



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



OFFICE OF AUDIT SERVICES, REGION IV  
61 FORSYTH STREET, SW, SUITE 3T41  
ATLANTA, GA 30303

June 15, 2012

Report Number: A-04-10-01091

Craig L. Gray, M.D., M.B.A., J.D.  
Director  
Division of Medical Assistance  
2501 Mail Service Center  
Raleigh, NC 27699-2501

Dear Dr. Gray:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Waiver Services That Were Not Family Planning*. 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Truman Mayfield, Audit Manager, at (850) 942-8900 extension 22 or through email at [Truman.Mayfield@oig.hhs.gov](mailto:Truman.Mayfield@oig.hhs.gov). Please refer to report number A-04-10-01091 in all correspondence.

Sincerely,

/Lori S. Pilcher/  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Jackie Garner  
Consortium Administrator  
Consortium for Medicaid and Children's Health Operations  
Centers for Medicare & Medicaid Services  
233 North Michigan Avenue, Suite 600  
Chicago, IL 60601

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NORTH CAROLINA INCORRECTLY  
CLAIMED ENHANCED FEDERAL  
REIMBURSEMENT FOR SOME MEDICAID  
WAIVER SERVICES THAT WERE NOT  
FAMILY PLANNING**



Daniel R. Levinson  
Inspector General

June 2012  
A-04-10-01091

# *Office of Inspector General*

<http://oig.hhs.gov>

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## **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 program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In North Carolina, the Division of Medical Assistance (State agency) is responsible for administering the Medicaid program.

The amount of funding that the Federal Government reimburses to State Medicaid agencies, known as the Federal share, is determined by the Federal medical assistance percentage (FMAP).

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.

Pursuant to Section 1903(a)(5) of the Act and Federal Regulations, 42 CFR § 433.10(c)(1), the amount the Federal Government is authorized to reimburse the State for expenditures in family planning services is calculated at an FMAP of 90 percent (enhanced rate). North Carolina's Administrative Code (10A NCAC § 13J.1402(a)(2)(C)) requires that providers adequately document services in the medical records.

From October 1, 2005, through September 30, 2007, the Federal Government reimbursed the State agency, at the enhanced rate, \$5,027,113 (Federal share) for Medicaid family planning waiver services for pharmacy, sterilization, and clinic and practitioner claims.

### **OBJECTIVE**

Our objective was to determine whether the State agency claimed Medicaid family planning waiver reimbursement in accordance with Federal and State requirements.

### **SUMMARY OF FINDINGS**

The State agency did not always claim Medicaid family planning waiver reimbursement in accordance with Federal and State requirements. Of 100 pharmacy claims in our simple random sample, 60 claims totaling \$2,644 (Federal share) met requirements. However, the remaining 40 claims totaling \$ 1,641 (Federal share) did not meet requirements. Based on our sample results, we estimated that the State agency improperly claimed \$662,790 (Federal share) in Medicaid waiver reimbursement for pharmacy claims from October 1, 2005, through September 30, 2007.

In addition, of 65 sterilization claims and 230 clinic and practitioner claims that we sampled, 3 sterilization claims and 21 clinic and practitioner claims did not qualify for reimbursement because the claims were not supported by consent forms that met Federal Requirements.

Based on our judgmental samples of sterilization claims and clinic and practitioner claims, the State agency improperly claimed \$2,038 (Federal share) and \$1,998 (Federal share), respectively, in Federal Medicaid waiver funds. We calculated these overpayments as the entire Federal Financial Participation amount because Medicaid waiver beneficiaries were not eligible for regular Medicaid.

The State agency made these improper claims because it did not have adequate controls to ensure that it claimed only Medicaid family planning waiver services at the enhanced rate.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund \$662,790 to the Federal Government for non-family-planning pharmacy waiver claims that were reimbursed at the enhanced rate,
- refund \$2,038 to the Federal Government for non-family-planning sterilization, waiver claims that were reimbursed at the enhanced rate,
- refund \$1,998 to the Federal Government for non-family-planning clinic and practitioner waiver claims that were reimbursed at the enhanced rate,
- improve controls to ensure that the State agency claims the enhanced rate only for Medicaid family planning waiver services, and
- reemphasize to providers that only services clearly provided for family planning purposes should be billed as family planning.

