



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General  
Office Of Audit Services

Region II  
Jacob K. Javits Federal Building  
26 Federal Plaza  
New York, NY 10278

September 15, 2003

Report Number A-02-02-01025

Dr. Antonia C. Novello, Commissioner  
New York State Department of Health  
Empire State Plaza, 14<sup>th</sup> Floor, Room 1408  
Corning Tower  
Albany, NY 12237-0041

Dear Dr. Novello:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "Review of New York Medicaid Nursing Home Ancillary and Durable Medical Equipment Payments". A copy of this audit report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe have a bearing on the final determination.

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To facilitate identification, please refer to report number A-02-02-01025 in all correspondence relating to this report.

Sincerely,

  
Timothy J. Horgan  
Regional Inspector General  
for Audit Services

Enclosures – as stated

**Direct Reply to HHS Action Official:**

Dr. Gilbert Kunken  
Acting Regional Administrator  
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**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF NEW YORK MEDICAID  
NURSING HOME ANCILLARY AND  
DURABLE MEDICAL EQUIPMENT  
PAYMENTS**



**Inspector General**

**September 2003**

**A-02-02-01025**

# *Office of Inspector General*

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Under the New York State Medicaid program, nursing homes were paid a daily all-inclusive per diem rate for services rendered to beneficiaries. This rate was based on actual cost data from the 1983 base-year trended forward to reflect current year costs. In addition, further adjustments were made to this cost to reflect the case mix at each facility and any appeals findings. The all-inclusive rate considered many factors that impacted the cost to the nursing home such as patient diagnosis, activity of daily living, and level of care needed. In New York State, reimbursement to all nursing homes includes the following ancillary services: physical therapy, occupational therapy, speech and language pathology, and dental services as well as durable medical equipment (DME).

### **OBJECTIVE**

The objective of our audit was to identify inappropriate Medicaid payments to ancillary service and DME providers for beneficiaries residing in nursing homes whose all-inclusive rate incorporated the costs of such services.

### **FINDINGS**

In general, the New York State Department of Health (Health) had sufficient controls in place to ensure that duplicate payments were not made for physical therapy, occupational therapy, speech and language pathology, as well as dental services provided to Medicaid beneficiaries residing in nursing homes. However, we found that Health did not have sufficient controls to ensure that DME providers did not separately bill Medicaid for DME it provided to nursing home residents.

We determined, based on computer matching, that in general, Health had controls in place to ensure proper payment for physical therapy, occupational therapy, speech and language pathology, as well as dental services. Some nursing homes received additional reimbursement for other ancillary services such as prescription drugs, laboratory, x-ray, and physician services as part of their Medicaid rate, which were not included in our audit. Our conclusion was primarily based on the fact that only 65 potential improper claims totaling \$736 (\$368 Federal share) for physical and occupational therapy, and no potential improper claims for speech and language pathology services were identified by our computer analyses. Further, we identified 635 potential improper claims for dental services totaling \$83,952 (\$41,976 Federal share).

Since the amount of potential duplicate claims for physical therapy, occupational therapy, speech and language pathology, as well as dental services was not significant, we focused our review on the potential duplicate DME claims. We identified a total universe of 24,276 potential duplicate Medicaid DME claim payments totaling \$4,808,413 (\$2,404,207 Federal share) for beneficiaries in nursing homes. We used stratified random sampling techniques to select a sample of 120 potential duplicate payments totaling \$268,781 (\$134,390 Federal share) for the 3-year period ended September 30, 2001. We estimate that Health made improper payments to DME providers totaling at least \$1,212,805 (\$606,403 Federal share).

Health paid DME providers a total of \$96,643 (\$48,322 Federal share) for 43 of the 120 claims reviewed that should have been included in the all-inclusive nursing home rate. Based on discussions with and written guidance provided by Health officials, we determined these DME claims were not separately billable to Medicaid. (See Appendix C for a detailed summary of Medicaid potential duplicate DME payments by provider).

