GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)

RECOVERY AUDIT CONTRACTOR (RAC)
Audit Agenda for the 1st Quarter (Q1) of
State Fiscal Year 2018

June 1, 2018
I. BACKGROUND

Myers and Stauffer LC (“MSLC”), under contract with the Department of Community Health (“the Department” or “DCH”) and in accordance with Federal law, is the Medicaid Recovery Audit Contractor (“RAC”) for the State of Georgia Medicaid program.

Pursuant to this contract and in consultation with the Department, MSLC develops and performs audits of fee-for-service (FFS) claims submitted to the Medicaid program for the purpose of identifying and recouping overpayments and identifying and restoring underpayments. The look back period for audits of FFS claims is five years.

The Department has approved the following audits for the first quarter (July 1, 2017 – September 31, 2017) of State Fiscal Year (SFY) 2018:

II. ACTIVE AUDITS

HOSPITAL INPATIENT NEONATAL INTENSIVE CARE UNIT (NICU) SERVICES (CATEGORY OF SERVICE 010)

Section 903.6, Part II, Policies and Procedures for Nursing Facilities, states that Medicaid only covers services that are medically appropriate and necessary and that to determine appropriateness of inpatient admission, inpatient-qualifying criteria designated by the Division [of Medical Assistance], such as InterQual™, will be used by the hospital…"based on information about the patient’s medical condition available at the time of presentation."

MSLC is engaged in an ongoing review of hospital claims for inpatient services involving Neonatal Intensive Care Unit (NICU) services. Such claims often qualify for supplemental outlier payments. This review is “complex”, involving the review of medical records. MSLC’s clinical team is reviewing hospitals’ utilization reviews and performing its own reviews utilizing InterQual™ criteria to determine if the daily levels of care are appropriate and correspond to appropriate revenue codes when billed to Medicaid. MSLC issued findings of overpayments to a number of hospitals, resulting in recoveries. We are expanding this review to include additional NICU claims submitted by providers in the pilot study, along with claims that include outlier payments from additional hospital providers where NICU services show a relatively frequent usage of the highest revenue code (RC174).

NURSING HOME AND HOSPICE CLAIMS WITH OVERLAPPING DATES OF SERVICE (COS 110 AND 690)

During the performance of patient liability reviews, MSLC auditors noted what appear to be claims for nursing home services and hospice services with overlapping dates of service for some members, resulting in potential overpayments. Following our review of records requested from a number of nursing home and hospice providers, we issued findings of overpayments to

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1 This list is subject to change at any time. The Department may request that MSLC terminate or modify audits or perform additional audits due to changed circumstances and/or new information.
a number of providers, most of whom have concurred with our findings and made repayments. We will monitor the remaining recoveries and close this review.

**OUTPATIENT HOSPITAL SERVICES WITHIN THREE DAYS OF “RELATED” INPATIENT SERVICES (COS 070)**

Section 906(H), *Part II, Policies and Procedures for Hospital Services*, provides that services provided within three (3) days of inpatient admission for the same or related diagnosis are considered part of the admission and are not separately reimbursable. MSLC performed claims data analysis which identified potential overpayments for claims submitted by numerous hospitals. After issuance of initial findings of overpayments to a limited number of hospitals and receipt of concurrences with our findings, we expanded this review and issued findings of overpayment to additional hospitals. We have extended this audit claims involving diagnostic codes defined by ICD-10, which became effective on October 1, 2015. To date, most providers have concurred with our findings. MSLC will continue our recovery efforts for this review.

**HOSPITAL INPATIENT CLAIMS FOR READMISSIONS (COS 010)**

Under section 904, *Part II: Policies and Procedures for Hospital Services*, a readmission for the same or related problem within three (3) days of discharge is considered the same admission. We have identified potential mispayments attributable to readmissions which have not paid in accordance with this policy, and have consulted with the Department regarding an appropriate review methodology which will regroup and reprice the consolidated inpatient claim. We initiated this review with issuance of findings of overpayment to several providers. Following our receipt of concurrences from a number of these providers and confirmation of our methodology, we expanded our review and have issued initial findings of overpayments to additional providers. We assisted the Department with the review of three providers initiated by DCH. Most providers have concurred with our initial findings of overpayments and recoveries have been initiated. MSLC will continue recovery efforts for the additional providers. To this point, relatedness of split billed admissions has been determined by matching the diagnostic category of each admission’s principal diagnosis. MSLC has identified additional admissions within the three day window that are related, but did not meet the prior methodology for relatedness. As a result, we plan to modify our methodology to include a clinical component when relating admissions. We are performing data analysis and will consult with the Program Integrity Director about potential overpayments.

**HOSPITAL INPATIENT CLAIMS – VALIDATION of DRGs with MAJOR COMPLICATIONS AND CO-MORBIDITIES (MCCs) (COS 010)**

With respect to DRGs for hospital inpatient claims, the Tricare DRG Grouper 30, which became effective on April 1, 2014, added third levels of severity - “major complications and comorbidities (MCCs)” – for certain DRGs. We have performed preliminary data analysis to determine potential mispayments attributable to the misuse of DRGs with MCCs, focusing on those which involve significant increases in reimbursement. We issued requests for records to five (5) hospital providers for documentation relating to the MCCs involving a sample of inpatient claims. MSLC issued initial findings for three (3) providers who concurred with our findings and two (2) providers who concurred after administrative review. As a result of MSLC’s
preliminary findings and review with DCH, we will expand this review and will include hospital inpatient claims grouped using Tricare DRG Grouper 24, reviewing "complications and comorbidities" (CC).