## **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency generally did not concur with three of our five recommendations. The State agency concurred with our second and third recommendations to refund \$2,038 and \$1,998 to the Federal Government to the extent that the State agency may have claimed enhanced Federal financial participation (FFP) for non-family planning sterilization claims, and clinic and practitioner waiver claims, respectively.

In response to our first recommendation to return FFP for family planning pharmacy claims that neither the pharmacy nor the prescriber could produce supporting documentation for, the State agency did not agree that it should refund the majority of the pharmacy waiver claims to the Federal Government. We had recommended that the State agency return to the Federal Government the estimated \$711,936 in pharmacy claims because the pharmaceuticals on 43 of the 100 sampled claims may have been prescribed for purposes other than family planning.)

Specifically, the State agency maintains that all pharmaceuticals in the contraceptive therapeutic class should be eligible for the enhanced family planning matching rate. Further, the State agency stated that the only way to ensure that pharmaceuticals in the contraceptive therapeutic class are prescribed only for family planning purposes would require implementing a methodology that is inconsistent with current medical practice and that would place an undue, disproportionate burden on prescribers of contraceptive drugs and pharmacies alike. For the same reasons, the State generally disagreed with our fourth and fifth recommendation.

The State agency also stated that we were inconsistent in our interpretation of Federal requirements for claiming enhanced FFP for family planning services and supplies and that our findings were therefore not consistent with other issued OIG reports. The State agency's comments appear in their entirety as Appendix C.

### **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing the State agency's comments and additional documentation provided by the State agency, we modified our first recommendation by removing three claims and adjusted our estimated overpayments for pharmacy claims accordingly. Nothing in the State agency's comments caused us to change our other findings or recommendations. We correctly applied Federal requirements to each of the reviewed claims.

Furthermore, the State agency's statement that our interpretation of Federal requirements during this audit is inconsistent with that of OIG audits in other States is inaccurate. OIG audits vary in objective, scope, and methodology. Therefore, OIG applies only those elements specific to the circumstances of the State it is auditing.

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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 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.

Pursuant to section 1902(a)(27) of the Act and implementing Federal regulations (42 CFR § 433.32), Medicaid providers must maintain documentation that fully discloses the extent of the services provided to the beneficiary. In addition, Federal regulations (42 CFR § 441.253) require States to maintain documentation indicating that all Medicaid sterilization patients (1) were at least 21 years old at the time of the procedure; (2) were not mentally incompetent; and (3) voluntarily gave informed consent at least 30 days, but not more than 180 days, prior to the date of sterilization.

#### **State of North Carolina Medicaid Program**

In North Carolina, the Division of Medical Assistance (State agency) is responsible for administering the Medicaid program. The State agency contracts with HP Enterprise Services (formerly Electronic Data Systems) to maintain its Medicaid Management Information System, a computerized payment and information reporting system that processes and pays Medicaid claims.

North Carolina's Administrative Code (10A NCAC § 13J.1402(a)(2)(C)) complements 42 CFR § 433.32 by requiring that providers adequately document services in the medical records. Specifically, the beneficiary's service record must contain a record of all services provided, including dates and times of the service(s), with entries dated and signed by the individual providing the service.

#### **Medicaid Waiver Coverage of North Carolina 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 (including minors who can be considered sexually active) who are eligible under the State plan and who desire such services and supplies.

Pursuant to Section 1903(a)(5) of the Act and Federal Regulations, 42 CFR § 433.10(c)(1), the amount the Federal Government is authorized to reimburse the State for expenditures in family planning services is calculated at an Federal medical assistance percentage of 90 percent (enhanced rate).

Effective October 1, 2005, CMS approved a Medicaid waiver for the State of North Carolina. The Family Planning waiver was designed to reduce unintended pregnancies and improve the well-being of children and families in North Carolina by extending eligibility for family planning services to women and men whose income is at or below 185 percent of the Federal poverty level. Individuals who would not otherwise be eligible for Medicaid coverage may be eligible under the waiver program.

