Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
Making government work better

Official Audit Report – Issued April 13, 2017

Office of Medicaid (MassHealth)—Review of Claims for Durable Medical Equipment

For the period July 1, 2010 through December 31, 2015

Commonwealth of Massachusetts
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April 13, 2017

Ms. Marylou Sudders, Secretary
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Ms. Sudders:

I am pleased to provide this performance audit of the Office of Medicaid (MassHealth). This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, July 1, 2010 through December 31, 2015. My audit staff discussed the contents of this report with management of the agency, whose comments are reflected in this report.

I would also like to express my appreciation to MassHealth for the cooperation and assistance provided to my staff during the audit.

Sincerely,

Suzanne M. Bump
Auditor of the Commonwealth

cc: Daniel Tsai, Assistant Secretary and Director of Medicaid

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LIST OF ABBREVIATIONS

CHIA	Center for Healthcare Information and Analysis
CMR	Code of Massachusetts Regulations
DME	durable medical equipment
EOHHS	Executive Office of Health and Human Services
MMIS	Medicaid Management Information System
OSA	Office of the State Auditor

EXECUTIVE SUMMARY

The Office of the State Auditor (OSA) receives an annual appropriation for the operation of a Medicaid Audit Unit to help prevent and identify fraud, waste, and abuse in the Commonwealth's Medicaid program. This program, known as MassHealth, is administered under Chapter 118E of the Massachusetts General Laws by the Executive Office of Health and Human Services, through the Division of Medical Assistance.

Medicaid is a joint federal-state program created by Congress in 1965 as Title XIX of the Social Security Act. At the federal level, the Centers for Medicare and Medicaid Services, within the US Department of Health and Human Services, administer the Medicare program and work with state governments to administer state Medicaid programs.

OSA has conducted an audit of claims paid for durable medical equipment (DME) for the period July 1, 2010 through December 31, 2015. During this period, MassHealth paid approximately $279 million for DME provided to 171,446 MassHealth members. The purpose of this audit was to analyze MassHealth's payment information for DME claims and determine whether MassHealth paid claims for DME in accordance with applicable laws, rules, and regulations. The audit focused on two specific types of overpayments: (1) payments made at rates higher than those established by state regulations and the state rate schedule and (2) duplicate payments. Based on our audit, we have concluded that some of MassHealth's payments for DME were contrary to state regulations and resulted in approximately $206,000 of improper payments to DME providers.

This audit was conducted as part of OSA's ongoing independent statutory oversight of the state's Medicaid program. Several of our previously issued audit reports disclosed significant weaknesses in MassHealth's claim-processing system, which resulted in millions of dollars in unallowable and potentially fraudulent claim payments. As with any government program, public confidence is essential to MassHealth's success and continued support.

Below is a summary of our findings and recommendations, with links to each page listed.

Finding 1 **Page 8**	MassHealth paid DME providers at higher-than-approved rates, resulting in $57,067 in overpayments.
Recommendations **Page 9**	1. MassHealth should ensure that changes made to the Center for Healthcare Information and Analysis's rate schedules are entered in its Medicaid Management Information System in a timely manner. 2. MassHealth should recoup the $57,067 of overpayments that we identified.
Finding 2 **Page 9**	MassHealth made $148,978 of duplicate payments to DME providers.
Recommendations **Page 10**	1. MassHealth should develop a system edit for crossover claims that identifies and denies duplicates caused by providers resubmitting claims with different modifiers. 2. MassHealth should issue a provider bulletin reminding providers of the proper way to submit claims for services provided to dual-eligibles. 3. MassHealth should recoup the $148,978 of duplicate payments that we identified.

OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services, through the Division of Medical Assistance, administers the state's Medicaid program, known as MassHealth. MassHealth annually provides access to healthcare services to approximately 1.9 million eligible low- and moderate-income children, families, seniors, and people with disabilities. In fiscal year 2016, MassHealth paid healthcare providers more than $14 billion, of which approximately 50%[1] was funded by the Commonwealth. Medicaid expenditures represent approximately 39% of the Commonwealth's total annual budget.

