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of the State Auditor

Department of Health Care Policy and Financing

***Controls Over Medicaid Claims for
Durable Medical Equipment and Supplies,
Laboratory, and Radiology Services
Performance Audit
October 2009***

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This report contains the result of a performance audit of payment controls and prior authorization/medical necessity practices used by the Department of Health Care Policy and Financing and its contractors to provide durable medical equipment and supplies, laboratory, and radiology services to Medicaid clients. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions and agencies of state government. The State Auditor contracted with Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, to conduct this performance audit in accordance with *Generally Accepted Government Auditing Standards*. This report presents our findings, conclusions and recommendations, as well as the responses of the Department of Health Care Policy and Financing.

Phoenix, Arizona
October 16, 2009

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Glossary of Terms and Abbreviations

ACS - Affiliated Computer Services, Inc. The fiscal agent for the State's Medicaid program client service plans.

CBMS - Colorado Benefits Management System. The information system used by the Department of Health Care Policy and Financing to maintain eligibility information for Medicaid clients.

CCR - Code of Colorado Regulations. The administrative rules of the executive agencies of the State of Colorado.

CDPHE - Colorado Department of Public Health and Environment. A principal department in Colorado government whose mission is to protect and preserve the health and environment of the people of Colorado and which is responsible for maintaining information on death certificates and other vital records.

CFMC - Colorado Foundation for Medical Care. Colorado's Quality Improvement Organization that, among other activities, reviews prior authorization requests for high-cost durable medical equipment—such as hospital beds, motorized lifts, respiratory devices, and certain prosthetic and orthotic equipment, for medical necessity.

CFR - Code of Federal Regulations. The codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government. These rules govern federally funded programs, such as Medicaid.

CLIA - Clinical Laboratory Improvement Amendments of 1988. The program standards used by the Centers for Medicare and Medicaid Services to regulate laboratories and ensure quality laboratory testing.

CMS - Centers for Medicare and Medicaid Services. The federal agency that regulates state Medicaid programs.

Department - Department of Health Care Policy and Financing. A principal department in Colorado state government that is ultimately responsible for administering the State's Medicaid program.

HMS - Health Management Systems. The organization that HCPF contracts with to conduct post payment review and recovery of Medicaid claims.

Judgmental, non-statistical sample - Sample is selected by the exercise of judgment, and not by chance. The results of judgmental, non-statistical samples cannot be extrapolated to the population as a whole.

MMIS - Medicaid Management Information System. The automated system used to maintain all billing claims and payment records for the State's Medicaid program.

PCPP - Primary Care Physician Program. A managed healthcare plan for Colorado Medicaid participants. Participants in this program choose a primary care provider to manage their medical care.

PIHP - Prepaid Inpatient Health Plan. Provides certain medical services to Medicaid enrollees under contract with HCPF, on the basis of prepaid capitation payments, or other payment arrangements that do not use state Medicaid plan payment rates. PIHPs provide, arrange for, or otherwise are responsible for the provision of any inpatient hospital or institutional services for their enrollees.

SSA - Social Security Administration. Federal agency responsible for managing the Nation's largest retirement entitlement programs, including the Retirement, Survivors, and Disability Insurance programs.

Controls Over Medicaid Claims for Durable Medical Equipment and Supplies, Laboratory, and Radiology Services Department of Health Care Policy and Financing October 2009

Purpose and Scope

This performance audit focused on the payment controls and the prior authorization and medical necessity practices used for durable medical equipment and supplies, laboratory, and radiology services provided to Medicaid clients in Colorado. Audit work was conducted from May 2008 through October 2009. The purpose of the audit was to: (1) identify Medicaid payments that were unallowable because the service was not covered by Medicaid or because Medicare should have paid all or a portion of the claim, (2) determine if claims were reimbursed at the appropriate fee-for-service rates, (3) determine if claims were paid for services delivered after a Medicaid client's date of death, and (4) verify that appropriate prior authorization processes were in place to ensure medical necessity. The audit scope did not include a review of services by and payments made to the health maintenance organizations under contract with the Department. Further, we were unable to complete our review of claims involving third party payers due to Department staff reporting to us late in the audit that the data file provided to us was not validated for accuracy and could not be relied upon for our analysis.

The Office of the State Auditor contracted with Mercer Government Human Services Consulting (Mercer) to conduct the audit. Mercer 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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Overview

Medicaid (Title XIX of the Federal Social Security Act) is a federally and state funded program that provides health care coverage to low income individuals, families, and persons with disabilities. Federal law requires certain basic services be available to all Medicaid recipients, such as physician's services, hospital services, laboratory and radiology services, and nursing facility services for persons age 21 and older. Federal requirements give states flexibility to determine other services to provide to their Medicaid clients. One optional coverage area for most Medicaid clients is durable medical equipment and supplies, which include items such as wheelchairs, prosthetic devices, hearing aids, support stockings, disposable diabetic supplies, and oxygen. However, if individuals are eligible for nursing facility services but choose to remain in their homes, states are required to provide them with durable medical equipment and supplies.

By statute, the Colorado Department of Health Care Policy and Financing (the Department) is the single state agency responsible for the administration of medical assistance programs,

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Controls Over Medicaid Claims for Durable Medical Equipment and Supplies, Laboratory, and Radiology Services Performance Audit – October 2009

including Medicaid, in Colorado. For Fiscal Year 2009 the Department spent about \$77 million for durable medical equipment and supplies and about \$28.4 million on laboratory and radiology services (e.g., x-rays, magnetic resonance imaging, computerized axial tomography scans). Nearly 436,800 individuals were enrolled in Colorado's Medicaid Program during this year.

Key Findings

Payment Controls

Payment controls, such as targeted claim reviews and on-site visits of providers, are essential to prevent and detect inappropriate payments for durable medical equipment and supplies, laboratory, and radiology claims. We identified questioned costs totaling about \$34,110 due to problems with payment controls in the following areas:

Payments for claims on behalf of dual-eligible clients. Of the 75 claims we reviewed for dual-eligible clients, the Department should have denied or recouped payment for 58 claims (77 percent) totaling \$18,590. We identified several reasons for the payment errors, including the Department's failure to recoup payments for 41 claims made for clients retroactively determined to be eligible for both Medicaid and Medicare benefits, a the lack of evidence to show that providers billed Medicare first for 13 claims in the sample, 2 claims where the provider was paid by both Medicare and Medicaid, and 2 claims where the explanation of benefits provided by the provider did not match the claim.

Payments paid in excess of maximum allowable rates. We identified about 69,420 claims for durable medical equipment and supplies, laboratory, and radiology services that appeared to have been paid at amounts above the Department's rate schedule. We judgmentally selected a non-statistical sample of 200 of these claims for further review. For 175 of the 200 claims, the Department informed us that the claims were paid using pricing methodologies not provided to us. Since it was too late in the audit to review these pricing methodologies, these 175 claims were excluded from the sample. For the remaining 25 claims totaling \$1,090 in payments, the Department did not apply the correct Medicare lower of pricing logic. The Department could not explain why these 25 claims were excluded from the lower of pricing requirements.

Medicaid claims paid after date of death. We identified 1,239 claims totaling about \$148,340 in payments for service dates after the client's date of death. We selected 279 of these claims (23 percent) to review, and found that 195 claims (70 percent) totaling about \$14,430 were not paid appropriately.

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Controls Over Medicaid Claims for Durable Medical Equipment and Supplies, Laboratory, and Radiology Services Performance Audit – October 2009

Administration

Prior authorization programs are important for decreasing unnecessary or redundant services, controlling costs, educating providers about appropriate application of program guidelines, and monitoring the quality of care. We noted the following problems with prior authorization practices, including questioned costs of about \$3,400:

Oversight of durable medical equipment and supplies providers. For 90 claims judgmentally selected from three of the largest providers of durable medical equipment and supplies in Colorado, we questioned about \$2,940 in payments made for 12 claims (13 percent) due to noncompliance with medical necessity and prior authorization requirements. For example, we found seven claims where there was no prescription or physician order in the provider's records that authorized the provision of the equipment or supplies to the client. For another three claims, the prior authorization document in the providers' files did not support the claim paid.

Oversight of laboratory and radiology providers. For 180 claims judgmentally selected from claims submitted by three laboratory providers and three radiology providers, we questioned about \$460 in payments made for nine claims (5 percent) because payments did not meet medical necessity criteria. For example, we identified five claims where the files did not include a physician's order or authorization. Additionally, we found that billing methods allowed by the Department create a risk that providers could double bill for these services.

Oversight of prior authorization contractors. We identified concerns with contract provisions and the Department's oversight of its two prior authorization contractors for durable medical equipment and supplies—Affiliated Computer Services (ACS) and Colorado Foundation for Medical Care (CFMC). Specifically, we found: (1) the ACS contract provisions are not as robust as those in the CFMC contract; (2) unqualified staff are approving and denying services without physician oversight because contracts do not require the decisions to be made by staff with minimum qualifications; (3) the Department relies upon self-reported data from the contractors and does not perform on-site reviews to verify the data or assess contract compliance; and (4) the Department has not evaluated the costs and benefits of contracting with two separate organizations to provide these services.

Data management. The Department was unable to provide complete, accurate, and timely data from MMIS at key points in the audit. This information is essential both for managing the Medicaid Program and for responding timely to federal and state oversight agencies. The data problems caused significant delays in our completion of this audit and limited our ability to test some payment controls used by the Department.

