Report of the Vermont State Auditor

May 8, 2007

MEDICAID

NEEDED SYSTEM IMPROVEMENTS AND QUESTIONED PAYMENTS IDENTIFIED

Thomas M. Salmon, CPA
Vermont State Auditor
RPT. No. 07-08

Mission Statement

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STATE AUDITOR

STATE OF VERMONT
OFFICE OF THE STATE AUDITOR

May 8, 2007

Governor James Douglas
Speaker of the House of Representatives Gaye Symington
President Pro Tempore-elect of the Senate Peter Shumlin
Secretary Cynthia D. LaWare, Agency of Human Services

Dear Colleagues:

This is the second report stemming from our review of Vermont's Medicaid program. The attached report identifies system improvements that could be made and approximately $900,000 in potential Medicaid overpayments to physicians and institutions.

The system issues that we found are associated with the edit and audit process used by the claims processing system employed by the State's Medicaid fiscal agent. The edit and audit process is a critical part of assessing the validity of provider claims and, if not implemented properly, can result in improperly paid claims. To its credit, the State's fiscal agent has corrected many of the weaknesses that we brought to its attention and plans on fixing the others. The financial impact of these changes has not been estimated. However, to illustrate the importance of the edit and audit process to payment integrity, for one of the edits that was changed in the course of this review, EDS estimates that it may be able to recoup about $70,000 after finding and analyzing certain claims that should have been rejected by this edit.

The overpayment findings are based on 13 targeted computer analyses of Vermont Medicaid payments to providers that were largely paid in 2004 and 2005. These analyses were performed through a data mining contract with HWT, Inc., of Chicago, a firm with Medicaid claims review experience in 21 states and are based on their proprietary algorithms, adjusted to fit applicable Vermont Medicaid policies and regulations, and applied to selected categories of physician and institutional claims. We have provided the Office of Vermont Health Access (OVHA) with an electronic file detailing each questioned claim. Not all of the dollars highlighted will be collected, or "recouped," from providers. The State may not be able to recoup some of the questioned claims because OVHA has not implemented part of an existing tool that could have identified some of the overpayments or providers could have documentation that supports questioned claims. On the other hand, we believe that it is feasible to recoup a great amount of the estimated overpayments, particularly those that are associated with system problems.

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The results of this audit indicate to me that data mining of paid claims is a useful tool, in conjunction with other controls, to detect potential improper payments. Whether conducted internally, or through a contractor, it should be considered by management as a standard practice. I should also say that, although we found some potentially improper claims as well as claims processing issues, relative to the number of claims that were reviewed, the data mining performed by our contractor did not identify an extremely high amount of potential overpayments. This is good news for the system.

Throughout this effort, we relied on, and appreciate, the cooperation and professionalism of staff at OVHA and the Electronic Data Systems Corporation (EDS) in Williston, the State's fiscal agent for the Medicaid program.

Sincerely,

Thomas M. Salmon CPA

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Vermont State Auditor

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Abbreviations in this report

AHS	Agency of Human Services
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
EDS	Electronic Data Systems Corporation
ESC	Error Status Code
GAO	Government Accountability Office
MFRAU	Medicaid Fraud and Residential Abuse Unit
OVHA	Office of Vermont Health Access
SAO	State Auditor's Office
SFY	State Fiscal Year
SURS	Surveillance and Utilization Review Subsystem
TC	Technical Component

Introduction

The State Auditor's Office (SAO) began an audit of the Medicaid Assistance Program, a Federal and State funded program, on May 16, 2006. In addition to general audit authority in 32 V.S.A. §163(1) and (2), SAO has authority pursuant to 32 V.S.A. §163(11) to "perform, or contract with independent public accountants to perform, financial and compliance audits as required by the Federal Single Audit Act of 1984, 31 U.S.C. §7501 *et seq*.," which covers State agencies' use of Federal funds.

This report is part of a broader effort by this Office to review and assess Medicaid's payment integrity controls. We selected pharmacy payments as the first area of review. Our report, *Medicaid: Audit Identifies $2.2 Million in Questioned Pharmacy Claims*, was issued December 28, 2006.

The objectives of this part of the overall review were to:

1. assess how pre-payment edits and audits in the claims processing system designed to reduce the risk of improper payments are functioning, and
2. use data mining techniques[1] to identify physician and institutional claims that may not have been paid in accordance with Vermont Medicaid rules or standard practice guidelines.

Though Medicaid is a joint Federal/State program, states are responsible for ensuring proper payment and recovering misspent funds. The Agency of Human Services (AHS) is the federally designated State Medicaid Agency. Within AHS, the Office of Vermont Health Access (OVHA) has been charged with the primary responsibility to detect improper payments and recover funds, especially through duties and staff assigned to the Surveillance and Utilization Review Subsystem (SURS) team. Federal regulations require the State to have in place methods for identifying, investigating, and referring suspected fraud cases to law enforcement officials.

[1] Data mining is a term applied to a variety of computer applications designed to extract and analyze specific data and patterns from large amounts of data.

Highlights: Report of the Vermont State Auditor

Medicaid: Needed System Improvements and Questioned Payments Identified

(May 8, 2007, Rpt. No. 07-08)

Why We Did This Audit

The Medicaid program has been designated a "High Risk" program by the U.S. Government Accountability Office (GAO) due to its size, growth, diversity, and fiscal management weaknesses. Vermont's annual Medicaid program and administration expenditures are approximately $1 billion and Medicaid is the largest programmatic area of State government.

Due to past audit findings by this Office and the accounting firm KPMG in audits of Federal Medicaid funds, we decided to focus our efforts primarily on pre-payment integrity controls and procedures and data mining. Data mining is a term applied to a variety of computer applications designed to extract and analyze specific data and patterns from large amounts of data. We selected a data mining contractor and worked with the firm to review paid professional services and institutional claims for potential improper payments.

What We Recommend

Several of our recommendations relate to actions that OVHA and EDS

Findings

One of the principal pre-payment control processes that the Medicaid fiscal agent uses to ensure that it pays only valid claims—the edits and audits process—could be improved. Specifically, we found that about 50 edits and audits were incorrectly inactive, had errors, or were incomplete. Although the fiscal agent, EDS, has corrected many of the errors that we brought to its attention and plans on fixing others, these problems point to a lack of a formal and comprehensive process by EDS and OVHA to manage the edit/audit process. In addition, the State is losing savings opportunities because a software tool designed to review claims for various anomalies has not been fully implemented and there is no plan with specific milestones for the complete implementation of this tool. The financial impact of making the changes to the edit and audits has not been estimated although EDS estimates that it may be able to recoup about $70,000 from one of the changes.

Our data mining analysis also identified nearly $900,000 in potential overpayments, largely in 2004 and 2005. In particular, after discussions with our contractor and OVHA we selected 13 algorithms that were likely to identify and quantify recoverable payments, based on results from other states. In brief, these are the findings:

Algorithm	Potential overpayment
Professional Services Claims Algorithms	
Obstetrical care unbundling—same providers	$4,175
Obstetrical care unbundling—different providers	0
Global surgical unbundling	0
High anesthesia units	257,050
Comprehensive code unbundling (professional services)	236,539
Medicare primary payer	61,388
Evaluation and management, multiple units of service	28,821
Professional services crossover duplicates	49,893
Total, professional services algorithms	$637,866
Institutional Claims Algorithms	
Comprehensive code unbundling (institutional)	$151,520
Outpatient radiology overpayments	54,977
Outpatient surgical rate unbundling	0
Outpatient claims during inpatient stay	18,165
Institutional crossover claim duplicates	20,821
Total, institutional algorithms	$245,483
Total, all algorithms	$883,349

Source: HWT.

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can take to improve the pre-payment edit and audit claims review process. We also recommend that OVHA use data mining as a ongoing tool and seek reimbursement for those claims that it has validated as having been overpaid.

In commenting on a draft of this report, the Secretary, Agency of Human Services provided a summary of actions that the Agency is in the process of taking, or plans to take, in response to our recommendations.