Specifically, overpayments for which DME providers incorrectly billed Medicaid included:

- \$66,323 (\$33,162 Federal share) for ten claims for augmentative communication devices;
- \$27,172 (\$13,586 Federal share) for seven claims for dialysis supplies;
- \$1,360 (\$680 Federal share) for five claims for oxygen or oxygen equipment rental;
- \$785 (\$392 Federal share) for fifteen claims for items shipped to the beneficiaries' home address when they were admitted to a nursing home several months prior to the shipping date;
- \$435 (\$218 Federal share) for three claims for supplies sent to the nursing home;
- \$358 (\$179 Federal share) for one claim for medical supplies sent to the nursing home for which the nursing home had not ordered or received, and;
- \$210 (\$105 Federal share) for two claims for DME rentals.

Reasons for the overpayments include:

- Health's prior approval process focused primarily on medical necessity and appropriateness rather than determining whether Medicaid or the nursing home is responsible for payment;
- Providers incorrectly assumed that certain DME items were not included in the nursing home rate. In June 2002, Health issued a Medicaid Update clarifying its policy that only medically necessary custom-made DME is separately billable to Medicaid for eligible residents of a nursing facility. Prior to this, the guidance from Health was not always clear;
- Providers were apparently not notified when beneficiaries moved to a nursing home and continued to ship various items to the beneficiary's home. Further, these providers were automatically refilling prescriptions without the beneficiary's authorization as required by Health's policy;
- Monthly billings for DME (including rentals) were not prorated to reflect the actual time beneficiaries resided in a nursing home;

- One provider was not aware that the addresses to which it shipped DME were nursing homes, and;
- The nursing home rate is based on actual cost data from 1983 trended forward to determine current year cost. This rate would not include any of the relatively new technology available to residents such as augmentative communication devices, which were not available at that time, and therefore would not be included in the base year costs. According to Health officials, the nursing home, however, is expected to provide these services even though their rate does not include payment for the items because the reimbursement also includes payment for items that are no longer provided by the nursing home. Therefore, Health officials believe the rate adequately reimburses the nursing homes.

## RECOMMENDATIONS

We recommend that Health:

- Refund \$606,403 to the Federal Government for its share of the identified overpayments;
- Ensure that DME providers bill the nursing home rather than Medicaid for services included in the nursing home rate by requiring the Medicaid reviewer, during their prior approval process, to determine whether Medicaid or the nursing home is responsible for payment;
- Issue guidance to DME providers specifying that augmentative communication devices are not custom-made and therefore, not separately billable to Medicaid for nursing home residents;
- Instruct DME providers not to refill any prescriptions without the beneficiary's or their representative's authorization, and;
- Prospectively, calculate Medicaid per diem rates to more closely reflect the changes in medical technology and nursing home operating costs.

## HEALTH COMMENTS

In its comments to our draft report, Health disagreed with our first recommendation to refund \$606,403 to the extent that this amount included co-payments for services approved under Medicare Part B. In addition, Health indicated prior approval staff has in the past, and will continue to use nursing home residency, as a criterion to approve the requested services to the extent the information is available at the time of the review. Health concurred with the third recommendation to issue additional guidance on augmentative communication devices to DME providers. Further, Health also concurred with our fourth recommendation and will prepare a Medicaid Update article reminding DME providers not to refill orders without the authorization of the beneficiary or their representative. Finally, Health felt that current regulations prohibit recalculation of the Medicaid per diem rates. The full text of Health's comments is presented as APPENDIX D to the report.

## OIG RESPONSE

We are pleased that Health concurs with recommendations two, three and four. With respect to our first recommendation, in determining the universe of claims for this audit, all claims with a Medicare approved amount were eliminated from the sample frame. Consequently, the claims universe did not include any Medicaid co-insurance claims or co-payments. Therefore, we continue to recommend that NYS refund \$606,403 to the Federal Government. We assume that Health now concurs with this recommendation.