Our recommendations and responses from the Department of Health Care Policy and Financing can be found in the Recommendation Locator and in the body of the report.

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RECOMMENDATION LOCATOR
Agency Addressed: Department of Health Care Policy and Financing

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
1	20	Ensure Medicare is the primary payer on claims for dual-eligible Medicaid clients by: (a) revising policies, as necessary, to require providers to submit a Medicare explanation of benefits for paper claims after Medicare makes a payment determination; (b) analyzing the paid claims for all clients whose eligibility changed from Medicaid-only to dual-eligible and instituting recovery action when required; (c) instituting a quarterly audit of all claims paid for dual-eligible clients to identify claims paid incorrectly and seek recoupment from providers, when necessary; and (d) enhancing efforts to educate providers about the Department's billing policies and processes for claims associated with dual-eligible clients.	a. Agree b. Agree c. Agree d. Agree	a. December 2011 b. Implemented c. Implemented d. March 2010
2	24	Review the policy excluding certain procedures from the Medicare lower of pricing logic to assess the appropriateness of these exclusions, justify in writing the reasons for these exclusions if the Department decides to keep them in its policy, and work with the federal Centers for Medicare and Medicaid Services to determine whether an amendment to Colorado's State Plan should have been submitted related to these exclusions and whether any payments made for claims falling under these exclusions should be recovered.	Agree	January 2011
3	27	Improve controls to prevent Medicaid payments for services 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; (b) working with its contractor to expand data matches and recoveries for claims paid after a client's death to include oxygen services and other rental supplies; (c) continuing to investigate the claims identified by this audit that were paid for services provided after the date of death and recover any inappropriate payments; and (d) enhancing efforts in educating providers on claims payment issues surrounding clients' date of death.	a. Agree b. Agree c. Partially Agree d. Agree	a. July 2010 b. July 2011 c. July 2010 d. June 2010
4	36	Improve 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 meet medical necessity, prior authorization, and other clinical requirements; (b) developing uniform standards for providers to follow for the purchase and billing of new and used equipment and related-party purchases and referrals; (c) regularly updating its provider manual and bulletins to include detailed information about provider's maintenance of documentation in each client's medical record; and (d) strengthening communication with providers and educating them about the Medicaid Program and technical assistance available to them.	a. Partially Agree b. Agree c. Agree d. Agree	a. Ongoing b. June 2010 c. March 2010 d. November 2009

RECOMMENDATION LOCATOR
Agency Addressed: Department of Health Care Policy and Financing

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
5	41	Improve oversight of Medicaid laboratory and radiology providers by: (a) performing periodic clinical reviews of providers, preferably on-site, to assess whether they comply with the six applicable criteria established in state regulations; (b) periodically reviewing laboratory and radiology claims to ensure the Department has not double paid for the technical and professional components of these services and consider modifying policies to control costs paid for these services; (c) developing utilization and cost trend reports to identify drivers of program cost for laboratory and radiology services and monitor aberrant patterns in patient or provider utilization; and (d) considering implementing a prior authorization process for high-cost procedures (e.g., magnetic resonance imaging and computerized axial tomography scans).	a. Partially Agree b. Agree c. Agree d. Agree	a. Ongoing b. October 2009 c. October2009 d. July 2011
6	47	Strengthen contract provisions and monitoring of contractors responsible for performing prior authorization reviews for durable medical equipment and supplies requested for Medicaid clients by: (a) standardizing requirements in contracts related to prior authorization and medical necessity activities; (b) strengthening contracts by defining qualifications of staff performing prior authorization and medical necessity functions; (c) implementing a formal oversight program for each of its prior authorization contractors; (d) requiring prior authorization contractors to standardize how providers submit prior authorization requests; and (e) assessing whether consolidating prior authorization functions under one contract would be cost-effective.	a. Agree b. Partially Agree c. Agree d. Agree e. Agree	a. July 2010 b. July 2010 c. July 2010 d. July 2010 e. July 2010
7	52	Hold management staff accountable for the effectiveness of data systems and for timely, accurate, and complete responses to audit and other information requests by oversight agencies; include this expectation in each applicable manager's annual performance plan and evaluate managers on this factor annually; and evaluate options for enhancing data systems to ensure staff are able to retrieve accurate, complete, and timely information from the systems.	Partially Agree	Implemented

Background and Description

Chapter 1

The Medicaid Program

Medicaid (Title XIX of the Federal Social Security Act) is a federally and state funded program that provides health care coverage to low income individuals, families, and persons with disabilities. Subject to certain optional coverage groups, such as low-income adults with no children, any state participating in the program must serve all eligible and enrolled individuals. Under federal law, Medicaid benefits are available to the following populations:

- Low-income families with children
- Recipients of Supplemental Security Income for the Aged, Blind, and Disabled (including disabled children)
- Individuals qualified for adoption assistance agreements or foster care maintenance payments under Title IV-E of the Social Security Act
- Qualified pregnant women
- Newborn children of Medicaid-eligible women
- Various categories of low-income children
- Some low-income Medicare beneficiaries

Federal law requires certain basic services be available to all Medicaid recipients. These federally-required services include:

- Physicians' services
- Hospital services (inpatient and outpatient)
- Laboratory and radiology services
- Early and periodic screening, diagnostic, and treatment services for eligible individuals under 21 years of age
- Federally-qualified health center and rural health clinic services
- Family planning services and supplies
- Pediatric and family nurse practitioner services
- Nurse midwife services
- Nursing facility services for persons age 21 and older
- Home health care for persons eligible for nursing facility services
- Transportation services

Federal Medicaid requirements give states flexibility to determine what other services to provide to their Medicaid clients. One optional coverage area for most Medicaid clients is durable medical equipment and supplies. For individuals who are eligible for nursing facility services, but choose to remain in their homes, durable medical equipment and supplies are mandatory services. We discuss the types of durable medical equipment and supplies covered by Colorado's Medicaid Program later in this chapter.

Medicaid Program Administration

By statute, the Colorado Department of Health Care Policy and Financing (the Department) is the single state agency responsible for the administration of medical assistance programs, including Medicaid, in Colorado. Determining client eligibility for Medicaid is shared between the Department and local eligibility sites. Individuals and families apply for benefits at their local county departments of human/social services or at designated Medical Assistance sites, which are collectively referred to as eligibility sites. The eligibility sites are responsible for administering the benefit application process, entering the required data for eligibility determination into the Colorado Benefits Management System (CBMS), and approving/denying applicants' eligibility. The Department is responsible for supervising the eligibility sites' administration of the Medicaid Program.

Colorado offers Medicaid services to clients through one of four options: (1) the Primary Care Physician Program (PCPP), (2) a prepaid inpatient health plan (PIHP), (3) a health maintenance organization, or (4) fee-for-service. Under the PCPP and fee-for-service coverage options, the Department contracts directly with providers and reimburses each provider for services delivered to Medicaid clients. Under the PIHP option, the Department contracts with the Rocky Mountain Health Plan (the plan) and pays the plan: (1) a fixed monthly rate per member/per month fee for administrative coordination of services and (2) the fee-for-service rate for the services provided to clients. The plan is then responsible for paying its contracted practitioners for the services they provide to clients. For services delivered through a health maintenance organization, a fixed monthly rate per member/per month (capitated rate) is paid to provide all medically necessary covered services to participants, regardless of the number or type of service provided.

The Department contracts with a fiscal agent—currently Affiliated Computer Services (ACS)—to process provider claims for services rendered under the rules and regulations defined by the Department. As part of its Medicaid State Plan, each state is required by federal regulations to have an automated claims processing and information retrieval system, commonly called the Medicaid

Management Information System (MMIS). In Colorado, ACS manages the MMIS system and uses it to process all Medicaid claims. The Department is responsible for overseeing all fiscal agent activities to ensure ACS makes provider payments in an accurate and timely manner.

The Department contracts with Colorado Foundation for Medical Care (CFMC) and ACS for prior authorization services related to durable medical equipment and supplies. CFMC, which is Colorado's Quality Improvement Organization¹, reviews prior authorization requests and determines medical necessity for high-cost durable medical equipment, such as hospital beds, motorized lifts, respiratory devices, and certain prosthetic and orthotic equipment. In addition to its other fiscal agent responsibilities, ACS reviews prior authorization requests for other types of equipment and supplies, such as equipment repairs, oxygen, and medical supplies. ACS also completes the non-automated data entry for prior authorization requests (including those reviewed by CFMC) and sends notifications of approval or denial of services to clients and providers. It should be noted that during the audit period (State Fiscal Years 2005 through 2007), ACS completed all data entry for prior authorization requests. Partial automation of the process did not occur until late December 2008.

Medicaid Spending

Funding for the Medicaid Program is shared between the federal and state governments, based on a State's per capita income. If a State's per capita income is equal to or greater than the national average, the federal share is 50 percent. If a State's per capita income is lower, the federal share increases. From State Fiscal Years 2005 to 2008, Colorado's share was 50 percent. The American Recovery and Reinvestment Act of 2009 temporarily increased the federal share for every state as of October 1, 2008 by 5.5 percent to 11.5 percent, depending on each State's quarterly increase in unemployment. In Colorado, at the time of the audit, the State's contribution was set at 41.22 percent and the federal match at 58.78 percent.