The identified potential overpayments are relatively small compared to the large number of claims reviewed, which is good news. Nonetheless, some of the data mining results pointed to system processing errors and improvements that could be made (and, in some cases, were recently made) to catch these claims before they are paid.

The identification of these potential overpayments is just the start of a process to recoup monies. For example, though the data mining results went through a quality control review, including a review by HWT's medical director, OVHA must review the complete claims information we are providing with this report and determine whether or not those claims are valid and properly paid.

Background

Medicaid was established by the Federal government as a result of amendments in 1965 that added Title XIX to the Social Security Act. Medicaid is jointly funded by the Federal government and the State and pays for medical services for individuals and families with low incomes and resources. Medicaid is the State's largest single program expenditure, with approximately $1 billion in program expenditures in fiscal year 2006. (See appendix I for data on Medicaid spending in Vermont in recent years.)

AHS is the single State Agency designated to administer the Medicaid program. Within the Agency, OVHA is charged with assisting beneficiaries in accessing clinically appropriate health services, as well as administering Vermont's various Medicaid programs efficiently and effectively.

Though jointly financed by states and the federal government, individual states are primarily responsible for ensuring appropriate Medicaid payments through provider enrollment screening, claims review, overpayment recovery, and case referral to law enforcement. Federal statutes or regulations governing Medicaid require states to have an automated claims payment and information retrieval system—intended to verify the accuracy of claims, the correct use of codes, and patients' Medicaid eligibility—and a claims review system—intended to develop statistical profiles on services, providers, and beneficiaries to identify potential improper payments.

Vermont's Medicaid claims processing system is managed and operated by the Electronic Data Systems Corporation (EDS) at its location in Williston. The State paid EDS approximately $700,000 per month during the audit period for its claim processing services.

In 2003 the federal Government Accountability Office (GAO) added Medicaid to its list of high-risk programs, owing to the program's size, growth, diversity and fiscal management weaknesses.[1] The GAO noted insufficient federal and state oversight of Medicaid, putting the program at significant risk for improper payments. The GAO recently noted that funds lost to improper payments and waste can impact states' abilities to serve beneficiaries in need.

[1]GAO's 2007 report, *High-Risk Series: An Update*, continues to list Medicaid as a high-risk program.

Scope & Methodology

In order to assess how pre-payment edits and audits in the claims processing system are functioning, we reviewed applicable EDS system documentation and interviewed EDS systems and claims personnel to gain a general understanding of how the claims processing system worked. In addition, we obtained a table from the EDS system that identified the universe of potential edits and audits in use. For most of the edits and audits,[2] we compared the information in this table to other data in the system to determine whether the edit and audit was active and consistent with related information in the EDS procedures manual and the State's policies. In those cases in which we found that the edit or audit was not active or consistent with EDS or OVHA documentation, we made inquiries to EDS claims personnel as to the cause and documentation of the change. In cases in which additional clarification was needed, we also discussed the issue with OVHA's Director of Reimbursement. During the course of our audit, EDS staff made changes to the system to address many of our findings. In these cases, we verified that the changes were made by reviewing the applicable screens in the claims processing system.

We also obtained and reviewed the planning, decision making, and cost documentation related to the implementation of the McKesson ClaimCheck® and ClaimReview® tools as part of the edit and audit analysis. In addition, we discussed the rationale for the decisions made regarding these tools with the former EDS Claims Manager and the OVHA Deputy Director.

With respect to our data mining objective, we employed a data mining contractor, HWT, Inc., of Chicago, Illinois and Portland, Maine, that specializes in State Medicaid claims analysis. EDS provided HWT with electronic files of professional services and institutional claims paid by Vermont Medicaid. Using these files, HWT analyzed professional services[3] and institutional claims[4] that were paid between July 1, 2004 and December 30, 2005 and July 1, 2004 and March 31, 2006, respectively. (Three of the

[2]We mainly reviewed the edit, limitation audit, and ClaimCheck® and ClaimReview® categories of edits and audits.

[3]Professional services claims include these categories of services: Physician, Dental, Vision, Medicare Professional Services Crossovers, and Medicare Part B Institutional Crossovers.

[4]Institutional claims include these categories of services: Outpatient, Inpatient, Nursing Home, Hospice, Home Health, and Medicare Part A Institutional Crossovers.

professional services claims analyses used data that had paid dates that began January 2, 2004.)

The EDS files contained a total of 9,941,541 paid professional claims (largely physicians) and 1,985,702 paid institutional claims (largely hospitals). However, Physician, Outpatient, and Medicare Crossover paid claims were the primary areas of investigation for this data mining project and these numbered a total of 6,975,942.

Algorithms

An "algorithm" is a mathematical and computing term that means a set of specific steps, procedures, or calculations to address a question or problem. In simplest terms, an algorithm could be considered a recipe, or a list of procedures.

HWT developed the algorithms used in this report based on (1) its work with a variety of state Medicaid agencies, (2) its subject matter expertise regarding national standards and guidelines, such as the American Medical Association's Current Procedural Terminology (CPT) Manual and the federal Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI), and (3) reviews of Vermont's Medicaid policies and rules. Moreover, before running the algorithms against the paid claims data, the State Auditor's Office, HWT, and OVHA worked together to identify Vermont's provider reimbursement policies and billing instructions that applied to the payments under review.

HWT performed validation tests on the preliminary data results, reviewed findings with its medical director, and issued draft results to the State Auditor's Office for further evaluation. The initial algorithms were adjusted and rerun, as necessary, to (1) remove claims that were determined by the HWT Medical Director as likely to be valid and (2) address anomalies identified by HWT, SAO, and/or OVHA staff.

Potential provider overpayment amounts are calculated uniquely for each algorithm, based on the data being examined and Vermont Medicaid rules and standards. Details of the specific overpayment calculation formulas have been included with the final results provided to OVHA.

In addition to calculating the potential overpayments, we also met with EDS and OVHA officials and reviewed applicable system documentation to identify systemic issues that may have caused some of the results.

Government Audit Standards

We conducted this audit from May 2006 to mid-April 2007 in accordance with Generally Accepted Government Auditing Standards, issued by the Comptroller General of the United States.

Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence that provides 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 objectives.

Pre-payment Reviews of Claims

One of the principal processes that the Medicaid fiscal agent, EDS, uses to ensure that it pays only valid non-pharmacy[5] claims—pre-payment edits and audits—could be improved. Specifically, we found that about 50 edits and audits were incorrectly inactive, had errors, or were incomplete. To its credit, EDS corrected many of the problems that we brought to its attention and plans on fixing others. However, the problems that we found point to a lack of a formal and comprehensive process by EDS and OVHA to manage the edit/audit process. In addition, EDS has not yet completely implemented a software tool designed to review claims for various anomalies and does not have a plan with specific milestones and identified resources for the complete implementation of this tool. Until this tool is fully implemented, the State is losing savings opportunities.

Edits and Audits

All non-pharmacy claims are subject to a wide variety of edits and audits—called Error Status Codes (ESC)—in the Medicaid claims processing system. An edit is a computer system inspection of claim data for validity, accuracy and the relationship of information within the claim. An audit compares each new claim to the beneficiary's claims history. There are various types of edits and audits. For example, a limitation audit checks whether a beneficiary has exceeded certain criteria, such as the number of units (e.g., office visits or type of procedure) allowed in a given period of time. ESCs are pivotal to

[5]Pharmacy claims are paid by the EDS system, but are processed and validated by another contractor. Accordingly, the EDS edit and audit process does not pertain to these types of claims.

ensuring the integrity of the Medicaid payment process because they check the validity of claims before payment is made.

Not all claims trigger the execution of every ESC. Some ESCs are only applicable when a claim has specific attributes, such as claim type (e.g., dental, vision, inpatient, and home health services) or procedure codes[6] (e.g. surgery, office visit, consultation, etc.). In addition, once the system determines that a claim meets the criteria in the ESC and "sets" the edit, a table in the system determines the disposition of the edit. The disposition can be set to ignore the ESC result or to deny or suspend the claim. If a claim suspends for failing one or more ESCs, it is reviewed by an EDS employee (generally a member of the claims resolution staff) to determine whether the claim is valid (or partially valid). If the claim is deemed to be valid (e.g., if an exception to certain criteria had been previously authorized or additional supporting documentation provided) then the ESC is overridden and the claim is paid.