Health officials contend that prior approval staff uses nursing home residency as a criterion for approving services. However, we found that even when residency information was available, prior approval staff was allowing DME reimbursement when the patient was a nursing home resident. Specifically, 71 of the 120 claims in our sample had received prior approval from Health, yet the reviewer had information indicating that 33 of these patients were residents of a nursing home at the time of the approval. Further, during our audit, Health officials acknowledged that they primarily look at the medical necessity documentation when approving services and do not necessarily look at the place of residency. We continue to recommend that Medicaid reviewers, during the prior approval process, be required to determine whether Medicaid or the nursing home is responsible for payment.

Although Health stated it was unable to change the base year used for the rate calculation, there is no Federal regulation prohibiting such practice. Health could submit a State Plan Amendment to the Centers for Medicare & Medicaid Services' (CMS) to calculate the Medicaid rates on a more current base year. We continue to recommend that Health prospectively calculate Medicaid per diem rates to reflect the changes in nursing home costs.

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## INTRODUCTION

### ***BACKGROUND***

#### ***Medicaid Program***

Title XIX of the Social Security Act authorizes Federal grants to states for Medicaid programs that provide medical assistance to low-income families, elderly individuals, and persons with disabilities. The Medicaid program is administered by each state in accordance with an approved state plan. While the state has considerable flexibility in designing its plan and operating its Medicaid program, it must comply with Federal requirements specified in the Medicaid statutes, regulations, and program guidance. Section 1902(a)(30)(A) of the Social Security Act requires a state plan to meet certain requirements in setting payment amounts for covered Medicaid care and services. One of these requirements is the state plan assure that payments are consistent with efficiency, economy, and quality of care. Additionally, the Secretary of Health and Human Services, who has delegated this authority to the Centers for Medicare & Medicaid Services (CMS)<sup>1</sup>, must approve the plan.

The New York State Department of Health (Health) was the single state agency responsible for administering the Medicaid program in New York State (NYS). Health contracted with a fiscal agent, Computer Sciences Corporation, to process Medicaid claims and make payments to providers through the Medicaid Management Information System (MMIS), a computerized payment and information reporting system.

#### ***Nursing Home Reimbursement Methodology***

Reimbursement to nursing homes in NYS was via an all-inclusive rate for all services provided to residents of the facility. The all-inclusive rate considered many factors that impacted the cost to the nursing home such as patient diagnosis, activity of daily living, and level of care needed. This rate includes payment for Durable Medical Equipment (DME) and various ancillary services. In NYS, the reimbursement to all nursing homes includes payment for ancillary services for physical therapy, occupational therapy, speech and language pathology, dental services as well as most DME. Custom made DME, which are items that cannot be readily modified to conform to another resident's medical needs, are not included in the nursing home rate. Some nursing homes received additional reimbursement for other ancillary services such as prescription drugs, laboratory, x-ray, and physician services as part of their Medicaid rate, which were not included in our audit. The nursing home reimbursement rate is based on actual cost data from the 1983 base-year trended forward to reflect current year costs. In addition, further adjustments were made to this adjusted cost to reflect the case mix at each facility and any appeals findings.

With respect to the nursing home rate, the New York Code of Rules and Regulations (NYCRR) 10, section 415.26(i)(1)(vii) set forth the basic services and equipment that a nursing home was required to provide to its residents. During the course of a covered Medicare or Medicaid stay, the facilities should not charge a resident for the following items and services:

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<sup>1</sup> CMS was formerly known as the Health Care Financing Administration (HCFA).

- (1) nursing services and specialized rehabilitative services;
- (2) dietary services;
- (3) an activities program;
- (4) room/bed maintenance services, and;
- (5) routine personal hygiene items and services.

Furthermore, subsection (k) of section 415.26(i)(1)(vii) provided that the facility was required to provide as part of its basic services “customarily stocked equipment, including but not limited to crutches, walkers, wheelchairs or other supportive equipment, including training in their use when necessary, unless such item is prescribed by a physician for regular and sole use by a specific resident.”

