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MaineCare Durable Medical Equipment and Medical Supplies — Measures to Control Costs Need Strengthening, 2009

Maine State Legislature

Office of Program Evaluation and Government Accountability

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FINAL
REPORT

MaineCare Durable Medical Equipment and Medical Supplies — Measures to Control Costs Need Strengthening

Report No. SR-DME-08

a report to the
Government Oversight Committee
from the
Office of Program Evaluation & Government Accountability
of the Maine State Legislature

July
2009

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Report Highlights

OPEGA Report No. SR-DME-08

Durable Medical Equipment and Medical Supplies — Measures to Control Costs Need Strengthening

What questions was this OPEGA review intended to answer?

- Does the State have effective systems to control and contain costs associated with durable medical equipment and medical supplies (DME) purchased through MaineCare? If not, why not?

What was OPEGA's overall conclusion?

Existing measures for preventing and detecting excessive, unnecessary or inappropriate claims need to be strengthened to more effectively control costs and better support DHHS' cost containment initiatives for MaineCare DME. As a result of issues identified, the State is not realizing the full benefit of its cost containment efforts.

OPEGA's analysis of DME claims identified $115,900.70 in potential overpayments or unnecessary expenditures during fiscal year 2008 (FY08) due to one or a combination of ineffective controls. We roughly estimate that there could be an additional $229,000 in overpayments related to those same issues that have occurred between July 1, 2008 and June 30, 2009.

In addition, we identified numerous situations that appeared to present risk of fraud or unnecessary expenditures. Fifty of these situations have been shared with DHHS and are being researched by the Program Integrity Unit and Office of MaineCare Services to determine whether any actual losses have occurred.

What actions has OPEGA recommended?

OPEGA recommended the Department take action to:

- ⇨ Strengthen the Program Integrity Unit's capacity to monitor MaineCare claims.
- ⇨ Ensure communication and action on issues identified by the Program Integrity Unit.
- ⇨ Better correlate units of measure on billed quantities with allowed rates.
- ⇨ Establish contracted rates for items covered by bulk purchasing agreements in the claims system Rate Tables.
- ⇨ Address irregularities in Rate Tables that allow vendors to be reimbursed at higher rates than intended.
- ⇨ Research questionable claims activity identified by OPEGA.
- ⇨ Investigate possible additional overpayments on incontinence supplies.
- ⇨ Proactively address procedure codes in Rate Tables with $0 reimbursement rates
- ⇨ Correct programming error that allowed payment of claims after the prior authorization had been voided.

To get a copy of the full report, or for more information visit the website listed at the bottom of this page or contact OPEGA at (207)287-1901.

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Acronyms Used in This Report

CMS - Centers for Medicare and Medicaid Services (federal)
DHHS - Department of Health and Human Services
DME - Durable Medical Equipment and Medical Supplies
FY - Fiscal Year
GOC- Government Oversight Committee
MECMS - Maine Claims Management System
MEPOPS - Maine Pharmacy Point of Purchase System
MIHMS - Maine Integrated Health Management Solution
OMS - Office of MaineCare Services (DHHS)
OPEGA - Office of Program Evaluation and Government Accountability
PA - Prior Authorization
PERM - Payment Error Results Measurement
PIU - Program Integrity Unit (DHHS)
SCHIP - State Children's Health Insurance Program
SURS - Surveillance and Utilization Review System

FULL REPORT

Durable Medical Equipment and Medical Supplies — Measures to Control Costs Need Strengthening

Purpose

OPEGA sought to determine whether the State has effective systems for controlling MaineCare costs associated with durable medical equipment and medical supplies.

The Maine Legislature's Office of Program Evaluation and Government Accountability (OPEGA) has completed a review of durable medical equipment and medical supplies provided by the Department of Health and Human Services (DHHS) through MaineCare. OPEGA conducted this review at the direction of the joint legislative Government Oversight Committee (GOC) of the 123rd Legislature, in accordance with 3 MRSA §§991-997.

Government Oversight Committee members, as well as other legislators, had expressed interest in whether sufficient measures were being taken to prevent, detect, and correct instances of fraud or unnecessary expenditure and, otherwise, to contain costs associated with MaineCare programs. OPEGA suggested durable medical equipment and medical supplies (DME)[1] as one possible area of focus after researching recent Medicaid program reviews conducted by other states and the U.S. Government Accountability Office. DHHS was also supportive of an OPEGA review in this area as the Department was interested in identifying more possibilities for containing DME costs.

OPEGA's review, as approved by the GOC, focused on whether the State has effective systems to control and contain costs associated with claims for durable medical equipment and medical supplies purchased through MaineCare. DME claims paid in fiscal year 2008 (FY08) totaled $18.9 million. Approximately $15.6 million was processed through the Maine Claims Management System (MECMS). The remainder, approximately $3.3 million in claims originating from pharmacies, was processed through the Maine Pharmacy Point of Purchase System (MEPOPS).

Scope and Methods

The scope of our review was generally limited to claims for DME paid through MECMS during FY08.

The scope of the review was generally limited to claims and cost-containment efforts associated with DME paid through MECMS in FY08. OPEGA's work included:

[1] For the purpose of the report, the acronym DME will refer to both durable medical equipment and medical supplies.

- interviewing management and staff associated with DHHS's Office of MaineCare Services (OMS), Program Integrity Unit and Rate Setting Unit;
- reviewing pertinent State and federal regulations, including the MaineCare Benefits Manual;
- reviewing reports and work plans from similar audits done in other states; and
- reviewing State Single Audit Reports and obtaining additional information from the State Auditor.

We conducted research that included interviews with DHHS and review of pertinent State and federal regulations. We also analyzed MECMS claims data for FY08.

In addition, we obtained and analyzed an extract of claims paid through MECMS in FY08. This extract included all DME claims as well as all other claims paid in FY08 (services or goods) for any MaineCare members who had DME claims within our time period. The claim data was analyzed for questionable transactions and unusual patterns that indicated potential fraudulent or unnecessary expenditures.

OPEGA did not learn about the DME claims processed through MEPOPS until part-way through the review. As shown in Table 1, MEPOPS claims constituted about 17% of the total dollars spent on DME in FY08. Given the time-consuming nature of the analysis work already underway, it was decided not to take the extra steps necessary to include MEPOPS claims in our review. We do, however, encourage DHHS to apply recommendations made in this report to claims processed through MEPOPS as appropriate.

