

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CALIFORNIA MADE UNALLOWABLE
MEDICAID PAYMENTS FOR ITEMS AND
SERVICES FURNISHED, ORDERED, OR
PRESCRIBED BY
EXCLUDED PROVIDERS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Deputy Inspector General

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A-09-11-02016

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

California made unallowable Medicaid payments of approximately \$1.9 million (\$1.2 million Federal share) for items and services furnished, ordered, or prescribed by excluded providers from July 1, 2009, through June 30, 2010.

WHY WE DID THIS REVIEW

The U.S. Department of Health and Human Services, Office of Inspector General (OIG), may exclude certain individuals and entities from participation in federally funded health care programs. (In this report, we refer to these individuals and entities as “excluded providers.”) One of the consequences of an exclusion is that the Medicaid program will not pay for items or services furnished, ordered, or prescribed by an excluded provider. OIG is conducting reviews of multiple States to determine whether they made such unallowable payments.

The objective of this review was to determine whether the California Department of Health Care Services (State agency) made Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers.

BACKGROUND

The Social Security Act prohibits Federal payment for any expenditure for an item or a service furnished by an excluded provider (§ 1903(i)(2)). It also provides that no payment may be made to a provider for items or services ordered or prescribed by an excluded physician. A Federal regulation specifies that no payment may be made by a State for any item or service furnished, ordered, or prescribed by an excluded provider (42 CFR § 1002). Centers for Medicare & Medicaid Services (CMS) guidance provides that States should conduct searches monthly of either of two Federal databases, one maintained by CMS and one maintained by OIG, to identify provider exclusions and reinstatements that have occurred since the last search.

To identify payments for items and services furnished, ordered, or prescribed by excluded providers, we reviewed approximately 236 million Medicaid fee-for-service claim lines paid by the State agency, totaling \$31.5 billion, with dates of service from July 1, 2009, through June 30, 2010.

WHAT WE FOUND

The State agency made unallowable Medicaid payments of \$1,900,466 (\$1,170,497 Federal share) for items and services furnished, ordered, or prescribed by excluded providers. The State agency made these payments because it did not have policies and procedures to (1) ensure that all agencies within California responsible for enrolling providers or processing Medicaid claims for reimbursement performed monthly reviews to identify excluded providers and (2) identify whether any furnishing, ordering, or prescribing providers listed on a claim were excluded. Although the amount of unallowable payments is small when compared with the \$31.5 billion in claims paid by the State agency, no Medicaid payments may be made for items or services furnished, ordered, or prescribed by excluded providers.

In addition, the State agency paid \$1,134,529 (\$698,756 Federal share) for additional items or services that may have been furnished, ordered, or prescribed by excluded providers and therefore may have been unallowable. The claim data provided by the State agency did not always include sufficient detail to verify whether some furnishing or prescribing providers were excluded or to determine the specific roles of some providers listed on the claims (i.e., ordering, prescribing, or referring). Because the exclusion status of some providers could not be verified and some providers may have been acting only as referring physicians and may not have ordered or prescribed the items or services claimed (in which case Medicaid payments to non-excluded providers would have been allowable), we set aside the Federal share of \$698,756 for resolution by CMS and the State agency.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund \$1,170,497 to the Federal Government for unallowable Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers;
- work with CMS to resolve the \$698,756 that we set aside and refund any payments for items or services furnished, ordered, or prescribed by excluded providers; and
- ensure that it does not pay for items or services furnished, ordered, or prescribed by excluded providers by developing and implementing policies and procedures to:
 - monitor agencies that enroll providers or process Medicaid claims to ensure compliance with CMS guidance that reviews be conducted monthly to identify excluded providers and
 - determine whether any providers (i.e., furnishing, ordering, or prescribing) listed on claims are excluded and deny those claims.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency partially agreed with our first and second recommendations and fully agreed with our third recommendation. In addition, the State agency provided information on actions that it had taken or planned to take to address our recommendations. Nothing in the State agency's comments caused us to revise our findings or recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

The U.S. Department of Health and Human Services, Office of Inspector General (OIG), may exclude certain individuals and entities from participation in federally funded health care programs. (In this report, we refer to these individuals and entities as “excluded providers.”) One of the consequences of an exclusion is that the Medicaid program will not pay for items or services furnished, ordered, or prescribed by an excluded provider. OIG is conducting reviews of multiple States to determine whether they made such unallowable payments.

