ATTACHMENT D

COLORADO DEPARTMENT OF HEALTH CARE POLICY

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • 303- 866-4411
Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

August 4, 2010

Ms. Sally Symanski, State Auditor
Office of the State Auditor
Legislative Council Building
200 E. 14th Avenue
Denver, CO 80203

Dear Ms. Symanski:

Please find the Department of Health Care Policy and Financing's status update to October 2009 Controls Over Medicaid Claims for Durable Medical Equipment and Supplies, Laboratory, and Radiology Services Performance Audit.

If you have any questions or comments, please feel free to contact the Department's Audit Coordinator, Laurie Simon at 303-866-2590 or laurie.simon@state.co.us.

Sincerely,

Donna Kellow
Audit and Compliance Division Director

DK:las

cc:

Senator David Schultheis, Chair
Senator Lois Tochtrop, Vice-Chair
Senator Morgan Carroll, Legislative Audit Committee
Representative James Kerr, Legislative Audit Committee
Representative Frank McNulty, Legislative Audit Committee
Representative Joe Miklosi, Legislative Audit Committee
Senator Shawn Mitchell, Legislative Audit Committee
Represenative Dianne Primavera
HCPF Executive Director's Office
Sandeep Wadhwa, Medicaid Director
Laurel Karabatsos, Medicaid Program Division Director
Laurie Simon, HCPF Audit Coordinator

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Recommendation 1a:

The Department of Health Care Policy and Financing should ensure that Medicare is the primary payer on claims processed through MMIS for dual-eligible Medicaid clients by:

a. Reviewing and revising its policies, as necessary, to require providers to submit a Medicare explanation of benefits for paper claims after Medicare makes a payment determination.

Health Care Policy and Financing's Initial Response:

Agree.

The Department will update applicable billing manuals to require providers to submit a Medicare Explanation of Benefits (EOMB) for paper claims after Medicare makes a payment determination. An article will be published on this requirement in its provider bulletin by February 2010. Note that until system and process changes referenced below are completed, this requirement cannot be consistently enforced.

The Department will review the current MMIS system processes regarding EOMBs and implement system and process changes as necessary to ensure that EOMBs are submitted with paper claims for dual-eligible claims. Once implemented, claims will be denied if no EOMB is present. System and process changes will be done by December 2011

In addition, the Department is working with our federal partner, the Centers for Medicare and Medicaid Services (CMS) on the Medicare Medicaid (Medi Medi) data matching project.. By the first week of November 2009, data matches will be available for the Medi Medi Steering Committee to prioritize and assign primary investigative responsibilities to appropriate members. Medi Medi is going to generate referrals for the Department's Program Integrity Section, Medicaid Fraud Control Unit, US Attorney's Office, and HHS-OIG investigative staff. Overpayments will be recovered and civil / criminal prosecutions may result from the partnering of CMS, United States Attorney, Colorado's Attorney General's Office and the Department.

The data matching work has already begun and will look at duplicate payments made by Medicare and Medicaid. In addition to duplicate payments, this project looks to see if Medicare was billed at all, when Medicare is the primary carrier. If Medicaid paid claims that should have been submitted to Medicare, then Medicare will refund money to Medicaid. In addition to this, any identified aberrant billing schemes identified in the Medicare program are likely being committed in the Medicaid program as well, so Medicaid data will be analyzed.

Original Implementation Date: December 2011

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Health Care Policy & Financing August 2010 Status Update:

In Progress.

The Department will proceed with the Medi-Medi implementation described below and will initiate a policy change to require appropriate Medicare billing, but allow for simultaneous Medicaid billing where there appears to be no clear entitlement to Medicare benefits. Should Medicare reimburse the provider will be required to repay Medicaid payments. Dual payment data will be available from the Medi-Medi data review on an on-going basis to insurer no double payment is made.

If Medicaid paid claims that should have been submitted to Medicare, then Medicaid will attempt to recover payments from providers. If claims remain in Medicare timely filing, the provider can bill Medicare. In addition to this, any identified aberrant billing schemes identified in the Medicare program are likely being committed in the Medicaid program as well, so Medi Medi is already analyzing Medicaid claims data. This paragraph is to serve as a correction to the last 2 sentences of the Department's initial response.

The January, 2010 Provider Bulletin contained a front page article reminding providers of their responsibilities regarding dual-eligible clients and notifying them of a future requirement to provide the EOMB with paper claims for dual eligible clients. Updates to billing manuals are in progress. The Department continues to work on the system and process changes referenced in the initial response. Once completed this requirement will be consistently enforced.

Implementation Date: December 2011

Recommendation No. 1b and 1c:

The Department of Health Care Policy and Financing should ensure that Medicare is the primary payer on claims processed through MMIS for dual-eligible Medicaid clients by:

b. Analyzing the paid claims for all clients whose eligibility changed from Medicaid only to dual eligible, identifying claims for which recovery should be sought, and instituting recovery action.

c. Instituting a quarterly audit of all claims paid for dual-eligible clients and identifying claims that may have been paid incorrectly. The Department should seek recoupment from providers for any incorrectly paid claims.

