



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

June 17, 2008

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Report Number: A-02-06-01010

Jennifer Velez, Esq.
Commissioner
New Jersey Department of Human Services
222 South Warren Street
P.O. Box 700
Trenton, New Jersey 08625-0700

Dear Ms. Velez:

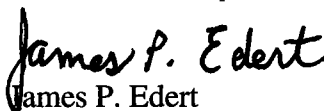
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Outpatient Medicaid Claims Billed as Family Planning by New Jersey." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact John Berbach, Audit Manager, at (518) 437-9390, extension 228 or through e-mail at John.Berbach@oig.hhs.gov. Please refer to report number A-02-06-01010 in all correspondence

Sincerely,


James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT
MEDICAID CLAIMS BILLED AS
FAMILY PLANNING BY
NEW JERSEY**



Daniel R. Levinson
Inspector General

June 2008
A-02-06-01010

Office of Inspector General

<http://oig.hhs.gov>

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), 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 Medicaid 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.

Section 1903(a)(5) of the Act and 42 CFR §§ 433.10 and 433.15 provide enhanced 90-percent Federal Medicaid funding for family planning services. According to section 4270 of the CMS “State Medicaid Manual,” family planning services prevent or delay pregnancy or otherwise control family size.

OBJECTIVE

Our objective was to determine whether outpatient Medicaid claims for clinic, laboratory, radiology, practitioner, or hospital services, for which New Jersey received Federal reimbursement at the enhanced 90-percent rate, qualified as family planning services.

SUMMARY OF FINDINGS

The State improperly received the enhanced 90-percent rate for clinic, laboratory, radiology, practitioner, or outpatient hospital services that did not qualify as family planning services. Of the 107 claims in our sample, 64 were for family planning services eligible for Federal Medicaid reimbursement at the 90-percent rate. However, 43 claims did not qualify as family planning services, and therefore were not eligible for Federal Medicaid reimbursement at the 90-percent rate. As a result, we estimate that the State improperly received \$597,496 in Federal Medicaid funds.

The overpayment occurred because: (1) the State’s Medicaid Management Information System (MMIS) did not have edits to identify all improperly coded claims that did not meet the requirements for 90-percent Federal funding, and (2) some family planning clinics improperly billed all services as family planning eligible for 90-percent Federal funding.

RECOMMENDATIONS

We recommend that the State:

- refund \$597,496 to the Federal Government;
- develop edits in its MMIS to identify all claims that do not meet the requirements for 90-percent Federal funding as family planning services; and

- issue guidance to family planning clinics that all services provided should not be billed to Medicaid as family planning services eligible for 90-percent Federal funding.

STATE COMMENTS

In its comments on our draft report, the State generally agreed with our first recommendation and fully agreed with our remaining recommendations. The State's comments are included in their entirety as Appendix C.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), 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 Medicaid 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.

New Jersey's Medicaid Program

In New Jersey, the Department of Human Services operates the Medicaid program. Within the Department of Human Services, the Division of Medical Assistance and Health Services administers the program. The Department of Human Services uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

The MMIS utilizes an edit routine to determine whether a claim is eligible for 90-percent Federal funding as a family planning service. The edit first checks the procedure code listed on the claim. The MMIS classifies procedure codes into three categories: (1) "always family planning," (2) "never family planning," or (3) "sometimes family planning." If the procedure code on a claim is "always family planning," the MMIS designates the claim as eligible for 90-percent Federal funding. Conversely, if the procedure code on a claim is "never family planning," the MMIS does not designate the claim as eligible for 90-percent Federal funding.

For procedure codes listed in the MMIS as "sometimes family planning," the MMIS looks for a family planning indicator on the claim, a data element populated by the provider. If the provider included a family planning indicator on a claim with a procedure code categorized as "sometimes family planning," the MMIS designates the claim as eligible for 90-percent Federal funding.

The Federal share of a State's Medicaid program is determined by the Federal medical assistance percentage (FMAP). During our audit period (February 1, 2001, through January 31, 2005), the FMAP in New Jersey was 50 or 52.95 percent.¹

Medicaid Coverage of Family Planning Services

Section 1905(a)(4)(C) of the Act requires States to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and who desire such services and supplies. Section 1902(a)(10)(A) of the Act specifies that family planning services be available to "categorically needy" Medicaid beneficiaries, while section 1902(a)(10)(C)

¹The FMAP was 50 percent from February 1, 2001, through March 31, 2003; 52.95 percent from April 1, 2003, through June 30, 2004; and 50 percent from July 1, 2004, through January 31, 2005.

specifies that the services may be provided to “medically needy” Medicaid beneficiaries at the State’s option. Section 1903(a)(5) of the Act and 42 CFR §§ 433.10 and 433.15 authorize 90-percent Federal funding for family planning services.