The EDS Medicaid claims processing system has about 600 active ESCs. Our analysis found that about 50 were incorrectly inactive, had errors, or were incomplete.[7] For example,

- Some ESCs were incorrectly inactive because they were still valid ESCs, but (1) they were not executed for any claim type, (2) the procedure codes used in the audit were obsolete and the new codes had not been added, or (3) the disposition of the ESC was set to ignore. For example, the disposition of the ESC that checked whether Medicare crossover claims were submitted in accordance with federal timeliness requirements was set to ignore thereby negating the results of this edit.
- Three ESCs had errors in the limitation criteria. For example, the criteria for one limitation audit was that vision refractions be limited to two every two years, but the policy is once every two years.
- In other cases, the ESCs were incomplete in that they were not executed for all applicable claims, had the wrong disposition set, or set the history retention requirement too low. For example, five ESCs were not executed for all applicable claim types. For instance, unlike all other claim types, the vision, home health, and Medicare Part A crossover claims were not

[6]A procedure code is a five-character code used to describe medical services or other health care.

[7]We did not review all ESCs. We mainly reviewed the edit, limitation audit, and ClaimCheck® and ClaimReview® ESCs.

subject to an edit that ensures that the beneficiary had not died prior to the claim's date of service.

In addition to issues with the ESCs themselves, we found that 27 ESCs did not have corresponding instructions in the EDS procedures manual and other ESCs had instructions that contained outdated information. This is important because these instructions provide the criteria that resolution clerks are supposed to use in determining whether a suspended claim should be paid or denied.

To their credit, when we brought these issues to the attention of EDS and OVHA staff, they developed the applicable sections of the procedures manual and corrected most of identified ESC problems and are planning to make changes to the remainder. For example, in February 2007, EDS staff changed the applicable date of death ESCs to cause them to be executed for vision, home health, and Medicare Part A crossover claims. In addition, since several issues that we found relate to mental health, the EDS Claims Supervisor stated that she is going to review all of the mental health ESCs and make changes based on this more comprehensive review.

The financial impact of making the changes to the edit and audits has not been estimated. However to illustrate the importance of the edit and audit process to payment integrity, for one of the edits that was changed in the course of this review, EDS estimates that it may be able to recoup about $70,000 after finding and analyzing certain claims that should have been rejected by this edit.

The problems that we found point to a lack of a formal and comprehensive process by OVHA and EDS in managing the edit and audit process. Per the Medicaid fiscal agent contract, the State and EDS share responsibility for the management of the ESC process. For example, the State is responsible for providing operational and policy parameters to be used by EDS in designing or modifying edits and audits and to determine edit and audit criteria. EDS's responsibilities, in turn, include maintaining up-to-date reference files (which are used in the ESC process), including disposition indicators. However, we found deficiencies in EDS and OVHA's fulfillment of these responsibilities, as follows:

- There is no single comprehensive list of active ESCs. Instead, there are several tables within the system that must be pulled together to determine whether an ESC is actually executing.
- EDS staff did not always understand which screens and data needed to be changed within the system to achieve various types of changes. For

example, a couple of types of problems (effecting multiple ESCs) that we found occurred because, until we brought it to their attention, EDS personnel in the claims area did not realize that they had to change multiple reference files in order to make the ESCs work as intended. In one case, an ESC restricting evaluation and management visits to once a day was not being executed for claims with procedure codes that contained a certain modifier.[8] Although a change to this ESC had been made to include the applicable modifier in the limitation criteria, the applicable EDS official had not realized that another screen in the system had to be updated for the expected change to occur. We also found about a dozen other similar examples in which either not all procedure code/modifier combinations were executing the ESC and/or they not were being counted against the limitation criteria. An EDS claims official attributed this lack of understanding of how the reference screens interrelate to the knowledge drain that occurred when a long-term employee who had performed these duties left EDS employ a couple of years ago. Nevertheless, the problems that we found that stem from misunderstandings of how the system works calls into question whether other changes to the ESCs related to procedure codes and procedure code/modifier combinations were implemented correctly.

- Weekly edit and audit meetings have been used by EDS and OVHA to oversee the ESC process, but these meetings have not resulted in a systematic review of the ESCs. According to OVHA and EDS officials, initially these meetings looked at ESCs that were causing a lot of suspended claims. More recently, these officials stated that the meetings were being used to address specific ESCs as potential concerns came to their attention.
- There are no written procedures that govern the management of the ESC process and, in many cases, changes were made to ESCs without adequate explanatory notes or other documentation that provide the rationale or the name of the approving official. An EDS claims official agreed that changes to ESCs that had been made in the past had not always been well documented. However, she noted that the process had become more formal in the past year. In particular, EDS had expanded the use of a ESC change process, called the "SLOG," to track additional types of changes as well as OVHA concurrence with the changes. However, the "SLOG" process is not documented. The claims official stated that EDS has recently initiated a project to integrate the documentation management

[8]Modifiers are a two character alpha-numeric code with a specific meaning that are used to further define the procedure code or provider to assist in claims adjudication.

between SLOGs, procedure code changes, and resolution manual updates. However, a planned completion date for this project had not been set as of mid-March 2007.

Another important part of the ESC process that has not been adequately assessed are the ESC override decisions. Most ESCs can be overridden by EDS resolution clerks as they review suspended claims (including, in some cases, even those that normally result in an automatic claim denial). The EDS procedures manual contains instructions regarding the circumstances in which ESCs should be overridden. The Medicaid fiscal agent contract states that the State is responsible for specifying and enforcing override policies and procedures and that EDS is responsible for monitoring the use of override codes to identify potential abuse. However, neither EDS nor OVHA are systematically reviewing how the override process is being carried out. OVHA officials cited a lack of resources as a reason why the override process has not been systematically reviewed. However, the OVHA Deputy Director stated that OVHA now has more knowledge of the EDS claims system and has recently added resources that may allow the agency to be able to monitor the use of the override process in the future. Regular and systematic reviews of overrides in the claims payment system are important to ensure that the process is being used correctly and is not being abused.

ClaimCheck® and ClaimReview®

The State's contract with the Medicaid Fiscal Agent requires EDS to implement the McKesson ClaimCheck® and ClaimReview® claim auditing system. This claims evaluation software offers a nationally accepted database and a comprehensive clinical knowledge base that incorporates, for example, American Medical Association, CMS, and specialty society guidelines and industry standards. According to the State, the purpose of implementing ClaimCheck® and ClaimReview® is to assess claims that have been incorrectly submitted, either inadvertently or intentionally, which may have led to excessive reimbursement.

ClaimCheck® and ClaimReview® have been partially implemented for physician, outpatient, and vision claims. The first and second phases of the implementation were completed in November 2004 and August 2005, respectively. In these phases, six ClaimCheck® and ClaimReview® edits

were applied that can result in claim denials or payment adjustments.[9] For example, one of the edits identifies (and adjusts) claims based on submitted codes that are not usually performed on the same patient on the same date of service while another identifies (and denies) claims based on whether an assistant surgeon modifier was inappropriately billed. According to EDS, the first two phases of the ClaimCheck® and ClaimReview® implementation have resulted in $1,168,110 in savings as of March 9, 2007.[10]

Although the ClaimCheck® and ClaimReview® edits executed to date have apparently resulted in savings, many other ClaimCheck® and ClaimReview® features have not been activated. At least 11 additional edits are expected to be activated in additional phases. However, no date has been set for the implementation of these phases nor have decisions been made regarding which edits will be implemented in each phase. Moreover, although it has been over a year and a half since the second phase was completed, neither EDS nor OVHA has a plan that includes the tasks, milestones, and resources needed to implement the future phases of ClaimCheck® and ClaimReview®.

