MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)

RECOVERY AUDIT CONTRACTOR (RAC)

Audit Agenda for the 4th Quarter (Q4) of
State Fiscal Year 2019

February 28, 2019

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

I. BACKGROUND

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

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

The Department has approved the following audits for the fourth quarter (April 1, 2019 – June 30, 2019) of State Fiscal Year (SFY) 2019[1]:

II. ACTIVE AUDITS

HOSPITAL INPATIENT NEONATAL INTENSIVE CARE UNIT (NICU) SERVICES (COS 010)

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

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

HOSPITAL INPATIENT CLAIMS – VALIDATION OF DRGs WITH MAJOR COMPLICATIONS AND CO-MORBIDITIES (MCCs) (COS 010)

Under Section 407, *Part I Policies and Procedures for Medicaid/Peachcare For Kids*, the Division may recoup payments previously made to a provider in accordance with applicable policy for services, items or drugs that the provider did not perform or provide. With respect to validation of DRGs for hospital inpatient claims, the Tricare DRG Grouper 30, which became

[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.

effective on April 1, 2014, added third levels of severity - “major complications and comorbidities” (MCCs) – for certain DRGs. We have performed preliminary data analysis to determine potential mispayments attributable to the misuse of DRGs with MCCs, focusing on the validation of those which involve significant increases in reimbursement. We issued findings to five (5) hospital providers who concurred with our findings. As a result of MSLC’s preliminary findings and review with DCH, this audit has been expanded to include “complications and comorbidities” (CCs) on hospital inpatient claims grouped using Tricare DRG Grouper 24. We have expanded this review to an additional round of hospitals and continue or recovery efforts on previous rounds of this review.

OUTPATIENT BILLED AS INPATIENT (COS 010)

In *Part II: Policies and Procedures for Hospital Services*, Section 903.6, a person must be formally admitted and acute inpatient qualifying criteria designated by the Division, such as InterQual, must be met to be considered an hospital inpatient. Also, *Part II: Policies and Procedures for Hospital Services*, Section 904.7 states inpatient admissions of less than twenty-four hours are considered as inpatient only if the services can only be provided on an inpatient basis.

MSLC has identified inpatient stays for complex clinical review where admission and discharge occurred on the same date. Our audit includes confirmation of admission orders, payment methods, and appropriateness for inpatient admission. MSLC continues recovery efforts on this review.

CREDIT BALANCE (COS 110)

Georgia Medicaid *Part I, Policies and Procedures for Medicaid/PeachCare for Kids*, Section 303.8 requires providers to submit quarterly reports showing identified Medicaid overpayments as credit balances in the provider’s accounting systems. To support DCH’s effort to recover overpayments to provider’s accounts, MSLC is performing a review of credit balances related to nursing facility Medicaid claims. This review includes a self-audit to determine whether credit balances for services provided to Medicaid recipients represent overpayments that should be returned to the Georgia Medicaid program. We are continuing to review the records received from self-audits issued to fifty (50) skilled nursing facilities. MSLC continues recovery efforts for this review.

HOSPITAL BACK TRANSFERS (COS 010)

Under *Part II, Policies and Procedures for Hospital Services*, Section 903.2 and Appendix C, Section 8, special “transfer pricing” occurs when a member is transferred from one hospital to another for a medically appropriate reason and is transferred back to the originating hospital. For transfers back to the originating hospital, the originating facility receiving the back-transfer for lower level of care is eligible to receive reimbursement for both confinements. To ensure accurate claim processing, the originating facility must request an adjustment to the precertification date span and adjust any previously paid claim for the initial hospitalization; and combine and resubmit as a single claim for both date spans. The dates of service spent in the alternate facility are reflected as leave of absence days.

MSLC has identified instances where transfer claims were not combined and resubmitted as a single claim. We have consulted with the Department to address issues raised during administrative review. MSLC continutes to review records and continues recovery efforts for previous rounds of this review.

UNBUNDLED POST-OPERATIVE OBSERVATION (COS 070)

Section 903.6 of *Part II Policies and Procedures for Hospital Services* states that outpatient observation is not covered for post-operative monitoring during the standard recovery period.

MSLC has identified outpatient hospital claims in which observation codes appear to have been billed immediately following outpatient surgical procedures. We completed a probe sample that identified overpayments related to unbundled post-operative observation. We have consulted with the Department to address issues raised during administrative review and continue to refine our methodology based on the feedback. MSLC has expanded this review to an additional round of hospitals and continues recovery efforts from previous rounds.

DUPLICATE INPATIENT BILLING (COS 010)

Part I, Policies and Procedures for Medicaid/PeachCare for Kids, Section 106*,* states that as general conditions of participation, all enrolled providers must:

- Neither bill the Division for any services not performed or delivered in accordance with all applicable policies, nor submit false or inaccurate information to the Division relating to provider costs, claims, or assigned certification numbers for services rendered.

- Accept responsibility for every claim submitted to the Division that bears the provider's name or Medicaid/PeachCare for Kids provider number. Submission of a claim by a provider or his agent, acceptance of a Remittance Advice, or acceptance of claim payment constitutes verification that the services were performed by that provider (or under his direct supervision, if allowed by the Division) and that the provider authorized submission of the claim for reimbursement.

MSLC has identified claim pairs from associated providers where inpatient hospital services were submitted for the same member on the same dates of service. MSLC is continuing recovery efforts for this review.

