



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION VII
601 EAST 12TH STREET, ROOM 0429
KANSAS CITY, MO 64106

April 23, 2012

Report Number: A-07-11-04177

Mr. Michael Hales, MPA
Director
Division of Medicaid & Health Financing
Utah Department of Health
P.O. Box 143103
Salt Lake City, UT 84114-3103

Dear Mr. Hales:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG), final report entitled *Utah Did Not Always Correctly Claim Medicaid Costs for Selected High-Dollar Outpatient Claims*. 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.

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If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Debra Keasling, Audit Manager, at (816) 426-3213 or through email at Debra.Keasling@oig.hhs.gov. Please refer to report number A-07-11-04177 in all correspondence.

Sincerely,

/Patrick J. Cogley/
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**

**UTAH DID NOT ALWAYS
CORRECTLY CLAIM
MEDICAID COSTS FOR
SELECTED HIGH-DOLLAR
OUTPATIENT CLAIMS**



Daniel R. Levinson
Inspector General

April 2012
A-07-11-04177

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 Federal requirements. In Utah, the Department of Health (the State agency) is responsible for administering the Medicaid program.

The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. The State agency's FMAP rates ranged from 70.14 percent to 80.78 percent for claims paid during calendar years (CY) 2007 through 2009 (January 1, 2007, through December 31, 2009).

Improper payments to providers are not allowable for Federal reimbursement under the State plan within the meaning of sections 1903(a)(1) and 1905(a) of the Act. Therefore, FFP in such payments constitutes an overpayment which must be adjusted under section 1903(d)(2)(A) of the Act. Pursuant to 42 CFR § 433.312(a)(2), a State must refund the Federal share of unallowable overpayments made to Medicaid providers.

During CYs 2007 through 2009, the State agency processed and paid 68,068 outpatient service claims with payments greater than \$1,000. We selected and reviewed 313 of these claims totaling \$8,460,635 (\$6,268,512 Federal share) for outpatient services with line item paid amounts greater than \$10,000 that the State agency processed and paid during this time period. We will refer to outpatient services whose claims included at least one line item paid amount greater than \$10,000 as "high-dollar outpatient service claims."

OBJECTIVE

Our objective was to determine whether the State agency claimed costs for selected high-dollar outpatient service claims during CYs 2007 through 2009 pursuant to Federal and State requirements.

SUMMARY OF FINDINGS

During CYs 2007 through 2009, the State agency did not always claim costs for selected high-dollar outpatient service claims pursuant to Federal and State requirements. Of the 313 high-dollar outpatient service claims that the State agency claimed for payments it made to providers during this period, 201 were allowable. For the remaining 112 high-dollar outpatient service claims, providers reported incorrect charges and could not provide documentation to support that

some of the outpatient services were provided. This resulted in overpayments totaling \$373,932 (\$276,800 Federal share).

Providers attributed the claim errors involving incorrect charges primarily to unit quantity errors and other billing errors. Although the State agency had procedures in place to detect incorrect charges for Medicaid high-dollar outpatient services, these procedures did not always prevent claim errors.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$276,800 to the Federal Government and
- use the results of this audit in its ongoing provider education activities related to incorrect charges and proper documentation.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency generally concurred with our first recommendation but added that overpayments to one provider identified in our review were actually correct. The State agency provided clarifying information regarding the payment methodology for this provider.

After reviewing the State agency's comments, we removed overpayments totaling \$8,845 (Federal share) for this provider from our findings, then revised the associated recommendation accordingly.

The State agency concurred with our second recommendation and described corrective actions that it had taken or planned to take.

The State agency's comments are included in their entirety as the Appendix.

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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 1903(a)(1) of the Act, Federal reimbursement is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. Pursuant to 42 CFR § 433.312(a), the State must refund the Federal share of unallowable overpayments made to Medicaid providers.

Utah Medicaid Program

In Utah, the Department of Health (the State agency) is responsible for administering the Medicaid program. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. The State agency's FMAP rates ranged from 70.14 percent to 80.78 percent for claims paid during calendar years (CY) 2007 through 2009 (January 1, 2007, through December 31, 2009).

Utah Medical Assistance for Outpatient Services

The State agency's Medicaid program provides certain medical services, including outpatient services. The State agency uses its Medicaid Management Information System (MMIS) to process outpatient hospital claims.¹ During CYs 2007 through 2009, the State agency processed and paid 68,068 outpatient service claims with payments greater than \$1,000. We selected and reviewed 313 of these claims for outpatient services with line item paid amounts greater than \$10,000 that the State agency processed and paid during this time period. We will refer to outpatient services whose claims included at least one line item paid amount greater than \$10,000 as "high-dollar outpatient service claims."