According to Section 409.413 of Title 130 of the Code of Massachusetts Regulations (CMR), MassHealth covers medically necessary durable medical equipment (DME) for its members. DME includes, but is not limited to, wheelchairs (manual and electric), traction equipment, canes, crutches, walkers, kidney machines, ventilators, oxygen, monitors, pressure mattresses, lifts, and nebulizers. The table below details the number of claims, number of members served, and amount paid for DME during the audit period, July 1, 2010 through December 31, 2015.

Calendar Year	Number of Claims	Members Served	Amount Paid
2010*	383,302	52,255	$ 23,921,470
2011	788,092	67,008	50,577,551
2012	770,132	67,116	51,384,417
2013	757,249	65,291	50,047,953
2014	725,535	66,053	52,019,080
2015	727,000	65,324	51,292,465
Total	4,151,310	383,047†	$ 279,242,936

* The audit period included only the last six months of 2010.
† Of these 383,047 members, the unduplicated count is 171,446.

Medicaid

Each state administers its Medicaid program in accordance with the state plan approved by the federal Centers for Medicare and Medicaid Services. States have considerable flexibility in designing and operating their Medicaid programs, but must comply with applicable federal requirements established by Section 1902 of Title XIX of the Social Security Act. MassHealth members are eligible to receive DME

1. During the federal government's fiscal year 2016, the Federal Medical Assistance Percentage for Massachusetts was 50%. This percentage is amount that the federal government contributes to joint federal-state programs.

when it is ordered or prescribed by a physician. MassHealth pays providers for DME based on state regulations and a rate schedule that the Center for Healthcare Information and Analysis[2] established and periodically updates. These regulations and rates are published in 114.3 CMR 22.

Claims for Dual-Eligibles

Certain MassHealth members are also enrolled in Medicare, the federal healthcare program for people with certain disabilities and for people age 65 and older. MassHealth members who are enrolled in both programs are referred to as dual-eligibles. Providers who perform services for dual-eligibles must submit claims for their services to Medicare. After Medicare processes the claim and determines its share of the cost, the claim is electronically transferred to MassHealth for further processing. MassHealth pays any remaining balance not covered by Medicare, such as Medicare coinsurance, copayments, and deductibles. Such claims are called crossover claims.

2. Until November 5, 2012, this agency was known as the Division of Health Care Finance and Policy.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of claims for durable medical equipment (DME) paid by MassHealth during the period July 1, 2010 through December 31, 2015.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide 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 objective.

Below is our audit objective, indicating the question we intended our audit to answer, the conclusion we reached regarding the objective, and where the objective is discussed in the audit findings.

Objective	Conclusion
1. Did MassHealth pay providers for DME claims in accordance with state regulations?	**No; see Findings 1 and 2**

Auditee Selection

On April 19, 2016, OSA issued "Office of Medicaid (MassHealth)—Review of Claims Submitted by Hudson Home Health Care, Inc." (Report No. 2015-1374-3M10). This audit identified a potential deficiency in MassHealth's processing of DME crossover claims. At the time, OSA did not report on this matter because it could affect all DME providers, not only Hudson Home Health Care, Inc. Moreover, it reflected a potential problem in MassHealth's claim-processing system, which would have required additional audit work to substantiate. Since that additional work was beyond the scope of the Hudson Home Health Care, Inc. audit, OSA conducted this audit of all DME crossover claims for July 1, 2010 through December 31, 2015.

Methodology

To achieve our audit objective, we reviewed applicable state and federal laws, rules, and regulations; MassHealth provider bulletins and transmittal letters; the MassHealth All Provider Manual; the Center for Healthcare Information and Analysis's (CHIA's) applicable DME regulations and rate schedule; and

administrative bulletins from the Executive Office of Health and Human Services (EOHHS) informing interested parties of changes to DME procedure codes, modifier codes, and payment rates. We interviewed MassHealth officials to gain an understanding of the payment process for DME crossover claims.