According to section 4270 of the CMS *State Medicaid Manual* (the manual) family planning services are those that prevent or delay pregnancy or otherwise control family size. That provision of the manual also generally permits the enhanced rate for the following family planning services and items: counseling services and patient education, examination and treatment by medical professionals according to each State's requirements, devices to prevent conception, and infertility services. The manual provides that only items and procedures clearly furnished or provided for family planning purposes maybe claimed at the enhanced rate.

From October 1, 2005, through September 30, 2007, the Federal Government reimbursed the State agency at the enhanced rate for 86,722 claims totaling \$5,027,113 (Federal share) for Medicaid family planning waiver services for pharmacy, sterilization, clinic and practitioner claims.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the State agency claimed Medicaid family planning waiver reimbursement in accordance with Federal and State requirements.

### **Scope**

Our audit covered certain Medicaid family planning waiver claims that the Federal Government reimbursed to the State agency at the enhanced rate for the period October 1, 2005, through September 30, 2007. We did not review the overall internal control structure of the State agency or the Medicaid program. We limited our review to internal controls directly related to our objective.<sup>1</sup> We performed fieldwork at the State agency in Raleigh, North Carolina, from November 2010 through April 2011.

### **Methodology**

To accomplish our objective, we:

- reviewed Federal laws, regulations, and the manual;

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<sup>1</sup> We reviewed family planning claims reimbursed under the State agency's standard Medicaid program in a separate audit (A-04-10-01089).

- interviewed State agency officials to understand the State’s policies, procedures, guidance, and methodology for claiming Medicaid reimbursement for family planning waiver services;
- obtained claims data from the State agency for family planning waiver services consisting of 86,722 pharmacy, sterilization, and clinic and practitioner claims totaling \$5,027,113 (Federal share) with dates of service from October 1, 2005, through September 30, 2007;
- selected a simple random sample of 100 pharmacy claims (\$4,285 Federal share) from 54,106 family planning pharmacy waiver claims and:
  - contacted providers to obtain medical record information for each sampled claim,
  - contacted pharmacies that filled the prescriptions for sampled pharmacy claims in which the prescribing physician was not known,
  - reviewed the written physician notes in the corresponding medical records to determine whether the drugs were prescribed for family planning purposes, and
  - obtained an independent medical review of all medical records for which we could not determine whether the drugs were prescribed for family planning purposes;
- selected judgmental samples of 30 beneficiaries of sterilization services and 30 beneficiaries of clinic and practitioner services from 32,616 family planning, sterilization, and clinic and practitioner waiver claims and:
  - requested and reviewed the medical records for 65 sterilization claims (\$51,121 Federal share) for these 30 beneficiaries<sup>2</sup> to verify that all documentation was completed in accordance with Federal regulations and
  - requested and reviewed the medical records for 230 clinic and practitioner claims (\$8,630 Federal share) for these 30 beneficiaries to verify that all documentation was completed in accordance with 42 CFR §§ 433.32 and 441.253;<sup>3</sup> and
- followed up with providers to obtain additional information when supporting documentation was inadequate or missing.

For our simple random sample of pharmacy claims, we estimated the total overpayment in the sample frame. (See Appendix A for our sample design and methodology and Appendix B for

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<sup>2</sup> A single beneficiary sterilization often resulted in multiple claims (e.g., preliminary visits and postoperative followup).

<sup>3</sup> Beneficiaries may have had more than one clinic or practitioner claim for the same date of service or had multiple dates of service based on the nature of the claims.

our sample results and estimates.) We did not estimate the total overpayment in the population we reviewed for the 295 claims associated with the 60 judgmentally selected beneficiaries of sterilization and clinic and practitioner services.

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 objective.