OBJECTIVE

Our objective was to determine whether the California Department of Health Care Services (State agency) made Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers.

BACKGROUND

Medicaid Program: Administration and Federal Reimbursement

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 plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of a State’s medical assistance expenditures under Medicaid based on the Federal medical assistance percentage, which varies depending on the State’s relative per capita income (§ 1905(b) of the Social Security Act (the Act)). Medical assistance expenditures include expenditures for items and services furnished, ordered, or prescribed by providers enrolled in the State’s Medicaid program.

Excluded Providers

OIG may exclude certain individuals and entities from participation in federally funded health care programs (§§ 1128, 1128A, and 1156 of the Act). Federal regulations specify certain bases on which OIG may, or in some cases must, exclude providers from participation in Medicaid and other Federal health care programs (42 CFR §§ 1001, 1003, and 1004). Federal regulations also address the authority of State agencies to exclude providers from participation in the Medicaid program (42 CFR § 1002).

The Act prohibits Federal payment for any expenditure for an item or a service furnished by an excluded provider (§ 1903(i)(2)). It also provides that no payment may be made to a provider for items or services ordered or prescribed by an excluded physician.

One of the consequences of an exclusion is that the Medicaid program will not pay for items or services furnished, ordered, or prescribed by an excluded provider. Payment for such items or services may not be made to the excluded provider, to anyone who employs or contracts with the excluded provider, or to any hospital or other provider where the excluded provider furnished items or services during the period of exclusion. The payment prohibition applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded provider. There is a limited exception permitting Federal payment to excluded physicians for the provision of certain emergency items or services not provided in a hospital emergency room. The exclusion period ends when OIG reinstates the provider.

Sources of Information on Excluded Providers

Two Federal databases contain information on excluded providers. OIG maintains a database called the List of Excluded Individuals/Entities (LEIE). CMS maintains a database called the Medicare Exclusion Database (MED). CMS guidance provides that States should conduct searches monthly of the LEIE or the MED to identify provider exclusions and reinstatements that have occurred since the last search.

List of Excluded Individuals/Entities

The LEIE contains information on excluded providers in the Medicare, Medicaid, and other Federal health care programs. The LEIE is updated monthly and is available on OIG's Web site in two formats: an online search engine and a downloadable version of the database. The online search engine identifies currently excluded providers. When a user finds a match between providers listed in the search engine and providers in the State agency Medicaid enrollment files, the user can verify the accuracy of the match using the Social Security number (SSN) or Employer Identification Number (EIN). The user may also compare information in the downloadable version of the database with information in State agency provider enrollment files. Unlike the online search engine, however, the downloadable version of the database does not contain SSNs or EINs.

Medicare Exclusion Database

In 2002, CMS developed the MED to collect information that aids in ensuring that no payments are made to excluded providers for services furnished during a provider's exclusion period. The MED uses two information sources: the LEIE and Social Security Administration data. MED files contain information on each excluded provider, including name, SSN, EIN, Unique Physician Identification Number (UPIN), and National Provider Identifier (NPI). CMS updates the MED files monthly and allows State Medicaid agencies to download them from a secure CMS Web site.

California Medicaid Program

In California, the State agency is the single agency responsible for administration of the Medicaid program. The State agency develops and maintains internal controls to administer the Medicaid program. In addition to the State agency, six other agencies within California are

responsible for enrolling new Medicaid providers and maintaining provider records. The seven agencies use different systems to maintain provider records and process claims. The seven agencies use multiple sources, including the LEIE and State-specific information, to identify excluded providers.

HOW WE CONDUCTED THIS REVIEW

We reviewed approximately 236 million Medicaid fee-for-service claim lines¹ paid by the State agency, totaling \$31.5 billion, with dates of service from July 1, 2009, through June 30, 2010. We compared the State agency's paid claims database with the MED to identify the claim lines containing items and services that were furnished, ordered, or prescribed by providers during their exclusion periods.

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.

Appendix A contains the details of our audit scope and methodology. Appendix B contains a list of related OIG reports on excluded providers in the Medicaid program.