Table 1: Dollar Amounts for Paid Claims By System	
Claims Processed Through	Paid Claims (millions, rounded)
MECMS	$15.60
MEPOPS	$ 3.30
Total Claims	$18.90

Source: Advantage ME data from the State's data warehouse

Background

Overview of Durable Medical Equipment and Medical Supplies

This review focused on two categories of goods—medical supplies and durable medical equipment—provided through MaineCare and intended to treat, control, relieve or improve a medical condition. Chapter II, Section 60 of the MaineCare Benefits Manual lists durable medical equipment and medical supplies and specifies whether or not their costs are covered by the MaineCare program.

Durable medical equipment and medical supplies are intended to treat, control, relieve or improve a medical condition. Examples of these items include bandages, rubber gloves, wheelchairs and crutches.

The MaineCare Benefits Manual defines medical supplies as those goods that are primarily needed to relieve or treat a medical condition. They are generally disposable or have a limited number of uses. Examples include bandages, syringes, rubber gloves and incontinence supplies.

Conversely, durable medical equipment covered by MaineCare must meet all four of the following criteria:

- Equipment that can withstand repeated use.
- Primarily used to serve a medical purpose, is medically necessary, and reasonable for the treatment of the member's illness or injury or to improve an altered body function.
- Not generally useful to a person in the absence of illness or injury.
- Appropriate for use in the home and is in safe and reasonably good condition and suitable for its intended use.

MaineCare members get doctor's prescriptions for medically necessary DME. Those prescriptions are filled by vendors enrolled in the MaineCare program.

Examples of durable medical equipment include wheelchairs, crutches, hospital beds and prosthetics.

To obtain durable medical equipment or medical supplies through MaineCare, individuals must first meet the eligibility requirements of the MaineCare program and then obtain a doctor's prescription for any items deemed medically necessary. Prescriptions are then brought to vendors enrolled in MaineCare to be filled with items the vendors have purchased from manufacturers.

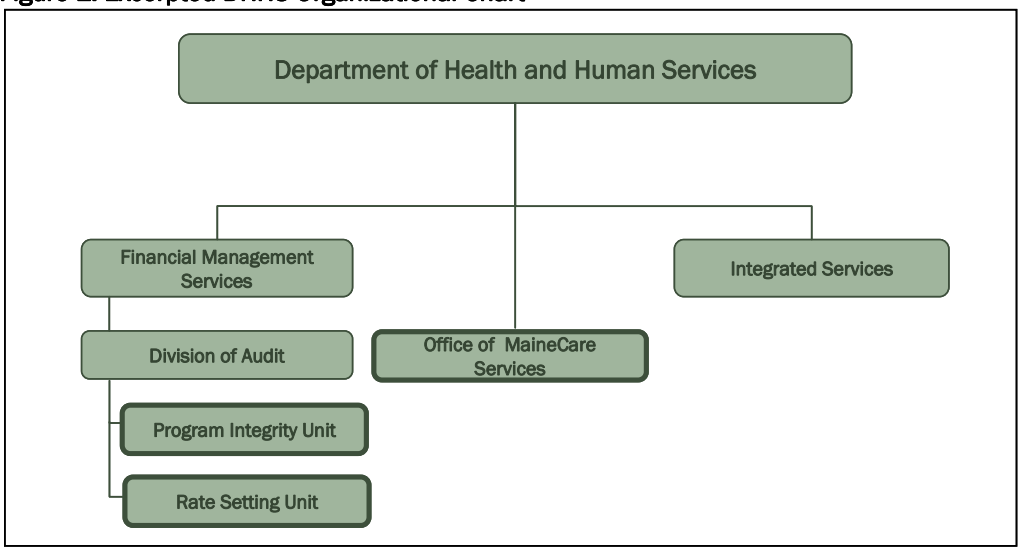
The Office of MaineCare Services works in concert with other DHHS offices to manage the delivery of MaineCare-funded services.

MaineCare programs and benefits encompass the federal Medicaid Program and State Children's Health Insurance Program (SCHIP). DHHS' Office of MaineCare Services (OMS), formerly the Bureau of Medical Services, has responsibility for the Medicaid Plan, the promulgation of rules and the oversight of the traditional medical services. OMS works in concert with the other DHHS offices to manage the delivery of MaineCare-funded services in an efficient and effective way.

As illustrated in Figure 1, there are also other DHHS offices outside of OMS with responsibilities related to controlling MaineCare costs. These include the Rate Setting Unit and the Program Integrity Unit, which is an audit function formerly known as the Surveillance and Utilization Review Unit. Both are located within the Division of Audit for MaineCare and Social Services under the Deputy Commissioner of Financial Services.

Two of the other offices with some responsibilities related to controlling MaineCare costs are the Rate Setting Unit and the Program Integrity Unit, which is an audit function.

Figure 1. Excerpted DHHS Organizational Chart



The Program Integrity Unit (PIU) assists in maintaining the integrity of the MaineCare program through discovering, pursuing, and preventing fraud; seeking reimbursement for overpayments; and providing a deterrent to future fraud. The Rate Setting unit works with OMS to determine reimbursement rates and to develop and implement financial policies and procedures in regards to methodologies for determining those rates.

DME Claims Processing

Vendors submit DME claims for reimbursement through MECMS. The MaineCare Benefits Manual specifies what cost bases the vendor can use in calculating the claim amount which is generally the lowest of four different costs.

Vendors get reimbursed for DME they have provided to MaineCare members by submitting claims through the State's current claims processing system, MECMS. Vendors provide key information including, but not limited to: the member's MaineCare ID, procedure code, item description, quantity provided and the total amount claimed for reimbursement.

Procedure codes are used by Medicare and Medicaid programs and are monitored by the federal Centers for Medicare and Medicaid Services (CMS). Every service and product, including durable medical equipment and medical supplies, are represented by a procedure code. These codes define the product and unit of measure, and correlate to a set reimbursement rate which is used in the determination of the maximum payment amount. The codes are uniform and generic in nature such that one procedure code could possibly be used in claims for many brands and sizes of a specific product purchased from any vendor.

Per the MaineCare Benefits Manual, the rate used by the vendor to calculate the requested reimbursement should be lowest of the following:

- The adjusted acquisition cost plus an allowed forty percent mark up not to exceed $2,000. The adjusted acquisition cost is the net cost of the item after deducting for any quantity discounts and exclusive of any shipping, freight, handling, and insurance costs. Prompt payment discounts received by the vendor from the manufacturer are not deducted from the acquisition cost.

