GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)

RECOVERY AUDIT CONTRACTOR (RAC)
Audit Agenda for the 4th Quarter (Q4) of State Fiscal Year 2015

May 19, 2015
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 and claims submitted to the Care Management Organizations (CMOs) 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. With respect to claims submitted to the CMOs, MSLC is authorized to perform audits of claims with dates of service greater than one year from the current date and within the five-year look back period.

The Department has approved the following audits for the fourth quarter of State Fiscal Year (SFY) 2015 (April 1, 2015 – June 30, 2015):

II. ACTIVE AUDITS

NURSING HOME AND HOSPICE PATIENT LIABILITY AUDIT
(CATEGORIES OF SERVICE (COS) 110 AND 690)

Section 1010, Part II, Policies and Procedures for Nursing Facility Services, provides that Medicaid members who reside in nursing facilities are required to share the cost of their services by paying an amount that is based on their income (the “patient liability amount”). The local county Department of Family and Children Services (DFACS) determines an individual’s patient liability amount when the individual applies for Medicaid eligibility. A similar patient liability policy applies to Medicaid members enrolled in hospice.

Section 104.3, Part I, Policies and Procedures for Medicaid Providers, provides that the Georgia Medicaid program is the “payor of last resort” and that Medicaid/PeachCare for Kids™ providers must exhaust third party or primary insurance sources prior to filing Medicaid claims.

The Department requested that MSLC initiate a review of hospice and nursing facility providers to determine if potential overpayments or underpayments resulted from systemic incorrect patient liability deduction calculations within the claims processing systems of the two Medicaid fiscal agent contractors (FACs), Affiliated Computer Services, Inc. (ACS) and Hewlett-Packard Enterprise Services (HP), both of whom provided fiscal agent services to DCH during the past five years.

A related issue that potentially impacts the patient liability audit is whether, with respect to some Medicaid members, there was an improper transfer of resources (TOR) which impacted

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.
members’ eligibility or resulted in penalties which affected members’ patient liability amounts.

The Department has requested that MSLC also review this issue as part of the patient liability review.

MSLC has requested from nursing home and hospice providers records which are being reviewed to determine if mispayments (both overpayments and underpayments) occurred. As these reviews are completed, MSLC issues Initial Finding and Final Decision letters. Upon the request of providers, MSLC also conduct administrative reviews to address issues and questions about this review.

**FAIR RENTAL VALUE (FRV) AUDIT OF NURSING HOME PER DIEM RATES (COS 110)**

MSLC performed a review of fee-for-service claims where it appears that nursing facility providers received incorrect reimbursement payments during State Fiscal Years (SFYs) 2010 and 2011 related to the adjustment to per diem rates based on the fair rental value system (FRVS). Claims prior to November 1, 2010 were processed by the fiscal agent Affiliated Computer Services, Inc. and after such date by the fiscal agent Hewlett-Packard Enterprise Services.

Section 1002.5 of Part II, Policies and Procedures for Nursing Facilities provides that:

> Effective for dates of service on and after July 1, 2009, the Property and Related Net Per Diem shall be the higher of: (i) such Per Diem being paid as of June 30, 2009 (based on the Dodge index); or (ii) the amount computed using the fair rental value (FRV) reimbursement system…. Property reimbursement under FRV will replace use of the Dodge index over a three year period beginning July 1, 2009.

FRVS calculations used to adjust per diem rates during the period July 1, 2009 through December 31, 2011 were based upon unaudited numbers; effective January 1, 2012, audited numbers, as determined by the Department of Audits and Accounts (DOAA), were used to calculate the adjustment to per diem rates based on the FRVS. Therefore, the Department determined that adjustments needed to be made for claims with dates of service from July 1, 2009 to December 31, 2011.

MSLC has previously issued Initial Findings of both overpayments and underpayments to approximately 198 nursing facility providers. As provider responses were received, MSLC issued Final Decisions and worked with the Department to collect overpayments. The Department restored underpayments to providers through prospective per diem rate adjustments over a three-month period, from October 1, 2013, through December 31, 2013. During the fourth quarter of SFY 2015 MSLC will continue to monitor and assist with the recoveries with any remaining overpayments in order to complete this review.

**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 production and 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.

As a result of MSLC’s preliminary findings, MSLC has expanded its review of claims for NICU services submitted to Medicaid by additional hospital providers whose claims triggering outlier payments show a relatively frequent usage of the highest revenue code (RC174).

GLOBAL SURGERY CLAIMS (COS 430)

Part II, Policies and Procedures for Physician Services, provides that global surgery claims are generally billed as “bundled” units and restricts, with some exceptions, the separate billing of additional services related to the global surgery procedure.

MSLC has analyzed global surgery claims and Evaluation and Management (E & M) services billed within global surgery periods and has identified E & M services which appear to have been related to the global surgery services, but were billed separately from the global claim, in potential violation of policy and applicable coding standards. MSLC has issued initial findings of potential overpayments and will continue to monitor and assist with the recoveries with any remaining overpayments in order to complete this review.