FINDINGS

The State agency made unallowable Medicaid payments of \$1,900,466 (\$1,170,497 Federal share) for items and services furnished, ordered, or prescribed by excluded providers. The State agency made these payments because it did not have policies and procedures to (1) ensure that all agencies within California responsible for enrolling providers or processing Medicaid claims for reimbursement performed monthly reviews to identify excluded providers and (2) identify whether any furnishing, ordering, or prescribing providers listed on a claim were excluded. Although the amount of unallowable payments is small when compared with the \$31.5 billion in claims paid by the State agency, no Medicaid payments may be made for items or services furnished, ordered, or prescribed by excluded providers.

In addition, the State agency paid \$1,134,529 (\$698,756 Federal share) for additional items or services that may have been furnished, ordered, or prescribed by excluded providers and therefore may have been unallowable. The claim data provided by the State agency did not always include sufficient detail to verify whether some furnishing or prescribing providers were excluded or to determine the specific roles of some providers listed on the claims (i.e., ordering, prescribing, or referring). Because the exclusion status of some providers could not be verified and some providers may have been acting only as referring physicians and may not have ordered or prescribed the items or services claimed (in which case Medicaid payments to non-excluded

¹ A claim can have multiple claim lines. Each claim line represents a service or an item provided.

providers would have been allowable), we set aside the Federal share of \$698,756 for resolution by CMS and the State agency.²

FEDERAL REQUIREMENTS

The Act prohibits Federal payment “with respect to any amount expended for an item or service” furnished by an excluded provider (§ 1903(i)(2)). It also provides that no payment may be made to a provider for items or services ordered or prescribed by an excluded physician. A Federal regulation specifies that no payment may be made by a State for any item or service furnished, ordered, or prescribed by an excluded provider (42 CFR § 1002). CMS guidance indicates that States should search the MED or the LEIE monthly to identify excluded providers.³

For details on the Federal requirements related to excluded providers, see Appendix C.

STATE AGENCY MADE UNALLOWABLE PAYMENTS FOR ITEMS AND SERVICES FURNISHED, ORDERED, OR PRESCRIBED BY EXCLUDED PROVIDERS

From July 1, 2009, through June 30, 2010, the State agency made unallowable Medicaid payments of \$1,900,466 (\$1,170,497 Federal share) for items and services furnished, ordered, or prescribed by excluded providers. For each provider role identified in the claim data, the table summarizes the total number of excluded provider claim lines and the payments made.⁴

Number of Claim Lines and Payment Amounts by Provider Role

Provider Role	No. of Claim Lines	No. of Excluded Providers⁵	Unallowable Payments	Federal Share
Billing Provider	4,104	176	\$1,673,519	\$1,030,720
Prescribing Provider	3,118	82	213,508	131,500
Furnishing Provider	200	13	13,439	8,277
Total	7,422	271	\$1,900,466	\$1,170,497

² If an excluded physician refers a patient to a non-excluded physician, and the non-excluded physician submits a claim for items or services that he or she furnished, ordered, or prescribed, the fact that the patient was originally referred by an excluded physician does not preclude Medicaid payment for claims by the non-excluded physician.

³ CMS’s State Medicaid Director Letter #08-003, dated June 12, 2008.

⁴ In California, a provider that submits a claim for Medicaid reimbursement is known as a billing provider. The billing provider may be the furnishing provider or a medical practice or hospital of which the provider is a member. A claim may not specifically identify who furnished an item or a service. In these instances, we treated the billing provider as if it had furnished the item or service.

⁵ These figures represent the number of unique providers that were matched to the MED. There is no overlap in the number of providers listed.

STATE AGENCY DID NOT HAVE POLICIES AND PROCEDURES TO PREVENT UNALLOWABLE PAYMENTS

The State agency did not have policies and procedures to ensure that the seven agencies responsible for enrolling providers or processing Medicaid claims performed monthly reviews to identify excluded providers and prevent unallowable payments. After reviewing information from officials at the seven agencies, we determined that the agencies used multiple sources, including the LEIE, to identify excluded providers. Three of these agencies performed monthly reviews of excluded providers. Of the four remaining agencies, one agency performed quarterly reviews. The other three agencies reviewed the status of providers only when enrolling them and did not perform any subsequent reviews.

In addition, the State agency did not have policies and procedures to identify whether any furnishing, ordering, or prescribing providers listed on a claim were excluded. The seven agencies determined only whether the billing provider had been excluded; they did not check whether other providers (for example, prescribing or furnishing) identified on a claim line had been excluded. Although billing providers were identified on enrollment, some claims associated with excluded providers may have been paid because the individual agency did not perform subsequent checks of the billing providers' status.