## **FINDINGS AND RECOMMENDATIONS**

The State agency did not always claim Medicaid family planning waiver reimbursement in accordance with Federal and State requirements. Of 100 pharmacy claims in our simple random sample, 60 claims totaling \$2,644 (Federal share) met requirements. However, the remaining 40 claims totaling \$1,641 (Federal share) did not meet requirements. Based on our sample results, we estimated that the State agency improperly claimed \$662,790 (Federal share) in Medicaid waiver reimbursement for pharmacy claims from October 1, 2005, through September 30, 2007.

In addition, of 65 sterilization claims and 230 clinic and practitioner claims that we sampled, 3 sterilization claims and 21 clinic and practitioner claims did not meet the requirements. Based on our judgmental samples of sterilization claims and clinic and practitioner claims, the State agency improperly claimed \$2,038 (Federal share) and \$1,998 (Federal share), respectively, in Federal Medicaid waiver funds. We calculated these overpayments as the entire Federal Financial Participation amount because Medicaid waiver beneficiaries were not otherwise eligible for Medicaid.

The State agency made these improper claims because it did not have adequate controls to ensure that it claimed only Medicaid family planning waiver services at the enhanced rate.

## **FEDERAL AND STATE REQUIREMENTS**

### **Family Planning**

Section 4270 of the manual generally permits an enhanced rate of Federal reimbursement for medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception. Pursuant to section 4270(B)(2) of the manual, “[o]nly items and procedures clearly provided or performed for family planning purposes may be matched at the 90 percent rate.”

### **Adequate Documentation**

Pursuant to section 1902(a)(27) of the Act and implementing Federal regulations (42 CFR § 433.32), Medicaid providers must maintain documentation that fully discloses the extent of the services provided to the beneficiary. The beneficiary’s service record must contain a record of all services provided, including dates and times of the service, with entries dated and signed by the individual providing the service (10A North Carolina Administrative Code

§ 13J.1402(a)(2)(C)). Therefore, for a claim to be valid for Medicaid reimbursement, it must be adequately documented.

Federal regulations (42 CFR § 441.253) require States to maintain documentation indicating that all Medicaid sterilization patients (1) were at least 21 years old at the time of the procedure; (2) were not mentally incompetent; and (3) voluntarily gave informed consent at least 30 days, but not more than 180 days, prior to the date of sterilization.

## **PHARMACY CLAIMS**

The State agency did not always properly claim Federal reimbursement at the enhanced rate for pharmacy claims. Of 100 pharmacy claims in our simple random sample, 60 claims totaling \$2,644 (Federal share) qualified for reimbursement at the enhanced rate. However, of the other 40 pharmacy claims, 9 claims totaling \$284 (Federal share) were prescribed for purposes other than family planning, and 31 claims totaling \$1,357 (Federal share) did not have adequate documentation.

For 9 sampled claims, independent medical reviewers determined that doctors prescribed the drugs for other than family planning purposes, such as prenatal vitamins, antibiotics, excessive bleeding, and weight control. Although doctors often prescribe the drugs associated with these claims for family planning purposes, the medical records for these claims indicated that doctors prescribed them for other than family planning purposes.

Thirty-one sampled claims were not adequately documented to be eligible for Federal reimbursement. For 16 of these 31 claims, doctors were unable to identify the patient or provide medical records supporting the pharmacy claims. For the remaining 15 claims, we were unable, after multiple attempts, to locate the prescribing physician using the information provided by the State agency.

See Appendix A for our sampling methodology for pharmacy claims, and Appendix B for our sample results and estimates.

## **STERILIZATION CLAIMS**

The State agency did not always properly claim Federal reimbursement at the enhanced rate for sterilization claims. Of the 65 sterilization claims that we reviewed, 62 claims totaling \$49,084 (Federal share) qualified for reimbursement at the enhanced rate. However, of the remaining three claims, one claim totaling \$1,533 (Federal Share) related to an inpatient stay, and two claims totaling \$505 (Federal Share) did not have adequate documentation.

The North Carolina Family Planning waiver program specifically excludes inpatient stays. The two other claims were inadequately documented to be eligible for Federal reimbursement at the enhanced rate. Missing documentation resulted from unidentifiable patients whose records the State agency could therefore not locate, physicians who were no longer employed at the facility, or providers whom we could not contact because the information provided by the State agency was incorrect for our audit period.