In Fiscal Year 2009 Colorado spent about \$2.7 billion in federal and state funds on behalf of beneficiaries in its Medicaid Program. During this same year, there were about 436,810 clients enrolled in the program. The table on the next page

¹ The Centers for Medicare and Medicaid Services contracts with one organization in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, to serve as that state/jurisdiction's Quality Improvement Organization (QIO) contractor. QIOs are private, mostly not-for-profit organizations, which are staffed by health care professionals, to review medical care, help Medicare beneficiaries with quality of care complaints, and implement improvements in the quality of care available.

shows Medicaid spending and enrollments in Colorado between State Fiscal Years 2005 and 2009.

Medicaid Program Expenditures and Enrollments State Fiscal Years 2005 Through 2009			
State Fiscal Year	Total Expenditures¹ (in billions)	Enrollments²	Cost Per Enrollee
2005	\$2.0	406,020	\$4,926
2006	\$2.1	402,220	\$5,221
2007	\$2.2	392,230	\$5,609
2008	\$2.4	391,960	\$6,123
2009 ³	\$2.7	436,810	\$6,181
Percent Change 2005 to 2009	+35%	+8%	+25%
Average Annual Percent Change	+8%	+2%	+6%
Source: Medicaid expenditure and enrollment data provided by the Department of Health Care Policy and Financing.			
¹ These figures represent total expenditures on behalf of Medicaid beneficiaries and do not include administrative expenses (e.g., personnel costs, information technology costs) for the Medicaid Program.			
² These figures represent average enrollment during each fiscal year.			
³ The 2009 figures represent the Department's estimates as of July 2009. The final figures will be available in November 2009.			

As shown in the table above, Medicaid spending in Colorado increased an average of about 8 percent per year between State Fiscal Years 2005 and 2009 or 35 percent over the five-year period. Further, Medicaid enrollments increased by an average of 2 percent per year, or 8 percent over these five years and cost per enrollee increased by 6 percent per year, or 25 percent during this time period.

Durable Medical Equipment and Supplies

Colorado elected to make medically necessary durable medical equipment and supplies covered benefits of the Medicaid Program. As mentioned earlier, durable medical equipment and supplies are optional benefits for most Medicaid clients according to federal Medicaid requirements. The Department pays for these services using one of three approaches: (1) fee-for-service payments to providers for all clients enrolled in the PCPP and fee-for-service options, (2) fee-for-service payments to the Rocky Mountain Health Plan for clients enrolled in the PIHP option, and the plan is then responsible for paying its contracted practitioners for these services, or (3) capitation payments for clients enrolled in health maintenance organizations. Durable medical equipment and supplies include equipment ranging from wheelchairs, prosthetic devices, and hearing aids

to support stockings, disposable diabetic supplies, and oxygen. State regulations [10 CCR 2305-10, Section 8.590.2] stipulate that for durable medical equipment and supplies to be considered medically necessary, they shall:

- Be prescribed by a physician and when applicable, recommended by an appropriately licensed practitioner.
- Be a reasonable, appropriate, and effective method for meeting the client's medical need.
- Have an expected use that is in accordance with current medical standards or practices.
- Be cost effective, which means that less costly and medically appropriate alternatives do not exist or do not meet treatment requirements.
- Provide for a safe environment.
- Not be experimental or investigational, but generally accepted by the medical community as standard practice.
- Not have as their primary purpose the enhancement of a client's personal comfort or to provide convenience for the client or caretaker.

The table on the next page shows the total expenditures paid and the number of durable medical equipment and supplies claims processed by the Department between State Fiscal Years 2005 and 2009. As shown, expenditures increased by an average of 11 percent per year, or 53 percent during this five-year period, claims processed increased by 9 percent per year, or 39 percent over the five years, and cost per enrollee increased 10 percent per year, or 42 percent during the five-year period.

Medicaid Program			
Expenditures and Claim Volume for Durable Medical Equipment and Supplies			
State Fiscal Years 2005 Through 2009			
State Fiscal Year	Total Expenditures (in Millions)	Total Number of Claims Processed	Cost Per Enrollee
2005	\$50.3	664,620	\$124
2006	\$58.7	732,560	\$146
2007	\$66.8	790,840	\$170
2008	\$75.8	885,180	\$193
2009 ¹	\$77.0	922,850	\$176
Percent Change 2005-2009	+53%	+39%	+42%
Average Annual Percent Change	+11%	+9%	+10%
Source: Data provided by the Department of Health Care Policy and Financing			
¹ The 2009 expenditure figure represents the Department's estimate as of July 2009. The final figure will be available in November 2009.			

Laboratory and Radiology Services

Medically necessary laboratory and radiology services are covered benefits of the Medicaid Program. As mentioned earlier, federal law requires that these types of services be available to all Medicaid clients. The Department pays for these services using the same three payment methods used for durable medical equipment and supplies. State regulations [10 CCR 2505-10, Section 8.660.1] describe the three components of laboratory and radiology services, which are as follows:

- **Clinical laboratory services** are "...examinations of fluids derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease, or the assessment of a medical condition."
- **Anatomical laboratory services** are "examinations of tissues derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease, or the assessment of a medical condition."
- **Radiology services** include x-rays, MRI, and CAT scans. Services must be performed by a provider whose equipment has been certified by the Colorado Department of Public Health and Environment (CDPHE) as meeting Medicare guidelines and whose personnel and director are qualified to operate said equipment.

Testing may be performed in a physician's office, a hospital laboratory, or by an independent laboratory. All participating laboratory providers are required to be certified by CDPHE in accordance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) certification requirements. In addition, radiology service providers are required to have CDPHE certify their radiology equipment.

The table below shows the total expenditures paid and the number of laboratory and radiology claims processed by the Department between State Fiscal Years 2005 and 2009. As shown, laboratory and radiology expenditures increased by an average of 13 percent per year, or 62 percent during the five-year period. Further, claims processed increased an average of 9 percent per year, or 43 percent over the five years, and cost per enrollee increased an average of 11 percent per year, or 51 percent during the five-year period.

Medicaid Program			
Expenditures and Claim Volume for Laboratory and Radiology Services			
State Fiscal Years 2005 Through 2009			
State Fiscal Year	Total Expenditures (in Millions)	Total Number of Claims Processed	Cost Per Enrollee
2005	\$17.5	1,313,000	\$43
2006	\$19.3	1,393,000	\$48
2007	\$20.4	1,492,000	\$52
2008	\$22.8	1,612,000	\$58
2009 ¹	\$28.4	1,872,000	\$65
Percent Change 2005 to 2009	+62%	+43%	+51%
Average Annual Percent Change	+13%	+9%	+11%
Source: Data provided by the Department of Health Care Policy and Financing			
¹ The 2009 expenditure figure represents the Department's estimate as of July 2009. The final figure will be available in November 2009.			

Audit Scope and Methodology

This audit was conducted because of significant increases in Medicaid expenditures and claims for durable medical equipment and supplies, laboratory, and radiology services between State Fiscal Years 2002 and 2006 and the risks associated with these types of services. In particular, the federal Centers for Medicare and Medicaid Services (CMS) found durable medical equipment and supplies under the Medicare Program to be a type of service prone to provider fraud and abuse; therefore, it is likely that similar risks exist for the Medicaid Program. This report includes the results of our audit of the payment controls and prior authorization/medical necessity practices used for these types of services. Specifically, our audit focused on:

- Identifying Medicaid payments that were unallowable or recoverable because: (1) the service was not covered by Medicaid or (2) the individual was Medicare-eligible and Medicare should have paid the claim or a portion of the claim before it was submitted to the Department for payment.
- Determining if claims were reimbursed at the appropriate fee-for-service rates.
- Determining if claims were paid for services delivered after a Medicaid recipient's date of death.
- Verifying that appropriate prior authorization processes were in place and practiced to ensure medical necessity.

The Office of the State Auditor contracted with Mercer Government Human Services Consulting (Mercer) to conduct the audit. During the audit, Mercer interviewed Department staff and collected and analyzed data provided by the Department. Mercer also interviewed representatives from two of the Department's contractors: (1) ACS, and (2) CFMC, the quality improvement organization that reviews certain prior authorization requests for durable medical equipment and supplies for medical necessity.

Mercer analyzed the fee-for-service claims data provided by the Department for durable medical equipment and supplies, laboratory, and radiology services to determine if payments for services delivered in State Fiscal Years 2005 through 2007 were allowable, appropriate, and accurate. In addition, Mercer's clinical staff judgmentally selected nine high-risk providers (three providers each of durable medical equipment and supplies, laboratory, and radiology services) and reviewed a random, non-statistical sample of 30 claims from each provider to ensure that appropriate prior authorization practices had occurred, medical necessity was explained, and delivery of the item to the client was documented.

This audit did not include a review of services by and payments made to the health maintenance organizations under contract with the Department. Further, we were unable to complete our review of third party payer claims. This issue will be discussed in more detail in Chapter 3.

Payment Controls

Chapter 2

Background

In Fiscal Year 2009 the Department of Health Care Policy and Financing (Department) paid about \$77 million for durable medical equipment and supplies and \$28.4 million for laboratory and radiology services provided to Medicaid clients. Since Fiscal Year 2005 these costs have increased by about 53 percent and 62 percent, respectively.

The provision of and billing practices related to durable medical equipment and supplies are often considered to be at risk of fraud and abuse schemes, particularly by the Medicare Program. Because of these risks, it is essential for the Medicaid Program to establish payment controls, such as targeted claim reviews and on-site visits of providers, to prevent and detect inappropriate payments made to providers.