The longer it takes to implement additional ClaimCheck® and ClaimReview® edits, the more opportunity for savings is lost. Additionally, OVHA has already paid EDS the full amount of the ClaimCheck® and ClaimReview® implementation ($1,252,504), but without the complete implementation of these tools, the State is not receiving the full value for its considerable investment. The OVHA Deputy Director stated that she has told EDS that she would like them to begin to move forward in completing the ClaimCheck® and ClaimReview® implementation.

Results of Data Mining

HWT's data mining of paid professional services and institutional claims identified $883,349 in possible improper payments, pending review by the State Medicaid program (see table 1). Improper payments are any payments that should not have been made or that were made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirement. Improper payments also include duplicate payments, payments

[9]In an additional two cases the ClaimCheck® and ClaimReview® results do not affect the payment of the claims. Instead, informational reports are sent to OVHA.

[10]We did not audit this amount.

for services not received or not covered, and payments that do not account for credit for applicable discounts.

Table 1: Summary of Algorithm Findings

Algorithm Name	Date range of paid claims reviewed	Amount of Potential Overpayments Identified
Professional Services Claims Algorithms		
Obstetrical care unbundling—same providers	1/2/04 - 12/30/05	$4,175
Obstetrical care unbundling—different providers	1/2/04 - 12/30/05	0
Global surgical unbundling	1/2/04 - 12/30/05	0
High anesthesia units	7/1/04 - 12/30/05	257,050
Comprehensive code unbundling (professional services)	7/1/04 - 12/30/05	236,539
Medicare primary payer	7/1/04 - 12/30/05	61,388
Evaluation and management, multiple units of service	7/1/04 - 12/30/05	28,821
Professional services crossover claim duplicates	7/1/04 - 12/30/05	49,893
Total, Professional Services Algorithms		$637,866
Institutional Claims Algorithms		
Comprehensive code unbundling (institutional)	7/1/04 - 3/31/06	$151,520
Outpatient radiology overpayments	7/1/04 - 3/31/06	54,977
Outpatient surgical rate unbundling	7/1/04 - 3/31/06	0
Outpatient claims during inpatient stay	7/1/04 - 3/31/06	18,165
Institutional crossover claim duplicates	7/1/04 - 3/31/06	20,821
Total, Institutional Algorithms		$245,483
TOTAL, ALL ALGORITHMS		**$883,349**

Source: HWT.

The initial identification of potential improper payments is just the beginning of a process that could lead to a recovery of funds. OVHA must undertake a review process, through a claim-by-claim review or other methods, to ascertain which claims are, indeed, valid and not subject to recovery action. In any recovery effort, providers should normally be given the opportunity to provide an explanation and/or documentation supporting the potentially invalid claims. For example, in the algorithm related to high anesthesia units,

providers should be asked to provide records which justify the higher-than-normal units of anesthesia. In addition, the State may not be able to recoup some of the questioned claims because OVHA has not implemented the part of the ClaimCheck® tool that could have identified some of the overpayments. Nevertheless, we believe that it is feasible to recoup a considerable amount of the estimated overpayments, particularly those that are associated with system problems, such as the findings related to the radiology algorithm (see below). In these cases, providers may only need to be notified of the error.

Once the above actions are taken and potential overpayments validated, the State can seek reimbursement for the improperly paid claim. In these cases, Federal regulations require that, within 60 days of identifying improper payments, the State must reimburse the Centers for Medicare and Medicaid Services for the approximately 60 percent Federal share.[11] In addition, if OVHA determines that a provider may have been submitting improper claims intentionally, OVHA may also need to refer such cases to the Vermont Medicaid Fraud and Residential Abuse Unit (MFRAU) for further investigation.

The potential overpayments identified could be the result of a variety of factors, including billing errors by the provider or his/her business office, or a claims processing error. For example, we employed an algorithm to identify instances in which the time billed for anesthesia procedures appeared to be excessively high. Anesthesia is billed in time units, with 1 unit equal to 15 minutes. In some cases, it appears that the provider or business staff may have billed the number of minutes rather than the number of 15-minute increments. Some potential overpayments also raise fraud concerns, such as a case in which a provider may have submitted the same claim twice. Lastly, the results of some of the algorithms point to processing issues with the claims payment system.

In the following subsections, we highlight those algorithms in which processing issues at least contributed towards the number of claims identified

[11] According to 42 CFR 433.316, the date in which an overpayment is discovered is the beginning date of the 60-day calendar period. In cases in which the overpayment is not as a result of fraud and abuse, the date is the earliest of the date on which (1) the state notifies a provider in writing of an overpayment and specifies a dollar amount, (2) a provider initially acknowledges a specific overpaid amount in writing, and (3) the state, or fiscal agent of the state, initiates a formal action to recoup a specific amount without first having notified the provider in writing. In the case of overpayments that result from fraud and abuse, the date of the overpayment is the date of the final written notice of the state's overpayment determination.

as having potential overpayments. The remaining algorithms are described in appendix II.

Comprehensive Code Unbundling

Comprehensive code unbundling are two algorithms that look for claims in which payment has been made for procedure codes for the same recipient, same date of service, and same performing provider, which should not be billed together because one of the procedures is considered to be an integral part of the more comprehensive code. One of the algorithms was run on professional services claims and the other on institutional claims. Taken together, these algorithms identified about $388,000 in potential overpayments.

These algorithms are based on CMS's correct coding initiative. CMS developed the NCCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Medicare Part B claims. The coding policies developed are based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The most comprehensive code under the NCCI guidelines is considered the valid claim, and the paid amount for the less comprehensive or second code is the amount of estimated overpayment. For example, under NCCI guidelines, procedure codes 90853 – for group psychotherapy – and 99233 – for a subsequent hospital care visit – on the same date of service should not be billed together unless an appropriate modifier is used. A provider billed both these codes without modifiers for the same recipient on the same day, October 31, 2005, and was paid for both. The tentative overpayment is $112.34 for the 99233 procedure code.

ClaimCheck® can be used to identify the same type of claims uncovered by these algorithms. However, EDS and OVHA have not yet implemented this part of the ClaimCheck® tool. Until they do, some claims with improper coding will continue to be paid.

Crossover Claim Duplicates

For dual eligible beneficiaries (those eligible for both Medicare and Medicaid), providers are required to bill Medicare first. After the Medicare payment, Vermont Medicaid pays the deductible and coinsurance. For Vermont and New Hampshire providers, claims submitted to the Medicare

carrier will cross over automatically to EDS for payment of the Medicaid portion (these are called crossover claims).[12] If the provider does not receive this payment within 6 weeks, it is allowed to submit a claim directly to EDS but it must wait the full 6 weeks. These two algorithms identify duplicate crossover claims—one for professional services crossover claims and the other for Medicaid Part A (inpatient) crossover claims. Taken together, these algorithms identified about $71,000 in potential overpayments.

Claims were considered to be duplicate if they were submitted and paid for the same recipient, same billing provider, same paid amount, and same dates of service. The overpayment amount is the paid amount of one of the duplicate claims. For example, a Medicare/Medicaid eligible recipient was an inpatient at a rehabilitation center and two claims for the same dates of service were submitted to Vermont Medicaid, apparently for the beneficiary's deductible and coinsurance amounts due, and the hospital was paid $3,243 twice.

We believe that these potentially duplicate claims should have been identified by the Medicaid claims processing system. However, one of the ESCs that identifies potentially duplicate claims had been inactive for crossover claims since December 2004. Specifically, while the ESC was executed for crossover claims, the system was set up to ignore the results so these types of claims were paid without further review. There was no documentation that explained why the system had been set to ignore the results of the ESC process for crossover claims. After we brought this situation to the attention of EDS staff, the system was changed so that the system now suspends crossover claims for manual review when this ESC finds a potential duplicate.

Outpatient Radiology Overpayments

Outpatient radiology service fees for Vermont Medicaid generally are made up of two parts: a technical component[13] paid to the facility, and a professional component[14] paid to the physician. Together, the two components typically add up to Vermont Medicaid's maximum allowable

[12]Out-of-state claims other than those in New Hampshire are processed in a different manner.

[13]The technical component includes the services of non-radiologist or non-physician personnel, materials, facilities, equipment and space used for diagnostic or therapeutic services.