Health Care Policy and Financing's Initial Response:

Agree. Implemented.

The Department has revised part of this process with our outside contractor, Health Management Systems, Inc. (HMS). HMS does a quarterly data match with Medicare eligibility data and disallows all claims on all clients that Medicaid paid as primary when Medicare entitlement existed. As of October 2009 HMS will be recovering claims over $50.00 each quarter. For Fiscal Year 2009, the Department recovered a total of $2,652,053 for Medicare/Medicaid eligible clients from providers. This includes Medicare A, B, and D.

Health Care Policy & Financing August 2010 Status Update:

As indicated in the Department's original response, this recommendation is implemented.

Implementation Date: Implemented.

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Recommendation 1d:

The Department of Health Care Policy and Financing should ensure that Medicare is the primary payer on claims processed through MMIS for dual-eligible Medicaid claims by:

d. Enhancing its effort to educate providers about the Department's billing policies and processes for claims associated with dual-eligible clients.

Health Care Policy and Financing's Initial Response:

Agree.

The Department will review and update its provider training material to ensure that its policies and process for claims for dual-eligible clients are included and clearly communicated. The Department will periodically publish reminders of its policies and processes for claims for dual-eligible clients in its provider bulletin.

Original Implementation Date: March 2010 and ongoing.

Health Care Policy & Financing August 2010 Status Update:

In Progress.

Provider training material is being updated to ensure that the Department's policies and processes for claims for dual-eligible clients are included and clearly communicated. A reminder of the Department's policies and process for dual-eligible clients was included as a front page article in the January, 2010 provider bulletin. The Department will publish similar reminders in its March and September provider bulletins each year.

Implementation of this recommendation has been delayed due to competing priorities and shortage of resources.

New Implementation Date: December 2010.

Recommendation 2:

The Department of Health Care Policy and Financing should review its policy that excludes certain procedures from the Medicare lower of pricing logic to assess the appropriateness of these exclusions, particularly related to cost-control strategies for the Medicaid Program. If the Department decides to continue excluding certain procedures from these pricing requirements, the Department should justify in writing the reasons for these exclusions and periodically reassess their appropriateness. Further, the Department should work with the federal Centers for Medicare and Medicaid Services to determine whether an amendment to Colorado's State Medicaid Plan should have been submitted related to these exclusions and whether any of the payments made for claims falling under these exclusions should be recovered.

Health Care Policy and Financing's Initial Response:

Agree.
Original Implementation Date: January 2011

The Department agrees that the 25 claims were excluded from lower of pricing. However, the Department does not agree that Mercer Health Benefits, LLC (Mercer) did not have the necessary pricing methodologies to conduct a review of the judgmentally sampled claims as described in the text of this audit report. At the beginning of the audit, Mercer was provided with the appropriate fee schedules and provider bulletins that describe the pricing methodologies. Therefore, Mercer had the necessary information to review the pricing methodologies for 168 out of the 175 claims.

The Department will review the list of procedures excluded from the Medicare lower of pricing logic to assess the appropriateness of the exclusion. If it is determined that exclusions are necessary, reasons for excluding procedures from the Medicare lower of pricing will be documented and the State Plan will be revised to reflect any category of procedure codes excluded from this pricing methodology. The Department will work with the Centers for Medicare and Medicaid Services to determine if a State Plan amendment should have been submitted and whether any payment made for claims excluded from the lower of Medicare pricing methodology should be recovered.

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Health Care Policy & Financing's August 2010 Status Update:

In Progress.

The Department has assigned this task to the Program Administration section. Staff will review the codes currently loaded in System List 4480, HCPCS Procedure Codes Exempt from Lower of Pricing. Staff will research why specific codes were placed on this list and determine if these exclusions are still necessary.

Implementation Date: January 2011

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Recommendation 3a

The Department of Health Care Policy and Financing should improve controls to prevent Medicaid payments for service to deceased individuals by:

a. Periodically evaluating the effectiveness of methods used to identify payments made for services provided after a client's death and implementing changes to these methods, as necessary.

   Health Care Policy and Financing's Initial Response:

   Agree.
   Original Implementation Date: July 2010

   The Department's current Date of Death (DOD) process involves matching data to compare dates of death for Medicaid recipients against the Paid Claims Files of Health Management Systems (HMS), a vendor of the Department. Multiple sources for the dates of death are used, including data supplied monthly by the Colorado Office of Vital Statistics at the Colorado Department of Public Health and Environment to HMS. The Department feels this process is cost-effective because HMS' comprehensive death data information from multiple sources is matched with Medicaid's eligibility files. The Department is in the process of determining how often these reviews will take place and revisiting the policy around date of death recoveries.