During our audit, we reviewed the controls in place for Colorado's Medicaid Program to prevent and detect inappropriate payments for durable medical equipment and supplies, laboratory, and radiology services. We tested samples of claims to determine whether the Department: (1) properly handled payments for services provided to dual-eligible clients (i.e., clients eligible for both Medicare and Medicaid benefits); (2) made payments for equipment, supplies, and services at appropriate rates; and (3) ensured payments were not made for services occurring after a client's date of death. We identified payment errors and concerns in all of these areas. We describe these issues in greater detail in this chapter.

Information Management

During the audit, we encountered a number of problems in obtaining Medicaid data from the Department that were accurate, complete, and timely. Due to these data problems, we were unable to fully evaluate the Department's compliance related to certain claims processing and payment activities. These problems raise concerns about the Department's ability to manage data for program decision making. This is particularly a concern because the Department's estimated expenditures of \$2.7 billion on behalf of Medicaid beneficiaries in Fiscal Year 2009 totaled about 13 percent of the State's estimated \$21.6 billion in expenditures for the year.

For example, one of the major obstacles faced during our audit was obtaining data in a timely manner. In December 2007 we requested the Department provide us with specific claims data by the end of January 2008. The Department attempted to respond to our request on two separate occasions in June and July of 2008. In both instances, the claims data provided by the Department were missing key information. The Department did not provide complete data files in response to our request until August 2008. Later in the audit, we experienced delays when clearing our audit exceptions. Specifically, we provided the Department with information on the audit exceptions in April 2009. The Department did not provide all of the documentation needed to determine the disposition of these exceptions until August 2009. These specific data concerns are discussed in greater detail in Chapter 3.

Under government auditing standards, lack of access to the data necessary to meet the objectives of an audit results in a scope limitation that directly impairs the effectiveness of the audit process. Delays in the provision of data or the repeated provision of incomplete or erroneous data increases the risk that an organization may be attempting to prevent auditors from identifying problems or performing accurate analysis. For this audit, we did not uncover evidence that the Department altered the data provided. The Department's lack of attention to providing complete and accurate data in a timely manner is troubling not only because it reduces the intended benefit of the audit, but because it raises concerns about the Department's ability to access these data for program oversight.

Despite the problems we encountered with receiving accurate, complete, and timely data, we were able to evaluate the Department's payment controls in several areas over claims paid for durable medical equipment and supplies, laboratory, and radiology services. We noted deficiencies and identified a total of \$37,510 in questioned costs for claims paid between July 1, 2004 and June 30, 2007. We describe these questioned costs in this chapter and in Chapter 3. Additionally, in Chapter 3 we discuss improvements the Department should make related to its processes for retrieving and using data for its own purposes and in response to audit requests.

Payments for Claims on Behalf of Dual-Eligible Clients

The Department is responsible for ensuring Medicaid payments are properly applied to services provided to dual-eligible clients. Dual-eligible clients are those individuals who are eligible for both Medicare and Medicaid benefits. Under federal regulations, the Medicare program is the primary payer for claims filed on behalf of dual-eligible clients, and the Medicaid program is the payer of last

resort. This means that providers must first file claims for dual-eligible clients with Medicare. After Medicare pays for services covered by its program or denies the claim, the claim can then be submitted to Medicaid for payment.

To determine if Medicaid payment rules were properly applied to durable medical equipment and supplies, laboratory, and radiology services provided to dual-eligible clients, we selected a judgmental, non-statistical sample of 75 claims (25 durable medical equipment and supplies, 25 laboratory, and 25 radiology claims) for services provided between July 1, 2004, and June 30, 2007. To select our sample, we identified more than 57,000 claims that met three criteria: (1) the client was dual-eligible; (2) the service/procedure was a Medicare covered benefit; and (3) the claim information provided by the Department indicated no Medicare payment was made for any portion of the claim. From this subset of claims, we randomly selected a non-statistical sample of 75 claims, which included claims filed electronically and by paper. These claims totaled about \$35,960 in payments to providers. For each claim, we requested the Department provide the explanation of benefits, which includes detail about Medicare’s payment or denial of the claim.

From the documentation provided by the Department, we determined that the Department should have denied or recouped payment for 58 of the 75 claims, or 77 percent, as shown in the table below. These claims totaled about \$18,590 in questioned costs, which represents 52 percent of the claims payments in our sample.

Medicaid Program						
Payment Errors for a Judgmental Sample of Claims Paid for Dual-Eligible Clients¹						
State Fiscal Years 2005 Through 2007						
Service Type	Claims			Dollars		
	Sample	Claims with Errors	Error rate	Sample	Value of Errors	Error Rate
Durable medical equipment and supplies	25	17	68%	\$23,564	\$6,921	29%
Laboratory	25	16	64%	\$2,837	\$2,104	74%
Radiology	25	25	100%	\$9,563	\$9,563	100%
TOTALS	75	58	77%	\$35,964	\$18,588	52%
Source: Mercer’s analysis of claims and explanation of benefits for a sample of 75 durable medical equipment and supplies, laboratory, and radiology claims. Errors cannot be extrapolated to the entire durable medical equipment and supplies, laboratory, and radiology claims population.						
¹ Dual-eligible clients are those individuals eligible for both Medicare and Medicaid benefits.						

We identified several reasons for the payment errors in our sample. Specifically:

- **No recoupment of payments made for Medicaid clients retroactively determined to be dual-eligible.** For 41 claims representing about \$11,470 in payments, the Department's MMIS showed these clients were only eligible for Medicaid benefits at the time the claim was paid. We determined that based upon the eligibility information in the system, at the time of adjudication, the Department correctly paid these claims. Subsequent to payment of these claims, the clients were retroactively determined to be eligible for both Medicaid and Medicare on the dates of services. Under federal regulations, the Department should have sought recovery of claims payments from providers because these benefits were covered by Medicare. However, we found no evidence in the documentation provided by the Department that these payments were recovered. The Department informed us that its current policy, which was approved by the federal Centers for Medicare and Medicaid (CMS) as part of Colorado's State Plan, states that the Department does not seek recovery of any claim that is less than \$50. Of the 41 claims, four (10 percent) were for payments of less than \$50 each, and the Department does not plan to recover these claims.
- **Lack of Medicare explanation of benefits.** For 13 claims totaling about \$6,460 in payments, the Department did not provide us with evidence, including a Medicare explanation of benefits, showing that the provider billed Medicare first for these claims. Providers indicated that they were unaware the clients were eligible for Medicare benefits and only submitted the claims to Medicaid. These claims were adjudicated and paid by the Medicaid Program even though eligibility records in MMIS indicated the clients were eligible for both Medicare and Medicaid benefits.
- **No recoupment when providers received full payment from both Medicare and Medicaid.** For two claims totaling about \$370 in payments, the providers informed us that they received full payment from both Medicare and Medicaid but stated that the Department later identified these errors and recouped the payments. However, we found no evidence in the recovery data provided by the Department showing that these claims were recouped.
- **The explanation of benefits provided did not match the claim.** For two claims totaling about \$290 in payments, the Department provided explanation of benefits that did not match the claims. For example,

one of the explanations of benefits showed that Medicare denied a durable medical equipment claim because the service was provided to a client residing in a skilled nursing facility and Medicare does not cover durable medical equipment for clients in this type of facility. However, the corresponding Medicaid claim listed the client's home as the place of service. Medicare covers durable medical equipment provided in a client's home. Therefore, Medicaid should not have paid the claim.

The Department does not have adequate controls over payments made for dual-eligible clients. In particular, the Department does not conduct periodic audits of providers to: (1) determine whether providers are retaining evidence that they submitted the claims to Medicare before filing them with the Department, and (2) identify clients with retroactive Medicare eligibility determinations. In addition, the Department does not require providers to submit Medicare explanations of benefits with paper claims, which provides evidence that the provider first filed the claim with Medicare. We also found that providers filing claims with the Department do not always complete the appropriate fields necessary for the Department to assess whether the claim was filed first with Medicare.

The Department should modify its policies to require providers filing paper claims to include the Medicare explanation of benefits as evidence that the claims for dual-eligible clients were first submitted to Medicare. Further, the Department should add edits to MMIS to ensure that MMIS will only accept claims if the providers complete all the necessary fields for assessing whether the claim was filed first with Medicare prior to claim submission to Medicaid. Upon making these changes, the Department should provide training and technical assistance to durable medical equipment and supplies, laboratory, and radiology providers on the proper billing procedures for dual-eligible clients.

The Department should also quarterly identify and recover any Medicare payments that should have been received for durable medical equipment and supplies, laboratory, and radiology services paid on behalf of dual-eligible clients, including those retroactively determined to be eligible for Medicare benefits, and develop procedures to ensure that Medicaid is the payer of last resort for these and all other claims.

Recommendation No. 1:

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

Department of Health Care Policy and Financing Response:

- a. Agree. Implementation Date: December 2011.

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 the US Department of Health and Human Services- Office of the Inspector General 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.

b., c. Agree. Implementation Date: 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.

d. Agree. Implementation Date: March 2010 and ongoing.

The Department will review and update its provider training material to ensure that its policies and processes 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.

Claims Paid in Excess of Maximum Allowable Rates

State regulations [10 C.C.R. 2505-10, Sections 8.660.5 and 8.590.7] stipulate how durable medical equipment and supplies, laboratory, and radiology services are to be reimbursed for Medicaid clients. For laboratory and radiology services, the Department pays the lesser of the provider's submitted charges or the fee in the Department's fee schedule. Reimbursement for durable medical equipment and supplies is more complex. The payment methodology used is based upon whether the equipment is new or used and if the equipment and supplies are subject to a maximum allowable charge listed in the Department's fee schedule.