In addition, NYCRR Title 18, section 505.5 stated, “payment for durable medical equipment will not be made for items provided by a facility organization when the cost of those items is included in the [facility’s] rate. As such, if the cost of the item is not included in the rate, payment under the Medicaid program may be made directly to the durable medical equipment supplier.”

## **OBJECTIVE, SCOPE AND METHODOLOGY**

### ***Objective***

The objective of our audit was to identify inappropriate Medicaid payments to ancillary service and DME providers for beneficiaries residing in nursing homes whose all-inclusive rate incorporated the costs of such services.

### ***Scope***

Our review was conducted in accordance with generally accepted government auditing standards. Fieldwork was performed at selected DME providers and nursing homes throughout NYS from December 2002 through February 2003. We did not assess the overall internal control structure at Health. Rather, our internal control review was limited to gaining an understanding of those controls related to payments made by Health for ancillary and DME services rendered to nursing home residents during our audit period and conducting substantive testing.

We matched physical therapy, occupational therapy, speech and language pathology and dental services claims against 11.3 million nursing home claims processed during our audit period. We identified 65 potential duplicate claims for physical and occupational therapy totaling \$736 (\$368 Federal share). We found no potential duplicate speech and language pathology claims. Further, by matching 574,658 dental claims against the 11.3 million nursing home claims, we identified 635 potential improper claims for dental services totaling \$83,952 (\$41,976 Federal share).

In addition, we matched 3.9 million DME claims against the universe of nursing home claims and identified 24,276 potential duplicate claims for DME. Since the amount of potential duplicate claims for physical therapy, occupational therapy, speech and language pathology, as well as dental services was not significant, we focused our review on the potential duplicate DME claims.

## ***Methodology***

To accomplish our objectives, we:

- Reviewed applicable laws and regulations including:
  - NYS Medicaid State Plan;
  - NYCRR;
  - MMIS DME Provider Manual, and;
  - Health Data Dictionary Descriptions.
- Interviewed Health officials.
- Using various computer applications we:
  - Developed computer programs to identify claims for ancillary services and DME rendered to Medicaid recipients in nursing homes to determine the effectiveness of MMIS controls in preventing inappropriate payments to ancillary and DME service providers. Our program matched nursing home claims with ancillary service and DME claims for the period October 1, 1998 through September 30, 2001 and identified potential duplicate payments because reimbursement for these services was already included in the nursing home reimbursement rate.
  - Identified 65 potential duplicate claims for occupational therapy and physical therapy services, with a total Medicaid paid amount of \$736 (\$368 Federal share).
  - Identified no potential duplicate speech and language pathology claims.
  - Identified 635 potential duplicate dental claims, with a total Medicaid paid amount of \$83,952 (\$41,976 Federal share).
  - Identified 751,432 total potential duplicate DME claims, with a total Medicaid paid of \$39,346,409 (\$19,673,204 Federal share).
- Performed additional analysis of the 751,432 DME claims and identified a total universe of 24,276 claims for which the cost of providing the service may have been included in the Medicaid all-inclusive per diem nursing home rate. A list of specific procedure codes was obtained from Health officials who indicated that reimbursement for these codes may have been included in the nursing homes reimbursement rate.
- Used stratified random sampling techniques to select a sample of 120 DME claims totaling \$268,781 (\$134,390 Federal share) from the universe of 24,276 DME claims.
- Obtained and reviewed documentation for the 120 randomly selected claims, including:
  - Medical records, and;

- Billing records, including remittance statements and claim forms.
- Obtained a limited understanding of the nursing home's internal controls by interviewing nursing home officials.
- Verified the accuracy of the MMIS claims data by:
  - Tracing the Medicaid paid amounts for the 120 sample claims to paid amounts shown on the DME provider's remittance statements;
  - Comparing medical and beneficiary data for the 120 sample claims with information contained in the supporting medical records, and;
  - Obtaining documentation from each nursing home to confirm the item billed was ordered and provided to the beneficiaries.
- Used a variables appraisal program to estimate the dollar impact of the improper payments in the total population of 24,276 claims.