STATE AGENCY PAID FOR ADDITIONAL ITEMS OR SERVICES THAT MAY HAVE BEEN UNALLOWABLE, BUT DATA WERE INSUFFICIENT TO DETERMINE WHETHER PROVIDERS WERE EXCLUDED

From July 1, 2009, through June 30, 2010, the State agency paid \$1,134,529 (\$698,756 Federal share) for items or services that may have been furnished, ordered, or prescribed by excluded providers and therefore may have been unallowable. The paid claims data that the State agency provided us did not always (1) contain identification numbers (i.e., SSN, EIN, UPIN, or NPI) for furnishing and prescribing providers that could be used to verify the providers' exclusion status or (2) separately identify ordering, prescribing, and referring providers:⁶

- According to the State agency's written description of the data fields, the fields for furnishing and prescribing providers can contain an NPI or other provider numbers, such as the number issued by the California Medicaid program. For some claim lines, these fields contained a provider identification number that could be matched to a UPIN in the MED but could not be traced to a specific excluded provider because the number could also have been a State medical license number or another number that we could not verify.
- According to the State agency's written description of the data fields, the field for a prescribing provider contains an identification number of a prescribing provider only if the claim line also indicates, through the use of a specific provider type code, that a pharmacy submitted the claim. For all other claim lines, the identification number is that

⁶ The State agency's prescribing provider data field was also used to list provider identification numbers for ordering and referring providers.

of a referring provider. However, there were many claim lines that did not contain a provider type code.

As a result of these issues, the data did not include sufficient detail on some of the claim lines to (1) determine whether the furnishing or prescribing provider was excluded or (2) differentiate between a provider who ordered or prescribed items or services and a provider who referred the beneficiary to a different, non-excluded provider. Therefore, we set aside the Federal share of \$698,756 for resolution by CMS and the State agency.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$1,170,497 to the Federal Government for unallowable Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers;
- work with CMS to resolve the \$698,756 that we set aside and refund any payments for items or services furnished, ordered, or prescribed by excluded providers; and
- ensure that it does not pay for items or services furnished, ordered, or prescribed by excluded providers by developing and implementing policies and procedures to:
 - monitor agencies that enroll providers or process Medicaid claims to ensure compliance with CMS guidance that reviews be conducted monthly to identify excluded providers and
 - determine whether any providers (i.e., furnishing, ordering, or prescribing) listed on claims are excluded and deny those claims.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency included the comments of several agencies. Those comments were not always in harmony, and the State agency characterized its response to the first two recommendations as partial agreement. Because the State agency presented its letter as its response to the report, we consider the comments within to be the State agency's official comments. The State agency's comments are included in their entirety as Appendix D.

STATE AGENCY COMMENTS

The State agency partially agreed with our first and second recommendations and fully agreed with our third recommendation. In addition, the State agency provided information on actions that it had taken or planned to take to address our recommendations.

Regarding the first recommendation, the State agency agreed to refund \$1,030,721 of the \$1,170,497. However, the State agency did not agree that the remaining \$139,777 represented unallowable Medicaid payments. Regarding the second recommendation, the State agency agreed to work with CMS to resolve the set-aside amount and refund any payments for services furnished by certain excluded providers.

The State agency disagreed with our first and second recommendations for the same two reasons, stating that (1) the data we provided did not positively identify unallowable Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers and (2) ordering and prescribing providers were not required to enroll in California's Medicaid program because they were not direct billing providers.

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding the first recommendation, we disagree that the data did not positively identify unallowable Medicaid payments, and the State agency did not provide us any additional information to demonstrate that any of the questioned payments were allowable. In addition, Federal requirements specify that no payment may be made by a State for any item or service furnished, ordered, or prescribed by an excluded provider. This prohibition is not limited to only those providers that bill for an item or a service that was furnished, ordered, or prescribed by an excluded provider. Therefore, we continue to recommend that the State agency refund the entire \$1,170,497, including the \$139,777, of unallowable Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers.

