ***State Medicaid Programs require that each dental practice obtain a provider number; and***
- ***Each dentist who will be performing dental services on Medicaid patients must be individually credentialed and admitted as a participating provider;***

and

- ***After being admitted as a participating provider in a State Medicaid Program, a dentist must still complete separate credentialing applications in order to become a participating provider in the various Medicaid Managed Care programs that may be available in your state.***

II. What's the Worst that Can Happen if You Improperly Bill the Services Of a Non-Credentialed Dentist / Non-Participating Dentist Under the Billing Number of a Credentialed Dentist / Participating Dentist?

Let's consider the following common hypothetical situation: suppose you own a growing dental practice that provides dental care and treatment services to both adults and children. You are a participating provider in the State Medicaid Program and also participate in a number of Medicaid Managed Care and private payor plans. You recently hired a new dentist to help with your ever-growing patient caseload. Although you are fully credentialed by each of the government and private payor insurance plans, your new dentist is still in the process of completing her credentialing applications, and you have been told that it may take 90 days (or even longer) for Medicaid, Medicaid Managed Care and private payors to review and approve the new dentist's credentialing application. ***How are you expected to bill for the dental services provided by your newly hired dentist? Can you bill for the services of a non-credentialed dentist using your provider number?*** As we will discuss below, the improper billing of dental services performed by a non-credentialed provider under the provider number of a credentialed dentist can lead to administrative, civil and even criminal liability.

Administrative Sanctions: At a minimum, if you improperly bill the dental services of a non-credentialed dentist under the name and provider number of a credentialed dentist, you should expect the payor to take the position that each of the improperly billed claims constitute an overpayment that must be repaid to the insurance company. Unfortunately, in many of the cases we have seen and / or defended, the government and private payors have imposed additional sanctions. In some instances, where the claims at issue have been covered by Medicaid or Medicaid Managed Care, the Department of Health and Services, Office of Inspector General (OIG) pursued Civil Monetary Penalties against the provider. We have also defended clients in cases where the payor had terminated the provider's participation in the payor plan and / or filed a complaint against the dentist with the State Board of Dental Examiners. Examples of cases where administrative sanctions have been imposed are set out below:

- **Indiana. $125,446 in Civil Monetary Penalties Assessed.** An Indiana dental

practice was assessed significant penalties by the Department of Health and Services, Office of Inspector General (OIG) as a result of alleged improper billing practices. The government alleged that the dental practice submitted claims to the state Medicaid program for dental services that were performed by non-credentialed dentists under the names of dentists who were credentialed with Indiana Medicaid.

- **Massachusetts. $841,120 in Civil Monetary Penalties Assessed.** In this case, a Massachusetts-based dental school was alleged to have submitted claims to Medicare[2] for dental services that were provided by non-credentialed dentists. Additionally, the OIG claimed that the level of dental service billed was not supported by the associated dental records and documentation.

- **Multiple States. Disciplinary Licensure Actions are Pending – Multiple State Boards of Dental Examiners.** We have been (and are currently) involved in multiple matters where Medicaid Managed Care and / or private payor insurance plans have filed complaints with State Dental Boards against dentists for allegedly submitting false or fraudulent claims to the insurance company. Notably, the improper conduct alleged has consistently included allegations that the dental practice submitted the claims of dental services performed by non-credentialed dentists under the names and NPIs of dentists who were properly credentialed in a particular plan.

Civil Sanctions -- False Claims Act Liability. Most of the cases brought under the False Claims Act[3] against Medicare and Medicaid participating providers in connection with the improper billing of services by a non-credentialed provider involved medical, rather than dental services. Nevertheless, this remains a significant risk for dental practices that bill Medicaid and Medicaid Managed Care plans. Two examples of False Claims Act cases that were brought against Medicare providers for the wrongful billing of services performed by non-credentialed physicians are set out below:[4]

- **$500,000 Settlement Under the False Claims Act.** In a case in the Western District of Oklahoma, a licensed physician allowed an uncredentialed practitioner to use his NPI to bill Medicare for Evaluation & Management (E/M) physical therapy services that the licensed physician did not personally perform or supervise. The government brought an action against the physician under the civil False Claims Act. The defendant had to pay **$500,000** to settle the case.