- The vendor's usual and customary charge.

- The manufacturer's suggested retail price for any medical supply or durable medical equipment (including replacement parts).

- The maximum MaineCare amount published at least annually on the Department's website, and made available to vendors.

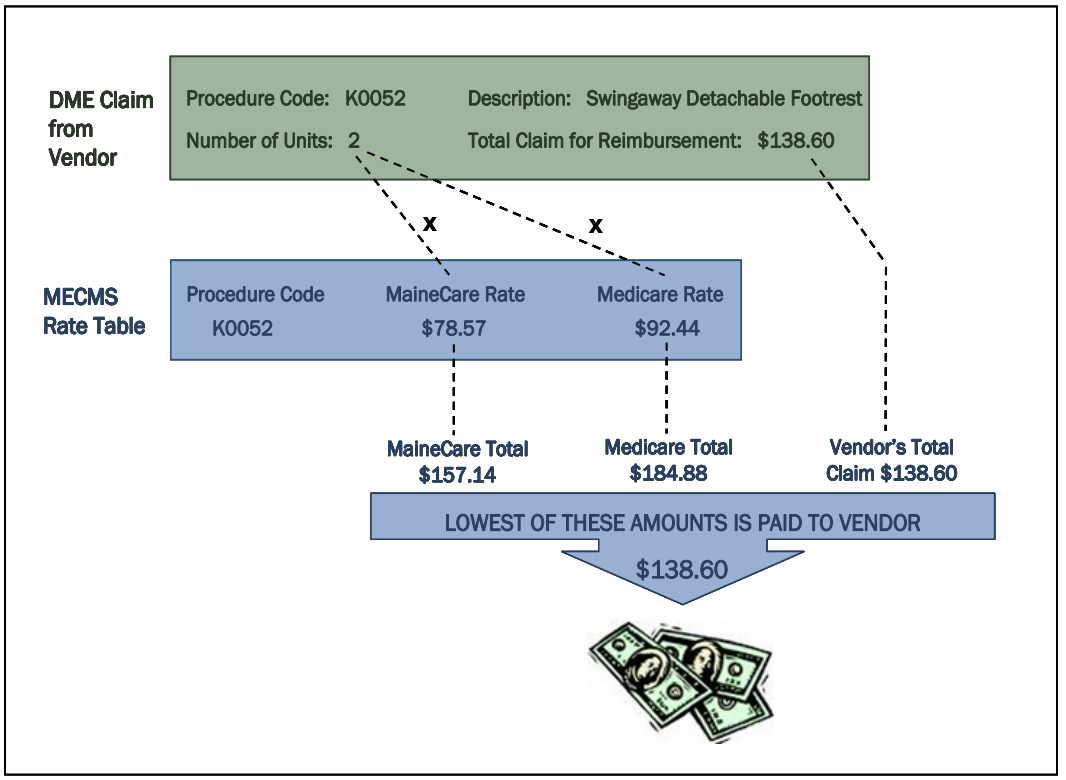
To ensure compliance with the rules for vendor billing, the Department may at any time require proof of the vendor's cost in the form of an invoice from the manufacturer.

In general, MaineCare does not pay more than an allowed maximum amount that is calculated based on established MaineCare and Medicare rates regardless of what the vendor claims for reimbursement. The MaineCare and Medicare rates are contained in a MECMS Rates Table and they are based on a unit of measure

MECMS calculates a maximum allowed reimbursement amount based on established MaineCare and Medicare rates and generally will not pay more than this amount regardless of what the vendor has claimed.

specified in the Procedure Code description. MECMS determines what amount to pay on a DME claim by applying the allowed MaineCare and Medicare rates for the applicable DME item to the quantity billed by the vendor. The system then pays the claim at the lowest of the calculated MaineCare amount, the calculated Medicare amount or the vendor's billed amount. Figure 2 shows an example of this calculation. OPEGA noted that the effectiveness of this control is diminished because billed quantities are not always in the same unit of measure that the maximum allowed rates are based on. See Recommendation 3 for more discussion.

Figure 2. How MECMS Determines the Payable Amount for Each Claim



The maximum Medicare rate is provided by CMS via an annual data feed through which the rates are uploaded to the MECMS Rate Tables. If the data feed contains Medicare rates for newly covered or defined products (i.e. new procedure codes) then the related MaineCare rate is automatically set by MECMS as a percentage of the Medicare rate. MaineCare rates for already established procedure codes typically stay the same, regardless of any updates to the Medicare rates, unless DHHS has negotiated prices with a manufacturer under a bulk purchasing contract. In these instances, the maximum MaineCare rate for an item would be based on the contracted rate. OPEGA found that MaineCare rates in the MECMS Rate Tables were not always updated to reflect the new contracted rates on bulk purchase agreements. See Recommendation 4 for further discussion.

In some instances, MaineCare rates exceed the Medicare rate and claims are paid at the higher MaineCare rate. This occurs when the Office of MaineCare Services must adjust rates appropriately to ensure that members have access to certain medical supplies or durable medical equipment. In these instances, MECMS is programmed to default to the MaineCare rate in determining the maximum allowed reimbursement amount.

In March 2010, the State will be contracting with a third party administrator to process claims and this will involve transitioning from MECMS to a new claims processing system.

Problems with MECMS have been well-documented since its implementation in 2005 and have never been fully resolved. As a result, in March 2010, the Department will transition to a third-party administrator for processing MaineCare claims and MECMS will be replaced with the Maine Integrated Health Management Solution (MIHMS). MIHMS will be an adaptation of an existing system already certified by the Centers for Medicare and Medicaid Services (CMS). DHHS management expects this new system to alleviate issues experienced with the current system.

Current Cost Containment Measures for DME

During this review, the Office of MaineCare Services cited several initiatives that have been undertaken to control costs associated with DME. These measures are either intended to secure better pricing or verify medical necessity for DME items being provided to MaineCare members. These cost containment measures include:

OMS has undertaken several initiatives to contain costs for DME by securing better pricing or verifying medical necessity for items in advance of vendors supplying them to MaineCare members.

