Our Junior Colleagues and Interstate Medicaid Clinics

By Michael W Davis, DDS

Any opinion expressed in this article is solely that of the author, and does not necessarily represent the views of the New Mexico Dental Association, its Officers, Directors, or Trustees.

Times are tough for recent dental school graduates. They can easily accrue a personal debt for school loans in excess of $150,000–250,000. This is before even a single dollar is earned in clinical practice.

Many of our junior colleagues are basically working as transient laborers. They may see little immediate hope in getting out of debt, while attempting to raise young families. Frequently, working conditions would disgust an OSHA inspector or Peer Review Member. Unfortunately, many recent graduates need their income too badly, to come forward.

In recent years, interstate Medicaid clinics have come onto the scene. Their focus is primarily the niche market of underserved Medicaid-eligible children. They argue that they fill the need of a demographic, which receives little to no dental care. They would further point out, most private sector dentists will not serve this population.

Dentists in the private sector contend Medicaid fees are often below overhead costs, to deliver proper (key word—proper) patient treatments. This patient population often has special needs, and a family history of challenged parenting skills, education, values, and possibly chemical abuse. The seemingly simple task of showing up for a scheduled appointment can be daunting.

Why are interstate Medicaid clinics highly profitable and "successful", while much of the private sector is far less likely to embrace this market? The answers, formerly only given in hushed whispers, are now in the Public Record and Public Domain.

Last year, one of the larger interstate dental corporations settled with the US Justice Department for $24 million, for alleged Medicaid fraud and abuse. This was hardly the first time for this corporation, with similar cases of alleged Medicaid fraud prosecuted throughout our nation at the states' level.

Medicaid fraud and abuse is big business. It is conducted within a large profitable business model. Fines, penalties, and legal settlements are just a small part of the cost of doing business. Individual doctors may be exposed to licensing sanctions, or even civil malpractice legal claims, but the corporations just keep rolling along. Associate dentists caught up in a gigantic system of fraud and abuses are expendable. Fresh grist for the corporate Medicaid Mills graduate every year.

Let's get down to the nuts and bolts of how these scams are perpetrated. *(Note: Medicaid orthodontic fraud is a huge subject in itself, & beyond the limited scope of this article.)* Billing for services never delivered is fairly common. Another tactic is to maximize the services rendered at every visit, regardless of the child's stamina, past dental experiences, or fear. Restraints become common and routine practice, to maximize dollars.

Restraint for children under age five is usually a "Papoose Board". For older children, a team of dental assistants may secure the child's body parts and forehead with tightly drawn towels or in a specially designed restraint chair. Obviously, these clinics discourage parents in clinical areas, although numbers have questioned their child's bruising, tears, and trembling after treatments.

Other billing schemes include "unbundling" of charges. Instead of billing for the service of a full mouth series of x-rays, Medicaid is billed for multiple x-rays, all totaling a greater fee. Instead of billing for 2 or 3-surface restorations, teeth are peppered with multiple 1-surface restorations, all on a single tooth.

"Upcoding" of services is another common scam. Sealants are billed as 2, 3, or 4-surface resin restorations. A lab technician is ordered to use less-costly non-precious alloy for a patient's crown, but the fraudulent billing is for noble or high noble alloy. A standard size "2" periapical radiograph may be turned 90 degrees horizontally, then billed as an occlusal x-ray.

Insurance actuaries use algorithms to determine the statistical validity in delivery of specific clinical services. In one Medicaid investigation, the frequency of restoration with nickel-chromium (Ni-Cr) crowns and pulpotomies ranged from 2-3x that of neighboring pedodontists. Not surprisingly, the Medicaid dollar payout for these crowns and pulpotomies vastly outstripped the allowable fees, for other more appropriate services. Pedodontic crowns and pulpotomies have become their bread-and-butter moneymaker, regardless of appropriateness.

Over-treatment with Ni-Cr crowns, pre-fabricated anterior resin crowns, and pulpotomies is a huge money generator. Medicaid fee schedules are generally antiquated and based on the older type of stainless steel crown, which required extensive marginal trimming, and expert crimping of margins, proximal contacts, and occlusal contacts. Modern Ni-Cr crowns are highly flexible and easily snap over buccal and lingual contours. A quick bur pass through on the occlusal and proximal surfaces is usually all the preparation required. The patient "bites in" their occlusal contacts. These crowns are not only far easier to place than an alternative direct restoration, but command 3-5x the revenue per tooth.