- **$859,500 Settlement Under the False Claims Act.** In this case, a well-respected state university health science center filed a self-disclosure with the OIG for submitting claims to Medicare using the NPIs of multiple physicians who did not render or supervise the services at issue. The university health science center was forced to pay **$859,500** to the government to settle alleged violations of the False Claims Act.

Criminal Sanctions: In a worst-case scenario, Federal prosecutors may take the position that the wrongful billing of dental services by a non-credentialed provider under the name and provider number of a credentialed provider constitutes health care fraud. In the case discussed below, a licensed dentist was prosecuted for engaging in various health care fraud schemes. One of the counts in the prosecution included the dentist's alleged "fraudulent" submission of services performed by a non-credentialed dentist. To be clear, we have not seen any Federal prosecutions which were based solely on this specific type of illegal conduct. Nevertheless, it is clear that if a dentist is alleged to have engaged in a broader scope of fraudulent conduct, prosecutors will not hesitate to include these types of false claims in an Information or Indictment against the physician.

- **Defendant Ordered to Pay $956,448 in Restitution and Sentenced to 33 Months in Jail.** In a recent criminal prosecution (June 2019) in the Middle District of Tennessee, a licensed dentist and his former practice administrator were charged with Conspiracy to Commit Health Care Fraud. The government further alleged that the defendant dentist *"took steps to conceal the fraud by discouraging employees from questioning billing practices"* and *"instructing employees to lie if questioned by insurance companies."Ultimately, the defendant dentist pled guilty to the charges*

*and was sentenced to 33 months in Federal prison. He was also ordered to pay $956,448.00 in restitution.*According to the Information filed against the defendant dentist, the defendant engaged in various acts of fraud against the Delta Dental, Cigna, TennCare and DentaQuest programs, including: **(1) Billing for dental services that were not completed or performed at all; (2) Falsifying dates of service to appear to comply with benefit programs' timeframe and preauthorization requirements; (3) *Falsifying claims to appear that services had been rendered by a benefits program credentialed dentist*;**

III. When Can Non-Credentialed / Non-Participating Dentists Properly Bill Under the Name and Number of a Participating Dentist?

Not surprisingly, Medicare, Medicaid and private payors have all established their own rules governing when, and if, a non-credentialed dentist can properly bill under a credentialed physician's name and billing number. In this section, we examine three of the most common scenarios in which a provider *can* bill for the dental services performed by a non-credentialed dentist:

Locum Tenens / Substitute Dentist. The term ***"locum tenens"*** is a Latin phrase that means ***"one holding a place."***[5] It is used to describe an independent contractor dentist or medical doctor who has been hired to temporarily take the place of a staff dentist or medical doctor who is absent due to illness, pregnancy, vacation or continuing dental education courses. It is also sometimes used to fill vacancies when a dental practice is short-staffed. The rules governing the proper billing of dental services performed by a locum tenens dentist often vary from payor to payor. For instance:

- **Medicare Locum Tenens / Substitute Dentist Rules.[6]** As set out under Section 1842(b)(6)(D) of the Social Security Act, a physician may receive Medicare payment for physician[7] services (and for services performed incident to such physician services) that are performed by another physician *on behalf of* the billing physician if the billing physician is unavailable to provide the services, and the services are furnished pursuant to an arrangement that is either: (1) Informal and reciprocal, or (2) Involves per diem or other fee-for-time compensation for such services.

In addition, the services must not be provided by the substitute physician over a continuous period of more than 60 days *unless* the billing physician is called or ordered to active duty as a member of a reserve component of the Armed Forces. Since the definition of "physician" includes both a Doctor of Dental Medicine and a Doctor of Dental Surgery (see Footnote 7), it can be argued that a Medicare-participating dentist would also qualify for the coverage of this rule

- **Medicaid Locum Tenens / Substitute Dentist Rules.** In Texas, ***"a locum tenens arrangement is not allowed for dentists"***[8] under the Texas Medicaid dental program.[9] However, under Texas Administrative Code (TAC) rules §354.1121 and §354.1221, it *is permissible* to bill for Medicaid dental services performed by substitute dentists as long as certain requirements are met.[10] The approach taken by a state's Medicaid program with respect to the billing of locum tenens dentists and / or substitute dentists can vary from state to state.

- **Private Payor Locum Tenens / Substitute Dentist Rules.** The requirements to bill a private payor plan for the services of a locum tenens or substitute dentist may vary widely depending on the individual plan. It is therefore important to research the billing rules that apply under each private payor contract.