   In addition, the Department was recently awarded $42 million over the next five years from the Health Resources and Services Administration (HRSA), State Health Access Program (SHAP) to fund a comprehensive set of initiatives that will lead to greater access to health care, increase positive health outcomes and reduce cost-shifting. One of the initiatives involves eligibility modernization which includes creating interfaces to other state and federal systems to electronically verify information regarding a client's income, citizenship and identity. This includes building interfaces with the state's Vital Statistics data base for birth and death records.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES, LABORATORY AND RADIOLOGY SERVICES PERFORMANCE AUDIT DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S AUGUST 2010 STATUS UPDATE

Health Care Policy & Financing's August 2010 Status Update:

Partially Implemented.

The Department's current Date of Death (DOD) process outlined in our original response is sufficient.

The Department has determined that its HRSA SHAP grant does not have a project that specifically focuses on death records. However, the Department is working on projects where any application being processed can be matched against the Social Security Administration, Department of Motor Vehicles and Vital Statistics and will identify if the individual at the time of application is deceased. The Department will be implementing these interfaces over the next two years.

New Implementation Date: December 2012

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Recommendation 3b

The Department of Health Care Policy and Financing should improve controls to prevent Medicaid payments for service to deceased individuals by:

b. Working with its contractor, Health Management Systems, to expand data matches and recoveries for claims paid after a client's death to include oxygen services and other rental supplies.

Response:

Health Care Policy and Financing's Initial Response:

Agree.
Original Implementation Date: July 2011

The Department will re-explore its policy with rental equipment and also explore with HMS the possibility of expanding data matches and recoveries for rental equipment claims paid after a client's death. This type of audit will be added to the scope of work for audits performed by HMS if a reasonable policy and procedure can be developed.

Health Care Policy & Financing's August 2010 Status Update:

In Progress.

The Benefits Management section is working with Benefit Coordination section to identify HCPCS codes that are impacted by policy to allow payment in month of death and create payment rules for those codes in month of death. The Department is exploring with HMS the possibility of expanding data matches and recoveries for rental equipment claims paid after a client's death following the Benefit Management Section's review. The Benefit Management section is working on educating DME providers through Bulletin articles and presentations to stakeholders on the date of death policy. The Department is also reviewing and developing a policy on payment for bulk shipped items involving date of service.

Implementation Date: July 2011

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Recommendation 3c

The Department of Health Care Policy and Financing should improve controls to prevent Medicaid payments for service to deceased individuals by:

c. Continuing to investigate the claims identified by this audit that were paid for services provided after the date of death recorded in CDPHE's or the Department's files for Medicaid clients. The Department should use the claims-specific data provided through this audit to identify and recover any payments made for services provided after death.

Health Care Policy and Financing's Initial Response:

Partially Agree.
Original Implementation Date: July 2010

The Department shall use the claim specific data to identify claims incorrectly paid after date-of-death. For claims improperly billed for services after date-of-death, the Department Program Integrity Unit shall investigate and pursue the recovery of overpayments.

Medicaid providers, who provide rental medical supplies or oxygen equipment rental, will submit claims pursuant to the client's eligibility status. If a current client is eligible in the Medicaid eligibility system the provider of rental equipment must assume the client is still utilizing the provider's equipment. The provider continues to provide their service and not recover their equipment until the client eligibility has ended or they receive notice the equipment is no longer required. This is current Department policy and procedure and providers who follow this procedure will have their claims paid.

Health Care Policy & Financing's August 2010 Status Update:

The Department initiated the DOD project in July 2008 to recover payments made to providers for Medicaid clients who were deceased prior to the service dates. Prior to July 2008, the last process to identify erroneous claims was performed in 2004. In July 2008 the DOD project looked back to 2004 and as a result, all after death payments have been, or will be, recovered unless the death payments owing are below a minimum threshold and not cost effective to recover.

Implementation Date: Implemented and Ongoing.

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Recommendation 3d

The Department of Health Care Policy and Financing should improve controls to prevent Medicaid payments for services to deceased individuals by:

d. Enhancing its efforts in educating providers on claims payment issues surrounding clients' date of death, including proper death notification and billing for services during the month of death.

Health Care Policy and Financing's Initial Response:

Agree.
Original Implementation Date: June 2010 and ongoing.

The Department will enhance efforts to educate providers on claim payment issues surrounding clients' date of death including death notification and billing for services during the month of the death. Specific actions that will be taken to educate providers regarding payment issues surrounding clients' date of death will include updating the billing manuals to identify the Department's expectations and procedures to be followed regarding claims for services provided in the month of the death and releasing a provider bulletin article identifying the same expectations.

Health Care Policy & Financing's August 2010 Update:

In Progress.

Draft policy for payments following date-of-death has been completed for each provider type. However, implementation of this recommendation has been delayed pending finalization of these payment policies.

Once confirmed by the Department's program and policy staff and management, billing manual updates will begin and articles published in the provider bulletin.