## **CLINIC AND PRACTITIONER CLAIMS**

The State agency did not always properly claim Federal reimbursement at the enhanced rate for clinic and practitioner claims. Of the 230 clinic and practitioner claims we reviewed, 209 claims totaling \$6,632 (Federal Share) qualified for reimbursement at the enhanced rate. However, 21 claims did not. Of these 21 claims, 4 claims totaling \$155 (Federal Share) were not related to family planning, and 17 claims totaling \$1,843 (Federal Share) did not have adequate documentation.

Of the four sampled claims that were not related to family planning, one claim totaling \$43 (Federal share) was on behalf of a patient who was pregnant and three claims totaling \$112 (Federal share) were for heavy bleeding, vaginal discharge, or pain during intercourse.

The remaining 17 sampled claims did not have adequate documentation to be eligible for Federal reimbursement. Missing documentation resulted from unidentifiable patients whose records the State agency could therefore not locate, physicians who were no longer employed at the facility, or providers whom we could not contact because the information provided by the State agency was incorrect for our audit period.

## **INADEQUATE CONTROLS**

The State agency made improper claims, resulting in overpayments, because it did not have adequate controls to ensure that it claimed only allowable family planning waiver services. Specifically, the State agency did not have sufficient policies and procedures to:

- ensure that providers always billed appropriately for family planning purposes and
- ensure that all pharmacy claims were prescribed for family planning purposes.

## **UNALLOWABLE AMOUNT**

Based on our simple random sample of pharmacy claims, we estimated that the State agency improperly claimed \$662,790 (Federal share) in Federal Medicaid waiver reimbursement for pharmacy claims that were not prescribed for family planning purposes or that lacked documentation. (See Appendix B for our detailed sample results.)

From our judgmental sample of sterilization claims, we found that the State agency improperly claimed \$2,038 (Federal share) in Federal Medicaid waiver funds.

From our judgmental sample of clinic and practitioner claims, we found that the State agency improperly claimed \$1,998 (Federal share) in Federal Medicaid waiver funds.

We did not estimate the total amount of overpayments for the population of all sterilization and clinic and practitioner claims.

## RECOMMENDATIONS

We recommend that the State agency:

- refund \$662,790 to the Federal Government for non-family-planning pharmacy waiver claims that were reimbursed at the enhanced rate,
- refund \$2,038 to the Federal Government for non-family-planning sterilization waiver claims that were reimbursed at the enhanced rate,
- refund \$1,998 to the Federal Government for non-family-planning clinic and practitioner waiver claims that were reimbursed at the enhanced rate,
- improve controls to ensure that the State agency claims the enhanced rate only for Medicaid family planning waiver services, and
- reemphasize to providers that only services clearly provided for family planning purposes should be billed as family planning.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency generally did not concur with three of our five recommendations. The State agency concurred with our second and third recommendations to refund \$2,038 and \$1,998 to the Federal Government to the extent that the State agency may have claimed enhanced Federal financial participation (FFP) for non-family planning sterilization claims, and clinic and practitioner waiver claims, respectively.

In response to our first recommendation to return FFP for family planning pharmacy claims that neither the pharmacy nor the prescriber could produce supporting documentation for, the State agency did not agree that it should refund the majority of the pharmacy waiver claims to the Federal Government. We had recommended that the State agency return to the Federal Government the estimated \$711,936 in pharmacy claims because the pharmaceuticals on 43 of the 100 sampled claims may have been prescribed for purposes other than family planning.) Specifically, the State agency maintains that all pharmaceuticals in the contraceptive therapeutic class should be eligible for the enhanced family planning matching rate. Further, the State agency stated that the only way to ensure that pharmaceuticals in the contraceptive therapeutic class are prescribed only for family planning purposes would require implementing a methodology that is inconsistent with current medical practice and that would place an undue, disproportionate burden on prescribers of contraceptive drugs and pharmacies alike. For the same reasons, the State generally disagreed with our fourth and fifth recommendation.