Regarding the second recommendation, because the paid claims data that the State agency provided did not always include sufficient detail to determine whether the items or services were furnished, ordered, or prescribed by excluded providers and whether the subsequent payments were unallowable, we set aside the \$698,756 for the State agency to determine whether the claims included excluded providers and refund any unallowable payments. Additionally, the payment prohibition applies to all providers and is not limited to only those providers that bill for an item or a service. Therefore, we continue to recommend that the State agency work with CMS to resolve the amount set aside and refund any payments for items or services furnished, ordered, or prescribed by excluded providers.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed approximately 236 million Medicaid fee-for-service claim lines paid by the State agency, totaling \$31.5 billion, with dates of service from July 1, 2009, through June 30, 2010. We did not review the overall internal control structure of the State agency or the Medicaid program because our objective did not require us to do so. Rather, we limited our review to the State agency's internal controls to prevent Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers.

We conducted our audit from January 2011 to February 2012 and performed fieldwork at the State agency's offices in Sacramento, California.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed State agency policies, procedures, and guidance related to prevention of Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers and held discussions with State agency officials;
- reviewed the LEIE as of March 2011 and the MED as of January 2011;⁷
- obtained the State agency's Medicaid provider database;
- obtained from the State agency a database that contained 236 million Medicaid claim lines for paid claims with dates of services from July 1, 2009, through June 30, 2010;
- developed a list of providers from the State agency's paid claims database with additional identifying information from the State agency's Medicaid provider database;
- compared the list of providers from the State agency's paid claims database with the list of excluded providers in the MED on the basis of the SSN, NPI, EIN, and UPIN;
- identified the Medicaid payments that the State agency made for claim lines that listed an excluded provider during the listed providers' exclusion periods; and

⁷ We used the MED in our analysis because it was a cumulative list and contained providers' exclusion and reinstatement dates as well as their SSNs and NPIs, which were also listed in the State agency's Medicaid provider database.

- calculated the Federal share of the payments for items and services furnished, ordered, or prescribed by excluded providers using the Federal medical assistance percentage (61.59 percent) applicable during the audit period.

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.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Oregon's Internal Controls Were Substantially Adequate To Prevent Medicaid Payments to Excluded Providers</i>	<u>A-09-11-02042</u>	11/17/11
<i>Review of Medicaid Excluded Providers in Iowa</i>	<u>A-07-10-03149</u>	02/11/11
<i>Review of Medicaid Excluded Providers in Missouri</i>	<u>A-07-10-03153</u>	02/04/11
<i>Excluded Medicaid Providers: Analysis of Enrollment</i>	<u>OEI-09-08-00330</u>	05/19/10

APPENDIX C: FEDERAL REQUIREMENTS RELATED TO EXCLUDED PROVIDERS

FEDERAL LAWS AND REGULATIONS

Section 1903(i)(2)(A) of the Act states: “Payment ... shall not be made ... with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished ... by any individual or entity during any period when the individual or entity is excluded”

Section 1903(i)(2)(B) of the Act states that payment may not be made for items or services furnished “at the medical direction or on the prescription of a physician, during the period when such physician is excluded ... and when the person furnishing such item or service knew or had reason to know of the exclusion”

According to 42 CFR § 1001.2: “*Exclusion* means that items and services furnished, ordered or prescribed by a specified individual or entity will not be reimbursed under Medicare, Medicaid and all other Federal health care programs until the individual or entity is reinstated by the OIG.” (Italics in original.)

With respect to these reimbursements or payments, 42 CFR § 1002.211(a) states:

[N]o payment may be made by the State agency for any item or service furnished on or after the effective date specified in the notice by an excluded individual or entity, or at the medical direction or on the prescription of a physician who is excluded when a person furnishing such item or service knew, or had reason to know, of the exclusion.

CENTERS FOR MEDICARE & MEDICAID SERVICES GUIDANCE

According to CMS’s State Medicaid Director Letter #08-003, dated June 12, 2008, States should search the MED or the LEIE by the name of any individual, entity, or individual with ownership or controlling interest in any entity providing services paid for by the Medicaid program or seeking to participate in Medicaid. States should search the MED or the LEIE monthly to identify exclusions and reinstatements that have occurred since the last search.