"Incident to" Billing of Dentist Services. At the outset, it is important to recognize that there is virtually no Medicare, Medicaid or private insurer guidance discussing whether the "***incident to"*** billing of dental services that are performed by a non-credentialed dentist is permitted (assuming, of course, that the requirements of incident to billing have been fully met**). Despite the absence of written guidance in this regard, based on the way the incident to rule has** been applied to physicians, an argument can be made that the concept also applies to dentists.

For example, Medicare has no rules which prohibit a non-participating physician who serves as auxiliary personnel to a participating physician from providing incident to services to the patient. In addition, Medicare does not preclude the supervising, participating physician from billing for incident to services performed by a non-participating physician as long as: ***(a) the services are reasonable, necessary and otherwise meet all of Medicare's incident to requirements***;[11] ***(b) the non-enrolled physician is properly licensed by the state; and (c) the incident to services comply with any applicable state law requirements.***

Given that the definition of "physician" pertains to both a Doctor of Dental Medicine and a Doctor of Dental Surgery, one could argue that the incident to rules apply to dental services as well as general medical services. Unfortunately, such an exception would only apply to dental services that qualify for coverage and payment by Medicare.

Medicaid, Medicaid Managed Care and private payor insurance plans have consistently opposed the applicability of incident to billing to dental services, even though nothing in their participation agreements mentions such billing practices.

IV. Reducing Your Level of Risk:

There are several steps that your dental practice can take to better comply with the credentialing and billing requirements that have been established by the Medicare, Medicaid, Medicaid Managed Care and private payor insurance programs. These include:

- ***Plan ahead by starting the credentialing process as soon as possible when a new dentist joins the practice.***
- ***Restrict non-credentialed dentists from performing dental services on patients covered under a payor plan that requires credentialing.***
- ***Until new hires are credentialed, have them limit their services to self-pay patients or other services that do not require credentialing.***
- ***Read your enrollment applications and their associated payor contracts. What are the credentialing requirements that must be met?***
- ***Does the insurance payor recognize incident to billing of dental services? Some private payor plans expressly prohibit the use of incident to billing. If that is the case, and a provider knowingly billing for services performed by a non-credentialed provider under the name and NPI of a credentialed provider, the insurance company may argue that the provider has committed health care fraud.***

[An updated article examining a number of the current audits and enforcement initiatives aimed at dentists and dental practices is covered in our article dated October 16, 2019, titled *"SIU Dental Audit Reviews by DentaQuest, Delta Dental and Cigna Can Ultimately Lead to Criminal Prosecution and Imprisonment. Are Your Dental Office's Medical Necessity, Documentation, Coding and Billing Practices Compliant?"*]

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[1] See https://www.jointcommission.org/assets/1/6/AHC_who_what_when_and_where_credentialing_booklet.pdf

[2] Although traditional Medicare Part A does not cover most dental care treatment services, it may cover certain dental procedures that are necessary for an otherwise covered service to be completed. For instance, a Medicare patient may obtain coverage for certain dental work in connection with jaw surgery. Additionally, several Medicare Advantage plans now cover routine vision and dental procedures.

[3] 31 U.S.C. § 3729-3733. The Federal civil False Claims Act is the primary civil enforcement tool used to combat fraud against the United States. The False Claims Act imposes civil monetary penalties and treble damages on any person who ***knowingly submits, or causes to be submitted, a false claim to the government for payment*****.**

[4] It is important to note that the two cited False Claims Act cases involved the submission of claims to the Medicare program. In these cases, the government noted that the improperly billed services were not performed or supervised by the credentialed provider under whom the service was billed. This language reflects the exemption that if Medicare's "Incident To" requirements are otherwise met, the services of non-credentialed physician can, in fact, be billed under the name of the supervising, credentialed physician.

[5] The Concise Oxford English Dictionary (Eleventh Edition).

[6] Please note, Medicare no longer uses the term "locum tenens" when referring solely fee-for-

time compensation arrangements. Under Section 16006 of the 21st Century Cures Act, the term "locum tenens arrangements" is now used to refer to both fee-for-compensation arrangements and reciprocal billing arrangements.

