DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

October 4, 2011

Report Number: A-07-11-04178

Ms. Susan E. Birch
Executive Director
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Dear Ms. Birch:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Costs Claimed for Selected High-Dollar Outpatient Services in the Colorado Medicaid Program During the Period January 1, 2007, Through December 31, 2009.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Debra Keasling, Audit Manager, at (816) 426-3213 or through email at Debra.Keasling@oig.hhs.gov. Please refer to report number A-07-11-04178 in all correspondence.

Sincerely,

/Patrick J. Cogley/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF COSTS CLAIMED FOR SELECTED HIGH-DOLLAR OUTPATIENT SERVICES IN THE COLORADO MEDICAID PROGRAM DURING THE PERIOD JANUARY 1, 2007, THROUGH DECEMBER 31, 2009

Daniel R. Levinson
Inspector General

October 2011
A-07-11-04178

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements. In Colorado, the Department of Health Care Policy and Financing (the State agency) is responsible for administering the Medicaid program.

The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. The State agency's FMAP rates ranged from 50.00 percent to 61.59 percent for claims paid during calendar years (CY) 2007 through 2009 (January 1, 2007, through December 31, 2009).

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

During CYs 2007 through 2009, the State agency processed and paid approximately 4.3 million outpatient service claims. We selected and reviewed 278 claims totaling $4,529,829 ($2,477,275 Federal share) for outpatient services with line item paid amounts greater than $10,000 that the State agency processed and paid during this time period. We will refer to outpatient services whose claims included at least one line item paid amount greater than $10,000 as "high-dollar outpatient service claims."

OBJECTIVE

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

SUMMARY OF FINDINGS

During CYs 2007 through 2009, the State agency did not always claim costs for selected high-dollar outpatient service claims pursuant to Federal and State requirements. Of the 278 high-dollar outpatient service claims that the State agency claimed for payments it made to providers during this period, 239 were allowable. For the remaining 39 high-dollar outpatient service

claims, providers reported incorrect charges and could not provide documentation to support that some of the outpatient services were provided. This resulted in overpayments totaling $272,626 ($149,248 Federal share).

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

RECOMMENDATIONS

We recommend that the State Agency:

- refund $149,248 to the Federal Government and

- use the results of this audit in its ongoing provider education activities related to incorrect charges and proper documentation.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described corrective actions that it implemented or planned to implement. The State agency's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

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

Colorado Medicaid Program

In Colorado, the Department of Health Care Policy and Financing (the State agency) is responsible for administering the Medicaid program. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. The State agency's FMAP rates ranged from 50.00 percent to 61.59 percent for claims paid during calendar years (CY) 2007 through 2009 (January 1, 2007, through December 31, 2009).

Colorado Medical Assistance for Outpatient Services

The State agency's Medicaid program provides certain medical services, including outpatient services. The State agency uses its Medicaid Management Information System (MMIS) to process outpatient hospital claims.[1] During CYs 2007 through 2009, the State agency processed and paid approximately 4.3 million outpatient hospital service claims. We selected 278 claims for outpatient services with line item paid amounts greater than $10,000 that the State agency processed and paid during this time period. We will refer to outpatient services whose claims included at least one line item paid amount greater than $10,000 as "high-dollar outpatient service claims."

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

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OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed 278 claims, or portions of claims, for high-dollar outpatient services totaling $4,529,829 ($2,477,275 Federal share) that the State agency claimed for Federal reimbursement during CYs 2007 through 2009.

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

We performed fieldwork at the State agency in Denver, Colorado, and at selected provider locations, from September through December 2010.

Methodology

To accomplish our objective, we did the following:

- We reviewed applicable Federal and State laws, regulations, and guidance, as well as the CMS-approved State plan.

- We interviewed State agency officials to gain an understanding of how the State agency processed and adjusted claims for outpatient services.

- We used the State agency's MMIS outpatient paid claims data to identify 278 high-dollar outpatient claims totaling $2,477,275 (Federal share) that had been paid to 34 providers. To identify high-dollar outpatient claims, we:

    - initially selected 35 claims (associated with 7 providers[2]) with line item paid amounts greater than $15,000 for which we reviewed the entire claim, and

    - additionally selected 243 claims (associated with 34 providers) with line item paid amounts greater than $10,000 for which we reviewed only the line item rather than the entire claim.

[2] These 7 providers were included in the 34 providers associated with the 243 claims mentioned just below.

- We contacted the State agency to determine whether the 278 high-dollar outpatient service claims had been reviewed by its Program Integrity unit.

- We contacted officials from the 34 providers that received the 278 high-dollar payments and requested assessments as to whether the information originally reported on the claims was correct, and if not, why the claims were incorrect. As part of this assessment, we requested corrected claim information if applicable.

- We reviewed supporting documentation received from the providers to verify the providers' assessments of the selected claims.

- We summarized and submitted to the State agency information regarding claim corrections, overpayments, and related correspondence that we received from the providers.