## **FINDINGS AND RECOMMENDATIONS**

In general, Health had sufficient controls in place to ensure that duplicate payments were not made for physical therapy, occupational therapy, speech and language pathology and dental services provided to Medicaid beneficiaries residing in nursing homes. However, we found that Health did not have sufficient controls to ensure that DME providers did not separately bill Medicaid for DME it provided to nursing home residents. Specifically, Health improperly paid DME providers a total of \$96,643 (\$48,322 Federal share) for 43 DME claims. We estimate that Health improperly paid at least \$1,212,805 (\$606,403 Federal share) to DME suppliers when beneficiaries were residents of a nursing home.

Based on discussions with Health officials and written guidance provided by them, we determined the DME claims that are separately billable to Medicaid for nursing home residents. These claims include custom made DME and DME provided to residents for use upon discharge from the facility. All other DME is included in the nursing home rate and is not separately billable to Medicaid.

Nursing homes provide residents with 24-hour nursing care. Included in the nursing home rate is basic care such as personal hygiene and toileting as well as more complex care such as tube feedings. The NYS Medicaid reimbursement rate included reimbursement for these basic care services as well as for numerous ancillary services and DME that were not custom made. The ancillary services we reviewed were for physical therapy, occupational therapy, speech and language pathology and dental services, which are included in the reimbursement rate for all NYS nursing homes. Nursing homes either delivered these services directly or contracted with providers to render them to residents. Therefore, if Medicaid paid separately for these services, it

may have paid twice for the same service. First, when it paid the facility at the all-inclusive nursing home rate, and again when it paid the provider for a separate ancillary or DME claim.

For the 3-year period ended September 30, 2001, we identified a total universe of 24,276 potential duplicate Medicaid DME claim payments totaling \$4,808,413 (\$2,404,207 Federal share) for beneficiaries in nursing homes. According to Health officials, the Medicaid nursing home rate may have included payment for these products and/or services; however, there may also be reasons for which Medicaid would have paid separately for them. For example, Medicaid pays separately for DME, such as a cane or walker, to be used by the resident upon discharge from the nursing home. Therefore, we randomly selected 120 of these claims amounting to \$268,781 (\$134,390 Federal share), submitted for reimbursement by 55 DME providers servicing 80 nursing homes to determine whether these claims were separately billable to Medicaid.

For each of the sample items, we determined the allowability of the potential duplicate payment. We used the lower limit at the 90 percent confidence interval to estimate the Federal share of the DME overpayments to be returned to the Federal Government. Appendix B contains the details of our sampling results and projections.

The NYS nursing home rate is based on actual cost data from 1983 trended forward to determine current year cost. The rate would not include any of the relatively new technology available to residents such as augmentative communication devices; however, the nursing home is expected to provide these services without further cost to Medicaid or the resident.

### ***Health Controls***

In general, Health had sufficient controls in place to ensure that duplicate payments were not made for physical therapy, occupational therapy, speech and language pathology and dental services provided to Medicaid beneficiaries residing in nursing homes. However, the controls over payments to DME providers for services provided to nursing home residents could be improved. We identified the major controls as follows:

- Regulations cited in NYCRR Title 10,
- Medicaid prior approval process,
- Provider reimbursement form which indicated nursing home residency status, and;
- The MMIS.

The DME providers obtained Medicaid reimbursement by submitting claims to the Medicaid Management Information System for services provided to NYS Medicaid beneficiaries. Providers are supposed to indicate whether the beneficiary is a resident of a nursing home on the order/prior approval request form. Health officials review claims during the prior approval process primarily for medical necessity and appropriateness rather than determining whether Medicaid or the nursing home is responsible for payment.