[14]The professional component consists of any examination of and discussion with the patient, supervision of technologist, interpretation of the results of diagnostic or therapeutic procedures and consultation with the attending physician.

payment amount. The system identifies the maximum allowable payment through the use of a procedure code. The procedure code has a modifier attached to it to identify when only the technical or professional component of the claim should be paid—the "TC" and "26" modifiers, respectively. This algorithm identified instances in which the outpatient facility was paid for the maximum allowable amount rather than just the technical component. Almost $55,000 in potential overpayments were identified.

The EDS claims processing system is supposed to automatically attach the "TC" modifier to applicable radiology claims so that the outpatient facility is only paid for the technical component portion of the fee. However, the part of the EDS system that attaches the TC modifier did not include some of the applicable codes. Therefore, for certain radiological claims, the TC modifier was not attached and the provider was paid for the maximum allowable payment amount rather than just the technical component portion of it.[15] For example, an outpatient facility was paid the maximum allowable amount of $77.59 for a mammogram service on September 22, 2004, but should have only been paid for the technical component, which is $50.80. This resulted in a probable overpayment of $26.79.

There may be additional incorrect payments related to radiology outpatient claims that were not picked up by this algorithm because the system problem may go as far back as 1993. Moreover, although the system problem was fixed in mid-March 2007, there would be at least another year of claims subsequent to the dates in our data mining review that could have been paid incorrectly due to this anomaly.

Medicare Primary Payer

Medicaid is the payer of last resort. As previously discussed, in cases of Medicaid beneficiaries who are also eligible for Medicare, providers are directed to first submit the claim to Medicare, the primary payer. If Medicare approves the claim, Vermont Medicaid pays the co-payment or deductible amount; this is called a crossover claim.

In the cases found by this algorithm, it appears that the provider submitted claims to both Medicare and Medicaid, resulting in payments for both a crossover claim and a separate physician claim. This resulted in cases in

[15]For a small number of radiology and diagnostic procedure codes, the fee for a claim with a technical component modifier is greater than the maximum allowable amount for the procedure code (i.e., the procedure code with no modifiers attached). In these cases, the hospital would have been paid less than the appropriate fee due to the system problem that did not attach the technical component modifier.

which the provider may have inappropriately received two payments. For example, an optometrist billed Medicare for a February 9, 2004 refraction test on a dual-eligible patient. Medicaid appears to have paid the provider for a crossover claim for a co-payment amount of $18.00 through the Medicare-to-Medicaid electronic claims process; Medicaid also paid a $16.23 fee for the refraction procedure based on a paper professional services claim submitted to Medicaid by the provider. In this case, the overpayment amount is $16.23. In total, we identified about $61,000 in overpayments under this algorithm.

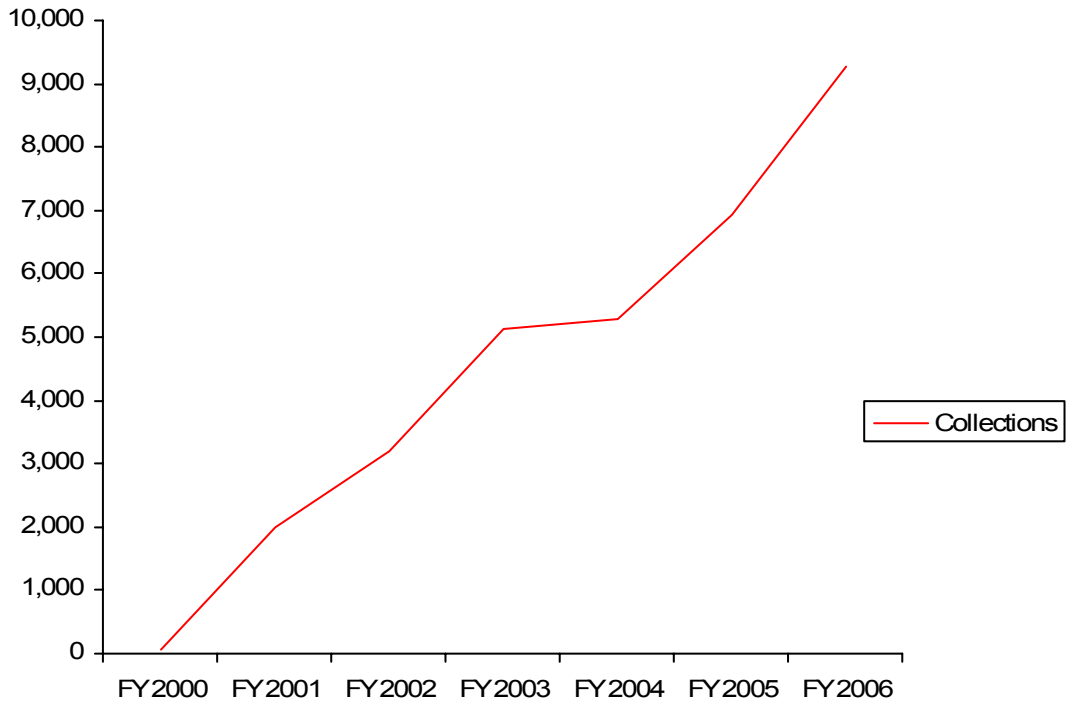
One of the reasons that these overpayments may have occurred is that the Medicaid claims processing system is limited in how it edits for duplicate activities that involve different claim types. In addition, some of the errors may be related to a computer problem experienced by the regional Medicare claims processor in 2004 in which some Vermont providers were paid for services to eligible Medicaid patients that were actually performed by a different provider, sometimes on the other side of the State.

Additional Data Mining Could Identify More Savings

The use of additional data mining could result in significant savings in the Medicaid program. For example, since our review only utilized a limited number of potential algorithms, the use of additional algorithms, or a longer audit period, could identify more potential overpayments, and needed controls in the claims processing system. Needless to say, it is better to catch problems before claims are paid (i.e., through preventive controls), rather than seek to rectify a problem once the funds have been disbursed.

In addition, as the State becomes more familiar with data mining it can expect better results. For example, the State of Washington has contracted for data mining expertise for Medicaid and Social Services payments since 2000 and has seen a steady increase in overpayments collected as a result (see figure 1).

Figure 1: Washington State Overpayments Collected Using Data Mining (in thousands)



Source: State of Washington.

We believe that through aggressive data mining and recovery action on the part of OVHA, millions of dollars might be saved now and in the future. This is critical not only because it makes sound fiscal sense but also because of Vermont's new agreement with the Federal government regarding the Federal payment of Medicaid claims. Specifically, the Global Commitment to Health Demonstration Waiver Program agreement with the Federal government caps Federal Medicaid funding for selected Medicaid expenditures between October 1, 2005 and September 30, 2010. The agreement notes, "The cap places the State at risk for enrollment and for Per Participant Per Month (PPPM) cost trends." Accordingly, even more than before, it is essential that the State pay only justified and documented claims.

Conclusions

Our analysis of Medicaid processing for professional services and institutional claims produced mixed results. On the one hand, we found that

significant improvements could be made in the edit and audit process and other system processing activities that would reduce the likelihood of inappropriate payments. Yet, relative to the number of claims that were reviewed, the data mining performed by our contractor did not identify an extremely high amount of potential overpayments.

Nevertheless, the development of a formal and comprehensive process by OVHA and EDS in managing the edit and audit process and the continued use of data mining can be expected to reduce the likelihood of future overpayments. The edit and audit process can be an effective pre-payment evaluation process while data mining is a post-payment audit tool that has the advantage of using an "all claims" approach through computer analysis of a large database of paid claims, rather than a traditional "audit sample" approach which reviews a much smaller number of claims. Moreover, as our findings demonstrate, data mining can also be used to identify systemic problems that should be corrected.

Lastly, in those cases in which our data mining results are validated and overpayments are determined to have occurred, it is important that OVHA seek recoupment from the applicable providers. The benefits of recoupment are twofold. First, the taxpayers of this State expect to pay only for valid Medicaid costs. Second, recoupment sends a valuable message to providers that the State will seek reimbursement whenever it finds that overpayments have occurred.