According to section 4270 of the CMS “State Medicaid Manual,” family planning services prevent or delay pregnancy or otherwise control family size. In addition, this section generally permits 90-percent Federal funding for counseling services and patient education; examination and treatment by medical professionals pursuant to State requirements; laboratory examinations and tests; medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception. Only services and supplies clearly performed or provided for family planning purposes may be matched at the 90-percent rate.

The CMS “Financial Management Review Guide Number 20” categorizes Current Procedural Terminology (CPT) and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) procedure codes relating to family planning. Specifically, the guide has three categories of family planning procedure codes: (1) “never or almost never a family planning service,” (2) “possibly a family planning service,” and (3) “almost always a family planning service.” According to the guide, procedure codes categorized as “possibly a family planning service” should be accompanied by ICD-9-CM diagnosis codes in the series V25 (contraceptive management), V26 (procreative management), 606 (male infertility), or 628 (female infertility) if the procedure/service is related to family planning.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether outpatient Medicaid claims for clinic, laboratory, radiology, practitioner, or hospital services, for which New Jersey received Federal reimbursement at the enhanced 90-percent rate, qualified as family planning services.

Scope

Our audit period covered February 1, 2001, through January 31, 2005. We did not review the overall internal control structure of the State or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective. We did not review the claims in our sample for compliance with Medicaid requirements for reimbursement other than those related to whether the claims qualified for 90-percent Federal funding as family planning services.

We performed fieldwork at the Division of Medical Assistance and Health Services in Mercerville, New Jersey, and at provider offices throughout the State.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance;

- held discussions with CMS officials and acquired an understanding of CMS’s guidance to State officials on Medicaid family planning claims;
- held discussions with State officials to ascertain State policies and procedures for claiming Medicaid reimbursement for family planning services;
- extracted all claims from the State’s MMIS reimbursed at the 90-percent Federal funding rate for the period February 1, 2001, through January 31, 2005, except prescription drug claims, which we reviewed in a separate audit (A-02-05-01019);²
- removed 114 claims for inpatient hospital services, which will be reviewed in a separate audit;
- removed 21,473 claims with a procedure code categorized as “almost always a family planning service” in the CMS “Financial Management Review Guide Number 20,” resulting in a revised universe of 221,305 claims totaling \$5,921,247 (\$5,329,034 Federal share) for clinic, laboratory, radiology, practitioner, or outpatient hospital services;
- used stratified random sampling techniques to select 107 claims from the population of 221,305 claims;
- obtained and reviewed medical records for the 107 claims in our sample to determine whether the claimed services were eligible for 90-percent Federal funding;
- submitted to a CMS physician, who is a policy expert on family planning, descriptions of sampled services provided by family planning clinics for his opinions and determinations;
- calculated the unallowable Federal funding, if any, paid for each sample claim; and
- estimated the unallowable Federal funding paid in the population of 221,305 claims.

Appendix A contains the details of our sample design and methodology.

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.

²“Review of Pharmacy Claims Billed as Family Planning Services Under New Jersey’s Medicaid Program” (July 2007).

FINDINGS AND RECOMMENDATIONS

The State improperly received the enhanced 90-percent rate for clinic, laboratory, radiology, practitioner, or outpatient hospital services that did not qualify as family planning services. Of the 107 claims in our sample, 64 were for family planning services eligible for Federal Medicaid reimbursement at the 90-percent rate. However, 43 claims did not qualify as family planning services, and therefore were not eligible for Federal Medicaid reimbursement at the 90-percent rate. As a result, we estimate that the State improperly received \$597,496 in Federal Medicaid funds.

The overpayment occurred because: (1) the State's MMIS did not have edits to identify all improperly coded claims that did not meet the requirements for 90-percent Federal funding, and (2) some family planning clinics improperly billed all services as family planning eligible for 90-percent Federal funding.

SERVICES UNRELATED TO FAMILY PLANNING

Section 4270 of the CMS "State Medicaid Manual" specifies that Federal funding at the 90-percent rate is available for the costs of services that prevent or delay pregnancy. Only services and supplies clearly performed or provided for family planning purposes may be paid at the 90-percent rate.

Forty of the 107 sample claims did not qualify as family planning services eligible for 90-percent Federal funding. Specifically:

- Sixteen claims were for clinic services that were not clearly performed for family planning purposes. These services included addressing patient complaints of vaginal discharge, abdominal pain, and frequent urination with pain.
- Nine claims were for pregnancy evaluation services at family planning clinics. For each of the claims, the Medicaid beneficiary was determined to be pregnant.
- Eight claims were for family planning clinic services for Medicaid beneficiaries who had previously been sterilized.
- Five claims were for services provided to Medicaid beneficiaries who were not of childbearing age. Specifically, one claim was for services provided to a 66-year-old Medicaid beneficiary and four claims were for services provided by a community health center – three claims for children age 11 and under (for services related to an earache, bronchitis, and an upper respiratory infection) and one claim for a 59-year-old with chest pain.
- Two claims were for services related to hospital emergency department visits – one for swollen ankles and one for a rash.