### ***Improperly Reimbursed Claims***

We found that Medicaid improperly reimbursed DME suppliers for 43 claims while the beneficiaries were residents of nursing homes. According to Health officials, the Medicaid nursing home rate included payment for these products and/or services. Therefore, the provider should have billed the nursing home rather than Medicaid. As a result, Health overpaid DME providers a total of \$96,643 (\$48,322 Federal share). Details are discussed below.

<b>Number of Claims</b>	<b>Description</b>	<b>Medicaid Amount</b>	<b>Federal Share</b>
10	Augmentative communication devices	\$66,323	\$33,162
7	Dialysis supplies	27,172	13,586
19	Other medical supplies	1,578	789
5	Oxygen supplies	1,360	680
2	Rental equipment	210	105
43	<b>Total</b>	\$96,643	\$48,322

Reasons for the overpayments include:

- Health’s prior approval process focused primarily on medical necessity and appropriateness rather than determining whether Medicaid or the nursing home is responsible for payment;
- Providers incorrectly assumed that certain DME items were not included in the nursing home rate. In June 2002, Health issued a Medicaid Update clarifying its policy that only medically necessary custom-made DME is separately billable to Medicaid for eligible residents of a nursing facility. Prior to this, the guidance from Health was not always clear;
- Providers were apparently not notified when beneficiaries moved to a nursing home and continued to ship various items to the beneficiary’s home. Further, these providers were automatically refilling prescriptions without the beneficiary’s authorization as required by Health’s policy;
- Monthly billings for DME (including rentals) were not prorated to reflect the actual time beneficiaries resided in a nursing home;
- One provider was not aware that the addresses to which it shipped DME were nursing homes, and;

- The nursing home rate is based on actual cost data from 1983 trended forward to determine current year cost. This rate would not include any of the relatively new technology available to residents such as augmentative communication devices, which were not available at that time and therefore would not be included in the base year costs. According to Health officials, the nursing home, however, is expected to provide these services even though their rate does not include payment for the items.

□ *Augmentative communication devices*

There were ten claims for augmentative communication devices totaling \$66,323 (\$33,162 Federal share) where Medicaid paid when the cost should have been included in the nursing home rate. For example, one provider received Medicaid reimbursement totaling \$8,080 for a claim for services provided on June 12, 2000. The prior approval form indicated the beneficiary was a resident of a nursing home and was reviewed and approved by Health officials. However, the prior approval process did not consider the place of residency or whether Medicaid or the nursing home is responsible for payment, but rather focused on the appropriateness and medical necessity.

Health classifies augmentative communication devices as a customized item that is included in the nursing home rate. Health's MMIS Provider Manual defined customized DME as components added to an already existing device that is assembled, adjusted or modified to fit the body. When the customization is no longer necessary, the modifications can be changed to conform to another beneficiary's medical needs and the equipment can be reused. Health restated its policy on DME in a June 2002 Medicaid update reiterating...

“only medically necessary custom-made DME is reimbursable by fee-for-service Medicaid for eligible residents of a skilled nursing facility (SNF), subject to prior approval. If a prior approval request for DME is denied for a SNF resident, not because of lack of medical necessity but because it is not custom-made equipment, the facility will be expected to provide the equipment.”

It further defines custom-made as “an item fabricated for the sole use by a particular resident from mainly raw materials and cannot be readily changed to conform to another resident's medical needs.” The beneficiary was a nursing home resident at the time the service was provided and the equipment was not custom made. The nursing home should have paid for this device in accordance with Health policy. We determined the overpayment for this claim to be \$8,080.