Recommendations

Pre-payment Edits and Audits

The Director of OVHA should direct EDS to:

- Complete correction of the identified problems related to specific edits and audits.
- Develop and maintain a single comprehensive list of active ESCs.
- Analyze, in a systematic manner and in conjunction with OVHA staff, current ESCs to determine whether additional changes need to be made to make sure that they are in line with current Medicaid policies, are executed for the appropriate claim types and procedure codes and procedure code/modifier combinations, and have an appropriate disposition.

- Expeditiously develop written procedures to govern the management of the ESC process.
- Train claims staff on how the reference screens interrelate, including instructions as to which screens and data need to be changed within the system to achieve various types of changes.
- Develop, in conjunction with OVHA staff, a monitoring process to periodically review ESC override decisions.
- Develop, in conjunction with OVHA staff, a plan to fully implement the McKesson ClaimCheck® and ClaimReview® tools in an expeditious manner. This plan should include specific tasks and the milestones and resources associated with their completion. EDS and OVHA should also track progress against this plan.
- Implement a new ESC or change an existing one to address the problem identified in the Medicare Primary Payer algorithm.

Future Data Mining and Recoupment of Identified Overpayments

The Director of OVHA should:

- Employ data mining of paid claims as an ongoing tool for post-payment review.
- Systematically review and validate the specific claims identified by our data mining contractor to clearly determine which of the claims were incorrectly billed or paid.
- Seek refunds for those identified claims that were improperly paid and for which providers are unable to document as valid claims. Providers should have the opportunity to provide documentation that supports the questioned paid claims.
- Review the feasibility of employing these or other algorithms on paid claims dated before July 1, 2004 and subsequent to our review dates to identify additional questionable payments and seek to recoup these payments, as appropriate.
- In the case of the Outpatient Radiology Overpayments algorithm, require EDS to perform an analysis of the paid claims affected by the system error related to the technical component modifier for the time period in which providers are required to keep supporting documentation (6 years). Using this analysis, OVHA should assess the extent that overpayments and underpayments were made and determine the feasibility of correcting these payments.

Agency Comments

In commenting on a draft of this report, the Secretary of the Agency of Human Services stated that the report had reaffirmed the Agency's commitment to manage the edit and audit function, complete implementation of ClaimCheck®, and fully develop its program integrity and utilization review functions. In addition, the Secretary stated that she is committed to fully developing appropriate and necessary management controls. (Appendix III contains a reprint of the Secretary's comments.)

The Secretary also provided a summary of actions that the Agency is in the process of taking, or plans to take, in response to our recommendations. For example,

- EDS is in the process of developing a single, comprehensive list of active ESCs.
- Final written procedures for the management of the entire ESC process are expected to be developed by early June.
- EDS plans to establish a review process to randomly review claims in which the ESC has been overridden and OVHA intends to perform a post review of the EDS process on a quarterly basis.
- EDS and OVHA plan to work together on developing a plan, including specific tasks and milestones, to implement additional ClaimCheck® edits.
- By January 2008, OVHA plans to review all data from our data mining contractor and make necessary recoveries.
- OVHA plans to perform a cost/benefit analysis of outpatient radiology payments to identify, with EDS, the underlying issues.

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In accordance with 32 V.S.A. §163, we are also providing copies of this report to the Secretary of the Agency of Administration, the Commissioner of the Department of Finance and Management, and the Department of Libraries. In addition, the report will be made available at no charge on the State Auditor's web site, http://auditor.vermont.gov/.

Any questions or comments about this report can be directed to the State Auditor's Office at 828-2281 or via e-mail at auditor@state.vt.us. George Thabault was the primary auditor of this examination, with the assistance of Linda Lambert, CPA, CISA.

Appendix I

Vermont Medical Assistance Program Expenditure History

Vermont Medical Assistance Program History as Reported on CMS Form 64

CATEGORY OF SERVICE	SFY01	SFY02	SFY03	SFY04	SFY05
HOSPITAL INPATIENT	61,235,605	65,925,694	70,815,722	83,998,647	93,134,418
VERMONT STATE HOSPITAL	245,652	636,151	228,087	76,209	174,781
NURSING HOMES	80,508,083	90,552,604	94,577,138	101,336,043	105,313,728
INTERMEDIATE CARE FACILITY FOR MENTALLY RETARDED	1,515,153	1,768,523	1,626,624	1,093,091	690,151
PHYSICIANS	39,750,085	42,751,245	45,817,421	49,602,098	61,939,053
OUTPATIENT	36,537,021	39,548,198	42,548,476	47,403,618	52,912,134
DRUGS / PHARMACY	81,216,599	87,417,341	94,125,511	115,519,050	136,917,816*
MENTAL HEALTH CLINIC SERVICES	3,247,654	1,520,806	1,933,475	3,641,692	2,448,006
LAB & RADIOLOGY	890,074	1,715,732	2,008,831	1,943,578	3,372,163
HOME HEALTH	6,124,961	6,941,838	5,599,250	5,902,849	7,483,258
RURAL HEALTH	4,130,272	4,996,085	4,659,949	5,323,502	5,172,132
MANAGED CARE CAPITATION PYMTS, **CRT eff FY00)**	34,554,863	36,013,569	38,136,484	18,539,735	34,149,945
BUY-IN	8,843,830	9,801,774	10,716,299	11,638,397	14,165,663
MENTAL HEALTH WAIVER	5,193,050	5,005,017	4,293,507	4,030,715	4,411,637
DEVELOPMENTAL SERVICES WAIVER	67,871,189	74,874,214	77,643,067	83,098,592	92,867,637
HOME CARE WAIVER	13,493,438	19,317,506	23,260,998	27,031,858	31,471,109
TRAUMATIC BRAIN INJURY WAIVER	2,124,564	2,059,814	2,205,963	2,400,295	2,633,223
ENHANCED RESIDENTIAL CARE WAIVER	1,219,894	1,770,393	2,156,820	2,391,180	2,711,956
TARGETED CASE MGMT. (DEPT. FOR CHILDREN & FAMILIES & DEPT. OF DEVELOPMENTAL AND MENTAL HEALTH SERVICES)	13,096,197	13,808,363	14,125,171	14,167,632	15,339,020
PERSONAL CARE SVCS	4,218,845	5,678,443	8,013,204	10,476,720	13,059,169
PRIMARY CARE CASE MGMT	3,777,440	7,667,766	7,881,456	4,905,117	4,950,545
ASSISTIVE COMMUNITY CARE SVCS	2,767,793	4,455,992	5,213,192	6,477,940	
OTHER CARE - OVHA	35,437,716	39,849,152	44,038,494	63,838,484	66,703,834
OTHER CARE - MENTAL HEALTH	20,136,883	25,024,013	32,013,020	37,691,801	37,349,447
OTHER CARE - HEALTH DEPT.	4,850,151	8,167,624	10,181,559	11,320,758	10,783,378
OTHER CARE – DEPT. FOR CHILDREN & FAMILIES	10,687,223	12,936,289	14,655,550	14,591,479	19,864,804
OTHER CARE – DEPT OF AGING & INDEPENDENT LIVING	551,437	1,022,805	2,235,614	2,596,031	2,623,296

Appendix I

Vermont Medical Assistance Program Expenditure History

OTHER CARE - EDUCATION	33,716,620	38,695,038	34,558,319	31,454,470	38,723,332
3RD PARTY LIABILITY / Overpayments / Premiums	(3,662,820)	(4,320,021)	(4,866,550)	(8,681,387)	(12,201,443)
TOTAL PROGRAM	**574,279,472**	**645,601,968**	**690,402,651**	**753,810,194**	**849,164,192**
ADMINISTRATION	44,523,043	51,760,309	61,942,138	66,242,833	61,959,399
MEDICAID GRAND TOTAL	**618,802,515**	**697,362,277**	**752,344,789**	**820,053,027**	**911,123,591**
percent change from previous year	9 percent	13 percent	8 percent	9 percent	11 percent

Source: AHS.