- Prior Authorization (PA). This is the process where an assigned MaineCare employee formally reviews requests for services or goods to be provided to a MaineCare member by a specific vendor. An approval must be granted before the service or good is administered or delivered to the member. The MaineCare Benefits Manual specifies when PA is required, which includes all transactions in excess of $499.99. In addition, many pieces of durable medical equipment require PA for any transaction, regardless of cost. The only exception to the PA rules is when Medicare is the primary payer and MaineCare is the secondary payer for a member. In these cases, PA is not required. DME transactions that require PA, but do not have a PA number in MECMS when the claim is processed are denied. However, OPEGA did discover a MECMS programming error that allowed claims to be paid after the PA was voided. See Recommendation 9 for discussion.

- Bulk Purchase Contracts. OMS continues to pursue bidding out entire categories of products and awarding contracts to single manufacturers, thus securing the best rates possible for the State. Vendors purchase items from the contracted manufacturer at the rate negotiated by the State and pass on these lower rates to the MaineCare program when they submit claims. Historically, eyeglasses and incontinence supplies have been contracted with single manufacturers and, during the course of this review, bids were being solicited and received for bent metal (canes, crutches, walkers), ostomy supplies, and wound care supplies.[2] OPEGA has documented several issues that limit DHHS' ability to ensure that the State does not pay vendors more than the contracted rates on items covered by bulk purchase contracts. The State's current contract for incontinence supplies is with the manufacturer Invacare and OPEGA identified potential overpayments to vendors on items covered by this contract. See Recommendations 1, 3, 4, and 7 for more discussion.

[2] Eyeglasses are not considered DME as per the MaineCare Benefits Manual. Consequently, OPEGA did not test for any overpayments associated with these items.

- Multi-State Purchasing. Maine participates in the New England States Consortium Systems Organization (NESCSO). This organization is working to get multi-state, bulk purchasing in place to reduce durable medical equipment costs for New England states. This effort is currently in progress and may have potential for future cost containment in other non-DME areas.

- Limits on Quantities. While this review was in progress, DHHS proposed, and the Legislature approved, an amendment to MaineCare rules that establishes limits on monthly allowances for items covered by the Invacare contract. Previously, the rule stated that vendors could not bill for more than a 34 day supply of an item for a given member. The quantity needed for a 34 day supply, however, was determined by vendors—who profit from these transactions—and varied significantly from member to member. The new quantity limits will help ensure that MaineCare does not incur unnecessary expenses by allowing stronger automated edits and checks to be built into the claims processing system. It is important to note, however, that these limits do not prevent members from receiving needed goods as quantities exceeding monthly limits may be approved through the PA process.

The Office of MaineCare Services reported that it had also explored purchasing durable medical equipment and medical supplies direct from manufacturers, but found that this would be a poor fit for the MaineCare program. The MaineCare Benefits Manual requires that all MaineCare vendors of durable medical equipment have a storefront for the sales and service of the supplies and equipment sold. This is to ensure that those members using these products have access to the service, training, and education associated with the use of such goods. These critical customer service elements would not be provided if purchases were made directly from manufacturers.

Audits and Monitoring of MaineCare Claims

The MaineCare program is subject to several regular audits in which samples of MaineCare claims are examined for compliance with various aspects of federal and State requirements. None of these audits focus specifically on durable medical equipment and medical supplies, but claims for DME items may be included in the samples of claims reviewed. These audits are:

- The State Single Audit of the federal Medicaid program and SCHIP conducted annually by the State Auditor. This audit typically focuses on 10 to 12 specific areas within those programs and includes testing of some claims paid with federal funds to ensure compliance with federal requirements.

- The Payment Error Results Measurement (PERM) audit, which is a federal audit required by law. The audit is conducted by CMS to determine the accuracy of Medicaid and SCHIP claims payments and the accuracy of eligibility determinations made by the State.

MaineCare claims are audited and monitored by several entities including federal CMS, OMS, the State Audit Department, and the Program Integrity Unit. None of these efforts focus specifically on DME, but DME claims may be included in samples of claims selected for review.

- A monthly audit performed by the Office of MaineCare Services' Quality Assurance group that selects 50 cases where eligibility was granted and 14 cases where it was denied to check the appropriateness of eligibility determinations made by staff.

- A quarterly audit performed by the Office of MaineCare Services' Quality Assurance group that, according to management, is the most likely to include some DME claims. In this audit, 200 claims per quarter are selected including 190 randomly selected claims and the ten highest paid claims for the quarter. These claims are reviewed for compliance in the following areas:

  - Eligibility
  - Third Party Liability Billing
  - Appropriate Procedure Codes
  - Correct Reimbursement Rates
  - Quantity Limits (if applicable)
  - Prior Authorization
  - Co-Pays
  - Medical Necessity
  - Accounting Strings (ensuring that claims are paid from the correct accounts)
  - Vendor Eligibility For Procedure Code Used

  Any errors found are categorized as to cause of the error and communicated to the Commissioner. They are also forwarded, as appropriate, to DHHS' Program Integrity Unit for potential further investigation and/or the Third Party Liability group to make any appropriate adjustments.

The Program Integrity Unit also monitors and reviews MaineCare claims with a focus on identifying, investigating and recovering losses from fraud, abuse or overpayments to providers. PIU sends out recoupment letters to providers when it determines that overpayments or payments on inappropriate claims have occurred. In discussions with PIU, OPEGA learned that the Unit has been hampered by the lack of a functioning SURS (Surveillance and Utilization Review) system since 1995. We also learned that there is no formal reporting of issues identified by PIU to managers who can take action to help prevent future program losses. See Recommendations 1 and 2 for further discussion.

In addition to these audits, the Department's Budget and Planning Group performs high-level trend analysis of billings by procedure code. This group examines the 20 highest paid specialties and the procedure codes within these specialties to track changes in usage. While not specifically targeted to durable medical equipment and medical supplies, it is a high level of oversight that may incorporate this category of products to some degree.

Conclusion

OPEGA concluded that existing measures for preventing and detecting excessive, unnecessary or inappropriate claims need to be strengthened. The State is not realizing the full benefit of its cost containment efforts.

Existing measures for preventing and detecting excessive, unnecessary or inappropriate claims need to be strengthened to more effectively control costs and better support DHHS' cost containment initiatives for MaineCare DME. Currently, efforts to control costs are significantly hindered by:

- weaknesses in automated system edits and checks;
- lack of a process for routine analysis and identification of transactions that present risk for fraud or unnecessary expenditures; and
- lack of communication and coordination among DHHS units.