As part of the audit, we analyzed Medicaid claims data for durable medical equipment and supplies, laboratory, and radiology services provided between July 1, 2004 and June 30, 2007 to determine whether any claims were paid in excess of the maximum allowable rate schedule (rate schedule). We identified about 69,420 claims that appeared to have been paid an amount above the Department's rate schedule. From these claims, we judgmentally selected a non-statistical sample of 200 claims representing about \$35,440 in payments to providers. The sample was selected to include claim types with a broad range of services. We asked Department staff to review this sample and either verify that the claim was paid above the maximum allowable rate or provide documentation showing the claim was paid appropriately.

The Department completed its review and reported that 175 of the 200 claims in the sample were paid using other pricing methodologies that were not provided to us when we submitted our request. Since it was too late in the audit to review these pricing methodologies, these 175 claims were excluded from the sample. Problems with obtaining complete and reliable information from the Department, including complete information on fee schedules, is discussed in more detail in Chapter 3.

We reviewed the Department's documentation for the remaining 25 claims in the sample. We questioned whether the Department appropriately paid all 25 claims because it appeared the Department did not apply the correct Medicare lower of pricing logic for these claims for dual-eligible clients. These claims included payments for oxygen and totaled about \$1,090 in Medicaid payments. The lower of pricing logic is used by states as a cost-containment mechanism to ensure the state does not pay more than its Medicaid-allowed amount less the Medicare payment for dual-eligible clients.

Department staff reported to us that these 25 claims were excluded from the lower of pricing requirements in the *Colorado MMIS System Documentation for Claims Pricing and Adjudication*. According to this policy, certain procedures are not subject to the lower of pricing logic requirements, including the two procedures—stationary gaseous oxygen systems and stationary liquid oxygen systems—listed on the 25 claims. Department staff informed us that they do not know the reasons why these procedures are excluded from the lower of pricing logic requirements. This is a concern because lower of pricing logic is intended to ensure that the Medicaid Program does not pay more than necessary for services provided to clients. The Department should assess whether it is appropriate to exclude procedures from the lower of pricing logic and justify in writing its reasons for any exclusions. Further, the Department should periodically reevaluate if these exclusions are still appropriate, with a particular focus on whether the exclusions are consistent with the Department’s cost-control strategies for the Medicaid Program.

We also reviewed Colorado’s State Medicaid Plan (State Plan) to determine whether the Department paid these 25 claims in accordance with the reimbursement methodologies described in the State Plan. Federal regulations [42 CFR, Section 447.201(b)] require states to describe in their state plans “the policy and the methods to be used in setting payment methods for each type of service included in the State’s Medicaid program.” According to CMS’s *State Medicaid Manual*, the state plan must reflect the payment amount for claims for dual-eligible clients. In addition, CMS states that its reviews of state payment methodologies and supporting documentation are intended to ensure the state plan methodology “is comprehensively described and that payment rates are economic, efficient, and sufficient to attract willing and qualified providers.” Further, states are required to submit a state plan amendment to CMS if they decide to change their reimbursement methods and standards for paying Medicaid providers.

Colorado’s State Plan includes a description of the reimbursement methodology for dual-eligible clients, but it does not list exclusions to this methodology, such as those exclusions in the Department’s policies related to lower of pricing logic requirements. Department staff were unable to provide evidence showing that the Department submitted an amendment to its State Plan for these exclusions. As a result, we determined that the 25 claims in our sample that were excluded from the lower of pricing logic requirements were not paid in accordance with the reimbursement methodology described in Colorado’s State Plan, and we consider the \$1,090 paid for these claims to be questioned costs. The Department should work with CMS to determine whether an amendment is required for the lower of pricing logic exclusions in the Department’s policy. Further, if the Department is required to submit an amendment to CMS, the Department should work with

CMS to determine whether claims paid using these exclusions should be recovered.

Recommendation No. 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 Plan should have been submitted related to these exclusions and whether any payments made for claims falling under these exclusions should be recovered.

Department of Health Care Policy and Financing Response:

Agree. 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.

Auditor's Addendum:

Extensive, repeated efforts were made to obtain complete pricing methodologies from the Department for reviewing the accuracy of fees paid for durable medical equipment and supplies, laboratory, and radiology claims. These efforts are well-documented in the audit workpapers. Complete pricing information was never provided by the Department.

Medicaid Claims Paid After Date of Death

In Colorado, caseworkers in county departments of human/social services are the primary contacts for families or nursing facilities to report the death of a Medicaid client. Nursing facility representatives are required to report a date of death within five business days of the individual's death. When a client does not reside in a nursing facility, the Department relies on the family to report the date of death. Upon receipt of date of death information, it is entered into the Colorado Benefits Management System (CBMS), which maintains eligibility records for Medicaid clients. Date of death information may also be reported to the Colorado Department of Public Health and Environment (CDPHE) by a funeral home representative.

To determine the extent of payments made for services occurring after the date of death, we obtained from the Department: (1) paid claims data for durable medical equipment and supplies, laboratory, and radiology services provided between July 1, 2004 and June 30, 2007, and (2) an eligibility file for this same time period. We compared approximately 3.5 million claims totaling about \$267 million in payments with death data from the CDPHE. The Office of Vital Statistics at CDPHE provided a death data file covering the same three-year period as the claims data we received from the Department. This file included the following information on each decedent, if available: social security number, name, date of birth, date of death, gender, and a code that indicated the county where the death occurred.

We originally identified 1,239 claims totaling about \$148,340 in payments for service dates after the client's date of death. These claims were for 666 clients whose date of death was recorded by the Department, CDPHE, or both agencies as occurring before the date of service. We provided these claims to the Department and asked staff to review a sample of claims to either verify that the claims were inappropriately paid for services occurring after the client's date of

death or provide documentation showing the claims were paid appropriately. The Department selected 279 of these claims (23 percent) to review, which represented about \$23,900 in payments (16 percent).

From the information provided by the Department from its review of the 279 claims, we determined that 195 claims (70 percent) totaling about \$14,430 (60 percent) were not paid appropriately and are questioned costs. The Department should recover these payments from providers. For the remaining 84 claims in the sample (30 percent), the Department provided us with data showing that they were paid appropriately because the claims covered a monthly or regularly scheduled service, such as oxygen delivery or diapers, occurring in the month of the client's death, and no payments were made for these services in subsequent months. For example, if the client received oxygen on the first day of the month, died on the 10th day of the month, and the service was billed at the end of the month, it would be appropriate to pay the claim for that month. These claims totaled about \$9,470 in payments, or about 40 percent of the payments in the Department's sample.

The Department should also review the remaining 960 claims from the 1,239 claims with payments after the date of death to determine the appropriateness of the payments. These 960 claims totaled about \$124,440. The Department should recover any payments for claims determined to be inappropriately paid for services occurring after a client's death. Further, the Department should educate providers on the requirements pertaining to proper death notification and billing for services occurring in the month of a client's death.

In addition, we found that the death records maintained by the Department and CDPHE did not always contain the same date of death for a client. In particular, we identified 704 claims from the 1,239 claims where the date of death did not match. These claims were for 288 clients and totaled about \$71,270 in Medicaid payments.

Payments for Medicaid claims with dates of service after a client's death has been an ongoing issue identified by the Office of the State Auditor in past audits. The November 2004 *Medicaid Claims Performance Audit* identified Medicaid claims that were paid to providers for service dates after a client's date of death. At that time the Department stated that it would perform periodic data matches with the CDPHE and/or the Social Security Administration (SSA). The *Statewide Single Audit – Fiscal Year Ended June 2008* also identified paid claims with service dates occurring after a client's date of death. However, the *Statewide Single Audit*, found that there still was not a regularly scheduled match or interface performed with SSA or CDHPE for the Medicaid Program.

Department staff reported to us that they researched automated links between CBMS and other death record databases. Staff informed us that implementing these links is not feasible at this time. As an alternative, the Department developed a date-of-death matching process to identify and recoup payments made after a client's date of death. Beginning in January 2009, the Department engaged the services of Health Management Systems (HMS) to perform date-of-death matches against multiple sources of death records, such as the SSA and CDPHE's Office of Vital Statistics. Department staff informed us that the data match and recovery project is currently in the implementation stage and will be regularly evaluated to determine the best practices for identifying and recovering payments made after a client's death. Currently these matches and recoveries do not include oxygen and other rental supplies. We found that a majority of the claims we identified with dates of service after a client's death were for oxygen services and other rental supplies. As a result, the Department should work with HMS to expand the data matches and recoveries to include oxygen services and other rental supplies. Further, the Department should periodically evaluate its methods for identifying payments made for services provided after a client's death to determine whether these methods are adequately identifying inappropriate payments. The Department should implement changes to improve these processes, as necessary.

Recommendation No. 3:

The Department of Health Care Policy and Financing should improve controls to prevent Medicaid payments for services 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.
- 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.
- 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 inappropriate payments made for services provided after death.

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

Department of Health Care Policy and Financing Response:

- a. Agree. 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 database for birth and death records.

- b. Agree. 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.

c. Partially Agree. 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.

d. Agree. 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.

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Administration

Chapter 3

Background

In Fiscal Year 2009 the Department of Health Care Policy and Financing (Department) contracted with about 1,290 durable medical equipment and supplies providers and about 230 laboratory and radiology providers to deliver services to Colorado Medicaid clients. Affiliated Computer Services, Inc. (ACS), the Department's fiscal agent, is responsible for managing the provider enrollment process. According to their contracts with the Department, Medicaid providers are required to comply with federal and state statutes, rules, and regulations related to the Medicaid Program.