Implementation of this recommendation has been delayed due to competing priorities and shortage of resources.

New Implementation Date: December 2010.

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Recommendation 4a:

The Department of Health Care Policy and Financing should improve its monitoring of and communication with Medicaid durable medical equipment and supplies providers by:

a. Performing periodic clinical reviews of providers, preferably on-site, to assess whether claims paid by the Medicaid Program meet medical necessity, prior authorization, and other clinical requirements. The Department should use a risk-based approach to select a sample of providers to visit each year. Additionally, the Department should report all deficiencies identified during the reviews to providers, ensure that providers correct deficiencies in a timely manner, and recover any unallowable claims payments identified.

Health Care Policy and Financing's Initial Response:

Partially Agree. Implemented and Ongoing.

The Department does not currently have adequate numbers of Program staff to perform onsite clinical reviews of durable medical equipment providers. Clinical reviews as described in this recommendation will require program staff time and travel expenses that are not expectations for current resources at the Department. The Department will explore the feasibility of requesting the needed resources.

As an alternative to regular Program onsite reviews of DME providers, Program Integrity has recently implemented an enhanced utilization reporting tool that determines a statistically sound peer comparison of provider claims ranking providers in order of highest outlier claims, referred to as "excepting providers". Identifying providers with the highest abnormal billing patterns allows the Department to assign available resources to focus on the excepting providers for further review. Post payment reviews can be performed by Program Integrity staff on the highest ranking excepting providers. As resources permit the Department will work with providers to encourage on-site reviews. Deficiencies found in these reviews are reported to the provider and recovery of unallowable payments is required.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES, LABORATORY AND RADIOLOGY SERVICES PERFORMANCE AUDIT DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S AUGUST 2010 STATUS UPDATE

Health Care Policy & Financing's August 2010 Update:

The Medicare and Medicaid Data Matching Project (Medi Medi) has assigned four investigators to Colorado for the week of June 14, 2010 to interview clients to determine whether services and items were actually rendered and delivered. Any aberrant findings will be further investigated by the Health and Human Services-Office of Inspector General and Colorado's Medicaid Fraud Control Unit.

Program Integrity continues to utilize an enhanced reporting tool "ESURS" to determine statistically sound peer comparison of provider claims which ranks providers in order of highest outlier claims, referred to as "excepting providers". Identifying providers with the highest abnormal billing patterns allows the Department to assign available resources to focus on the excepting providers for further review.

Implementation Date: Implemented and Ongoing.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES, LABORATORY AND RADIOLOGY SERVICES PERFORMANCE AUDIT DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S AUGUST 2010 STATUS UPDATE

Recommendation 4b:

The Department of Health Care Policy and Financing should improve its monitoring of and communication with Medicaid durable medical equipment and supplies providers by:

b. Developing uniform standards for providers to follow for the purchase and billing of new and used equipment and related-party purchases and referrals. The Department should ensure compliance with these requirements as part of its reviews of providers and new provider enrollment process.

Health Care Policy and Financing's Initial Response:

Agree.
Implementation Date: June 2010

The Department will work collaboratively with stakeholders to develop uniform procedures for all durable medical equipment providers to follow based on requirements identified in 10 CCR 2505-10, Sections 8.590.7.G.2 & 8.590.7.A. Compliance to these procedures will be monitored through post payment reviews conducted by the Program Integrity section.

Health Care Policy & Financing's August 2010 Status Update:

This recommendation has been implemented. Suppliers have been educated about the used equipment policy and the related party policies of the Department through scheduled trainings and the stakeholder advisory committee. The rules state that a client and provider can negotiate a price for trading-in unused medical equipment, which then allows a client to use the trade-in allowance to reduce the cost of new equipment. The Department will continue to work with stakeholders to monitor and develop policy as needed.

In reference to related-party purchases and referrals, the recommendation has been implemented through existing provider education and the DME Advisory Committee announcements.

Implementation Date: Implemented and Ongoing.

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Recommendation 4c:

The Department of Health Care Policy and Financing should improve its monitoring of and communication with Medicaid durable and medical equipment and supplies providers by:

c. Regularly updating is provider manual and bulletins to include detailed information about providers' responsibilities for maintaining documentation in each client's medical record.

Health Care Policy and Financing's Initial Response:

Agree.
Original Implementation Date: March 2010

Providers' responsibility regarding the maintenance of client and services documentation is noted in the provider's agreement and is included in current billing training for providers. The Department will update its provider application and training materials to include detail regarding the responsibility of providers to retain documentation. The Department will periodically and at least bi-annually publish a reminder in its provider bulletin of providers' responsibility regarding records retention.

Health Care Policy & Financing's August 2010 Status Update:

Partially Implemented.

The January, 2010 Provider Bulletin contained a front page article reminding providers of their responsibilities regarding dual-eligible clients and records retention. Updating of the provider billing manuals is in progress. A schedule for periodic reminders via the Department's provider bulletin has been established.