As a result of these issues, the State is also not realizing the full benefit of its cost containment efforts. For example, OMS signed a bulk purchase contract with the manufacturer Invacare to allow vendors to purchase incontinence supplies at a reduced price. Savings are supposed to be passed on to the MaineCare program when the vendor submits claims. However, for multiple reasons, the control in MECMS intended to prevent payment of claims that exceed the contracted rate is ineffective and, consequently, there is substantial risk that MaineCare will end up paying more than necessary for the items under contract.

Our analysis of claims identified $115,900 in potential overpayments in FY08. We roughly estimate that there could be an additional $229,000 for FY09.

Acting on a concern raised by a DHHS employee, PIU did recently review transactions related to the Invacare contract and identified over $400,000 in overpayments to vendors for claims paid between January 2005 and December 2007. Ideally, DHHS' Program Integrity Unit would have identified and investigated potential overpayments such as this as part of a routine, systematic monitoring of MaineCare claims, but PIU has not had a functioning Surveillance and Utilization Review System (nor an adequate substitute) for the past 14 years.

PIU also identified the inconsistency in billed quantities as a primary root cause of the overpayments. This issue remained unaddressed at the time of our review, however, because a formal process for communicating such issues to those with authority to take action did not exist. As a result, it appears that overpayments have continued.

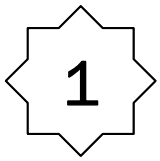
We also identified numerous situations that appeared to present risk of fraud or unnecessary expenditures. These are currently being researched by DHHS to determine whether any actual loss has occurred.

OPEGA's own analysis of transactions identified $115,900.70 in potential overpayments or unnecessary expenditures during FY08 from the continuing overpayments on the Invacare contract and other ineffective controls. Since the root causes remain unaddressed, we roughly estimate that there could be an additional $229,000 in losses that have occurred between July 1, 2008 and June 30, 2009.

In addition, we identified numerous situations that appeared to present risk of fraud or unnecessary expenditures. Thirty-four of these situations have been shared with DHHS and are being researched by the Program Integrity Unit to determine whether any actual losses have occurred. Sixteen others are being researched by the Office of MaineCare Services.

The Recommendations section of this report has a full discussion of the issues identified during this review, some of which also have implications for non-DME MaineCare claims. The Agency Response section of the report describes the actions DHHS plans to take in response to those recommendations. DHHS expects that many of the issues OPEGA identified will be resolved for future periods with the implementation of the new MIHMS. Consequently, we also recommend, in general, that the new MIHMS and the processes established by the third party administrator be audited at a future date to ensure that these issues do not continue after the transition in March 2010.

Recommendations



Strengthen the Program Integrity Unit's Capacity to Monitor MaineCare Claims

For the last 14 years, DHHS' Program Integrity Unit (PIU) has not been conducting routine, systematic monitoring of MaineCare expenditures for indicators of potential fraud or unnecessary expenditures. According to DHHS, the Surveillance and Utilization Review System (SURS) that was used to flag suspect transactions for investigation ceased functioning in 1995 as a result of a computer system failure. DHHS chose not to expend resources to restore it at that time. The new Maine Claims Management System (MECMS) that went into production in 2005 was supposed to include a SURS module, but that functionality was never developed.

The PIU reports that it has compensated somewhat by enlisting the help of Office of MaineCare Services' staff with strong database knowledge to occasionally generate simple reports through queries of the claims system databases. Creating such queries, however, is described as quite complex and time-consuming and consequently much of the Unit's work has been generated by inquiries or "tips" from both internal and external sources.

This practice appears to have produced leads and resulted in the recouping of substantial overpayments from providers. However, there may be other program losses that have gone undetected without routine, systematic monitoring to flag questionable claims activity. As noted in Recommendation 6, OPEGA's own analysis of FY08 MECMS claims for MaineCare members receiving DME identified numerous situations that had indicators of fraud or unnecessary expenditures.

Recommended Management Action:

The PIU expects routine, systematic monitoring of MaineCare transactions to once again become the standard for the Unit with the March 2010 implementation of the new claims processing system, MIHMS. The new system will include JSURS, a healthcare fraud and abuse identification analysis and reporting system that should address past deficiencies in system capabilities. OPEGA also recommends that DHHS take any additional steps necessary to ensure that the PIU is poised to make

effective and efficient use of the information that will be generated by JSURS including adequate staffing, training and technical support.

If successful implementation of JSURS does not occur or is significantly delayed, then the PIU should establish an alternative means of conducting routine, risk-based monitoring of MaineCare claims as soon as possible. OPEGA believes that a reasonable level of monitoring, similar to OPEGA's analysis for this review, could be achieved using readily available applications like MS Access or Excel. OPEGA is also familiar with other relatively inexpensive off-the-shelf data analysis software that can be set up to run established analytical routines against files of transactions on a recurring basis.

Issues Identified by the Program Integrity Unit Need Communication and Action

OPEGA found that the Program Integrity Unit has, in the past, identified control and policy issues that are root causes for overpayments on DME claims, but no action had been taken to address them. The conditions resulting in the overpayments continue to exist, making it highly likely that MaineCare has continued to pay out more for certain DME items than is necessary. (See Recommendations 3 and 7.) Recoupment of any continuing overpayments currently appears to depend upon whether the PIU returns to examine MaineCare claims for these particular items in the future.

Through further inquiry, we learned that there is no formal process in place to ensure that control and policy issues identified by the PIU are communicated to, and thoroughly understood by, those with authority and responsibility to address them. For example, the inconsistency in billing units that has contributed to the overpayments on incontinence supplies described in Recommendation 3 was purportedly identified by the PIU as an issue back in the 1980's. OMS management did receive copies of the recent recoupment letters the PIU sent to vendors, but the PIU did not otherwise formally communicate to management the control and policy weaknesses or their ramifications. At the time of our review, OMS management was still relatively unaware of the root causes of the overpayments on incontinence supplies or PIU's suggestions for potential solutions.

Recommended Management Action:

DHHS should establish formal processes that provide for documentation of conditions identified by PIU as contributing to overpayments, fraud or unnecessary expenditures and communication of those issues to managers that can address them. DHHS should also establish a system for tracking when and how the issues are addressed to ensure that appropriate action is taken to prevent future financial losses whenever possible.