Colorado regulations and Department policies set forth requirements related to determining medical necessity and criteria for completing prior authorizations for durable medical equipment and supplies, laboratory, and radiology services. Health care organizations and Medicaid programs often use prior authorizations as a mechanism to monitor health services utilization, specifically overuse. The original goals of prior authorization programs were to decrease unnecessary or redundant services and control costs. As these programs have matured and evidence-based guidelines have become more available, these programs have expanded from purely utilization management functions to now: (1) educating providers about appropriate application of guidelines and (2) monitoring the quality of care by avoiding the delivery of unnecessary and potentially harmful services to clients. This is especially true with services like radiology where unnecessary and redundant testing can result in increased radiation exposure.

Currently the Department requires prior authorizations for certain durable medical equipment and supplies before they can be purchased for clients. As mentioned earlier, the Department contracts with the Colorado Foundation for Medical Care (CFMC) and ACS to perform prior authorizations for certain durable medical equipment and supplies. We refer to these organizations collectively as prior authorization contractors. The Department did not require prior authorizations for laboratory or radiology services during the time period reviewed as part of this audit.

We evaluated durable medical equipment and supplies providers' compliance with medical necessity and prior authorization requirements and laboratory and radiology providers' compliance with clinical documentation requirements. Further, we reviewed the Department's oversight of providers and its prior

authorization contractors and the Department's ability to effectively manage and use program data. We noted problems in these areas, which we discuss in greater detail in this chapter.

Oversight of Durable Medical Equipment and Supplies Providers

Colorado's Medicaid Program only provides durable medical equipment and supplies if they are determined to be medically necessary. According to state regulations [10 CCR 2505-10, Section 8.590.2A], the equipment, supplies, and prosthetic and orthotic devices are considered to be medically necessary if they:

- Are prescribed by a physician;
- Reasonably meet the client's medical need;
- Have an expected use in accordance with current medical standards/practices;
- Are cost effective;
- Provide for a safe environment;
- Are not experimental or investigational; and
- Do not have as their primary purpose the enhancement of a client's personal comfort or to provide convenience for the client or caretaker.

Colorado regulations and Department policies require prior authorization of certain durable medical equipment and supplies to ensure that these items (typically those that are higher cost) are medically necessary.

As part of the audit, we judgmentally selected a non-statistical sample of three durable medical equipment and supplies providers to visit. Our sample selection was based upon a number of factors, including overall claim volume between July 1, 2004 and June 30, 2007. These providers were three of the four largest providers of equipment and supplies to Medicaid clients in Colorado during this time period. We then judgmentally selected a non-statistical sample of 90 durable medical equipment and supplies claims (30 claims per provider in our sample) with dates of service during this three-year period to assess whether services paid for by Medicaid met defined medical necessity criteria and were appropriately authorized prior to provision and payment. Claims in the sample were selected to include a wide range of services and Medicaid aid categories as well as to address other topics reviewed as part of this audit (e.g., claims for clients with dates of death, with invalid procedure codes, and with no evidence that required prior authorizations were obtained prior to service delivery). The total dollar value of the 90 claims was about \$25,320.

We identified questioned costs for 12 claims in our sample (13 percent) related to noncompliance with medical necessity and prior authorization requirements. These questioned costs totaled about \$2,940 in payments to providers, or 12 percent of the dollars paid for the sampled claims. These 12 claims represented 15 different exceptions, with 3 claims having two exceptions each. Specifically, we found:

- **Physician Orders and Prescriptions:** For seven claims, we found no prescription or physician order in the provider's records that authorized the provision of durable medical equipment or supplies to the client. These orders are required by state regulations [10 CCR 2505-10, Section 8.590.4.D.1].
- **Prior Authorizations:** For three claims, the prior authorization document in the providers' files did not support the claim paid. In particular, we identified two claims where the prior authorization number in the file did not match the number on the claim. Further, we found another claim where the supply item billed (barrier cream) was not the item authorized (ostomy paste). State regulations [10 CCR 2505-10, Section 8.590.4.D.2] require that durable medical equipment and supplies providers maintain documentation related to approved prior authorization requests.
- **Required Documentation on Equipment Supplied to Client:** For three claims, providers' files did not contain all of the required information about the equipment billed for and paid by the Medicaid Program. In particular, state regulations [10 C.C.R. 2505-10, Section 8.590.4.D] require providers to maintain documentation showing that the client has been given manufacturer's instructions, warranty information, registration documents, the service manual, and operating guides for the equipment provided. Further, the provider must maintain the manufacturer's name and address, date the equipment was acquired, acquisition cost, model and serial numbers, and any accessories, attachments, or special features included as part of the equipment. We did not find some or all of this required information for these three claims. In addition, we could find no proof for any of these claims that the equipment or supply was delivered to the client.
- **Equipment Repairs:** For two claims, we found no documentation in the file showing that requested repairs to a client's wheelchair occurred. According to the Department's provider policies, providers must maintain records that "fully disclose the nature and extent of services provided."

Improvements

The Department performs some oversight activities of durable medical equipment and supplies providers. For example, Department staff reported that its Program Integrity Unit uses a surveillance utilization system tool to identify providers whose billing patterns are unusual compared to their peers. The data analyzed by this tool is then used by the Program Integrity Unit to target its reviews of providers. According to staff, this tool was recently used to identify a durable medical equipment and supplies provider who billed the Medicaid Program for 500 diapers per client each month. This case was referred to the Medicaid Fraud Control Unit, within the Attorney General's Office, and the provider was charged with multiple felony counts for submitting the fraudulent claims. Department staff also cited other examples of fraud cases involving durable medical equipment and supplies that were referred by its Program Integrity Unit to the Medicaid Fraud Control Unit.

As part of the audit, we identified additional improvements the Department could make with its oversight of durable medical equipment and supplies providers. In particular, we found that the Department does not perform periodic on-site clinical reviews of these providers. Such reviews are beneficial because they ensure that providers are: (1) properly billing the Department for only equipment and supplies that have been provided to Medicaid clients and (2) maintaining records to support the medical necessity of the equipment and supplies, compliance with prior authorizations procedures, and other required documentation. On-site visits can also provide valuable educational opportunities for providers, ensure that ongoing operational issues are addressed, provide an opportunity to suggest program improvements, and enhance working relationships and communication between Department representatives and its provider network. While current statutes require the Department to offer the option of a desk review or on-site inspection, the Department should work with providers to encourage on-site reviews whenever possible.

One option for performing on-site reviews is for the Department to adopt a risk-based approach to selecting a sample of providers to visit on an annual basis. As part of this option, the Department could review its provider data to identify high-volume or other high-risk providers for on-site visits to ensure that claims submitted to the Department accurately reflect the services provided, that the services are medically necessary, and that documentation complies with Department prior authorization, recordkeeping, and claims submission requirements. For providers not meeting the Department's compliance standards, the Department should require them to submit corrective action plans and perform follow-up reviews until compliance is achieved. Further, the Department should recover any payments determined to be unallowable.

In addition, we noted improvements the Department could make with its communication and guidance to durable medical equipment and supplies providers statewide. Currently Department staff give guidance and assistance to providers through the Department's provider manual and bulletins and participation on the Durable Medical Equipment Board—a coalition of durable medical equipment supplies providers in the Denver area. However, the three providers we visited indicated they did not know whom to call at the Department with questions that could not be answered by the Department's prior authorization contractors. Further, we found that the Department's provider manual and supply bulletins do not describe the specific requirements related to the types of information providers must maintain in their medical records to document and support the provision of durable medical equipment and supplies. These requirements are clearly described in state regulations. However, the three providers we visited during the audit indicated that they were not familiar with the documentation requirements in state regulations and referred to Medicare guidelines when questions arose.

Potential ways to improve communication with the provider community may include performing the on-site reviews discussed earlier, conducting educational forums on compliance issues identified during on-site visits and on program policy and billing changes, and through ongoing and consistent participation in local provider boards or forums. Additionally, the Department could heighten providers' awareness of clinical documentation requirements through regular updates to its provider manual and bulletins.

Finally, the Department could strengthen requirements associated with used durable medical equipment and related-party transactions. According to state regulations [10 CCR 2505-10, Sections 8.590.7.G.2 and Section 8.590.7.A], durable medical equipment and supplies providers are not allowed to: (1) seek reimbursement for used equipment as if it is new (used equipment can only be reimbursed at 60 percent or less of the maximum allowable cost for new equipment) and (2) purchase equipment and supplies from a related party. As part of our site visits to the three providers in our sample, we requested and reviewed their policies and procedures pertaining to reimbursement of used equipment and related-party transactions. Two of the three providers did not maintain specific policies for use of new equipment, billing for used equipment, or interactions with related-party providers. All three providers reported to us that they do not purchase or receive referrals from related parties.

To heighten awareness of this requirement and better ensure providers' compliance, the Department should develop and implement policies and procedures for providers to use in seeking reimbursement for used equipment and

related-party transactions. As part of its annual reviews, the Department should determine whether providers are complying with these requirements.

Recommendation No. 4:

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 review 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.
- 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.
- c. Regularly updating its provider manual and bulletins to include detailed information about providers' responsibilities for maintaining documentation in each client's medical record.
- d. Strengthening communication 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.