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Pulpotomies are an added income source, regardless of patient benefit. No attention is paid to restoration of teeth soon to exfoliate, incipient lesions, or teeth of minimal orthothodontic space-saving importance, when it comes to maximization of crowns and pulpotomies for profit.

How do these clinics mollify parents' concerns? Firstly, parents are discouraged or denied from accompanying their children in clinical areas. Radio and TV is often turned up to maximal

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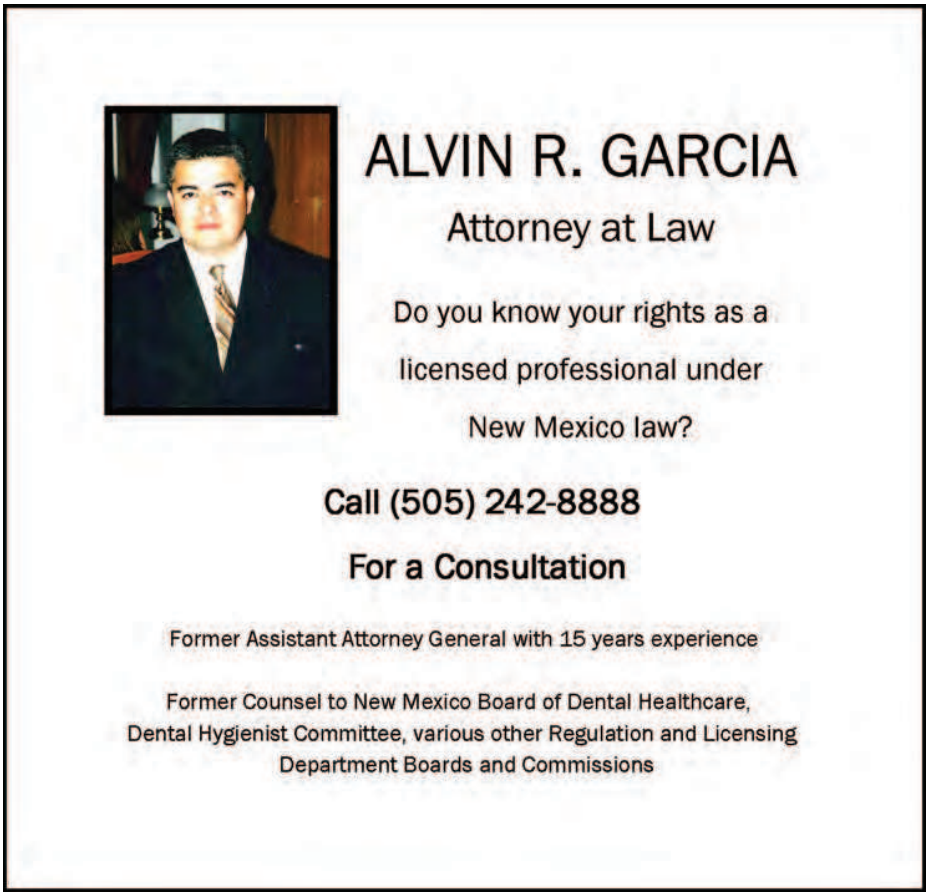

volume, to mask crying out of children. Professional-grade hairdryers may be used to dry urine-soaked clothing of overly frightened children, before returning to parents. When Informed Consents are given, restraints may be described (never demonstrated) as a "comfort pillow" or some other innocuous descriptor. Most of these parents are also at an Informed Consent disadvantage, because of limited education and English as a second language.

The front line for malpractice and fraud rests with the individual associate dentist. The next in line may be the "Lead Dentist", who on paper is the "Clinic Owner". No state regulates the management companies, which in reality own and operate these vast series of Medicaid clinics, which manipulate, direct, and tacitly threaten employee dentists.

What has been state government's involvement? Some may remember only a few years earlier, soda pop and junk food vending machines were placed in our public schools. State governments signed off on licensing these sales, until justly embarrassed by Organized Dentistry and concerned parents.

Few know that the major vending company's owners and officers responsible were dentists, who at that time owned and operated interstate children's Medicaid clinics. One is left to wonder about doctors involved in dental care of disadvantaged youngsters, feeding those same kids a diet high in sugar, caffeine, and empty calories. Profits seem to trump ethics.