3

Correlate Units of Measure for Quantities Billed with Allowed Rates to Prevent Overpayments

In analyzing DME claims, we discovered that quantities billed by vendors may vary as to the unit of measure and that the unit of measure is not specified by the vendor when submitting the claim. For example, the billed quantity for a box of 100 non-sterile gloves could be:

- 100 (to represent the number of individual gloves);
- 50 (to represent the number of pairs of gloves); or
- 1 (to represent the number of boxes of gloves).

This variability in billed quantities impacts MECMS' ability to prevent overpayments for DME items where members receive more than one of the item in a single container (i.e. gloves, disposal undergarments). As shown in the example below, if the vendor bills for a quantity in a different unit of measure than the maximum rates are based on, there is risk of an underpayment or overpayment to the vendor. It is likely that vendors would seek an adjustment for an underpayment, but perhaps not for an overpayment. In fact, the Program Integrity Unit recently sought recoupment of $416,712.16 from 24 vendors for overpayments related to this issue. See Recommendation 7.

This situation also has ramifications for the PIU's surveillance and utilization review activities. The ability to use data existing in the system to efficiently identify only those claims that truly have potential for overpayment is limited, as is the ability to detect abnormal quantities that might indicate abusive billing practices. In addition, determining whether there really has been an overpayment requires confirming with the vendor what unit of measure the billed quantity actually represents.

Example – Maximum Allowed Reimbursement Calculation

MECMS calculates the maximum allowed reimbursement amount for an item based on maximum rates for the applicable procedure codes and the quantity billed by the vendor. The unit of measure the rate is based on is specified in the procedure code description. Vendors, however, may not bill quantities in the same unit of measure and, consequently, MECMS calculates a significantly higher or lower maximum reimbursement amount.

In the simplified example below, procedure code A4927 is for "gloves, non-sterile, per 100". If a vendor bills for a quantity of 500 (representing the number of individual gloves) rather than 5 (representing 5 boxes of 100 each), MECMS calculates a maximum reimbursement amount of $2,023 rather than the correct $20.23. If the vendor's claim amount exceeds $20.23, but is anything less than $2,023, the vendor will be paid for the full amount claimed.

PROCEDURE CODE	CONTRACTED MAXIMUM RATE INC. MARK UP	QTY PER BOX	BILLED SERVICE UNITS	UPPER LIMIT CALCULATED BY MECMS
A4927	$4.046/BOX	100	5	$20.23
			500	$2,023.00

Lastly, inconsistencies in the quantity data available in MECMS hinder DHHS's ability to easily identify other DME items that might offer potential for savings through bulk purchasing. It might also affect the ability to negotiate the best rates on such contracts.

Recommended Management Action:

DHHS should take steps to ensure that billed quantities from vendors can be correlated in an automated fashion to the unit of measure on which the maximum allowed rates are based. Possible approaches to accomplishing this goal include:

- Requiring quantities to be billed at the lowest unit of measure possible, i.e. each rather than box, and either establishing rates in the Rate Tables to be at the lowest unit of measure, or creating a process for converting the allowed rates to that unit of measure.

- Creating a data field and requiring vendors to indicate the unit of measure represented by the billed quantities when submitting the claim. The data field could perhaps be designed with a drop down selection of units of measure, i.e. each, pair, box, case. The system could then be programmed to convert either the billed quantities or the rate if the unit of measure billed differed from what the rate was based on.

- Using an existing data field in the claims system to establish a maximum quantity for each DME item based on the unit of measure anticipated in the rate coupled with what a MaineCare member might reasonably be expected to use within a certain time period. The system could then be used to flag claims exceeding the maximum quantity for manual review prior to payment.

OPEGA also recommends that DHHS ensure that the new MIHMS and related processes are appropriately designed to address this situation.

Establish Contracted Rates for Items Under Bulk Purchase Agreements in Rate Tables

In examining the MECMS Rates Tables, OPEGA discovered that the MaineCare rates for those procedure codes covered by the contract with Invacare did not match the negotiated rates. DHHS confirmed that the current Rate Tables did not reflect the contracted rates.

As a result, the MECMS control to limit reimbursement to vendors to the contracted rate – thereby ensuring cost savings are achieved - is ineffective. For example, the highest contracted rate for latex gloves is $2.89 per box of 100 gloves. The MaineCare rate currently in MECMS—and used in determining the maximum reimbursement amount—is $25.00 per 100 gloves. MECMS would, therefore, pay any claimed amount that was less than $25.00 per box.

Recommended Management Action:

The Department needs to establish procedures to ensure all contracted rates for all bulk purchasing agreements are entered into MECMS or MIHMS so that system controls are effective in supporting DME cost containment efforts.

Address Procedure Code Modifiers in Rate Tables to Prevent Overpayments to Vendors

The Rate Tables in MECMS currently contain two different active rates for DME items in new condition. Consequently, the maximum allowed reimbursement to vendors could be based on either rate depending on the billing code used. This situation, which has been resulting in overpayments to vendors since January 2008, went undetected until the time of our review.

Annually, the federal CMS provides the Office of MaineCare Services with a data feed containing the updated federal reimbursement rates for goods and services. Each line in this data feed contains the procedure code for a given item (or service) along with a procedure description, the reimbursement rate, the dates to and from which the rate is applicable, and a modifier code.

The modifier code allows for the distinction between a used, rented, or new DME item. Historically, a modifier code of "UE" indicated used, "RR" indicated a rental, and no code (or "null" as it appears in the database) indicated an item in new condition. These codes, as well as the other fields of the data feed, are shown in the excerpt from the MECMS Rate Tables included in the example below.

For 2008, CMS issued a data feed in which a new modifier code—"NU"—was used to indicate a product in new condition. MECMS did not recognize the lines with the "NU" modifier code as replacements for the earlier "null" rate (which was intended), but rather as completely different records. Because the previous rates for DME items in new condition had an expiration date in the year 2999, both rates have been active since January 2008.

This situation, as illustrated in the example below, presents the risk of overpayments because reimbursement rates for new DME items generally decreased from 2007 to 2008. Vendors submitting claims for these items with no modifier code, which had previously been the norm for new items, would receive the higher "null" reimbursement rate, rather than the intended—and lower—reimbursement rate with the "NU" modifier code. There were also instances where the reimbursement rates for a new item increased from 2007 to 2008 and in these instances vendors that billed with no modifier code would be underpaid.