- We provided the results of our review to State agency officials on May 10, 2011.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

During CYs 2007 through 2009, the State agency did not always claim costs for selected high-dollar outpatient service claims pursuant to Federal and State requirements. Of the 278 high-dollar outpatient service claims that the State agency claimed for payments it made to providers during this period, 239 were allowable. For the remaining 39 high-dollar outpatient service claims, providers reported incorrect charges and could not provide documentation to support that some of the outpatient services were provided. This resulted in overpayments totaling $272,626 ($149,248 Federal share).

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

FEDERAL REQUIREMENTS

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

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

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

STATE REQUIREMENTS

Pursuant to 10 Code of Colorado Regulations 2505-10, section 8.040.2, providers are required to maintain documentation to support claims for a minimum of 6 years. Required documentation includes information concerning the recipient, the service, the charges, and the provider.

UNALLOWABLE HIGH-DOLLAR OUTPATIENT SERVICE CLAIMS

Of the 278 high-dollar outpatient service claims that we reviewed, 39 contained errors resulting in overpayments. Although the State agency had procedures in place to detect incorrect charges for Medicaid high-dollar outpatient services, these procedures did not always prevent claim errors.

Based on the results of our review, we determined that the State agency received $149,248 in unallowable Federal reimbursement.

Unit Quantity Errors

Providers submitted 26 claims with unit quantity errors, resulting in overpayments of $213,854 ($117,162 Federal share). Unit quantity errors refer to instances in which a provider bills for an incorrect number of units for a particular service provided. For example, one provider submitted a claim whose unit quantity was based on the dosage rather than on the actual units of service. Specifically, the provider should have billed for one unit (a 250ml dose) of a tetanus shot. Instead, though, the provider billed for 250 units (each of a 250ml dose) of the tetanus shots. This error resulted in an overpayment of $51,049 ($31,441 Federal share).

Other Billing Errors

Providers submitted three claims with other billing errors, resulting in overpayments of $30,749 ($18,074 Federal share). For example, one provider submitted an incorrect claim because its chargemaster[3] contained an incorrect billing amount for the medical supply used. This error resulted in an overpayment of $23,581 ($13,861 Federal share).

Unsupported Claims

In addition, providers billed for 10 claims, each of which included some outpatient services for which the providers were unable to provide supporting documentation. The providers indicated that these errors resulted in overpayments that required claim adjustments. The overpayments totaled $28,023 ($14,012 Federal share).

[3] A provider's chargemaster contains data on every chargeable item or procedure that the provider offers.

RECOMMENDATIONS

We recommend that the State Agency:

- refund $149,248 to the Federal Government and

- use the results of this audit in its ongoing provider education activities related to incorrect charges and proper documentation.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described corrective actions that it implemented or planned to implement. The State agency's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

September 7, 2011

Patrick J. Cogley, Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services, Region VII
601 E. 12th St., Room 0429
Kansas City, MO 64106

Mr. Cogley:

Please see the attached document that contains the Department of Health Care Policy and Financing's submission of responses to the draft report entitled *Review of Costs Claimed for Selected High-Dollar Outpatient Services in the Colorado Medicaid Program During the Period January 1, 2007, Through December 31, 2009* (Report Number A-07-11-04178).

If you have any questions or comments, please contact me at 303-866-6575 or kim.nguyen@state.co.us.

Sincerely:

Kim Nguyen
Audit Tracker and Analyst, Audits and Compliance Division
Department of Health Care Policy and Financing

Department of Health Care Policy and Financing's
Initial Response to the
Department of Health & Human Services
Office of Inspector General
Review of Costs Claimed for Selected High-Dollar Outpatient Services in the Colorado Medicaid Program During the Period January 1, 2007, Through December 31, 2009
Control Number A-07-11-04178
August 2011

RECOMMENDATION 1

We recommend that the State Agency:

- refund $149,248 to the Federal Government.

Response: *Concur.*

The Department agrees to refund the federal financial participation of $149,248 for unallowable federal reimbursement. The Department has already verified $42,063 in identified overpayments, and they have been recovered through provider submitted claims adjustments. For the remaining $107,185 of unallowable federal reimbursement, the Department has sent demand for repayment letters to the hospitals involved.

At this time, providers can appeal the demand for repayment. The Department will proceed with offsetting of payments to recover the remaining overpayments once the appeal period has passed. The Department does not anticipate any challenges as all providers previously agreed with the OIG that incorrect billed amounts were submitted.

RECOMMENDATION 2

We recommend that the State Agency:

- use the results of this audit in its ongoing provider education activities related to incorrect charges and proper documentation.

Response: *Concur.*

The Department will publish a provider newsletter article specific to the results of this audit, which illustrates the expense and impact of clerical errors and of insufficient records retention.

The Department has recently begun to, twice-yearly, include an article in its provider newsletter to remind providers about their responsibility to retain records for six (6) years. This requirement is routinely communicated in provider training given by the Department's fiscal agent and is clearly documented in provider billing manuals.