* Note: Medicare Part D prescription coverage took effect in SFY 06 beginning Jan. 1, 2006. Full implementation was delayed until March. As a result of Medicaid-eligible seniors moving their pharmaceutical coverage to Medicare Part D, the SFY 06 Medicaid expenditures for pharmacy dropped to $108.5 million, according to AHS.

Appendix II

Algorithm Descriptions

This appendix provides additional descriptions and explanations for the algorithms not addressed in the body of the report.[1]

Evaluation and Management Multiple Units of Service

$28,821 in potential improper payments identified.

Timeframe of Claims Analyzed

Claims paid between 7/1/04 – 12/30/05

Purpose

This algorithm identifies instances in which physicians billed more than one unit of service for evaluation and management codes indicating more than one visit per day was billed.

Description

The evaluation and management codes used in this algorithm are described in the CPT Codebook as per-day codes and the algorithm allows the provider payment for one visit. Accordingly, in cases in which physicians billed more than one unit of service for per-day evaluation and management codes for the same recipient on the same date of service, the later claim or the claim for the lesser amount is considered the invalid one. For example, for services provided to the same patient on the same day – January 29, 2005 – a provider submitted two claims under procedure code 99312.[2] The second payment received, $55.34, is the potential overpayment amount.

[1]We do not include in this appendix the algorithms related to outpatient surgical rate unbundling, which identifies instances in which the rate for outpatient surgery has been reimbursed separately, and global surgical unbundling, which identifies claims where physicians were paid for pre-operative and post-operative services that are typically included in a single reimbursement of a surgical procedure. Our assessment of the initial results of these algorithms (in consultation with OVHA and EDS officials) found that the questioned claims were supported by OVHA policy.

[2]Procedure code 99312 is a per-day evaluation and management code related to subsequent nursing facility care.

Appendix II

Algorithm Descriptions

Obstetrical Care Unbundling – Same Providers

$4,175 in potential improper payments identified. ($0 identified for different providers.)

Timeframe of Claims Analyzed

Claims paid between 1/2/04 – 12/30/05

Purpose

This algorithm identifies instances in which ante-partum and/or post partum care was reimbursed separately from the global obstetrical package, which included those services by the same provider.

Description

The total obstetrical package includes ante-partum, delivery, and post partum care. Ante-partum care includes monthly visits up to 28 weeks gestation, biweekly visits up to 36 weeks gestation and weekly visits until delivery. Delivery services include admission, management of labor and vaginal delivery, or Cesarean delivery. Post partum care includes hospital and office visits following vaginal or Cesarean section delivery.

Under normal pregnancy conditions, the same provider should not bill for (1) ante-partum care, post partum care, labor management or office visits 9 months prior to the delivery date or 6 weeks after the delivery date when they use a total obstetrical package code or (2) post partum care, labor management or office visits 6 weeks after the delivery date when they use certain postpartum codes. Accordingly, this algorithm considers the amount paid for the ante-partum, post partum, labor management, office visit, or contraceptive management procedure codes to be the overpayment amount. For example, a provider billed for a Caesarian section delivery that occurred May 24, 2004 and later billed for an office visit evaluation and management code, 99213 that occurred on June 1, 2004. The office visit paid amount of $32.54 is potentially invalid.

Appendix II

Algorithm Descriptions

High Anesthesia Units

$257,050 in potential improper payments identified.

Timeframe of Claims Analyzed

Claims paid between 7/1/04 – 12/30/05

Purpose

This algorithm identifies instances in which the time billed for anesthesia procedures appears to be excessively high.

Description

Anesthesia is billed in timed units with 1 unit equal to 15 minutes. An initial outlier analysis of all anesthesiology procedures billed in the range of 0 to 09999 was performed to establish a peer review and determine the number of claims, average units (with outliers removed), and the upper and lower 5 percent outliers based on the submitted units. Questioned claims under this algorithm were due to the high units billed in relationship to Vermont Medicaid peers (in all cases the claims fell above the 95th percentile upper limit).

In an effort to treat all providers fairly the overpayment methodology allows the base amount of units[3] set by CMS plus one additional unit and adjusts for a conversion factor set by OVHA ($18.15) and certain procedure code modifiers.[4] For example, a hospital submitted a claim for anesthesia services performed by a Certified Registered Nurse Anesthetist related to a gall bladder laparoscopy. The upper outlier is 20 units of service (95 percent of claims are for 20 or fewer units). The hospital's claim was for 75 units, or 18.75 hours. The overpayment formula in this case identified a potential overpayment of $439.80.

In many cases it appears the provider may have billed the number of minutes rather than the number of 15-minute increments. In other cases, it appears the

[3]One unit equals 15 minutes.

[4]Modifiers are a two character alpha-numeric code with a specific meaning that are used to further define the procedure code or provider to assist in claims adjudication. For example, in the case of an anesthesia claim, modifier QX indicates that the procedure was performed by a Certified Registered Nurse Anesthetist under direction of an anesthesiologist. Anesthesia procedure codes with modifier QX are paid at 50 percent of such codes without this modifier.

Appendix II

Algorithm Descriptions

providers billed an excessively high amount of time that does not appear to correlate to the procedure performed. However, hospital documentation could show that some of these claims are valid, such as in the case of a complication that occurred during surgery.

Outpatient Claims During Inpatient Stay

$18,165 in potential improper payments identified.

Timeframe of Claims Analyzed

Claims paid between 7/1/04 – 3/31/06

Purpose

This algorithm identifies instances in which it appears that duplicate services have been reimbursed in that outpatient services were billed and paid while the patient was an inpatient or immediately following hospitalization.

Description

Institutions should not submit claims for outpatient services when a recipient is an inpatient. This generally also includes those cases in which a patient starts as an outpatient, but ends as an inpatient on the same day of service. This algorithm identifies cases in which an outpatient claim was submitted for a recipient on dates of services within the timeframe of an inpatient stay. However, in cases in which the billing provider for the inpatient and outpatient claims were not the same and the outpatient date of service was the same as the admission date, the claim was accepted as valid.

The potential overpayment in this algorithm is the allowed charge[5] for the outpatient claim. For example, a Medicaid beneficiary was admitted to a hospital on June 27, 2004. The hospital submitted a claim for radiation services performed on June 28. The patient was discharged June 29. The radiation services were billed as if the beneficiary was an outpatient; the

[5]This algorithm uses the allowed charge amount in its overpayment calculation instead of the paid amount of the claim because the types of claims under evaluation in this algorithm are paid at the "header" level, which includes charges other than those for the procedure codes under review. Accordingly, using the paid amount of the claim would result in overestimation of the overpayment amount.

$54.51 allowable charge for this service is deemed to be the overpayment amount.

Appendix III

Agency Comments from the Secretary, Agency of Human Services

State of Vermont
Agency of Human Services
Office of the Secretary
103 South Main Street
Waterbury, VT 05671-0204
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Cynthia D. LaWare, Secretary

May 2, 2007

Thomas M. Salmon, CPA
Vermont State Auditor
132 State Street
Montpelier, Vermont 05633-5101

Re: Report of the Vermont State Auditor - Medicaid – Needed System Improvements and Questioned Payments Identified - Report 07-08

Dear Mr. Salmon,

Thank you for the opportunity to review the draft of the Vermont State Auditor Report No. 07-08 "Medicaid, Needed System Improvements and Questioned Payments Identified." Below please find our response to the findings and recommendations.

On October 1, 2005 the Office of Vermont Health Access (OVHA) became the State's Medicaid managed care organization. This represented a significant change in perspective and expanded the mission of the Medicaid program and of OVHA. Until that time, the mission of the Medicaid program and of OVHA had largely been to maximize federal receipts to provide health care services to Vermonters in need. Currently, in addition, OVHA's mission must be accomplished in the context of managing the provision of care to Vermonters as well as managing the system that provides the needed care.