The State agency also stated that we were inconsistent in our interpretation of Federal requirements for claiming enhanced FFP for family planning services and supplies and that our findings were therefore not consistent with other issued OIG reports. The State agency's comments appear in their entirety as Appendix C.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing the State agency's comments and additional documentation provided by the State agency, we modified our first recommendation by removing three claims and adjusted our estimated overpayments for pharmacy claims accordingly. Nothing in the State agency's comments caused us to change our other findings or recommendations. We correctly applied Federal requirements to each of the reviewed claims.

Furthermore, the State agency statement that our interpretation of Federal requirements during this audit is inconsistent with that of OIG audits in other States is inaccurate. OIG audits vary in objective, scope, and methodology. Therefore, OIG applies only those elements specific to the circumstances of the State it is auditing.

# **APPENDIXES**

## **APPENDIX A: SAMPLE DESIGN AND METHODOLOGY**

### **POPULATION**

The population was all Medicaid prescribed drug line items billed as waiver family planning services by North Carolina Division of Medical Assistance at a Federal medical assistance percentage of 90-percent (enhanced rate) from October 1, 2005, through September 30, 2007, audit period.

### **SAMPLING FRAME**

We obtained from the State agency 57,885 line items totaling \$2,178,038 (Federal share) from the Medicaid Management Information System paid claims files. From this population, we eliminated all negative (credit) adjustment line items and all corresponding positive (debit) line items for the same person, date of service, and dollar amount. The resulting sampling frame was 54,106 unique prescription drug line items totaling \$2,178,181 (Federal share). Each line item is a unique claim.

### **SAMPLE UNIT**

The sample unit was a claim.

### **SAMPLE DESIGN**

We used a simple random sample.

### **SAMPLE SIZE**

We selected a sample of 100 items to review.

### **SOURCE OF RANDOM NUMBERS**

A Region IV statistical specialist generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software, RAT-STATS 2010, Version 1, Random Number Generator.

### **METHOD OF SELECTING SAMPLING ITEMS**

We consecutively numbered the prescription drug line items from 1 to 54,106. After generating 100 random numbers, we selected the corresponding frame items for the 100 random numbers.

### **ESTIMATION METHODOLOGY**

We used OIG/OAS statistical software to estimate the amount of unallowable payments.

## APPENDIX B: SAMPLE RESULTS AND ESTIMATES

### Sample Results: Federal Share Amounts

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Claims With Errors	Overpayments
54,106	\$2,178,181	100	\$4,285	40	\$1,641

### Estimate of Overpayments (Federal Share) *(Limits Calculated for a 90-Percent Confidence Interval)*

Point Estimate	\$888,004
Lower Limit	\$662,790
Upper Limit	\$1,113,218

**North Carolina Department of Health and Human Services**

2001 Mail Service Center • Raleigh, North Carolina 27699-2001

Tel 919-855-4800 • Fax 919-715-4645

Beverly Eaves Perdue, Governor

Albert A. Delia, Acting Secretary

March 7, 2012

Ms. Lori S. Pilcher  
Regional Inspector General for Audit Services  
US DHHS Office of Inspector General  
61 Forsyth Street SW  
Suite 3T41  
Atlanta, GA 30303

Re: North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Waiver Services That Were Not Family Planning  
**CIN A-04-10-01091**

Dear Ms. Pilcher:

The North Carolina Department of Health and Human Services (NCDHHS) received your January 20, 2012 letter and draft report entitled "*North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Waiver Services That Were Not Family Planning*" [Audit A-04-10-01091].

**OIG Recommendation 1:**

The recommendations were for the State agency to:

- Refund \$711,936 to the Federal Government for non-family planning waiver claims that were reimbursed at the enhanced rate,
- Refund \$2,038 to the Federal Government for non-family planning sterilization, waiver claims that were reimbursed at the enhanced rate,
- Refund \$1,998 to the Federal Government for non-family-planning clinic and practitioner waiver claims that were reimbursed at the enhanced rate,
- Improve controls to ensure that the State agency claims the enhanced rate only for Medicaid family planning waiver services, and
- Reemphasize to providers that only services clearly provided for family planning purposes should be billed as family planning.



