DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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

April 23, 2012

Report Number: A-07-11-04180

Ian McCaslin, M.D., M.P.H.
Director
Missouri HealthNet Division
Missouri Department of Social Services
P.O. Box 6500
Jefferson City, MO 65102

Dear Dr. McCaslin:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG), final report entitled *Missouri Did Not Always Correctly Claim Medicaid Costs for Selected High-Dollar Outpatient Claims.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

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If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Debra Keasling, Audit Manager, at (816) 426-3213 or through email at Debra.Keasling@oig.hhs.gov. Please refer to report number A-07-11-04180 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

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

Daniel R. Levinson
Inspector General

April 2012
A-07-11-04180

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 Missouri, the Department of Social Services, Missouri HealthNet Division (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 62.42 percent to 74.43 percent for claims paid during calendar years (CY) 2008 through 2010 (January 1, 2008, through December 31, 2010).

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 2008 through 2010, the State agency processed and paid approximately 6.1 million outpatient service claims. We selected and reviewed 411 claims totaling $14,481,171 ($10,445,002 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 2008 through 2010 pursuant to Federal and State requirements.

SUMMARY OF FINDINGS

During CYs 2008 through 2010, the State agency did not always claim costs for selected high-dollar outpatient service claims pursuant to Federal and State requirements. Of the 411 high-dollar outpatient service claims totaling $10,445,002 (Federal share) that the State agency claimed for payments it made to providers during this period, 211 were allowable. For the remaining 200 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 $321,292 ($226,158 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 $226,158 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 agreed with our recommendations and described corrective actions that it had taken or planned to take.

The State agency's comments appear 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)(2), the State must refund the Federal share of unallowable overpayments made to Medicaid providers.

Missouri Medicaid Program

In Missouri, the Department of Social Services, Missouri HealthNet Division (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 62.42 percent to 74.43 percent for claims paid during calendar years (CY) 2008 through 2010 (January 1, 2008, through December 31, 2010).

Missouri 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 2008 through 2010, the State agency processed and paid approximately 6.1 million outpatient service claims. We selected and reviewed 411 claims for outpatient services with line item paid amounts greater than $10,000 that the State agency processed and paid during this time period. We will refer to outpatient services whose claims included at least one line item paid amount greater than $10,000 as "high-dollar outpatient service claims."

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

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed costs for selected high-dollar outpatient service claims during CYs 2008 through 2010 pursuant to Federal and State requirements.

Scope

We reviewed 411 claims for high-dollar outpatient services totaling $14,481,171 ($10,445,002 Federal share) that the State agency claimed for Federal reimbursement during CYs 2008 through 2010.

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 Jefferson City, Missouri, and at selected provider locations, in June and August 2011.

Methodology

To accomplish our objective, we did the following:

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

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

- We used the State agency's MMIS outpatient paid claims data to identify 1,970 high-dollar outpatient claims totaling $36,249,442 (Federal share) that had been paid to 80 providers. We then selected and reviewed 411 of these high-dollar outpatient claims totaling $10,445,002 (Federal share) that had been paid to 20 providers. (We considered an outpatient service claim containing at least one line item paid amount greater than $10,000 as a high-dollar outpatient claim.)

- We contacted the State agency to determine whether the 411 high-dollar outpatient service claims had been reviewed by the Missouri Medicaid Audit and Compliance Unit.

- We contacted officials from the 20 providers that received the 411 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 February 1, 2012.

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 2008 through 2010, the State agency did not always claim costs for selected high-dollar outpatient service claims pursuant to Federal and State requirements. Of the 411 high-dollar outpatient service claims totaling $10,445,002 (Federal share) that the State agency claimed for payments it made to providers during this period, 211 were allowable. For the remaining 200 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 $321,292 ($226,158 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 13 Code of State Regulations 70-3.030(3)(A)4, providers are required to maintain documentation to support claims for a minimum of 5 years.

UNALLOWABLE HIGH-DOLLAR OUTPATIENT SERVICE CLAIMS

Of the 411 high-dollar outpatient service claims totaling $10,445,002 (Federal share) that we reviewed, 200 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 $226,158 in unallowable Federal reimbursement.

Unit Quantity Errors

Providers submitted 147 claims with unit quantity errors, resulting in overpayments totaling $159,575 ($114,654 Federal share). Unit quantity errors refer to instances in which a provider bills for an incorrect number of units for a particular service provided. For example, one provider incorrectly billed the State agency for an implant device. The provider billed for two devices although only one had actually been implanted. This unit error resulted in an overpayment of $33,472 ($23,845 Federal share).

Other Billing Errors

Providers submitted eight claims with other billing errors resulting in overpayments totaling $102,593 ($70,545 Federal share). For example, one provider incorrectly billed two inpatient service claims as outpatient service claims. These two errors resulted in an overpayment of $73,584 ($49,650 Federal share).

Unsupported Claims

In addition, providers billed for 45 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 $59,124 ($40,959 Federal share).

RECOMMENDATIONS

We recommend that the State agency:

- refund $226,158 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 agreed with our recommendations and described corrective actions that it had taken or planned to take.

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

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

JEREMIAH W. (JAY) NIXON, GOVERNOR • BRIAN KINKADE, INTERIM DIRECTOR

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March 23, 2012

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Inspector General
601 East 12th Street, Room 0429
Kansas City, MO 64106

Dear Mr. Cogley:

This is in response to the Office of Inspector General's (OIG) draft report entitled "Missouri Did Not Always Correctly Claim Medicaid Costs for Selected High-Dollar Outpatient Claims", Report Number A-07-11-04180. The Department of Social Services' (DSS) responses are below. The OIG recommendations are restated for ease of reference.

Recommendation 1: OIG recommends that the State agency refund $226,158 to the Federal Government.

DSS Response: DSS agrees with this recommendation. The State has recovered the overpayments for approximately half of the payments. For the remaining overpayments, the State will initiate system adjustments or request a check from the provider for claims too old to adjust systematically. As the State recovers these payments from the provider, the appropriate adjustments will be reported on the CMS64.

Recommendation 2: OIG recommends that the State agency use the results of this audit in its ongoing provider education activities related to incorrect charges and proper documentation.

DSS Response: DSS agrees with this recommendation. The State completed system work in April 2010 to suspend provider's claims for review when an established threshold has been exceeded. Providers are educated based on the review determination.

Please contact Julie Creach of my staff at 573/751-8985 if you have further questions.

Sincerely,

Ian McCaslin, M.D., M.P.H.
Director

IM:jc

cc: James G. Scott