Thanks to outstanding investigative journalism by Paul Gessing, of the Rio Grande Foundation, we learned of the sorted connection between our state government and one of these large Medicaid operations. The New Mexico State Investment Council (SIC), then headed by former Governor Bill Richardson, awarded a specific dental Medicaid provider $550,000. The SIC was mandated to assist only New Mexico based businesses. This corporation was headquartered in Tennessee. An investment banking company in the Islamic nation of Bahrain claimed ownership. Earlier, this same Medicaid provider made political donations to both Governor Bill Richardson and New Mexico US Congressman Ben Ray Lujan. The political game of "Pay-to-Play" may not have been invented in New Mexico, but we take that corrupt game to artful depths.

I've had the opportunity to review several employee contracts proffered to young associate dentists. Sometimes the manner in which Employee

income was calculated seemed overly complex and bizarrely esoteric.

Seemingly a beneficent term in one contract was to offer the employee dentist a regular salary draw against future earnings. (Note: Earnings were based on a complex formulation in some odd manner related to a percentage of Medicaid collections.) If the employee were to terminate their contract, they would be responsible to reimburse the employer for "overpayments". Superficially, this may seem fair, but it may also trap an employee in *Debt Bondage*, in a workplace rife with abuses.

The Employee Contract clauses for covenant not-to-compete can be designed to keep the employee frozen, in their current employment. One employer wished to enforce a non-compete clause, within a 10-mile radius of every clinic they maintained in the state. This effectively excluded 80% of our state's population from access to this doctor.

Employees in some contracts are required to give 90-days notice of termination. Of course, the contract neglects to mention no termination notice is required in cases of workplace harassment and certain other workplace abuses. It's seemingly just one more method to keep young dentists shackled "down on the farm".

Some contracts also stipulate, employees are not to make copies of employer's Records. Seriously, what clinical or business methodology in the dental profession, especially in a Medicaid clinic, is a cutting-edge proprietary business secret? This obviously seems designed to limit record access in Qui Tam (Whistleblower) legal investigations.

Another "benefit" in some Employee Contracts is the Employer payments for malpractice insurance. Would "your" attorney (assigned to you, by your Employer's insurance carrier) possibly have a conflict of interest? Is there a possibility a Prosecutor's Office with evidence of fraud may accept the employer's "full and complete cooperation", and accept associate dentists as "fall guys"?

Currently, there are pleadings before Federal District Court by representatives of the malpractice insurance industry. They argue that usual and customary business practices of one of their large corporate Medicaid Providers is so egregious, fraud and abuse is routine. They seek relief from the Court to not honor contractual obligations of malpractice insurance, based on unethical and unlawful business models of their insured. Good

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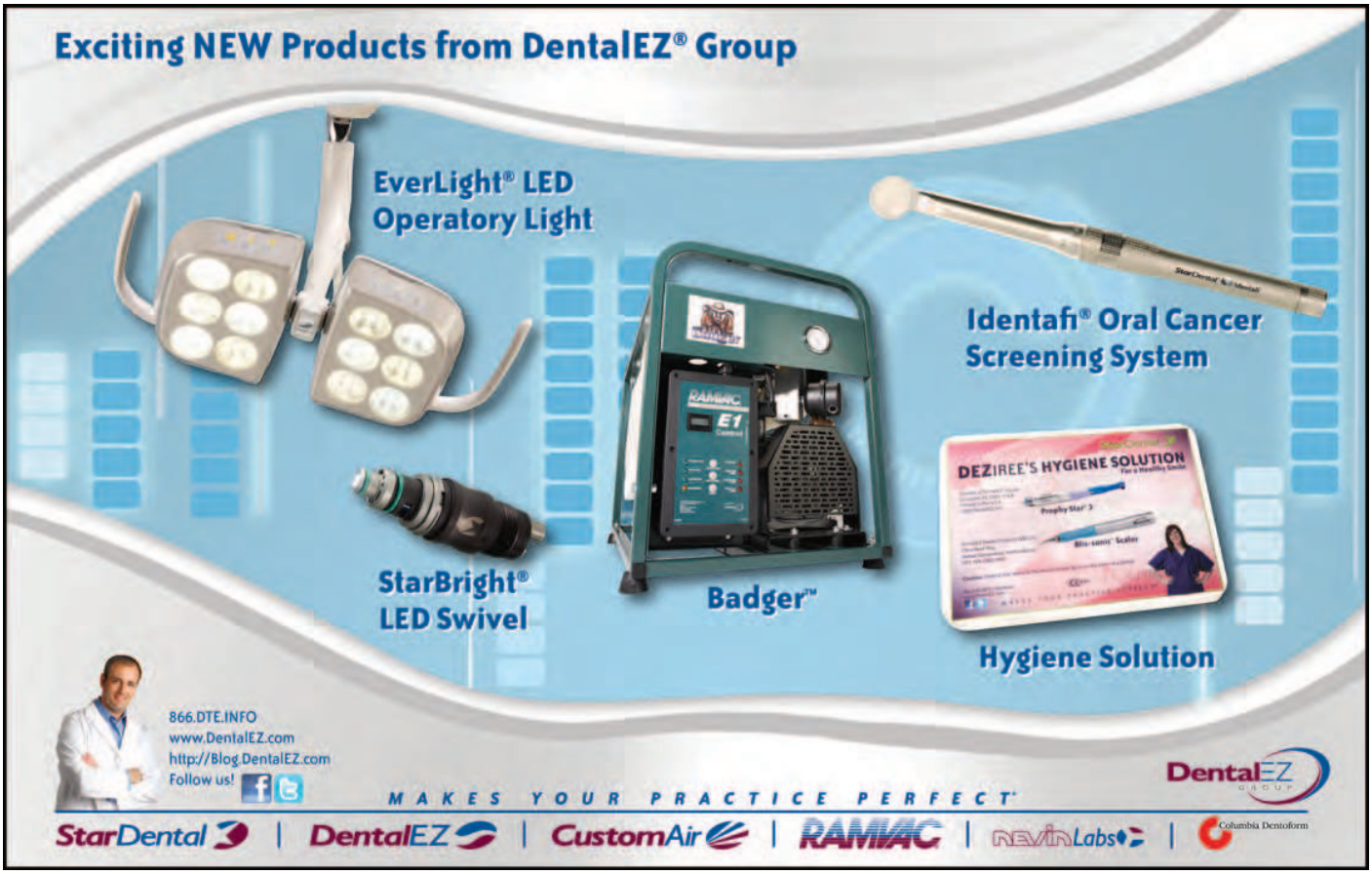