Ms. Lori S. Pilcher  
 Audit A-04-10-01091  
 March 7, 2012  
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***DHHS Response – Recommendation 1:***

NC DHHS partially concurs.

To the extent that the Department may have claimed FFP for family planning pharmacy claims for which neither the pharmacy nor the prescriber can produce supporting documentation that the pharmaceutical was prescribed at all, and the provider has not declared bankruptcy or gone out of business, the Department concurs that such FFP should be returned

The Department disagrees with the Office of the Inspector General's (OIG's) recommendation that the majority of the estimated \$711,936 be returned to the federal government because the pharmaceuticals on 43 of the 100 sampled claims may have been prescribed for purposes other than family planning. There are three primary reasons for the disagreement.

- (1) North Carolina State law 10A NCAC 22F.0107 which went into effect on April 1, 1988, requires that Medicaid billing records be retained for only five years. (The law can be viewed at <http://ncrules.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2022%20-%20medical%20assistance%20eligibility/subchapter%20f/10a%20ncac%2022f%20.0107.pdf> <http://www.ncdhhs.gov/dma/plan/sp.pdf>.) In some sampled claims, the five year period had already expired before a records request could be made. Nevertheless, these claims were considered unallowable due to “no documentation”. The Department asserts that the provider is not obligated to retain records for a period longer than contractually required.

The Department also asserts that the only way to ensure that claims for pharmaceuticals in the contraceptive therapeutic classification are only claimed at the enhanced match rate when prescribed specifically for the purposes of family planning would be to require pharmacies to include a diagnosis code on the claim. Pharmacies would be unable to do this unless the prescriber included the diagnosis code on the prescription. Requiring the diagnosis code on the prescription is not consistent with current medical practice and places an undue, disproportionate burden on prescribers of contraception and pharmacies alike and unfairly segregates a certain class of medication to be processed differently.

The Department wishes to address the issue of the stigma that some women associate with discussing and requesting contraception. It is not uncommon for individuals to withhold sensitive and deeply personal information from health care providers, especially regarding sexual activity. Some women may feel more comfortable requesting contraceptives to manage dysmenorrhea or menorrhagia rather than for birth control. Further, at the client's request, providers may document a non-family planning purpose as the primary reason for the prescription in order to allay fears a client may have regarding privacy. Also, for all of the 29 claims in question, the patient was a female of child bearing age. No clinical records came to our attention that the patients in question were unable to conceive. So while a client may request contraception for another reason, it still could prevent a pregnancy despite the client's medical records not accurately reflecting the client's sexual activity and/or reasons for taking a contraceptive drug. Finally, Section 4270 of the State Medicaid Manual allows States to establish a way to identify family planning services and apply for the enhanced match. Therefore, the Department maintains that all pharmaceuticals in the contraceptive therapeutic class should be eligible for the enhanced family planning matching rate.

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- (2) Lastly, the Department believes that the OIG is not consistent across state audits in its interpretation and application of the guidance in the Centers for Medicare and Medicaid Services (CMS) Financial Management Review Guide #20 regarding states' claiming of enhanced federal financial participation (FFP) for family planning services and supplies. Nor does the Department believe that the OIG is consistent across state audits in its interpretation and application of Section 4270 of the State Medicaid Manual or the cited 1992 Departmental Appeals Board administrative law ruling.

During the course of the audit, the Department explained to the OIG that North Carolina's enhanced claiming for family planning pharmacy claims was governed by therapeutic classification code. It appears that many other states use this methodology for claiming the enhanced family planning match on pharmacy claims. In other audits conducted by the OIG of states' enhanced family planning pharmacy claiming, the Department found that in only one of these audits were the specific prescription diagnoses questioned. In the majority of these audits, the OIG found no issue with states claiming enhanced FFP on all claims for prescriptions with drugs that had been appropriately assigned to the contraceptive therapeutic classification code. Specifically, in one audit report released on February 28 2011 (A-09-09-00049), the OIG states, "***We reviewed \$19 million (Federal share) for family planning services and supplies that did not contain approved diagnosis codes or approved therapeutic classification codes.***" [Emphasis added]. All of the 104 sampled claims in North Carolina's audit contained the appropriate classification codes by using the 'family planning indicator' that First Data Bank (national drug file compendia) sends to us, and this indicator results in identification of contraceptive therapeutic classification codes. Thus, the Department disagrees with the OIG's recommendation to return the enhanced FFP for more than 40% of its family planning pharmacy claims.