LACK OF DOCUMENTATION

Section 1902(a)(27) of the Social Security Act and Federal regulations (42 CFR §§ 431.17 and 433.32) require that services claimed for Federal Medicaid funding be documented. For 3 of the 107 sampled claims, the providers could not locate any documentation to support the service billed.

CAUSES OF THE OVERPAYMENT

As discussed below, we identified two main causes of the overpayment.

Insufficient State Controls

Overpayments occurred because the State's MMIS did not have edit routines to identify all improperly coded claims that did not meet the requirements for 90-percent Federal funding.

As stated above, CMS's "Financial Management Review Guide Number 20" classified family planning procedure codes as (1) "never or almost never a family planning service," (2) "possibly a family planning service," or (3) "almost always a family planning service." According to the guide, services categorized as "possibly a family planning service" should be accompanied by ICD-9-CM diagnosis codes in the series V25, V26, 606, or 628, if the procedure/service is related to family planning. The State's MMIS had similar designations for family planning claims. However, for claims with a procedure code designated as "sometimes related to family planning," the State's MMIS did not use diagnosis codes to determine whether the claim qualified for 90-percent Federal funding. Rather, the State's MMIS looked to whether the provider included a family planning indicator on the claim. If the provider populated the family planning indicator field on a claim that contained a procedure code that was designated as "sometimes related to family planning," the MMIS categorized the claim as eligible for 90-percent Federal funding, regardless of the diagnosis code or the service provided. Because of this, some claims in our sample were incorrectly marked as eligible for 90-percent Federal funding.

Improper Claims From Family Planning Clinics

During our visits to family planning clinics throughout the State, many providers (especially Planned Parenthood providers) stated that they billed all claims to Medicaid as "family planning." Officials at these clinics stated that they believed that all of the services they provided were related to family planning. Therefore, officials at these clinics often populated the family planning indicator field on Medicaid claims even though the service provided did not meet the criteria for 90-percent Federal funding. By populating this field, the MMIS designated the claim as eligible for 90-percent Federal funding.

ESTIMATION OF THE UNALLOWABLE AMOUNT

Of the 107 claims in our statistical sample, 64 were for family planning services eligible for Federal Medicaid reimbursement at the 90-percent rate. However, 40 were improperly paid at the 90-percent rate rather than the applicable FMAP of 50-percent or 52.95-percent. For the three remaining sample claims, we questioned the entire Federal Medicaid reimbursement

because these claims had no supporting documentation. Extrapolating the results of our sample, we estimate that the State improperly received \$597,496 in Federal Medicaid funds. The details of our sample results and estimates are shown in Appendix B.

RECOMMENDATIONS

We recommend that the State:

- refund \$597,496 to the Federal Government;
- develop edits in its MMIS to identify all claims that do not meet the requirements for 90-percent Federal funding as family planning services; and
- issue guidance to family planning clinics that all services provided should not be billed to Medicaid as family planning services eligible for 90-percent Federal funding.

STATE COMMENTS

In its comments on our draft report, the State generally agreed with our first recommendation and fully agreed with our remaining recommendations. The State's comments are included in their entirety as Appendix C.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine whether outpatient Medicaid claims for clinic, laboratory, radiology, practitioner, or hospital services, for which New Jersey received Federal reimbursement at the enhanced 90-percent rate, qualified as family planning services.

POPULATION

The population was Medicaid claims billed by New Jersey at 90-percent Federal funding for clinic, laboratory, radiology, practitioner, or outpatient hospital services during our February 1, 2001, through January 31, 2005, audit period.

SAMPLING FRAME

The sampling frame was a computer file containing 221,305 Medicaid claims for clinic, laboratory, radiology, practitioner, or outpatient hospital services billed as family planning at 90-percent Federal funding during our review period. The total Medicaid reimbursement for the 221,305 claims was \$5,921,247, of which the Federal share was \$5,329,034. The Medicaid claims were extracted by our advanced audit techniques staff from New Jersey's Medicaid payment files provided to us by staff of the State's Medicaid Management Information System fiscal agent.

SAMPLING UNIT

The sampling unit was an individual Medicaid claim for clinic, laboratory, radiology, practitioner, or outpatient hospital services billed as family planning at the enhanced 90-percent rate.

SAMPLE DESIGN

We used stratified random sampling techniques to evaluate the population of Medicaid paid claims. To accomplish this, we separated the sampling frame into two strata:

- Stratum 1: Claims with a Federal share payment amount from \$0.01 to \$400, consisting of 221,298 claims.
- Stratum 2: Claims with a Federal share payment amount greater than \$400, consisting of 7 claims.