Implementation of this recommendation has been delayed due to competing priorities and shortage of resources.

New Implementation Date: September 2010

Recommendation 4d:

The Department of Health Care Policy and Financing should improve its monitoring of and communication with Medicaid durable medical equipment and supplies providers by:

d. Strengthening communications with providers and educating them about the Medicaid Program and technical assistance available to them from the Department and its contractors. This should include providing additional training and forums to providers statewide.

Health Care Policy and Financing's Initial Response:

Agree. November 2009 and ongoing.

The Department has already taken steps to meet this recommendation. The Department updated its Durable Medical Equipment (DME) Prior Authorization Request (PAR) and claims training material in September 2009. Continued communications and training will occur via the monthly provider Bulletins and at the Durable Medical Equipment Advisory Committee meetings. Committee meetings will include a call-in line for providers and clients unable to be present. Updated DME information will be included in the statewide billing and prior authorization training conducted by the fiscal agent.

Health Care Policy & Financing's August 2010 Status Update:

As indicated in the Department's original response, this recommendation is implemented.

Implementation Date: Implemented and ongoing.

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Recommendation 5a:

The Department of Health Care Policy and Financing should improve its oversight of Medicaid laboratory and radiology providers by:

a. Performing periodic clinical reviews, preferably on-site of laboratory and radiology providers to assess whether providers comply with the six criteria established in state regulations related to laboratory and radiology services. The Department should use a risk-based approach to select a sample of providers to visit each year. Additionally, the Department should report all deficiencies identified during the reviews to providers, ensure that providers correct deficiencies in a timely manner, and recover any unallowable claims payments identified.

Health Care Policy and Financing's Initial Response:

Partially Agree. Implemented and Ongoing.

The Department does not currently have adequate numbers of Program staff to perform onsite clinical reviews of laboratory and radiology providers. Clinical reviews as described in this recommendation will require program staff time and travel expenses that are not expectations for current resources at the Department. The Department will explore the feasibility of requesting the needed resources.

As an alternative to regular Program onsite reviews of laboratory and radiology providers, Program Integrity has recently implemented an enhanced utilization reporting tool that determines a statistically sound peer comparison of provider claims ranking providers in order of highest outlier claims, referred to as "excepting providers". Identifying providers with the highest abnormal billing patterns allows the Department to assign available resources to focus on the excepting providers for further review. Post payment reviews can be performed by Program Integrity staff on the highest ranking excepting providers. As resources permit, the Department will work with providers to encourage on-site reviews. Deficiencies found in these reviews are reported to the provider and recovery of unallowable payments is required.

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Health Care Policy & Financing's August 2010 Status Update:

Program Integrity has dedicated a reviewer to monitor radiology and laboratory providers. Excepting reports have already been built and these providers are being monitored for aberrant billing patterns. Desk audits are planned to begin in calendar year 2011 to see if provider source documentation substantiates their claims for reimbursement, for prior authorized services/items, and for physician orders for all services/items to confirm medical necessity. Data analyses are underway and excepting providers will be receiving request for records to initiate desk audits.

Implementation Date: Implemented and Ongoing.

Recommendation 5b:

The Department of Health Care Policy and Financing should improve its oversight of Medicaid laboratory and radiology providers by:

b. Periodically reviewing laboratory and radiology claims to ensure that it has not double paid for the technical and professional components of these services. The Department should also review claims for these services to determine if it pays higher rates through split billing rather than global billing and consider modifying its policies to control costs paid for these services (e.g., only paying claims on a global basis).

Health Care Policy and Financing's Initial Response:

Agree. October 2009.

The Program Integrity Unit has recently implemented an enhanced utilization reporting tool, the Enterprise Surveillance Utilization Reporting System (ESURS), that determines a statistically sound peer comparison of provider claims ranking providers in order of highest outlier claims, referred to as "excepting providers". Identifying providers with the highest abnormal billing patterns allows the Department to assign available resources to focus on the excepting providers for further review. The excepting providers become internal generated referrals that receive a preliminary investigation to determine if a full investigation is needed. If a full investigation is needed, records are requested and reviewed, clients can be interviewed and an onsite inspection could be scheduled. The merits of each individual case will drive investigative steps.

This tool will allow the Department to monitor laboratory and radiology claims to ensure that Medicaid has not double paid for the technical and professional components of these services. In addition, we can review paid claims data for these same services to determine if there is unbundling (paying higher rates through split billing rather than global billing.)

ESURS queries are currently being designed. Report results will be available by October 31, 2009 with monthly surveillance cycles.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES, LABORATORY AND RADIOLOGY SERVICES PERFORMANCE AUDIT DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S AUGUST 2010 STATUS UPDATE

Health Care Policy & Financing's August 2010 Status Update:

Program Integrity has dedicated a reviewer to monitor radiology and laboratory providers. Excepting reports have already been built and these providers are being monitored for aberrant billing patterns. Desk audits are planned to begin by June 30, 2010 to see if provider source documentation substantiates their claims for reimbursement, for prior authorized services/items, for physician orders for all services/items to confirm medical necessity, and to monitor for upcoding or unbundling of services. Data analyses are underway to determine whether professional and technical claims are being paid in excess of policy. Excepting providers will be analyzed to determine which will be receiving request for records to initiate desk audits.