The report has reaffirmed our current commitment to manage the audit-and-edit function of the EDS system, to complete implementation of the ClaimCheck® system, and to fully develop the program integrity and utilization review functions. We are pleased that the State Auditor found "… relative to the number of claims that were reviewed, the data mining performed by our contractor did not identify an extremely high amount of potential overpayments." We do, however, agree that data mining, when judiciously employed, can be an effective tool of management and the recovery of potential overpayments to providers.

VERMONT

Appendix III

Agency Comments from the Secretary, Agency of Human Services

Response to recommendations:

Pre-payment Edits and Audits

The Director of OVHA should direct EDS to:

- Complete correction of the identified problems related to specific edits and audits

Response	Target Date	Status
Edit 416 – Updated disposition status to suspend	04/02/07	Complete
Edits 751 – Quantity Unit clarification, updated reso page and audit appropriately	10/02/06	Complete
Edit 754 –Reviewed audit and reso instructions are consistent	04/25/07	Complete
Edit 850 – Need to evaluate benefit limitation specific to Department of Health program for applicable code set.	05/01/07	Open
Edit 866 – this edit became obsolete with HIPAA implementation 02/04. Remove audit	05/01/07	Open
Edit 827 – this edit became obsolete with the Mental Health Parity act. Remove audit	05/01/07	Open
Edit 828 – this edit became obsolete with the Mental Health Parity act. Remove audit	05/01/07	Open
Edit 890 – OVHA clinical considering revision of the unit limit	05/30/07	Open
Edit 930 – This edit became obsolete with HIPAA implementation 02/04. Remove audit	05/01/07	Open
Edit 803 - Modified procedure code list to include all valid procedure/modifier combinations to the audit limitation.	04/23/07	Complete
Edit 832 – Need to update audit to include all valid procedure/modifier combinations to the audit limitation.	05/15/07	In process
Edit 848 - Need to update audit to include all valid procedure/modifier combinations to the audit limitation.	05/15/07	In process
Edit 987 - Need to update audit to include all valid procedure/modifier combinations to the audit limitation.	05/15/07	In process
Edit 864 - Need to update audit to include all valid procedure/modifier combinations to the audit limitation	05/15/07	In process
Edit 462 – Edit disabled in 1992 as only primary diagnosis is relevant for claim payment. Remove edit	04/25/07	Complete
Edit 465 – Edit disabled in 1992 as only primary diagnosis is relevant for claim payment. Remove edit	04/25/07	Complete
Edit 898 - this edit became obsolete with the Mental Health Parity act. Remove audit	05/01/07	Open
Question on procedure code set (97001,97003,97010,97032,97033,97035,97112,97116,97140,97530,97750) – and whether or not they should apply to Audits 850,720,721,722. These audits currently apply to the Department of Health program limitations. These audits will be evaluated with the DOH and OVHA to ensure appropriate procedure code lists and limitations are in place.	05/01/07	Open

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Appendix III

Agency Comments from the Secretary, Agency of Human Services

- Develop and maintain a single comprehensive list of active ESCs.

Response	Target Date	Status
EDS will develop a single comprehensive list of active ESC and provide a copy to OVHA. This list will be maintained as changes are made to existing or newly established edits/audits. Draft reviewed with OVHA on approach and content.	05/31/07	In Process

- Analyze, in a systematic manner and in conjunction with OVHA staff, current ESCs to determine whether additional changes need to be made to make sure that they are in line with current Medicaid policies, are executed for the appropriate claim types and procedure codes and procedure code/modifier combinations, and have an appropriate disposition.

Response	Target Date	Status
EDS and OVHA will add an agenda item to the weekly Edit/Audit meeting to review Edits/Audits on a routine basis. All aspects of the edit/audit will be reviewed, validated and approved by OVHA. The basis for this review will be the comprehensive list of Active Edits/Audits.	06/05/07	On-Going

- Expeditiously develop written procedures to govern the management of the ESC process.

Response	Target Date	Status
EDS will prepare a "Reso Instruction" page for any modifications to an edit or audit. The Reso Instruction page will include an OVHA authorization signature line. The Reso Instruction page will include the edit logic, applicable claim types and disposition status. EDS will use this authorization to implement any updates to all aspects of an Edit/Audit. All Reso Instructions with OVHA signature will be permanently archived through the existing State Correspondence Log (SLOG) process.	06/05/07	On-Going
Final written procedures will be developed for the management of the entire Error Status Code (ESC) process once the initial review of the active ESC list has been developed.	06/05/07	Open

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- Train claims staff on how the reference screens interrelate, including instructions as to which screens and data need to be changed within the system to achieve various types of changes

Response	Target Date	Status
EDS will provide a formal training session for all personnel associated with the maintenance of the reference file information. As part of this training, updated user manuals will be developed.	06/26/07	Open

- Develop, in conjunction with OVHA staff, a monitoring process to periodically review ESC override decisions.

Response	Target Date	Status
EDS will establish a review process designed to randomly review claims that have been overridden by the resolutions staff. This process will be performed on a weekly basis and the results will be summarized in a monthly report to OVHA.	07/30/07 – for first monthly report	Complete
OVHA, Program Integrity Unit will perform a post review of the EDS process on a quarterly basis.	09/01/07 – for first quarterly review	Complete

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- Develop, in conjunction with OVHA staff, a plan to fully implement the McKesson ClaimCheck® and ClaimReview® tools in an expeditious manner. This plan should include specific tasks and the milestones and resources associated with their completion. EDS and OVHA should also track progress against this plan.

Response	Target Date	Status
EDS will work with OVHA to develop a plan to implement additional ClaimCheck edits, the plan will include specific tasks and milestones.	06/01/07	
EDS will meet with McKesson (ClaimCheck Software Vendor) to discuss high level approach to implementation of the remaining edits.	04/30/07	
EDS added a ClaimCheck Analyst position to assist with the implementation. This position has been filed and training is in process	03/19/07	Complete
Additional Note: In determining the approach to implementing ClaimCheck edits, OVHA and EDS worked together to focus primarily on those edits that would provide the most immediate return on investment (cost savings), primarily focusing on those edits that were not already a component of the existing MMIS editing process. Many of the remaining edits are duplicated in the MMIS. For example, multiple surgery. Although the multiple surgery claim check is not yet in place, there is an existing MMIS edit that enforces this policy, and OVHA has adopted the ClaimCheck pricing methodology for determining the appropriate payment for these services.	N/A	N/A

- Implement a new ESC or change an existing one to address the problem identified in the Medicare Primary Payer algorithm.

Response	Target Date	Status
EDS and OVHA will review the claim samples provided to identify the specific issues with the existing edits. New and/or modified edit requirements will be established to appropriately address any duplicate payment issues.	06/30/07	Open

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Future Data Mining and Recoupment of Identified Overpayments:

- Employ data mining of paid claims as an ongoing tool for post-payment review:

Response	Target Date	Status
The OVHA has hired two auditors to work with the existing nursing staff and combined that function with the data mining staff along with the Fraud, Abuse and Detection Software purchased in 2006	05/01/07	Complete
An RFP to purchase service to achieve the level of edits post-payment as that of HWT	10/01/07	Open

- Review and validate specific identified claims and seek appropriate refunds:

All outcome data from the HWT audit will be reviewed and follow up will be done. This will include chart reviews and necessary recoveries made.	01/01/08	Open

- Review feasibility employing similar algorithms of claims data prior to July 1, 2004 and subsequent to the HWT review based on service type

A cost benefit analysis will be done for services prior to July 1, 2004 and algorithms will be employed for services after the HWT review based on service type.	In conjunction with RFP Process for purchase of services	Open

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- Outpatient Radiology Overpayments

Cost/benefit analysis of Outpatient Radiology will be done by OVHA to further identify with EDS underlying issues	10/01/07	Open

We appreciate the thorough review conducted by the State Audit team. Acknowledging that the OVHA is currently transitioning to a Managed Care Organization, I am committed to fully developing appropriate and necessary management controls.

I trust this letter is responsive to your report. Please let me know if I can be of further assistance.

Sincerely,

Cynthia D. LaWare

Cynthia D. LaWare, Secretary
Agency of Human Services

cc: Joshua Slen, Director, OVHA
Jan Westervelt, Audit Chief

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