SAMPLE SIZE

We selected a sample size of 107 claims:

- from stratum one, a random sample of 100 claims, and
- from stratum two, all 7 claims.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services (OAS) statistical sampling software, RAT-STATS, dated June 2005. We used the random number generator for our random sample.

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the 221,298 claims in stratum one. We selected 100 random numbers for stratum one and selected the corresponding frame items. We also selected all seven claims in stratum two and created a list of the 107 sample items.

CHARACTERISTICS MEASURED

We determined whether a claim was improper and unallowable based on applicable Federal laws and regulations, Federal guidance, a review of all information contained on the claim form, and a review of documentation from the provider that submitted the claim. If a claim did not meet the criteria for reimbursement at the 90-percent Federal funding rate, we determined the claim in error.

If a sample claim was determined to be in error, but allowable for Federal Medicaid funding, we disallowed the portion of the claim between 90-percent and New Jersey's regular Federal medical assistance percentage for non-family planning services. If a sample claim was determined to be in error, and unallowable for Federal funding, we disallowed the entire amount of the claim.

TREATMENT OF MISSING DOCUMENTATION

If supporting documentation was not found, we considered the sample claim an error.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We used the lower limit at the 90-percent confidence level to estimate the overpayment associated with the claims in error.

SAMPLE RESULTS AND ESTIMATES

The results of our review of the 107 sample claims are as follows:

Sample Results

Strata	Claims in Frame	Value of Frame Federal Paid	Sample Size	Value of Sample Federal Paid	Number of Error Claims	Value of Error Claims Federal Paid
1	221,298	\$5,319,708	100	\$ 2,350	41	\$ 424
2	7	9,326	7	9,326	2	639
Total	221,305	\$5,329,034	107	\$11,676	43	\$1,063

Estimates

(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	\$939,120
Lower Limit	\$597,496
Upper Limit	\$1,280,744
Precision Percent	36.38%



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May 30, 2008

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Regional Inspector General for Audit Services
Department of Health and Human Services
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New York, NY 10278

Report Number A-02-06-01010

Dear Mr. Edert:

This is in response to your correspondence of March 31, 2008 concerning the Department of Health and Human Services, Office of the Inspector General's (OIG) draft audit report entitled "Review of Outpatient Medicaid Claims Billed as Family Planning by in New Jersey." The letter provides an opportunity to comment on the draft audit report.

The draft audit report contains one finding and three recommendations. The report makes the finding that New Jersey improperly received the enhanced 90-percent rate for clinic, laboratory, radiology, practitioner, or outpatient hospital services that did not qualify as family planning services. Of the 107 claims in the sample, 64 were for family planning services eligible for Federal Medicaid reimbursement at the 90-percent rate. However, 43 claims did not qualify as family planning services, and therefore were not eligible for Federal Medicaid reimbursement at the 90-percent rate. As a result, the auditor estimated that the State improperly received \$597,496 in Federal Medicaid funds for the four-year audit period from February 1, 2001 through January 31, 2005.

The recommendations contained in the report and our responses are provided below:

1. New Jersey should refund \$597,496 to the Federal Government.

Staff of the Division of Medical Assistance and Health Services is reviewing the details of the specific claims identified by the auditor and will take appropriate

James P. Edert
May 29, 2008
Page 2

action based on the results of this review. Any claims not appropriately classified as family planning will be adjusted on the Quarterly Statement of Medicaid Expenditures (Form CMS-64).

2. New Jersey should develop edits in its MMIS to identify all claims that do not meet the requirements for 90-percent Federal funding as family planning services.

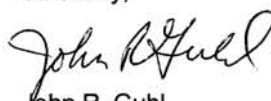
New Jersey will review edits on procedure codes categorized as “possibly a family planning service,” and “almost always a family planning service.” At least in the second category, the State will investigate the possibility of hard coding appropriate diagnosis codes that must appear, along with the procedure code.

3. New Jersey should issue guidance to family planning clinics that all services provided should not be billed to Medicaid as family planning services eligible for 90-percent Federal funding.

New Jersey will issue a Newsletter to all family planning clinics that place of service does not justify billing as a family planning service. Similarly, a Newsletter will be issued to other providers of family planning services reminding the providers that a diagnosis code must be documented and subject to record review. Further, this will be added as an agenda item for the semi-annual meeting between Medicaid staff and the Family Planning Council.

The opportunity to review and comment on this draft report is greatly appreciated. If you have any questions or require additional information, please contact me or David Lowenthal at 609-588-7933.

Sincerely,



John R. Guhl
Director

JRG: L

c: Jennifer Velez
David Lowenthal