Department of Health Care Policy and Financing Response:

- a. Partially Agree. Implementation Date: 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 Durable Medical Equipment providers, the Program Integrity Unit 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 Unit 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.

b. 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 Unit.

c. Agree. 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.

Update of the provider application – December 2009. Update of training materials – March, 2010. Reminders in provider bulletins – Beginning January, 2010 and ongoing.

- d. Agree. Implementation Date: 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.

Oversight of Laboratory and Radiology Providers

According to state regulations [10 CCR 2505-10, Section 8.660.3.A], laboratory and radiology services are only a benefit of the Medicaid Program if the following six conditions are met:

- The services have been authorized by a licensed physician.
- The services are performed to diagnose conditions and illnesses with specific symptoms.
- The services are performed to prevent or treat conditions that are benefits under the Medicaid Program.
- The services are not routine diagnostic tests without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.
- The laboratory services are performed by a certified laboratory in accordance with the federal Clinical Laboratory Improvement Amendments (CLIA) of 1988.
- The x-ray services are performed by a provider certified by the Colorado Department of Public Health and Environment and enrolled as a Medicaid provider.

We judgmentally selected a non-statistical sample of three laboratory and three radiology service providers to visit. Our sample selection was based on a number of factors, including overall claim volume during the review period. We then judgmentally selected a non-statistical sample of 90 laboratory and 90 radiology claims (30 claims per provider in our sample) with dates of service between July 1, 2004 and June 30, 2007 to assess whether the services paid for by Medicaid

met the six criteria described above. Claims in the sample were selected to include a wide range of services and Medicaid aid categories as well as to address other topics reviewed as part of the audit (e.g., claims for clients with dates of death and with invalid procedure codes). The total dollar value of the claims was about \$19,370.

We conducted site visits to review provider documentation for the 180 claims in our sample. Of the 180 claims in our sample, we identified questioned costs for nine claims (5 percent) totaling about \$460 in payments that did not meet the required criteria for medical necessity. Specifically, we found:

- **Orders and Requisitions:** For five claims, the files did not include an authorizing order or requisition from a licensed physician, as required by state regulations [10 CCR 2505-10, Section 8.660.3.A.1]. This documentation is essential for ensuring that the tests and x-rays are medically necessary.
- **Prescriptions:** For two claims, the prescription on file was not signed by a specific physician or mid-level practitioner, as required by state regulations [10 CCR 2505-10, Section 8.660.3.A]. For another claim, the diagnosis on the prescription was different than the one listed on the claim.
- **Radiology Report:** For one claim, the radiologist did not sign the radiology report, as required by state regulations [10 CCR 2505-10, Section 8.660.3.A.6].

We also confirmed that all three laboratory providers we visited were CLIA-certified providers. The Department does not perform periodic on-site clinical reviews of laboratory and radiology providers. While current statutes require that the Department offer the option of a desk review or on-site inspection, the Department should work with providers to encourage on-site reviews whenever possible. Additionally, as with durable medical equipment and supplies providers, the Department could adopt a risk-based approach to select a sample of providers to visit on an annual basis.

The Department should also perform periodic matches of laboratory and radiology claims to ensure that it has not double paid for these services, primarily due the methods providers can use to bill for these services. Specifically, claims for radiology and laboratory services include: (1) a technical component, which covers the cost of the procedure and (2) a professional component, which covers the cost of clinical interpretation of the results. Claims can be submitted for payment either by including the technical and professional components on one

claim, which is referred to as a “global bill,” or through split billing where two separate bills are generated for each component. Claims data provided by the Department primarily included radiology claims with only the professional component billed. As part of our on-site visits with providers, we learned that many hospitals and free standing radiology centers contract with independent radiology groups to perform the professional reads. When this occurs, it is possible that two claims could be submitted to the Department for the same client and the same service—one claim submitted as a global bill and another claim submitted for the professional component only. If the Department pays both claims, it has paid for the professional component twice. As a result, it is essential for the Department to periodically review laboratory and radiology claims to ensure it has not overpaid for these services.

Further, the Department should review its laboratory and radiology claims payment practices to determine if split billing results in higher payments than global billing rates and consider policy changes to eliminate this payment difference. Many managed care organizations and the federal Centers for Medicare and Medicaid Services have implemented policies to only pay radiology claims on a global basis to eliminate additional costs. Currently the Department does not have similar policies in place.

We also found that the Department could enhance its use of financial trend data currently monitored by ACS and CFMC related to laboratory and radiology services. In particular, the Department should use these data to develop utilization and cost trend reports intended to identify drivers of program costs related to these services and monitor aberrant patterns in patient or provider utilization that could signify the need for medical chart review or provider discussions. The Department could use these data as part of its selection of providers to visit annually.

The Department did not have any prior authorization requirements in place for laboratory and radiology services during the time period reviewed for the audit. Prior authorization programs not only monitor health services utilization, including overuse, but also facilitate provider education about appropriate application of guidelines and improve clients’ quality of care by avoiding delivery of unnecessary and potentially harmful services. We recommend that the Department consider implementing a prior authorization process for high-cost radiology procedures.

Recommendation No. 5:

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 review each year. Additionally, the Department should report all deficiencies identified during the reviews to providers, ensure that providers correct any deficiencies identified in a timely manner, and recover any unallowable claims payments identified.
- 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).
- c. Developing utilization and cost trend reports to: (1) identify drivers of program costs 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.
- d. Considering implementing a prior authorization process for high-cost procedures (e.g., MRIs and CAT scans).

Department of Health Care Policy and Financing Response:

- a. Partially Agree. Implementation Date: 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, the Program Integrity Unit 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 Unit 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.

b. Agree. Implementation Date: 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.

c. Agree. Implementation Date: October 2009.

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.)

d. Agree. 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.

Oversight of Prior Authorization Contractors

As mentioned earlier, the Department contracts with ACS and CFMC to provide prior authorization services for durable medical equipment and supplies. CFMC

reviews prior authorization requests for medical necessity for high-cost equipment, such as hospital beds, motorized lifts, respiratory devices, and certain prosthetic and orthotic equipment. ACS reviews prior authorization requests for other items, such as medical supplies, equipment repairs, and oxygen. Additionally, during the period of the audit, ACS was responsible for completing the data entry for all prior authorization requests, including those reviewed by CFMC, and sending notification of approval or denial of services to clients and providers.

As part of the audit, we interviewed staff from the Department and the two prior authorization contractors to gain an understanding of the requirements and processes used for prior authorizations of durable medical equipment and supplies and the Department's oversight of these activities. We also examined meeting minutes from the Acute Care Utilization Management Committee meetings, the Prior Authorization Reviews Processing group, and the Prior Authorization Review Improvement Team; annual reports submitted by CFMC and ACS; policies; and other documents related to these functions. We identified several concerns with contract provisions and oversight of prior authorization and medical necessity determination services performed by the Department's two contractors, which are described in greater detail below.

Contract Provisions: We noted improvements that could be made with provisions in the contracts. Specifically, provisions in the Department's contract with ACS related to operational responsibilities and timeliness are not as robust as those in the CFMC contract. For example, ACS's contract does not include specific requirements related to its prior authorization responsibilities and does not require ACS to:

- Prospectively review a specified number of prior authorization requests for quality control purposes.
- Process requests within a specific timeframe.
- Define the type of medical professional who should perform prior authorization functions. We will discuss this issue in greater detail later in this section.
- Implement a process for tracking and reviewing appeals.
- Provide reporting to the Department on a predetermined schedule and with pre-approved formats of prior authorization activity and timeliness.
- Participate in status meetings with the Department.

The request for proposal related to ACS's contract does include these requirements. However, by not including them in the final ACS contract, the Department lacks assurance that ACS will adhere to these requirements. In comparison, CFMC's contract cites numerous requirements related to its prior

authorization responsibilities, including the number of prior authorization reviews to be conducted annually, the need for written policies and procedures, timeframes for conducting the reviews, the denial and appeal process, and reporting responsibilities.

Although CFMC staff perform prior authorization reviews of more medically complex equipment and supplies, the services provided by both contractors are similar and standardizing contract provisions would ensure consistency of service delivery, provide needed guidance to ACS regarding its responsibilities, and improve the quality of services provided to Medicaid clients and contracted physicians. The Department should review both contracts and identify ways to standardize them.

Staff Qualifications: We noted differences in the types of staff assigned by both contractors to perform prior authorization reviews. CFMC assigns only registered nurses (RNs) and physicians to conduct medical necessity decisions. RNs review all prior authorization requests and solicit input from physicians, as necessary. If an RN determines that a request should be denied, that request is forwarded to a physician with specialty expertise (if necessary) to make the final decision. In comparison, at the time of our audit, ACS assigned two licensed practical nurses (LPNs) and an emergency medical technician (EMT) to perform medical necessity reviews. ACS staff reported that prior to 2007, two RNs performed these reviews, but due to ongoing nursing shortages, they were replaced with two LPNs and one EMT. In addition, there is no physician oversight of the prior authorization process at ACS, even when a denial of service is considered.

The Department's contracts do not clearly state the qualifications needed to approve and deny prior authorization requests. Additionally, the contracts are not standardized. For example, the CFMC contract states that prior authorization reviews "shall be performed by qualified clinical staff and conducted in accordance with applicable state and federal regulations utilizing nationally recognized, evidenced-based criteria." In comparison, the ACS contract states that the "Contractor shall screen all designated Contractor personnel to ensure that all individuals are fully qualified to work on this contract and, if required by law or ordinance, are validly licensed and/or have obtained all requisite permits." We found that neither contract defines "qualified clinical staff" or "individuals that are fully qualified."