¹ An MMIS is a mechanized claims processing and information retrieval system that States are required to use to record Title XIX program and administrative costs, report services to recipients, and report selected data to CMS.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed costs for selected high-dollar outpatient service claims during CYs 2007 through 2009 pursuant to Federal and State requirements.

Scope

We reviewed 313 claims, or portions of claims, for high-dollar outpatient services totaling \$8,460,635 (\$6,268,512 Federal share) that the State agency claimed for Federal reimbursement during CYs 2007 through 2009.

We did not review the State agency's overall internal control structure because our objective did not require us to do so. Rather, we reviewed only the internal controls that pertained directly to our objective. Achieving our objective did not require us to reconcile the MMIS outpatient paid claims data provided by the State agency to the costs it reported to CMS or perform a medical necessity review of the selected services or claims.

We performed fieldwork at the State agency in Salt Lake City, Utah, and at selected provider locations, in February and March 2011.

Methodology

To accomplish our objective, we did the following:

- We reviewed applicable Federal and State laws, regulations, and guidance, as well as the CMS-approved State plan.
- We interviewed State agency officials to gain an understanding of how the State agency processed and adjusted claims for outpatient services.
- We used the State agency's MMIS outpatient paid claims data to identify 313 high-dollar outpatient claims totaling \$6,268,512 (Federal share) that had been paid to 24 providers. To identify high-dollar outpatient claims, we:
 - initially selected 156 claims (associated with 14 providers²) with line item paid amounts greater than \$20,000 for which we reviewed the entire claim, and
 - additionally selected 157 claims (associated with 19 providers) with line item paid amounts greater than \$10,000 for which we reviewed only the line item rather than the entire claim.

² Nine of the 14 providers associated with our initial selection were also included in the additional selection of 157 claims (associated with 19 providers) mentioned just below.

- We contacted the State agency to determine whether the 313 high-dollar outpatient service claims had been reviewed by its Program Integrity unit.
- We contacted officials from the 24 providers that received the 313 high-dollar payments and requested assessments as to whether the information originally reported on the claims was correct, and if not, why the claims were incorrect. As part of this assessment, we requested corrected claim information if applicable.
- We reviewed supporting documentation received from the providers to verify the providers' assessments of the selected claims.
- We summarized and submitted to the State agency information regarding claim corrections, overpayments, and related correspondence that we received from the providers.
- We provided the results of our review to State agency officials on December 21, 2011.

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

During CYs 2007 through 2009, the State agency did not always claim costs for selected high-dollar outpatient service claims pursuant to Federal and State requirements. Of the 313 high-dollar outpatient service claims that the State agency claimed for payments it made to providers during this period, 201 were allowable. For the remaining 112 high-dollar outpatient service claims, providers reported incorrect charges and could not provide documentation to support that some of the outpatient services were provided. This resulted in overpayments totaling \$373,932 (\$276,800 Federal share).

Providers attributed the claim errors involving incorrect charges primarily to unit quantity errors and other billing errors. Although the State agency had procedures in place to detect incorrect charges for Medicaid high-dollar outpatient services, these procedures did not always prevent claim errors.

FEDERAL REQUIREMENTS

Pursuant to sections 1903(a)(1) and 1905(a) of the Act, improper payments to providers are not allowable for Federal reimbursement under the State plan. Federal reimbursement is authorized to State Medicaid agencies for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. Therefore, Federal funding in cases of improper payments constitutes overpayments which must be adjusted under section 1903(d)(2)(A) of the Act.

Pursuant to 42 CFR § 433.312(a)(2), a State must refund the Federal share of unallowable overpayments made to Medicaid providers.

In addition, section 1902(a)(27) of the Act requires that services claimed for Medicaid reimbursement be documented.

STATE REQUIREMENTS

Pursuant to Utah Administrative Code R432-100-33, providers are required to retain medical documentation to support claims for at least 7 years.

UNALLOWABLE HIGH-DOLLAR OUTPATIENT SERVICE CLAIMS

Of the 313 high-dollar outpatient service claims that we reviewed, 112 contained errors resulting in overpayments. Although the State agency had procedures in place to detect incorrect charges for Medicaid high-dollar outpatient services, these procedures did not always prevent claim errors.

Based on the results of our review, we determined that the State agency received \$276,800 in unallowable Federal reimbursement.

Unit Quantity Errors

Providers submitted 74 claims with unit quantity errors, resulting in overpayments totaling \$218,103 (\$165,140 Federal share). Unit quantity errors refer to instances in which a provider bills for an incorrect number of units for a particular service provided. For example, one provider incorrectly billed the State agency for an implant device. The provider billed for two devices although only one had actually been implanted. This unit error resulted in an overpayment of \$33,496 (\$27,058 Federal share).