Implementation Date: Implemented and Ongoing.

Recommendation 5c:

The Department of Health Care Policy and Financing should improve its oversight of Medicaid laboratory and radiology providers by:

c. Developing utilization and cost trend reports to (1) identify drivers of program cost for laboratory and radiology services and (2) monitor aberrant patterns in patient or provider utilization that could signify the need for medical chart review or provider discussion. The Department could use this information as part of its risk-based approach for selecting laboratory and radiology providers for clinical reviews.

Health Care Policy and Financing's Initial Response:

Agree. October 2009.

Regarding utilization and cost trend reports, the Benefits Management department now gets regular reports on cost and utilization for laboratory and radiology services.

Program Integrity has recently implemented an enhanced utilization reporting tool, the Enterprise Surveillance Utilization Reporting System (ESURS), that determines a statistically sound peer comparison of provider claims ranking providers in order of highest outlier claims, referred to as "excepting providers". Identifying providers with the highest abnormal billing patterns allows the Department to assign available resources to focus on the excepting providers for further review. The excepting providers become internal generated referrals that receive a preliminary investigation to determine if a full investigation is needed. If a full investigation is needed, records are requested and reviewed, clients can be interviewed, and an onsite inspection could be requested under Section 25.5-4-301(d3)(a)(IV), C.R.S. The merits of each individual case will drive investigative steps.

This tool will allow the Department to monitor laboratory and radiology claims and modify policies to ensure that Medicaid has not double paid for the technical and professional components of these services. In addition, we can review paid claims data for these same services to determine if there is unbundling (paying higher rates through split billing rather than global billing.)

DURABLE MEDICAL EQUIPMENT AND SUPPLIES, LABORATORY AND RADIOLOGY SERVICES PERFORMANCE AUDIT DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S AUGUST 2010 STATUS UPDATE

Health Care Policy & Financing's August 2010 Status Update:

As indicated in the Department's original response, this recommendation is implemented and ongoing.

Implementation Date: Implemented and ongoing.

Recommendation 5d:

The Department of Health Care Policy and Financing should improve its oversight of Medicaid laboratory and radiology providers by:

d. Considering implementing a prior authorization process for high-cost procedures (e.g., MRIs and CAT scans).

Health Care Policy and Financing's Initial Response:

Agree.
Original Implementation Date: July 2011

Effective August 1, 2009, the Department initiated a prior authorization review process for all non-emergent CAT scans and MRIs and all PET scans performed in free standing radiology centers. Requirements to perform prior authorization review for all non-emergent CAT scans and MRIs and all PET scans performed in outpatient hospital settings will be initiated once requested system changes are made to the Medicaid Management Information System (MMIS). The MMIS changes are expected to be completed by July 2011.

Health Care Policy & Financing August 2010 Status Update:

Partially Implemented.

A prior authorization requirement (PAR) was implemented for non-emergent MRIs and CAT scans.

The current system does not allow us to PAR institutional claims, so a systems change will be needed to implement that piece, but services billed on a 1500 are being prior authorized.

Implementation Date: July 2011

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Recommendation No. 6a:

The Department of Health Care Policy and Financing should strengthen contract provisions and its monitoring of contractors responsible for performing prior authorization reviews of durable medical equipment and supplies requested for Medicaid clients by:

a. Standardizing the requirements in its contracts related to prior authorization and medical necessity activities for durable medical equipment and supplies.

Health Care Policy and Financing's Initial Response:

Agree.
Original Implementation Date: July 2010

The Department agrees that there is an opportunity to strengthen the contract provisions and monitoring of contractors responsible for performing prior authorization review of durable medical equipment. Changes to contract provisions may include revised performance requirements, including activities, timeframes, reporting, staffing expectations, and interactions with the Department, among others. The Department is currently reviewing requirements for Prior Authorization Request (PAR) reviews.

Health Care Policy & Financing August 2010 Status Update:

In Progress.

Standardized contract language and increased performance requirements are part of vendor consolidation, which will occur with the re-procurement of the Quality Improvement Organization (QIO) contract now scheduled to take place in FY 10-11. This consolidation was authorized in a 2009 budget decision item to strengthen contract provisions -- improving review consistency, streamlining authorization processes, and achieving administrative savings. The new implementation date reflects additional time required for utilization program re-design -- part of the Department's Evidence-Guided Utilization Review initiative, which preceded the procurement process. The Department, in this contract, seeks to de-emphasize process in favor of outcomes. It will include performance incentives as well as extensive liquidated damages for non-performance. Contractually defined outcomes include rapid authorization response times enabled through Web-based algorithms; reduced administrative burden through a single provider portal and structured data submission using fax or optical character recognition; defined key personnel and new accreditation requirements for program oversight; adaptive program plan to benchmark, anticipate trends, and project return-on-investment for proposed activities throughout the contract year; and other goals. In the meantime, the Department has made progress on several fronts to strengthen contractor oversight. This includes on- and off-site meetings with CFMC; intensive review of nurse advice line operations; a new system for reviewing outpatient diagnostic imaging; new advanced review criteria for hospital re-admissions; increased review clarity provided through the Benefits Collaborative initiative, which is defining program benefits scope, amount and duration; and other activities.