To ensure high-quality and consistent prior authorization reviews from both contractors, the Department should develop standard qualifications for personnel making medical necessity decisions. Health care accreditation entities, such as the National Committee for Quality Assurance and the Utilization Review and Accreditation Commission, require that all medical necessity review programs

include physician oversight and should be conducted by licensed health care professionals. Further, several national managed care organizations and state Medicaid programs require that registered nurses perform these reviews. The standards and recommendations of these organizations can serve as resources to the Department in developing applicable requirements.

Processing of Prior Authorization Requests: We noted inconsistencies with requirements related to prior authorization request submissions. At the time of our audit, providers submitted prior authorization requests to CFMC via fax or mail. Once a request was approved or denied, CFMC forwarded the paperwork to ACS via courier, and ACS staff input the necessary information into the MMIS. In comparison, providers submitted requests to ACS via a web-portal, and ACS staff made decisions electronically. For all requests, ACS notified the provider and client of the decision via mail. Providers and staff from the two prior authorization contractors informed us that these two different submission methods were often confusing to providers and sometimes led to adverse outcomes. For example, if a prior authorization request was sent to the wrong contractor, that contractor denied the request and issued the denial in writing to the provider. Once the provider received the denial, it had to forward the paperwork to the correct contractor and the process began again. This could result in delays in proper care being delivered to clients.

During our audit, the Department began implementing an electronic system, which it hopes will standardize and streamline the processing of prior authorization requests. However, this system only allows the one-way transfer of information from CFMC to ACS. To truly streamline the prior authorization process, the Department should consider an electronic system that allows the transmission of information among providers, the two prior authorization contractors, and the Department.

Contract Oversight: We found that the Department does not specifically monitor the two contractors' activities related to prior authorizations and medical necessity determinations for durable medical equipment and supplies. Instead, Department staff primarily rely upon self-reported data from the contractors to monitor compliance. Currently Department staff do not perform on-site reviews of the contractors' records to verify the accuracy of self-reported data and measure compliance with contract provisions related to prior authorization and medical necessity functions for equipment and supplies. We also found that Department staff responsible for overseeing the durable medical equipment and supplies program and the two prior authorization contracts were not familiar with many of the operational details of the program and relied solely upon each contractor's request for proposal response for information on the contractors' processes and performance.

Periodic on-site reviews of the contractors would be valuable to ensure compliance with contractual requirements and Department policies and to determine the appropriateness of medical necessity determinations and prior authorization decisions. Further, the Department could use these performance reviews to assess the effectiveness of the processes used by the contractors and to identify improvements to the system, including ways to standardize processes and strengthen the Department's contracts related to these responsibilities. It is standard industry practice to monitor contractor performance, although the extent of this monitoring can vary from state to state and contractor to contractor based on the type of responsibilities the contractor has and the resources available within the state.

Contractual Arrangement: The Department has not recently evaluated the cost-benefit of contracting with two separate organizations to provide prior authorization services for durable medical equipment and supplies requested for Medicaid clients. Such an evaluation could help the Department determine whether its current contractual arrangements for these services are effective and efficient. As discussed earlier, we identified several inconsistencies and inefficiencies with the contracts' provisions for and services delivered by the two contractors. Consolidation of the two contracts into one could eliminate some of these problems. For example, consolidation may improve the timeliness of decision-making, ensure that qualified staff are making and overseeing medical necessity decisions, streamline the process for providers, and standardize reporting. Consolidation would also streamline contract monitoring by the Department and reduce costs associated with this monitoring.

Recommendation No. 6:

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.
- 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.

- c. Implementing a formal oversight program for each of its prior authorization contractors, including on-site visits.
- d. Requiring its prior authorization contractors to standardize how providers submit prior authorization requests, including the use of electronic processing and interfaces.
- e. Assessing whether consolidating prior authorization functions under one contract would be cost-effective.

Department of Health Care Policy and Financing Response:

- a. Agree. 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.

- b. Partially Agree. 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.

c. Agree. 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.

d. Agree. 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.

e. Agree. 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.

Data Management

As discussed throughout this report, there were several instances during the audit where the Department was unable to provide complete, accurate, and timely data from MMIS that is essential for managing its Medicaid Program. These data problems not only caused significant delays in our completion of this audit but also limited our ability to test the payment controls used by the Department for durable medical equipment and supplies, laboratory, and radiology claims paid by the Medicaid Program. These problems raise concerns about the Department's ability to manage data for program decision making and respond timely to federal oversight agencies, such as the Centers for Medicare and Medicaid Services. We describe the data problems we identified below.

Data on Dual-Eligible Clients: During the audit, the Department twice provided us with incomplete and inaccurate claims information. Additionally, early in the audit we discovered conflicting information in the eligibility files provided by the Department related to Medicaid clients' eligibility for Medicare. We notified the Department of the discrepancies, and the Department provided further instruction on how to use the appropriate fields within the existing data extract. Later in the audit, when we provided potential exceptions to the Department for review, the Department reported that the data files did not contain the fields necessary to complete our analysis. In particular, these missing fields were necessary to identify whether the provider submitted the claim to Medicare prior to billing Medicaid. Because of the delays in the audit as a result of these problems, it was too late to request another data extract; therefore, we were unable to test the appropriateness of claims for dual-eligible clients to the extent originally planned.

Data on Third Party Liability Coverage: As mentioned in Chapter 1, we were unable to complete our review of claims involving third party payers. Specifically, Department staff reported to us late in the audit that the third party payer information in the data file provided to us was not validated for accuracy and could not be relied upon for our analysis.

Department staff also described to us some of the problems they have encountered with obtaining timely and accurate data on third party payers from MMIS. Staff explained that the Department maintains two different files related to third party payers, one file in Colorado Benefits Management System (CBMS, which is the State's eligibility system) and another in MMIS (the system used to pay claims). Third party payer information recorded in CBMS must be transferred on a weekly basis to MMIS. As a result, updated information is not available to Department staff and in MMIS for 36 hours after the transfer begins. Department staff reported that this delay can lead to inaccurate claims payments because the correct third party payer data are not available at the time claims are processed. In

addition, Department staff reported that updating third party payer information is a time-intensive process. This is because any changes to this information must be manually entered into CBMS, which takes approximately 20 to 30 minutes per client. Staff report that they receive between 500 and 1,500 records per month requiring updates to this information. Further, Department staff must contact insurers and query the companies' Web sites to verify all information recorded in CBMS. The Department has assigned one FTE to input the data, and as a result, third party files are often not current.

Department staff reported that they have requested that the Customer Service Request Committee, which includes staff from ACS and the Department, make certain system enhancements intended to reduce manual data entry time, improve the reliability of the third party payer information in MMIS and CBMS, and ensure there are no improper claims payments. However, as of our audit, these system enhancements have not been developed, approved, or implemented.

Pricing Data: Department staff did not provide complete information about the different pricing methodologies used for durable medical equipment and supplies, laboratory, and radiology services until late in the audit. Our initial data request asked for all allowable reimbursement rates and fee schedules by procedure code for durable medical equipment and supplies, laboratory, and radiology services. The Department only provided us with one fee schedule. After our analysis was completed, Department staff informed us that it used six different pricing methodologies to determine the fees paid to providers. Due to this omission, we were unable to assess whether claims were appropriately paid using the additional pricing methodologies. We also identified other discrepancies with the pricing data provided by the Department. For example, the fee schedule we received from the Department contained conflicting fees for the same procedure codes and dates of service. Further, certain procedure codes contained no fee or a fee value of zero, although the fee schedule instructions listed a payment amount other than zero.

The Department's ability to access and use timely, accurate, and complete data is essential to the effective and efficient operations of its Medicaid Program, particularly related to functions such as budgeting and forecasting, medical management, program planning and reporting, eligibility determinations, claims payments, and contractor oversight. Further, the Department's provision of timely, accurate, and complete data to auditors is important for ensuring the integrity of the audit process. The Department needs to reassess the policies, procedures, and systems in place for retrieving Medicaid data for its own uses as well as for audit requests from federal agencies and other oversight entities, such as the General Assembly. In particular, the Department should evaluate:

- Whether its current processes ensure that appropriate and knowledgeable staff are responding to questions and retrieving data about the Medicaid Program. We experienced a number of delays in completing this audit because Department staff could not address our data questions and, in many instances, provided erroneous data to us, as described in the examples listed above. Further, Department managers reviewing the data often did not identify errors. Currently the Department does not include the expectation that managers provide timely, accurate, and complete responses to audit and other information requests by oversight agencies in managers' performance plans. This is one way the Department could hold its managers accountable for providing timely, accurate, and complete responses.
- Whether accurate data essential for managing the program can be retrieved from its data systems. In particular, the Department should explore options for enhancing its data systems to provide accurate third party payer data in an efficient and timely manner.

The Department should use the results of this evaluation to improve its management of Medicaid data for its own uses and to respond to audit requests from oversight agencies, such as federal agencies and the General Assembly.

Recommendation No. 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.

Department of Health Care Policy and Financing Response:

Partially Agree. Implementation Date: 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.

Auditor's Addendum:

Extensive, repeated efforts were made to address the Department's data omissions, errors, and discrepancies and to work with staff to clarify the fields to be used for data analysis. The larger concern is the Department's ability to access accurate and timely data to support decision-making and to respond to oversight bodies.

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