North Carolina has been using an automated approach through their MMIS system to restrict claims for enhanced FFP on family planning to only those claims with a pharmaceutical classified as family planning by a nationally recognized organization with expertise in the classification of pharmaceuticals.

An apparently very similar process was proposed by the State of Kansas as quoted in the OIG report A-07-09-04146 where the Kansas responded to the OIG recommendations stating:

*"As a result, the policy changes implemented on June 18, 2010 ...add new system logic to remove the provider from the process of identifying family planning services eligible for enhanced FFP. The identification of family planning services takes place in the coding and editing of the MMIS claims process, which has the advantage of preventing claims of enhanced FFP for services the provider could have misidentified as being related to family planning."*

The OIG responded as follows to the above comments:

*"The corrective actions that the State agency described in its comments, should, when fully implemented, adequately address our findings."* [Emphasis added].

The North Carolina MMIS has had system edits in place for over a decade in this regard. All of the 100 sampled claims in North Carolina's audit contained the appropriate

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therapeutic classification codes and pharmaceuticals that were appropriately assigned to those therapeutic classification codes. As such, the Department respectfully disagrees with OIG's recommendation to return the enhanced FFP for a quarter of its family planning pharmacy claims, especially since the OIG has already informed at least one State agency that these controls are considered adequate by the OIG.

### **OIG Recommendation #2**

We recommend that the State Agency:

Refund \$2,038 to the Federal Government for non-family planning sterilization, waiver claims that were reimbursed at the enhanced rate.

#### ***DHHS Response – Recommendation 2:***

NC DHHS partially concurs.

Using an academic, “text book” approach the recommendation seems valid. However, as a practical matter, the costs to implement a control would likely far exceed any benefit, which in this instance is \$2,038. The cost of additional controls is borne by both the Federal government and the State. Currently the Department is not able to justify the expenditure for controls which are not cost-effective.

### **OIG Recommendation #3**

We recommend that the State Agency:

Refund \$1,998 to the Federal Government for non-family planning clinic and practitioner waiver claims that were reimbursed at the enhanced rate.

#### ***DHHS Response – Recommendation 3:***

NC DHHS partially concurs.

Using an academic, “text book” approach the recommendation seems valid. However, as a practical matter, the costs to implement a control would likely far exceed any benefit, which in this instance is \$1,998. The cost of additional controls is borne by both the Federal government and the State. Currently the Department is not able to justify controls which are not cost effective.

### **OIG Recommendation #4:**

We recommend that the State Agency:

Improve controls to ensure that the State agency claims the enhanced rate only for Medicaid family planning waiver services.

#### ***DHHS Response – Recommendation 4:***

NC DHHS partially concurs.

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The Department is receptive to cost-effective procedures for strengthening controls which are not contrary to medical best practices. However, the Department is currently not aware of any control enhancements in this area which are both cost effective and in compliance with best medical practices.

**OIG Recommendation #5**

Reemphasize to providers that only services clearly provided for family planning purposes should be billed as family planning.

***DHHS Response – Recommendation 5***

NC DHHS disagrees.

This recommendation would be very difficult to implement because the Department does not currently process claims based upon a specifically stated purpose. Instead, the Department processes claims based upon service codes which classify a medical procedure.

We appreciate the assistance and professionalism provided by your staff in the performance of this audit. If you need any additional information, please contact Monica Hughes at (919) 855-3720.

Sincerely,



Albert A. Delia

cc: Dan Stewart, CPA  
Craigian Gray, MD, MBA, JD  
Tara Larson  
Eddie Berryman, CPA  
Laketha M. Miller, CPA  
Monica Hughes