Example – Active Rates in MECMS Rate Table for Procedure Code E0110

Modifier codes "null" and "NU" both are active rates in MECMS for an item in new condition. Vendors billing without the "NU" modifier code would be paid a maximum of $77.21 ("null" code) on the claim. They should, however, have been reimbursed at the most current $65.95 rate ("NU" code) and those reimbursed at the old $77.21 rate were overpaid.

Procedure Code	Procedure Description	Modifier Code	From Date	To Date	Rate
E0110	Crutch forearm pair	RR	1/1/2008	12/31/2008	13.59
E0110	Crutch forearm pair	UE	1/1/2008	12/31/2008	49.45
E0110	Crutch forearm pair	null	10/1/2002	12/31/2999	77.21
E0110	Crutch forearm pair	NU	1/1/2008	12/31/2008	65.95

OPEGA's analysis of MECMS claims for DME occurring between January 1, 2008 and June 30, 2008 identified 1,884 transactions with total potential overpayments of $36,427.41. We also identified potential underpayments totaling $1,328.35 on 297 transactions. These totals reflect only those transactions paid during the last six months of FY08. FY09 has just concluded and this same issue (two active rates) has existed throughout its duration. Assuming that vendors have not changed their billing practices and that the level of claims for new DME items has remained constant, we roughly estimate the net additional overpayments for July 1, 2008 through June 30, 2009 to be $70,000.

Recommended Management Action:

DHHS should immediately inform vendors of the requirement to submit claims for new DME items with a "NU" modifier code and remove the records with active rates for "null" codes from the MECMS Rate Tables. On an on-going basis, DHHS should periodically run exception reports, including after receiving a data feed from CMS, to identify and take action on any irregularities in the Rate Tables that would affect the system's payment controls.

Research Questionable Claims Activity Identified by OPEGA

OPEGA's analysis of DME claims included tests designed to identify claims or patterns of claim activity that met certain indicators for potential fraud or unnecessary expenditures. As a result, thirty-four situations with higher potential, as per the number or nature of the indicators they met, have been referred to DHHS' Program Integrity Unit for further research and sixteen have been referred to OMS. These situations were not referred to DHHS until the end stages of this review and, as of the date of this report, the research is still in progress.

Recommended Management Action:

DHHS should complete its research into the questionable claims activity flagged by OPEGA. The results of that research, including an estimate of any dollars associated with identified overpayments, fraud or unnecessary expenditures, should be reported to OPEGA and the Government Oversight Committee. OPEGA would use these results to determine whether the remainder of transactions with similar indicators should be forwarded to the Department for further examination. OPEGA would also report to the GOC as to whether there are additional recommendations it would make for action on any problematic situations identified.

DHHS should maintain adequate documentation of its research and results to allow OPEGA or another audit entity to validate the work and results if necessary.

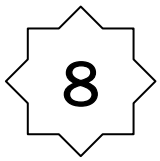
Investigate Possible Additional Overpayments For Incontinence Supplies

Due to the situations described in Recommendations 2, 3 and 4, there has been a continuing risk of overpayments on incontinence supplies covered by the Invacare contract. The PIU had previously identified $416,712.16 in overpayments during the period January 2005 through December 2007 and had sought recoupment from 24 providers.

OPEGA analyzed claims from January 1, 2008 to June 30, 2008, which was the portion of FY08 that the Program Integrity Unit had not already investigated. Payment amounts were reconciled with quantities and then compared to the corresponding rates established in the contract. A total of $79,606.29 was identified as being potentially overpaid in that period. We roughly estimate that there may be an additional $159,000 in overpayments for FY09 bringing total potential overpayments for the period January 2008 through June 2009 to nearly $239,000.

Recommended Management Action:

The Program Integrity Unit should review the potential additional overpayments identified by OPEGA, determine whether actual overpayment occurred and initiate recoupment from vendors as appropriate. DHHS should report back to OPEGA and the GOC on the results of this research and any actions taken.



Proactively Address Procedure Codes with Reimbursement Rates of Zero to Prevent Rejection of Vendor Claims

The data feed from CMS, mentioned earlier, often includes procedure codes with a reimbursement rate of $0 which become established in the MECMS Rate Tables as the maximum allowable rate. According to OMS, these are errors but the Office currently does not have a process for proactively identifying these situations and correcting them. Consequently, any vendor claims submitted for these procedure codes are rejected as they exceed the maximum reimbursement rate. Vendors must then make inquiries about the rejected claims. After receiving a complaint, OMS determines whether or not to cover the specific item and has DHHS' Rate Setting Unit establish an allowable rate.

OMS reports that many of the procedure codes with $0 maximum rates are not used in vendor claims and, therefore, claim rejections for this reason are not frequent. OPEGA has not assessed the actual frequency or impact but it does appear that, at the very least, the current reactive approach to $0 rate errors likely results in extra steps and delayed payments for vendors who do bill for any of these procedure codes.

Recommended Management Action:

Exception reports should be run periodically (such as after a data feed is received from CMS) to identify procedure codes with reimbursement rates of zero.

Decisions on whether or not to cover these DME items and the determination of appropriate rates should then be made proactively to eliminate needless rejected claims for vendors.

Correct Programming Error to Ensure Transactions Without Required Prior Authorization Are Not Paid

OPEGA tested a sample of DME claims that appeared to have been paid without the required prior authorization (PA). In doing so, we identified one transaction for which OMS could not provide a reasonable explanation. Further research by the Office of Information Technology discovered a MECMS programming error that allowed a payment of $1,195.35 on the transaction after OMS staff had voided the PA on the system.

It appears OMS staff initially granted the PA in error, realized this error, and voided the PA in the same day. Although it is likely that instances of this scenario are few, the potential does continue to exist that claims with PA that have been voided within a particular time frame will be paid.

Recommended Management Action:

The Department should correct the programming error in MECMS and ensure that a similar error does not exist in the new MIHMS system slated for implementation on March 1, 2010.

Agency Response

OPEGA discussed the preceding findings and recommendations with the Department of Health and Human Services in advance and provided an opportunity for the Department to submit their own planned management actions in response to those recommendations. The management actions provided by DHHS are detailed in this section, and are numbered to correspond with the issues described by OPEGA in the Recommendations section of the report.

DHHS actions on some of the recommendations have been underway during the time period that this report was being finalized. Due to timing, OPEGA has not had an opportunity to assess whether those actions are adequate to fully address the issues identified and make any appropriate adjustments to reported recommendations. Consequently, review of these actions will be incorporated into the normal report follow up process.