APPENDIX D: STATE AGENCY COMMENTS



State of California—Health and Human Services Agency
Department of Health Care Services



FEB 08 2013

Lori A. Ahlstrand
Regional Inspector General for Audit Services
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Dear Ms. Ahlstrand:

The California Department of Health Care Services has prepared its response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled *California Made Unallowable Medicaid Payments for Items and Services Furnished, Ordered, or Prescribed by Excluded Providers*, Report Number A-09-11-02016. DHCS appreciates the work performed by OIG and the opportunity to respond to the draft report.

Please contact Ms. Raj Khela, Audit Coordinator, at (916) 650-0298 if you have any questions.

Sincerely,

Toby Douglas
Director

Enclosure

cc: See next page

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Department of Health Care Services'
Response to the Office of Inspector General's Draft Report Entitled:

***California Made Unallowable Medicaid Payments for Items and
Services Furnished, Ordered, or Prescribed by Excluded Providers
Report Number A-09-11-02016***

Recommendation: The State Agency refund \$1,170,497, the Federal Financial Participation (FFP) amount, to the Federal Government for unallowable Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers.

Response: DHCS partially agrees with the recommendation.

Agree – The California Department of Social Services (CDSS) agrees to refund the FFP amount of \$1,009,305 to the Federal Government. CDSS will work with DHCS to ensure that all ineligible provider data files are made available to ensure we identify and disallow Medicaid payments for items and services furnished to excluded providers.

Agree – The Mental Health Services Division agrees to refund the FFP amount of \$21,402 to the Federal Government for unallowable Medicaid payments made under the Department of Health Care Services (DHCS) for items and services furnished, ordered, or prescribed by the Mental Health Medi-Cal excluded provider identified for the dates of service from July 1, 2009 through June 30, 2010.

Disagree – The California Medicaid Management Information Systems (CA-MMIS) Division and the Provider Enrollment Division (PED) disagree with this finding. CA-MMIS disagrees to this finding based on the review of claims identified by the Office of Inspector General (OIG) as out of compliance. The data provided by OIG does not positively identify unallowable Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers. CA-MMIS agrees to refund the FFP amount of \$14 made to billing providers that were excluded to participate in the Medicaid program during the period of the audit. However, CA-MMIS does not agree with the \$139,777 (FFP) identified by OIG as unallowable Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers. In addition, CA-MMIS and PED do not agree with this recommendation because ordering and prescribing providers are not required to enroll in the Medi-

Cal program since they are not direct billing providers. Effective January 1, 2013, SB 1529 required ordering and prescribing providers to enroll. DHCS has informed CMS of the change in requirements and has approved this change through a State Plan Amendment.

Recommendation: The State Agency work with CMS to resolve the \$698,756 that we set aside and refund any payments for items or services furnished, ordered, or prescribed by excluded providers.

Response: DHCS partially agrees with the recommendation.

Agree – The Medi-Cal Dental Services Division (MDSD) agrees with the recommendation. MDSD agrees to work with CMS to resolve the set aside amount and to refund any payments for services furnished by excluded Denti-Cal providers, where applicable.

MDSD is currently conducting research to verify if any of the Dental providers who received payments were listed for exclusion and to identify the amount, if any, to be refunded. Anticipated completion date for the data validation analysis is the first quarter of calendar year 2013.

1. MDSD will perform an analysis of the OIG dental claims file submitted to DHCS. MDSD will compare and validate claims payment data from the California Dental Medicaid Management System (CD-MMIS) to the data in the OIG report to ensure that the data in both files are consistent.

If the results of the analysis identify discrepancies between the data in CD-MMIS and the data in the OIG report, DHCS will schedule a meeting with CMS to discuss the discrepancies identified and to determine next steps.

2. If no data discrepancies are identified between the OIG dental claims file submitted to DHCS and the claims payment data from CD-MMIS, DHCS will request that CMS provide a Medicare Exclusion Database (MED) spreadsheet that contains all excluded Denti-Cal providers for the time period in question. Once the MED file is provided to DHCS, it

will be used to verify if the rendering providers were listed as excluded providers.

If it is determined that any of the providers in the claims file from OIG were inappropriately paid, MDSD will identify the amounts of overpayments.

MDSD anticipates completing the verification of excluded providers and identification of the overpayment amount within 30 days after receiving the MED information from CMS.

Additionally, MDSD will implement the following corrective actions 60 days from the date MED is available for use electronically:

1. Denti-Cal will suspend excluded dental providers listed on the CMS MED and will attempt to recoup any overpayments made to excluded providers.
2. The Denti-Cal Provider Enrollment Unit will include the CMS MED as part of their current credentialing process, and will implement the 42 CFR Final Rule requirement of monthly verification via database checks for all dental providers.