[7] As set out on CMS's website, the definition of "Physician" includes the following:

"For the purposes of Open Payments, a "physician" is any of the following types of professionals that are legally authorized by the state to practice, regardless of whether they are Medicare, Medicaid, or Children's health Insurance Program (CHIP) providers:

- *Doctors of Medicine or Osteopathic Medicine*
- *Doctors of Dental Medicine or Dental Surgery*
- *Doctors of Podiatric Medicine*
- *Doctors of Optometry*
- *Chiropractors*

Note: Medical residents are excluded from the definition of physicians for the purpose of this program."

https://www.cms.gov/OpenPayments/About/Glossary-and-Acronyms.html.

[8]
https://hhs.texas.gov/about-hhs/communications-events/news/2017/11/services-rendered-a-substitute-dentist-may-be-billed-tmhp-utilizing-modifier-u5-effective-january-1.

[9] Notably, that is not the case when it comes to medical doctors. Texas Medicaid does permit locum tenens arrangements for physicians. As set out under Section 9.2.2 of the Texas Medicaid Provider Procedures Manual, "*Physicians may bill for the service of a substitute physician who sees clients in the billing physician's practice under either a reciprocal or locum tenens arrangement*." A complete rendition of Section 9.2.2 can be found at:

http://www.tmhp.com/Manuals_HTML1/TMPPM/Archive/2016/Vol2_Medical_Specialists_and_Physicians_Services_Handbook.24.083.html.

[10] These requirements include, but are not limited to:

"Dentists who take a leave of absence for no more than 90 days may bill for the services of a substitute dentist who renders services on an occasional basis when the primary dentist is unavailable to provide services. Services must be rendered at the practice location of the dentist who has taken the leave of absence. A locum tenens arrangement is not allowed for dentists.

This arrangement will be limited to no more than 90 consecutive days. Under this temporary basis,

the primary dentist (who is the billing agent dentist) may not submit a claim for services furnished by a substitute dentist to address long-term vacancies in a dental practice. The billing agent dentist may submit claims for the services of a substitute dentist for longer than 90 consecutive days if the dentist has been called or ordered to active duty as a member of a reserve component of the Armed Forces. Medicaid and CSHCN accepts claims from the billing agent dentist for services provided by the substitute dentist for the duration of the billing agent dentist's active duty as a member of a reserve component of the Armed Forces.

Providers billing for services provided by a substitute dentist must bill with modifier U5 in Block 19 of the American Dental Association (ADA) claim form.

The billing agent dentist may recover no more than the actual administrative cost of submitting the claim on behalf of the substitute dentist. This cost is not reimbursable by Medicaid or CSHCN.

The billing agent dentist must bill substitute dentist services on a different claim form from his or her own services. The billing agent dentist services cannot be billed on the same claim form as substitute dentist services.

The substitute dentist must be licensed to practice in the state of Texas, must be enrolled in Texas Medicaid, and must not be on the Texas Medicaid provider exclusion list.

The dentist who is temporarily absent from the practice must be indicated on the claim as the billing agent dentist, and his or her name, address, and National Provider Identifier (NPI) must appear in Blocks 53, 54, and 56 of the ADA claim form.

The substitute dentist's NPI number must be documented in Block 35 of the ADA claim form. Electronic submissions do not require a provider signature."

https://hhs.texas.gov/about-hhs/communications-events/news/2017/11/services-rendered-a-substitute-dentist-may-be-billed-tmhp-utilizing-modifier-u5-effective-january-1.

[11] As discussed in MLM Matters Number: SE0441:

"To qualify as "incident to," services must be part of your patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment. You do not have to be physically present in the patient's treatment room while these services are provided, but you must provide direct supervision, that is, you must be present in the office suite to render assistance, if necessary. The patient record should document the essential requirements for incident to service. More specifically, these services must be all of the following:

- *An integral part of the patient's treatment course;*

- *Commonly rendered without charge (included in your physician's bills);*
- *Of a type commonly furnished in a physician's office or clinic (not in an institutional setting); and*
- *An expense to you."*

Additionally, in an office setting:

"In your office, qualifying "incident to" services must be provided by a caregiver whom you directly supervise, and who represents a direct financial expense to you (such as a "W-2" or leased employee, or an independent contractor).

You do not have to be physically present in the treatment room while the service is being provided, but you must be present in the immediate office suite to render assistance if needed. If you are a solo practitioner, you must directly supervise the care. If you are in a group, any physician member of the group may be present in the office to supervise."