ALLERGY SERVICES (CATEGORY OF SERVICE 430)

MSLC performed claims analysis of physician claims for services involving allergen immunotherapy, including allergy testing, antigen preparation and allergy injections, including but not limited to, Current Procedural Terminology (CPT) code 95165.

MSLC completed its review of records requested from a number of physicians, and this review revealed potentially improper billing, including claims submitted for services performed by independent contractors. To date, recoveries have been obtained from a number of physicians who received initial findings of overpayments. MSLC has received several requests for administrative review and we are assisting the Department in handling these matters.

“CLIA-WAIVED” DRUG TESTING CLAIMS (COS 430)

MSLC performed preliminary data analysis of drug screens (primarily CPT code 80101) which revealed a high volume of drug screen claims billed by some physicians. MSLC subsequently requested records from selected physicians and performed a review of these records. The current DCH IG has requested that MSLC continue analysis of these claims for potential review or fraud referrals.
HOSPITAL INPATIENT CLAIMS INVOLVING USE OF V27.0 AS THE PRIMARY DIAGNOSIS CODE (COS 010)

At the former DCH IG’s request, MSLC initiated a review of hospital inpatient claims involving use of V27.0 (single live newborn) as the primary diagnosis code, potentially resulting in improper DRG payments. Under coding policies, V27.0 should not be used as a primary diagnosis code. MSLC has identified a number of hospitals which appear to have received incorrect payments due to use of the V27.0 diagnosis code and has issued initial findings to selected hospitals. To date, most of the responding hospitals have concurred with MSLC’s findings. MSLC will continue to monitor any remaining recoveries.

HOSPITAL “DISCOUNT” PROGRAM FOR OUTPATIENT SERVICES (COS 070)

At the former DCH IG’s request, MSLC issued a request for information and records to one hospital relating to its program for patients to pay a discounted price for outpatient services. The issue is whether such a program complies with Medicaid’s policy that providers bill Medicaid for no more than the lowest price offered to the general public. MSLC received and reviewed the records and performed additional data analysis and following consultation with the DCH IG, issued an initial finding of overpayment and received a request for administrative review from the provider. We are consulting with the Department on this matter.

HOME HEALTH SERVICE (COS 200)

MSLC has performed preliminary data analysis of fee-for-service home health services to develop a potential audit plan. Following consultation with the former DCH Deputy Inspector General, MSLC met with AdvanceMed, Georgia’s Medi Medi contractor, which performed preliminary data analysis of Medicare and Medicaid home health service claims. As a result of this data analysis, MSLC issued record requests to a number of home health providers. After receiving responses from these providers and reviewing the records, MSLC has identified vulnerabilities and will consult with the Program Integrity Director before proceeding further.

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 the same Diagnosis Related Group (DRG) is assigned to both hospital claims. In such instances, policy requires that each hospital’s payment will be the lesser of the DRG rate or a rate calculated by the cost-to-charge ratio (CCR).

MSLC previously reviewed hospital transfer claims ending in 2010 and identified and recovered overpayments. During July, 2014, MSLC updated its review of claims involving hospital transfers and identified potential additional overpayments to 98 hospitals. Initial finding letters were issued to these hospitals and during the fourth quarter of SFY 2015 MSLC will continue to monitor and assist with the recoveries with any remaining overpayments in order to complete this review.
PHYSICIANS UPPER PAYMENT LIMIT (UPL) PROGRAM (COS 430)

At the request of the former DCH IG, MSLC is reviewing one hospital and its related physicians’ association for compliance with Federal and State law and policies governing the use of intergovernmental transfers (IGTs) to obtain supplemental physician UPL reimbursement. MSLC has requested supplemental financial records for this review and will continue our review of these records during the fourth quarter of SFY 2015.

MEDICAID WAIVER SERVICES (COS 440, 590, 660, 680, 681 and 930)

With the approval of the former DCH IG, MSLC consulted with Georgia Medicaid’s Medi Medi contractor, AdvanceMed, on a project focusing on a review of Medicaid waiver service claims during periods when dual eligible members received institutional services (e.g. hospital inpatient, skilled nursing care) from Medicare. Preliminary analysis showed potential overpayments attributable to the payment of waiver services during such periods. We are consulting with the Department regarding policy issues and next steps in this review.

NURSING HOME (COS 110)

We previously advised the former DCH IG of an issue identified during the course of performing the patient liability reviews. This issue involves potential overpayments for cross-over claims for dual eligible members (Medicare and Medicaid) who were receiving nursing facility services. It appears that due to a processing anomaly during the period when ACS was the fiscal agent, some non-covered charges were not taken into account when reimbursement for the nursing service claims were calculated, resulting in potential overpayments. This will be an automated review, not requiring a record review.