Disagree – CA-MMIS disagrees based on the review of claims identified by OIG as out of compliance. The data provided by OIG does not positively identify unallowable Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers. CA-MMIS compared the claims identified by OIG against the list of excluded providers, and finds no providers on the list of excluded providers. In addition, DHCS does not agree with this recommendation as ordering and prescribing providers are not required to enroll in the Medi-Cal program since they are not direct billing providers. SB 1529, effective January 1, 2013, will make the enrollment of ordering and prescribing providers a requirement. DHCS has informed CMS of the change in requirements and has approved this change through a State Plan Amendment.

Recommendation:

The State Agency ensure that it does not pay for items or services furnished, ordered, or prescribed by excluded providers by developing and implementing policies and procedures to:

1. monitor agencies that enroll providers or process Medicaid claims to ensure compliance with CMS guidance that reviews be conducted monthly to identify excluded providers and
2. determine whether any providers (i.e., furnishing, ordering, or prescribing) listed on claims are excluded and deny those claims.

Response:

DHCS agrees with the recommendations.

Agree – CA-MMIS agrees with the recommendation and has initiated System Development Notice (SDN) 12014 to utilize data, on a monthly basis, from the MED, Excluded Providers List System (EPLS), System for Award Management (SAM) and the List of Excluded Individuals/Entities (LEIE) databases. DHCS was to begin utilizing the Medicare data beginning January 2013 however, this date will be extended due to delays in obtaining access to the Medicare data. These delays are attributable in part, to Medicare not yet having the process in place for States to obtain automated downloads of their data from all of their systems.

Once available, the CMS Excluded Provider data will be downloaded and used to create reports that will be used by DHCS staff to update the CA-MMIS with excluded provider information. In addition, DHCS has requested Provider Revalidation data extracts from the CMS database Provider Enrollment Chain and Ownership System (PECOS) in an effort to perform data matches with providers existing in CA-MMIS. DHCS currently has access to the PECOS application itself, but is unable to obtain data extracts, which will facilitate automated file comparisons. Due to the size of the Medi-Cal program, it is preferred that DHCS leverages an automated PECOS extract to reduce the manual effort of individual provider look-ups. Upon receipt of an automated data extract from CMS, DHCS plans to contact any providers that were not revalidated by Medicare within the past year and take appropriate action to ensure compliance with annual revalidation requirement.

Agree – MHSD agrees with the recommendation.

1. MHSD will develop policies and procedures where, on a monthly basis, we will electronically screen our provider database to identify Mental Health Medi-Cal excluded providers. MHSD will require that Mental Health Plans (MHP) and/or their billing system vendors perform a

similar screen on all contracted providers and sub-contracted providers who provide specialty mental health services and claim for such services through Mental Health Medi-Cal on behalf of the MHP.

2. MHSD will develop policies, procedures and business rules that will identify, by Federal Identifier or otherwise, excluded Mental Health Medi-Cal providers. Once identified, excluded providers will be denied payment through Mental Health Medi-Cal claim systems.

Agree – PED agrees with the recommendation.

To ensure compliance with CMS guidelines related to the identification of excluded providers, the Interagency Agreements (IAs) between DHCS and all California Departments which enroll providers will be strengthened. This may include amending the IAs, auditing the IAs, and/or enforcing the terms of the IAs to help ensure that California does not pay for items or services furnished, ordered, or prescribed by excluded providers.

To comply with provisions of the 2010 Patient Protection and Affordable Care Act, the PED will begin enrolling the ordering, referring, and prescribing providers effective January 1, 2013. In addition, all actively-enrolled providers will be subject to a monthly data match utilizing data from the MED and the SAM database in order to update the CA-MMIS with excluded provider information. PED will terminate the enrollment of providers if they are identified in these monthly matches as being excluded from participation

Beginning January 1, 2013, PED will also be utilizing the Medicaid and Children's Health Insurance Program (CHIP), State Information Sharing System (MCSIS) database to check provider terminations so that providers terminated from Medicare or another state Medicaid or CHIP program will not be enrolled in Medi-Cal or will be terminated from Medi-Cal and thus unable to submit claims for payment.