In accordance with 3 MRSA §996, OPEGA also provided the Department of Health and Human Services an opportunity to submit additional comments on the draft of this report.

1

Strengthen the Program Integrity Unit's Capacity to Monitor MaineCare Claims

The JSURS tool provided by the new Fiscal Agent will address this issue with regular reports. JSURS will be implemented March 1, 2010. In the meantime, two quarterly reports are being developed to enable the Program Integrity Unit to actively monitor per unit pricing and number of units purchased and follow up on any spikes or unusual patterns that may indicate fraud and abuse. Each report will provide the number of units billed, the number of units paid, and the amount paid per unit. One report will provide this information by dealer and the other will be by member. The first reports which cover the last quarter of FY09 are expected in August 2009 and then will be generated monthly thereafter.

2

Issues Identified by Program Integrity Unit Need Communication and Action

As of July 14, 2009, the Program Integrity Unit has instituted bi-weekly staff meetings to discuss cases and identify issues that require a systems review or adjustment. A list of the issues identified will be prepared and communicated to the appropriate units within DHHS and other State agencies. In this way, issues or concerns that could be detrimental to the MaineCare program, either financial or programmatic, are highlighted for attention.

Overpayments that are identified by PIU will also be recorded, tracked and pursued for collection through the processes and structure that have been recently created for such purposes.

3

Correlate Units of Measure for Quantities Billed with Allowed Rates to Prevent Overpayments

The new MIHMS system will require that the number of units and unit cost information (i.e. 10 diapers at $0.77 each) be entered for every purchase, and an upper limit will be established for the number of units that may be billed at one time. A project team is working to establish billing and unit limits, which will be implemented in MIHMS to prevent potential excessive billing. That work will be complete by August 15, 2009 and MIHMS will be implemented March 1, 2010. In the meantime, the quarterly reports being developed in response to Recommendation 1 should help identify potential overpayments related to this issue.

4

Establish Contracted Rates for Items Under Bulk Purchase Agreements in Rate Tables

The incontinent supply contract has recently been renewed and new rates will be effective as of August 1, 2009. All new contracted rates will be entered into the system Rate Tables by then. The new limits on quantity of these items that can be supplied for a particular time period will also go into effect on August 1, 2009. Vendor compliance with these limits will need to be manually monitored until MIHMS is implemented March 1, 2010.

In addition, DHHS has implemented a reporting process to monitor billing (claims) submitted by vendors using data collected through the contracted manufacturer. These reports will go to the contract manager and are meant to work in conjunction with the reports developed in response to Recommendation 1. These reports will allow staff to compare utilization by distributor, dealer and member. The reports are required by the contract terms and conditions and the first report is due September 7, 2009.

5

Reconcile Procedure Code Modifiers in Rate Tables to Prevent Overpayments to Vendors

A quarterly report has been developed to show any null modifier codes and $0 rate values in the MECMS Rate Tables so they can be reviewed and corrected in the system. The first of these reports has been run and, hereafter, will be generated quarterly following the receipt of the CMS rate list. The report will be manually reviewed and items identified will either be recoded in MECMS or eliminated. This issue is expected to be resolved under MIHMS which will not allow blank fields. In the meantime, instructions will go out to the vendors that they must use the "NU" modifier and rate for items in new condition.

6

Research Questionable Claims Activity Identified by OPEGA

The Program Integrity Unit has completed its initial review of 18 of the 34 situations referred to it that OPEGA had identified as possibly representing cases of fraud or unnecessary expenditures. As a result, PIU determined there was a total of $7,726 in overpayments on five of these situations and has initiated recovery as appropriate which included recoupment of overpayments or vendor adjustments of the claims. In addition, PIU determined that four of the other 18 situations warrant a more detailed examination and those examinations are in progress. PIU has begun review of the remaining 16 situations referred and will seek clarification from OPEGA on the specific concerns related to them as necessary in determining how to proceed.

The Office of MaineCare Services has also completed its review of the 16 situations referred to it. Reasonable explanations existed for the questions raised by OPEGA and none of the situations were deemed to represent instances of fraud or unnecessary expenditures.

DHHS will provide periodic updates on the progress and results of actions taken on this recommendation to OPEGA and the Government Oversight Committee beginning in September 2009.

7

Investigate Possible Additional Overpayments for Incontinence Supplies

The majority of overpayments previously identified by the Program Integrity Unit audit have been collected. OPEGA had identified approximately 6,000 claims with potential additional overpayments in the period from January 1, 2008 to June 30, 2008. PIU continues to work with OPEGA to prioritize those claims. PIU will then evaluate the return on investment in devoting limited staff resources to investigating these claims and proceed as appropriate. DHHS will provide periodic updates on PIU actions taken on this recommendation and related results to OPEGA and the Government Oversight Committee beginning in September 2009.

8

Proactively Address Procedure Codes with Reimbursement Rates of Zero to Prevent Rejection of Vendor Claims

A quarterly report has been developed to show any null modifier codes and $0 rate values in the MECMS Rate Tables so they can be reviewed and corrected in the system. The first of these reports has been run, corrections are in progress and are expected to be complete by August 7, 2009. Hereafter reports will be generated quarterly following the receipt of the CMS rate list. The reports will be manually reviewed and items identified will either be recoded in MECMS or eliminated.

9

Correct Programming Error to Ensure Transactions Without Required Prior Authorization Are Not Paid

This issue was the result of a MECMS failure that permitted the payment of a claim even after the PA had been cancelled. PA's must occasionally be cancelled if, for instance, a PA is issued to the wrong Provider ID. In MECMS, when a PA is cancelled the record remains in the system (with the status "cancelled"), and a new PA is issued to the correct Provider ID. However, the system should never pay a claim to a cancelled PA.

The MIHMS PA process will be in place on March 1, 2010 and eliminates this issue.

Acknowledgements

OPEGA would like to thank the management and staff of the Department of Health and Human Services who worked with us throughout this audit including the:

- Commissioner's Office;
- Office of MaineCare Services;
- Division of Audit for MaineCare and Social Services; and
- Rate Setting Unit.

Also a special thanks to those individuals within DHHS, the DHHS Service Center, the Office of the State Controller and the Office of the Executive Director of the Legislative Council for providing the data we requested to perform our analyses and helping us to understand how to interpret it.

Lastly, we appreciate the assistance of the Office of Information Technology in researching some of the issues we identified.