PSYCHOLOGICAL SERVICES (COS 570)

Under Part II, Policies and Procedures for Psychological Services, there is an annual limitation of five units (hours) per member for psychological testing. Preliminary data analysis suggests that some providers have exceeded this limit without the requisite pre-authorization which would allow additional testing. MSLC will issue initial findings of overpayment to a limited number of providers and consult with the Program Integrity Director about possible expansion of this review.

HOSPITAL INPATIENT CLAIMS FOR 96 OR GREATER HOURS OF MECHANICAL VENTILATION (COS 010)

With respect to inpatient hospital services, several DRGs involve 96 or greater hours of mechanical ventilation provided to members admitted for inpatient services (e.g. DRGs 565 and 575). We will review hospital inpatient claims involving these DRGs to determine the appropriateness of the coding. The preliminary focus of this review will be lengths of stay of four days or less. Similar reviews have been performed elsewhere and have revealed potential overpayments. Following issuance of record requests for samples of claims to selected hospitals, we have issued initial findings and are receiving and reviewing the hospitals’ responses and assisting with recoveries of overpayments.
III. PRELIMINARY AUDITS

PHARMACY CLAIMS FOR MEMBERS ENROLLED IN HOSPICE (COS 300)

As provided by both hospice (Section 903.7, Part II, Policies and Procedures for Hospice Services) and pharmacy (Section 908, Part II, Policies and Procedures for Pharmacy Services) policies, certain categories of medications (e.g. antifungals, sedatives, etc.) are considered to be palliative in nature and are excluded from coverage in the outpatient pharmacy program for hospice members.

Preliminary data analysis has revealed Medicaid reimbursement for outpatient pharmacy claims for medications in these therapeutic classes for members enrolled in hospice. Some of the pharmacies receiving reimbursement specialize in LTC and/or hospice services. We will perform further data analysis and consult with the Program Integrity Director on potential recoveries resulting from improper payments inconsistent with these policies. We will also consult with hospice and pharmacy policy Subject Matter Experts (SMEs) about this review.

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

During the course of performing the patient liability reviews, MSLC auditors have noted for some members what appear to be claims for nursing home services and hospice services with overlapping dates of service. We will perform data analysis to determine if this has, in fact, occurred, and if so, the extent and scope of any resulting potential overpayments. Any review would need to determine which service had priority and this may require a review of records such as the hospice enrollment and/or revocation documents. We will continue data analysis in this review and address questions we have received from the Program Integrity Director.

HOSPITAL INPATIENT CLAIMS FOR DRGs INVOLVING BIRTH WEIGHTS FOR NEWBORNS (COS 010)

A newborn’s weight at time of birth is used to determine assignment of the appropriate DRG for purposes of reimbursement. Birth weight is normally recorded in the medical records. Indications of weight less than actual birth weight may result in the use of improper DRGs and potential overpayments.

Under this proposed review, we have requested that providers self-audit for the accuracy of birth weights on a sample of claims. We are in the process of receiving providers’ responses and will report the results to the Program Integrity Director.
J-CODES UNDER PHYSICIAN SERVICES (COS 430) (new)

We have identified a potential review involving “J-code” claims billed under the physicians program. Some infusion drugs, including iron dextran (J1750), are properly coded by units for billing purposes, although the drugs are injected based on amounts or volume. Iron dextran is billed according to units, and one unit contains 50 mg. This drug is typically billed for one to two units (50-100 mg) per infusion, and according to standards, dosages of this drug should not exceed 1000 mg (20 units). Medicaid policy currently allows a maximum of 100 units (5000 mg) of iron dextran to be billed. Claims analysis reveals that some providers are billing claims exceeding 20 units (1000 mg), and it is possible that these providers are billing, erroneously, by milligrams rather than by units. If occurring, such a practice would result in overpayments. We are performing data analysis and will consult with the Program Integrity Director about potential overpayments.

NATIONAL CORRECT CODING INITIATIVE (NCCI) AND MEDICALLY UNLIKELY EDITS (MUEs) (COS 430) (new)

The Department has been implementing CMS’s National Correct Coding Initiative (NCCI) to promote correct coding methodologies and to control improper coding leading to inappropriate payments. NCCI procedure-to-procedure (PTP) edits are designed to prevent inappropriate payment of services that should not be reported together. NCCI editing also includes Medically Unlikely Edits (MUEs), designed to prevent payment for an inappropriate number or quantity of the same service on a single day.

We have analyzed physician claims for infusion services where it appears that the NCCI edits have denied some, but not all, of the NCCI conflicts. Specifically, our analysis has revealed instances where primary codes have been denied due to NCCI conflicts but add-on codes which are dependent upon the primary codes (e.g. 96361, 96366, 96367, 96368) have been paid and not denied along with the primary codes. (We have dubbed these “orphaned” add-on codes.) We are performing further data analysis and will consult with the Program Integrity Director about potential overpayments.

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