New Implementation Date: March 2011.

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Recommendation No. 6b:

The Department of Health Care Policy and Financing should strengthen contract provisions and its monitoring of contractors responsible for performing prior authorization reviews of durable medical equipment and supplies requested for Medicaid clients by:

b. Strengthening the contracts by defining the qualifications of staff performing prior authorization and medical necessity functions. At a minimum, the Department should ensure that physicians oversee these functions. Additionally, the Department should consider adopting best practices and require registered nurses to conduct prior authorization reviews.

Health Care Policy and Financing's Initial Response:

Partially Agree.
Original Implementation Date: July 2010

The Department agrees that its contracts should reference qualifications of staff performing prior authorization and medical necessity functions. Qualifications must at a minimum conform to federal regulations such as those defined in 42 C.F.R. Section 476.98(a), which requires peer review by physician. However, it is not clear that all staff overseen by physician reviewers must be RNs. The Department will seek guidance from the accreditation agencies referenced in the audit report as it seeks to strengthen contract language around staff qualifications. The Department plans to include revised contract language regarding staff qualifications in the new contract scheduled to go into effect July 2010.

Health Care Policy & Financing's August 2010 Status Update:

In Progress.

Revised language in the Request-for-Proposal for a new QIO contract which will consolidate durable medical equipment and supplies review includes a requirement that review staff meet national standards set by Utilization Review Accreditation Commission (URAC) or another nationally recognized quality review credentialing body. A new contract is targeted to be in place March 2011. The new contract implementation date reflects additional time required for utilization program re-design -- part of the Department's Evidence-Guided Utilization Review initiative, which preceded the procurement process.

New Implementation Date: March 2011

DURABLE MEDICAL EQUIPMENT AND SUPPLIES, LABORATORY AND RADIOLOGY SERVICES PERFORMANCE AUDIT DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S AUGUST 2010 STATUS UPDATE

Recommendation No. 6c:

The Department of Health Care Policy and Financing should strengthen contract provisions and its monitoring of contractors responsible for performing prior authorization reviews of durable medical equipment and supplies requested for Medicaid clients by:

c. Implementing a formal oversight program for each of its prior authorization contractors, including on-site visits.

Health Care Policy and Financing's Initial Response:

Agree.
Original Implementation Date: July 2010

Although the Department currently conducts site visits with prior authorization vendor ACS, the Department plans to formalize a system of oversight for both utilization review vendors (CFMC and ACS), taking advantage of existing contract provisions that allow for site visits, performance reviews, and corrective action requests largely at the discretion of the Department. The Department's focus with both prior authorization vendors in the near term will be on conformance with federal regulations and operational issues identified in the audit report. When a new durable medical equipment utilization review vendor contract is in place in July 2010, energy will be directed toward the monitoring of new processes – including automated authorization systems as well as medical reviewers – along with defined performance goals, which the Department anticipates will be a core element of the new contract.

Health Care Policy & Financing's August 2010 Status Update:

In Progress.

The Department intends to further increase vendor oversight through a new performance-based contract that will consolidate authorization review activities with one vendor in March 2011. The Department did conduct an onsite visit with CFMC in FY 09-10 to clarify expectations and set the stage for further oversight activities. It also has used monthly operations meetings including both ACS and CFMC to strengthen oversight and increase vendor accountability. One example of progress is a recent project where this group reviewed a list of infrequently used billing codes where review responsibility was unclear. The result was assignment of these codes to ACS and CFMC, replacing indecision and delays when one vendor would assume the other should be accountable. The Department also strengthened vendor oversight by clarifying of benefits through its Benefits Collaborative initiative – including amount, scope and duration; creating a formalized review process for outpatient radiology; refining and clarifying the Department's hospital readmissions review policy; undertaking an intensive review of the nurse advice line; and other oversight activities.

New Implementation Date: March 2011

**DURABLE MEDICAL EQUIPMENT AND SUPPLIES,
LABORATORY AND RADIOLOGY
SERVICES PERFORMANCE AUDIT
DEPARTMENT OF HEALTH CARE POLICY & FINANCING'S
AUGUST 2010 STATUS UPDATE**

Recommendation No. 6d:

d. Requiring its prior authorization contractors to standardize how providers submit prior authorization requests, including the use of electronic processing and interfaces.