MEDICARE PART B ONLY INPATIENT CLAIMS (COS 010)

Per policy, when a patient receives inpatient hospital care and is covered by Medicare Part B but is not covered by Medicare Part A, ancillary charges should be billed as a Medicare Part B crossover claim and all payments for the crossover claim should be deducted from the DRG payment of the Medicaid inpatient claim. The *Medicaid Secondary Claims User Guide*, Chapter 5 – Inpatient Part B only hospital claims, describes the correct coordination of benefits for Medicare Part B only inpatient claims:

- Submit the Part B ancillary charges to Medicare
- The Part B ancillary charges are paid by Medicare and then crossover to Medicaid

- If Medicaid approves the claim, a payment of the lesser of the coinsurance and deductible up to the Medicaid maximum allowable amount for the claim will be made on the Part B charges
- Submit the Part A Inpatient Charges with the EOMB from Medicare Part B along with the Medicaid Remittance Advice showing the amount that Medicaid paid for the coinsurance and deductible electronically through the GAMMIS web portal, www.mmis.georgia.gov.
- Medicaid will process the Inpatient claim as a COB Hybrid claim by deducting the paid ancillary charges from the Diagnosis Related Grouper (DRG) amount to be paid.

MSLC has identified inpatient hospital stays where providers have incorrectly stated prior payments from corresponding Medicare Part B claims. Missing deductions for prior payments are considered overpayments on the inpatient claim. MSLC has expanded this review to an additional round of hospitals and continues recovery efforts from previous rounds.

ALLERGY IMMUNOTHERAPY (COS 430, 431, 740)

CPT codes 95144 - 95170 are defined for the preparation and provision of antigens for allergen immunotherapy. This serum preparation requires additional training to complete, and is not typically performed by providers that are not allergy specialists.

Previous reviews of allergy services conducted by MSLC and the Georgia MFCU revealed providers that billed for serum preparation under their own provider ID number, when the serum had instead been prepared by an outside vendor. Per *Part II, Policies and Procedures for Physician Services*, Section 601, this “pass-through” billing from independent contractors is not permitted.

Per the request of DCH, a new analysis of claims for CPT codes 95144 - 95170 has been completed. MSLC has identified claims for allergy immunotherapy serum preparation rendered by providers with no listed specialty in allergy services. Claims for serum preparation are considered overpaid if the serum was prepared outside of the physician’s practice. MSLC continues to review medical records and pursue recovery efforts for the initial round of this review. We plan to expand this review to additional providers.

HOSPITAL TRANSFER (COS 010)

Under *Part II, Policies and Procedures for Hospital Services*, Section 1001 and Appendix C, 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 is continuing recovery efforts for this review.

WAIVER SERVICES DURING HOSPICE CARE (COS 590, 660, 680, 681, 690, 930, 970)

Georgia Medicaid *Part II, Policies and Procedures for Hospice Services,* Section 907 and *Part II, Policies and Procedures for SOURCE*, Section 700 require that when a member is receiving waiver services (COS 590, 660, 680, 681, 930, 970) and simultaneously receives hospice care

(COS 690), the two providers must coordinate care to prevent duplication of services. This coordination of care must be documented, or the services are subject to recoupment.

Policy defines some waiver services to be non-duplicative of hospice services. Those procedures are excluded from our analysis.

MSLC has identified instances where claims for waiver services and claims for hospice services were paid for the same member on the same dates of service. If coordination of care between the waiver and hospice providers is not documented, then the services are considered overpaid. We have consulted with the Department to address issues specific to waiver services and continue our review of hospice services.

III. PRELIMINARY AUDITS

PHYSICIANS PROGRAM (COS 430)

To support DCH's effort to recover overpayments to provider's accounts, MSLC is performing audits to confirm compliance with *Part II Policies and Procedures for Physician Services*. We will perform high level data analysis to identify providers for potential mispayments. This analysis will include measures such as modifier usage, allowed amounts, billed charges, numbers of procedures, and units billed. MSLC will consult with the Department with respect to further audit work on these claims.

DME MAXIMUM ALLOWABLE PAYMENTS (COS 320)

Part II Policies and Procedures for Durable Medical Equipment Services refers DME providers to the "DME Services Fee Schedule," often referenced as the Schedule of Maximum Allowable Payments (SMAP), to access Medicaid-defined limitations on the number of allowable units for each HCPCS code for medical equipment and supplies. Units in excess of the limit defined by the SMAP should not be reimbursed without prior authorization.

The SMAP is referenced numerous times throughout the DME Medicaid policy manual, which include but is not limited to the following sections:

- Section 904, Coverage for Medical Supplies, states in part that DME supplies are limited to the maximum allowed units issued by CMS' NCCI-Medically Unlikely edits, Georgia Medicaid Policy (see SMAP), or the quantity ordered by the treating physician. Overutilization may be requested through the prior authorization process.
- Appendix N, History of Policy Revisions, notes that providers were given notice in 2015 that audits will be implemented to enforce the maximum units over time as displayed on the SMAP.

MSLC has identified DME claims that are in excess of the limitations defined by the DME SMAP. These claims appear to be inappropriately paid. MSLC is continuing to refine our analysis, and is consulting with the Department regarding an audit of these claims.

ALLERGIST EXCESSIVE UNITS (COS 430)

CPT code 96165 is defined for the preparation and provision of antigens for allergen immunotherapy. Georgia Medicaid adopts the CMS billing unit definition of one unit billed representing one cc of serum prepared. The vial of prepared serum is then used to administer many allergy injections to that patient. Standards of care for allergen immunotherapy (from the Joint Council of Allergy, Asthma and Immunology, and others) indicate that a typical course of treatment would use around 10 cc of serum in a single month.

MSLC has identified allergy specialists that are billing for an abnormally high number of units of 95165 within a 30 day period. MSLC is reviewing medical records from these providers in order to validate the number of units billed. Pursuant to Section 106 of *Part I, Policies and Procedures for Medicaid/PeachCare for Kids*, providers may not bill for services not performed or delivered. Any units paid in excess of the quantity of serum actually prepared are considered overpaid.