luck to any associate dentist seeking to purchase a reasonably priced liability "tail," as required under Employee Contract.

Eventually taxpayers with their limited resources will demand an accounting of the Medicaid money-pit. Their frustrations will certainly be vented at corporate creeps who scammed the system, and government regulators, who gave these crooks a pass. The question we in the dental profession must ask is, "Did we take appropriate steps to protect the public interest, taxpayers, Medicaid recipients, and our junior colleagues?" Or, did we turn our collective backs on a problem seemingly too large, complex, and uncomfortable to face?

A number of these Medicaid Providers are clearly operating as organized criminal enterprises, masquerading as legitimate business. Some officials in state government are involved in aiding and abetting these criminals. A recently graduated doctor has little opportunity for professional growth within such negative environments. The public receives questionable benefit, all at substantial financial and emotional costs.

In summation, many of our junior professionals are facing hard times and hard choices. Some face the prospect of either not paying bills, or working and contributing to the abuse of disadvantaged children. Medicaid fraud and abuse is big business, and played out on a vast interstate corporate stage. State government may collude with these large dental corporations in abusing poor children for profit. We either address these problems, or face wholesale collapse of Medicaid programs, and a sellout of large segments of our junior colleagues.

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August 29, 2011

Mark Moores, ED, NMDA
NMDA Journal Editor
New Mexico Dental Association
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Dear NMDA Editor,

I received the enclosed notice from the Medical Protective Company, attempting to sell me higher liability limits. They used a scare tactic, saying that, "The National Practitioner Data Bank has indicated a significant increase in '7-figure' dental malpractice judgments during the past few years."

The notice gives as reference National Practitioner Data Bank data from 2004 to 2010. Being me, I downloaded the entire National Practitioner Data Bank data file, which is about 115 MB in size. I analyzed the data for New Mexico dentists. From the first database record, in 1991, through 2011, there were 256 judgments or settlements. That's about 13 malpractice judgments or settlements per year against New Mexico Dentists.

The average amount is $50,212 with the high award $995,000, and the low amount $300. There are two awards of $995,000, according to the downloaded data (a funny coincidence). They skewed the day considerably. The standard deviation is about $113,058. Add that to the average, and most of the payments are under about $164,000. I made a scatter chart from this data, so I could visualize trends. According to the data for New Mexico dentists, payments have been going down for the last 5 years. It turns out that my standard liability policy of $1,000,000/$3,000,000 is enough so that I don't have to increase my premium for more coverage.

I wonder why Medical Protective didn't tell me that. Hmmm. I can't believe they'd be devious or dishonest.

Sincerely,

Robert L. Wartell, DMD