We gained an understanding of the internal control we deemed significant to our audit objective: MMIS detect-and-deny controls to ensure that claims are not paid at an amount above what state regulations allow. However, based on prior audits, we found that the controls were not working, and we could not test the effectiveness of this control. We still achieved our audit objective by increasing the number of claims tested to reflect the highest level of risk.

We queried all 4.1 million MassHealth DME claims for the audit period, from the Commonwealth's Medicaid Management Information System (MMIS) and the MassHealth Data Warehouse, to determine whether they were billed appropriately. We performed data analytics to identify which claims represented DME crossover claims. We tested the DME crossover claims to determine whether they were paid appropriately or determine specific instances in which MassHealth made overpayments or duplicate payments. To make this determination, we reviewed DME provider claims to identify overpayments made when the MassHealth payment was greater than the amounts allowed under CHIA's rate schedule. We determined that a duplicate payment was made whenever MassHealth paid two claims involving the same member ID, DME procedure code, service date, number of units billed, amount billed, amount allowed, and billing provider.

In a previous project (No. 2015-8020-14O), OSA assessed the reliability of the MassHealth data in MMIS, which is maintained by EOHHS. As part of this assessment, we reviewed existing information, tested selected system controls, and interviewed knowledgeable agency officials about the data. Additionally, we performed validity and integrity tests on all claim data, including (1) testing for missing data, (2) scanning for duplicate records, (3) testing for values outside a designated range, (4) looking for dates outside specific time periods, and (5) tracing a sample of claims queried to source documents. Based on the analysis conducted, we determined that the data obtained were sufficiently reliable for the purposes of this report.

Based on the evidence we gathered to form a conclusion on our objective, we believe that all audit work, in particular the work referred to above, taken as a whole is relevant, valid, reliable, and sufficient and that it supports the findings and conclusions reached in this report.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. MassHealth paid providers of durable medical equipment at higher-than-approved rates, resulting in $57,067 in overpayments.

MassHealth did not pay durable medical equipment (DME) providers in accordance with the Center for Healthcare Information and Analysis's (CHIA's) rate schedule; this resulted in overpayments totaling $57,067. The overpayments represented 14,630 claims submitted by 87 DME providers during the audit period. Although the average overpayment per claim was small, the large number of claims involved was significant, indicating a systemic problem within MassHealth's claim-processing system. These overpayments, detailed in the table below, represent wasted Commonwealth funds that could have been used for other needed services.

DME Type	Number of Claims	Overpayments
Enteral and parenteral therapy	513	$ 39,049
Wheelchair accessories	133	4,037
Orthopedic devices	146	4,008
Miscellaneous supplies	110	2,995
Dressings	13,615	2,639
Ostomy supplies	18	2,628
Oxygen and related respiratory equipment	45	1,020
Vascular catheters	13	489
Supplies for oxygen and respiratory equipment	2	121
Walkers	15	56
Patient lifts	1	10
Non-oral drugs	18	9
Hospital beds and accessories	1	6
Total	14,630	$ 57,067

Authoritative Guidance

The Division of Health Care Finance and Policy (known as CHIA as of November 5, 2012), under Section 22.01(1) of Title 114.3 of the Code of Massachusetts Regulations (CMR), "governs the determination of rates of payment to be used by all governmental units in making payment to eligible providers of durable medical equipment provided to publicly-aided individuals."

In addition, according to 130 CMR 450.235(A)(3), overpayments to providers include, but are not limited to, amounts "in excess of the maximum amount properly payable for the service provided, to the extent of such excess."

Reasons for Excessive Payments

MassHealth officials stated that the Medicaid Management Information System (MMIS) was not updated in a timely manner to reflect CHIA's current rate schedule and that this had resulted in overpayments to certain providers. They did not explain why MMIS had not been updated promptly.

Recommendations

1. MassHealth should ensure that changes made to CHIA's rate schedules are entered in MMIS in a timely manner.
2. MassHealth should recoup the $57,067 in overpayments that we identified.