Health Care Policy and Financing's Initial Response:

Agree.
Original Implementation Date: July 2010

The Department agrees that each utilization review vendor has established separate processes by which providers submit prior authorization requests. Where possible, the use of web, fax, and telephonic systems will be maximized for enhanced quality and service to the Departments clients and providers.

When a new durable medical equipment utilization review vendor contract is in place in July 2010, energy will be directed toward automated systems, including use of a Web portal for provider prior authorization requests as well as algorithms to obviate human medical review where possible for faster response times.

Health Care Policy & Financing's August 2010 Status Update:

In Progress.

QIO contract re-procurement to be completed in winter 2011 is set to standardize submission for all DME and supply review activities along with other types of reviews. The new contract will require a centralized Web portal for structured submission and response capabilities. The new implementation date reflects additional time required for utilization program re-design. The re-design is part of the Department's Evidence-Guided Utilization Review initiative, which preceded the procurement process.

New Implementation Date: March 2011

Recommendation No. 6e:

e. Assessing whether consolidating prior authorization functions under one contract would be cost-effective.

Health Care Policy and Financing's Initial Response:

Agree.
Original Implementation Date: July 2010

The Department agrees that there would be benefits from having all PAR responsibilities consolidated under one vendor. The Department will look into the feasibility of consolidating these activities with one vendor.

Health Care Policy & Financing's August 2010 Status Update:

In Progress.

The Department has received legislative approval to consolidate review activities with one vendor. This consolidation is set to take place in March 2011.

New Implementation Date: March 2011.

Recommendation 7:

The Department of Health Care Policy and Financing should hold its management staff accountable for the effectiveness of its data systems and for timely, accurate, and complete responses to audit and other information requests by oversight agencies. This expectation should be included in each applicable manager's annual performance plan, and managers should be evaluated on this factor annually. Additionally, the Department should evaluate options for enhancing its data systems to ensure staff are able to retrieve accurate, complete, and timely information from the systems.

Health Care Policy and Financing's Initial Response:

Partially Agree. Implemented.

The Department agrees that it is responsible for timely, accurate and complete audit responses, information and data and has processes in place to accomplish this task. The Department conducts quality reviews on data and information given to the public and the General Assembly. However, the Department disagrees with some of the conclusions drawn in this audit report. The Department has responded timely and accurately to many federal and state audits and was recently complimented by the federal Centers for Medicare and Medicaid Services during a program integrity audit for being responsive and able to provide information and data quickly and accurately.

The Department communicated with the Office of the State Auditor (OSA) at the beginning of the audit that the Department did not have the resources for five external State audits along with several federal audits being conducted simultaneously. A decision was made between the Department and the OSA to delay the audit but pursue the data requests. Initially the Department stated that it would take six months to provide the data outlined in the 18 page data request from Mercer. However, in good faith the Department attempted to expedite the data request to work with the OSA in completing the audit.

The Department feels it already has adequate processes for retrieving accurate, complete, and timely information, however, translating the auditor's requested information from the normal structure used in the claims adjudication system required extensive time mapping the Department's native data from the existing structure into the table and file layouts requested for the audit. More importantly, the complexities of the data and claims adjudication process required that Mercer clearly understand how the data are used and the details of claims adjudication.

As an example, Mercer was provided with all the necessary information and data to accurately analyze and review the third party claims. However, Mercer did not consult with the Department while conducting the analysis and used an inappropriate field to assess these claims even though the correct field and data had been provided. Had Mercer discussed this with Department staff, they would have been able to use to the appropriate field in the first analysis and perhaps provide a more meaningful recommendation.

As part of the Department's continued effort toward improvement, the Department will continue to

review its data systems and processes to find any opportunities to improve the data retrieval for audits. The Department will continue to hold its staff accountable for data and information during audits.

Health Care Policy & Financing's August 2010 Status Update:

As noted in the Department's original response, this recommendation has been implemented. Since the time of the audit, the Department has continued to provide data in a timely and accurate manner to the Office of the State Auditor (OSA) and numerous federal oversight bodies. To improve the Department's existing processes, when extensive data request are made from OSA or federal oversight bodies, the Department now asks that the requester meet in person with Department staff to discuss the data request and the data elements. This helps to ensure that the external customer receives the information requested and understands the data fields and data layout. The Department has found this process to be useful. The Department will continue to hold its staff accountable for data and information during audits.

In addition, as part of the Departments continuous quality improvement efforts and to leverage technology more efficiently, the Department has instituted the following data tools:

1. TOAD for Data Analysis –This is a new Sequel computer language software that can be used to extract large volumes of data from the Colorado Rates database.

2. New Business Intelligence tool - Cognos, allows the Department to do more in-depth analysis.

3. The Medicaid Management Information System/ Decision Support System (DSS) upgrade. The Department is currently replacing all servers for the DSS. This should allow for faster data retrieval and more disk space.

Implementation Date: Implemented.