Other Billing Errors

Providers submitted nine claims with other billing errors, resulting in overpayments totaling \$24,518 (\$18,712 Federal share). For example, one provider billed for an incorrect level of service. The service actually rendered was an emergency room visit, but the provider incorrectly billed this event as a critical care service, which is a higher and costlier level of service. This error resulted in an overpayment of \$9,366 (\$6,709 Federal share).

Unsupported Claims

In addition, providers billed for 29 claims, each of which included some outpatient services for which the providers were unable to provide supporting documentation. The providers indicated that these errors resulted in overpayments that required claim adjustments. The overpayments totaled \$131,311 (\$92,948 Federal share).

RECOMMENDATIONS

We recommend that the State agency:

- refund \$276,800 to the Federal Government and
- use the results of this audit in its ongoing provider education activities related to incorrect charges and proper documentation.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency generally concurred with our first recommendation but added that overpayments to one provider identified in our review were actually correct. The State agency provided clarifying information regarding the payment methodology for this provider.

After reviewing the State agency's comments, we removed overpayments totaling \$8,845 (Federal share) for this provider from our findings, then revised the associated recommendation accordingly.

The State agency concurred with our second recommendation and described corrective actions that it had taken or planned to take.

The State agency's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS



State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health

W. David Patton, PhD
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

March 21, 2012

Patrick J. Cogley
Regional Inspector General for Audit Services
Department of Health and Human Services
601 East 12th Street
Room 0429
Kansas City, Missouri 64106

Dear Mr. Cogley:

Thank you for the opportunity to respond to the audit entitled "Utah Did Not Always Correctly Claim Medicaid Costs for Selected High-Dollar Outpatient Claims" (Report No. A-07-11-04177). The Department of Health is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need to be improved.

We appreciate the effort and professionalism of you and your staff in this review. In Utah, the Office of Inspector General of Medicaid Services (Utah OIG) is charged with the task of conducting the Program Integrity reviews that look at the documentation Medicaid providers are required to keep when they submit Medicaid claims. As with all review processes, the number of potential reviews far exceed the number of staff available to do reviews. Therefore, the reviews conducted by your staff provided an opportunity to increase the number of claims reviewed here in the State. We believe that your assistance will help promote a better, more efficient Medicaid program.

Response to Recommendations

Recommendation 1

We recommend that the State agency refund \$285,645 to the Federal Government.

Department response:

In general, we concur with this recommendation. However, we believe payments to one provider identified in the review were actually correct. Utah Valley Specialty Hospital is a long-term acute care hospital, which is reimbursed based on negotiations. Due to



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MMIS system limitations, this provider is paid a negotiated rate in the outpatient hospital category.

The Utah State Plan, Attachment 4.19-D, Subsection 1020 states (emphasis added):

“Each qualifying patient will have a contract rate which is determined by negotiations between the State and the skilled nursing facility, long term acute care or rehabilitation hospitals. The rate will consider specialized equipment and supplies as well as specialized care, including special rehabilitative needs. The rate will be in effect for a period specified in the contract. In addition, the intensive skilled payment is limited to the amount Medicare would pay for the same services at the same facility.”

As such, we believe the \$8,845.53 for Utah Valley Specialty Hospital identified in the review was a correct payment and should not be repaid. The State agrees with the OIG finding regarding the balance of the identified amount – \$276,799.98.

The State will process the federal refund of \$276,799.98 on its June 30, 2012 quarterly CMS-64 report. In addition, the Department of Health will work with the Utah OIG to ensure that collection letters are sent to each of the providers that failed to maintain sufficient support for the claims they submitted. These letters will be sent to providers by April 30, 2012.

Recommendation 2

We recommend that the State agency use the results of this audit in its ongoing provider education activities related to incorrect charges and proper documentation.

Department response:

We concur. During our annual provider training conducted this summer and fall, we will remind providers that:

- They may only bill Medicaid for services which are medically indicated and documented appropriately in the patient's record. All documentation must substantiate services that were billed to Medicaid.
- They have signed a provider agreement by which they have agreed to abide by all state and federal laws related to the Medicaid program, including providing medical and billing records for the purposes of conducting Medicaid and Medicaid Fraud Control Unit audits.
- They need to be cognizant of the state and federal documentation retention rules.

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In summary, the Utah Department of Health recognizes the need for Medicaid providers to keep proper documentation for the claims they submit since any fraud, waste, or abuse in the Medicaid system raises costs for taxpayers in Utah and around the country. The Department is committed to implement the changes described in this letter.

Sincerely,



Michael Hales
Deputy Director, Department of Health
Division Director, Medicaid and Health Financing