Auditee's Response

MassHealth agrees with this finding. MassHealth will explore the identified claims and implement corrective action where appropriate. MassHealth is also presently exploring streamlining its rate setting and rate update processes, including by procuring a Long Term Services and Supports Third Party Administrator (TPA) that MassHealth anticipates will be able to speed MassHealth's ability to identify and to quickly implement fee schedule changes and claims edits. . . .

MassHealth agrees with [Recommendation 2] and will recoup all validated overpayments.

2. MassHealth made $148,978 of duplicate payments to DME providers.

MassHealth made $148,978 of duplicate payments to providers during the audit period. In each case, a DME provider submitted a claim to Medicare and then submitted a claim to Medicaid for the same item, with the same member ID, DME procedure code, service date, number of units billed, amount billed, amount allowed, and billing provider. In each case, the only billing difference between the two claims was that they contained different modifier codes. (Modifier codes provide additional information needed to process a claim; if approved, they determine the correct payment.) In total, 2,931 claims were affected. This indicates a systemic problem in MassHealth's claim-processing system, not an isolated problem with a single provider. These duplicate payments represent wasted Commonwealth funds that could have been used for other needed services.

The table below summarizes these duplicate payments by DME type.

DME Description*	Duplicate Payments
Parenteral nutrition solution; 10 to 51 grams of protein	$ 40,030
Parenteral nutrition solution; 74 to 100 grams of protein	13,824
Intermittent urinary catheter with insertion supplies	13,445
Blood glucose test or reagent strips for home blood glucose, per 50 strips	12,258
Parenteral nutrition solution, per 10 grams lipids	9,222
Parenteral nutrition solution; 52 to 73 grams of protein	4,470
Wheelchair accessory, power seating system, tilt only (new equipment)	4,382
Male external catheter, with or without adhesive, disposable	4,289
Parenteral nutrition solution; over 100 grams of protein	4,146
Full face mask used with positive airway pressure device	2,634
Other	40,278
Total	$ 148,978

* These procedure-code descriptions are shortened versions of the descriptions in 114.3 CMR 22.

Authoritative Guidance

According to 130 CMR 450.307(B)(1), the following billing practice is unallowable:

> *duplicate billing, which includes the submission of multiple claims for the same service by the same provider or multiple providers.*

Reasons for Duplicate Payments

MassHealth has an edit in MMIS that is intended to prevent duplicate payments by denying claims for the same service for the same member on the same day. However, during our audit, we determined that this edit did not work when providers resubmitted crossover claims using different modifier codes. In such instances, MMIS processed and paid the second (duplicate) claim even though the services were already paid for.

Recommendations

1. MassHealth should develop a system edit for crossover claims that identifies and denies duplicates caused by providers resubmitting claims with different modifiers.
2. MassHealth should issue a provider bulletin reminding providers of the proper way to submit claims for services provided to dual-eligibles.

3. MassHealth should recoup the $148,978 of duplicate payments that we identified.

Auditee's Response

MassHealth generally agrees with [Recommendation 1]. In fact, as part of an ongoing and continuous review of program integrity, MassHealth had, previous to learning of this recommendation by the Auditor, operationalized a system edit in October 2016 which triggers a pre-pay review of certain claims that may have also been paid as a crossover. MassHealth will continue to refine its system edits and review processes as it completes additional internal analysis on this issue. . . .

MassHealth generally agrees with [Recommendation 2]. In fact, as part of an ongoing and continuous review of program integrity, MassHealth had, previous to learning of this recommendation by the Auditor, identified issues associated with crossover DME claims and issued a series of DME Provider Bulletins in September 2016 that clarified and emphasized provider responsibilities when submitting crossover claims for DME: [Durable Medical Equipment Bulletin 19, Orthotics Bulletin 6, Oxygen Bulletin 15, and Prosthetics Bulletin 10].

MassHealth believes these previously-issued bulletins accomplish the goal of the Auditor's recommendation. . . .

MassHealth agrees with [Recommendation 3] and will recoup all validated overpayments.