**DURABLE MEDICAL EQUIPMENT (DME) RENTAL CAP (COS 320)**

Under section 807, *Part II: Policies and Procedures for Durable Medical Equipment*, providers are not reimbursed for more than ten (10) months rental for certain DME items and equipment or for more than the maximum allowable purchase price.

MSLC identified claims involving rental of equipment or supplies which exceed the monthly cap (normally ten months) or the purchase price. After consulting with the Program Integrity Department's DME Subject Matter Experts (SMEs) regarding our audit methodology, initial findings of overpayment were issued. A number of providers have concurred with our initial findings. MSLC will continue to obtain recoveries for the initial round of this review. As a result of MSLC’s preliminary findings, we will expand this review to additional providers.

**IV INFUSION ADD-ON CLAIMS (COS 070)**

We have performed preliminary data analysis identifying IV infusion add-on codes that have been paid without corresponding primary procedure codes. Primary procedure codes must either be billed and paid in history prior to billing the add-on codes or billed along with the add-on codes on the same claims. Overpayments have been identified for category of service 070 (outpatient) and the following CPT codes: 96361, 96366, 96367, 96368, 96370, 96375, 96376, 96411, 96415, and 96417. We consulted with the Department’s SMEs regarding the application of NCCI procedure-to-procedure (PTP) edits in regards to this review. The SMEs confirmed inappropriate denials where modifiers should have bypassed NCCI PTP edits. As a result, our methodology was revised to exclude claims where add-on codes were orphaned due to the inappropriate denial of primary infusion codes for NCCI. The revised methodology was used to issue initial findings of overpayments to additional providers. A number of providers have concurred with our initial findings of overpayments and recoveries have been initiated. There have been multiple requests for administrative reviews and we have consulted with the Department to address issues raised by these providers. MSLC will continue to monitor the remaining recoveries and close this review.

**DURABLE MEDICAL EQUIPMENT (DME) DURING NURSING HOME STAY (COS 320)**

Under section 902.1, *Part II: Policies and Procedures for Durable Medical Equipment*, with limited exceptions, claims for DME equipment, supplies and services may not be submitted for members who reside in nursing facilities. DME services are generally provided to resident Medicaid members by the nursing facilities which receive *per diem* rates paid under the nursing services program.

MSLC identified claims for DME equipment, supplies, or services which appear to have been paid for members residing in nursing facilities. The purpose of this review was to determine whether any such claims constitute overpayments. After consulting with the Program Integrity Department’s DME SME regarding our audit methodology, initial findings of overpayment were
We performed several administrative reviews and discussed the providers’ questions with Department SMEs. In cases where providers contended recouped rentals should not count toward rental caps, claims were submitted to the Department for additional review. DCH completed their reviews and indicated when the provider was entitled to additional rentals. We will monitor the remaining recoveries and close this review.

**DURABLE MEDICAL EQUIPMENT (DME) MONTHLY INDEFINITE RENTALS (COS 320)**

Under Section 907, *Part II: Policies and Procedures for Durable Medical Equipment Services*, certain life-sustaining and respiratory related equipment are considered to be indefinite rentals. Providers receive a monthly rental payment for each month an item of equipment is determined to be medically necessary.

MSLC identified claims for DME equipment designated as indefinite rentals which appeared to have been billed more than the allowable frequency of one per month. The purpose of this review was to determine whether any such claims constitute overpayments. We consulted with the Department’s DME SME about an appropriate audit methodology and issued initial findings. A number of providers have requested administrative reviews regarding the allowance of ventilation backup units. In these cases, Department SMEs clarified policy and instructed MSLC to continue with our original methodology. We continue to recover identified overpayments.

**ONE DAY INPATIENT STAYS (COS 110)**

MSLC has identified inpatient stays for complex clinical review where admission and discharge occurred on the same date. Our audit would include confirmation of admission orders, payment methods, and appropriateness for inpatient admission. MSLC will consult with the Department with respect to further audit work on these claims. MSLC issued record requests to five (5) providers.

**PSYCHOLOGICAL TESTING CPT 96101 (COS 570)**

We have identified potential overpayments for claims with units billed over the five unit maximum for psychological testing CPT 96101. DCH has policies in place limiting the use of CPT code 96101 to a maximum of five units per member per calendar year. MSLC issued initial findings to ten (10) providers.

**CREDIT BALANCE (COS 110, 690, and 010)**

GA Medicaid policy requires providers to submit quarterly reports showing identified Medicaid overpayments as credit balances in the provider’s accounting systems. To support DCH’s effort to recover overpayments to providers accounts, MSLC will review credit balances at acute care hospitals, nursing facilities and certain noninstitutional providers. MSLC will be issuing records request to five (5) hospitals and five (5) nursing facilities.

### III. PRELIMINARY AUDITS
PHYSICIANS PROGRAM (COS 430)

We will perform high level data analysis to identify providers for potential mispayments. This analysis will include measures such as modifier usage, allowed amounts, billed charges, numbers of procedures, and units billed. MSLC will consult with the Department with respect to further audit work on these claims.

INPATIENT HOSPITAL TRANSFERS (COS 010)

Under Part II, Policies and Procedures for Hospital Services, special “transfer pricing” occurs when a member is transferred from one hospital to another for a medically appropriate reason and is transferred back to the originating hospital. For transfers back to the originating hospital, the originating facility receiving the back-transfer for lower level of care is eligible to receive reimbursement for both confinements. To ensure accurate claim processing, the originating facility must request an adjustment to the precertification date span and adjust any previously paid claim for the initial hospitalization; and combine and resubmit as a single claim for both date spans. The dates of service spent in the alternate facility are reflected as leave of absence days. MSLC has identified instances where transfer claims were not combined and resubmitted as a single claim. We are performing data analysis and will consult with the Program Integrity Director about potential overpayments.