□ *Dialysis supplies*

There were seven claims for peritoneal dialysis supplies totaling \$27,172 (\$13,586 Federal share) where Medicaid paid the provider when the cost should have been included in the nursing home rate. One provider submitted all seven claims for Medicaid beneficiaries residing at the same nursing home. For example, this provider received Medicaid reimbursement totaling \$3,078 for a claim for services provided on May 1, 1999 that indicated

the beneficiary was a resident of a nursing home. The claim was reviewed by Health officials and approved for payment. However, the DME provider billed Medicaid rather than the nursing home for these supplies. According to Health, “medical-surgical supplies should not be requested or filled after the recipient has moved to a nursing home, as supplies are included in the per diem rate.” In NYS, dialysis supplies are considered medical-surgical supplies as indicated in the Medicaid reimbursement manual. We calculated this overpayment to be \$3,078.

□ ***Other medical supplies***

There were 19 claims for other medical supplies including diapers, enteral formulae, and glucose testing products totaling \$1,578 (\$789 Federal share). For 15 of these claims, the supplies were shipped monthly to the beneficiary’s private residence. The other four claims were for supplies sent to the beneficiary’s attention at the nursing home. For example, one provider received Medicaid reimbursement totaling \$86 for a claim for services provided on February 25, 2001 for disposable diapers sent to a beneficiary’s home. A physician’s order was signed on October 2, 2000 that initiated the first shipment and was valid for refills up to six months. The beneficiary was admitted to a nursing home on November 20, 2000 - three months prior to shipment. A refill of diapers was not needed since the nursing home provides diapers, which are included in their Medicaid reimbursement rate. In addition, the beneficiary did not initiate a request for a refill.

On February 21, 2003, Health provided a written response to OIG indicating, “the recipient must initiate all requests for refills of medical-surgical supplies. Refills should not be requested or filled after the recipient has moved to a nursing home, as supplies are included in the per diem rate.” However, the DME provider continued to ship the diapers to the beneficiary’s home even though the beneficiary did not request the refill. We calculated the overpayment to be \$86 for this claim.

□ ***Oxygen supplies***

There were five claims for portable oxygen system rentals and oxygen concentrator supplies totaling \$1,360 (\$680 Federal share) for beneficiaries who resided in nursing homes. For example, one provider received Medicaid reimbursement totaling \$435 for a claim for services provided on May 8, 1999 that indicated the beneficiary was a resident of a nursing home. Oxygen concentrator and oxygen equipment rentals are billed on a monthly basis and require a prior approval authorization that is valid for six months. In its written response dated February 21, 2003, Health informed us that oxygen supplies are included in the nursing home Medicaid rate. In addition, Health requires that “DME providers should be notified when equipment is no longer needed. The ordering practitioner determines if a DME item is still needed.” However, the DME provider billed Medicaid for the equipment rental, even though the cost for this service was included in the nursing home’s Medicaid per diem rate. We determined the overpayment to be \$435 for this claim.

□ ***Rental equipment***

There were two claims for rental DME equipment totaling \$360 (\$180 Federal share) to beneficiaries that should have been discontinued when the beneficiaries were admitted to a nursing home. For example, a provider received Medicaid reimbursement totaling \$300 for rental of a continuous positive airway pressure device when the beneficiary had been admitted to a nursing home. The beneficiary had been using the device for several months prior to being admitted to the nursing home. According to Health officials, these devices are included in the all-inclusive rate paid to the nursing home to provide for the beneficiary's care. The DME provider continued to bill Medicaid and received payment for the equipment rental although the cost for this service was included in the nursing home's Medicaid per diem rate. We calculated the overpayment to be \$150 for this claim, which is a prorated amount to account for the period that the beneficiary was in the nursing home.

The second claim was for rental of a manual wheelchair for the beneficiary's use upon discharge from a hospital. There was a physician's order dated February 2, 2001, for the wheelchair rental that included a refill for 5 additional months. Although the beneficiary was admitted to a nursing home on February 12, 2001, the DME provider billed Medicaid for the monthly rental fee for April 2001. According to Health officials, the all-inclusive rate paid to the nursing home included payment for the resident's wheelchair. We determined the monthly rental of \$60 for this claim to be an overpayment.

***Nursing Home Medicaid Rates***

Section 1902(a)(30)(A) of the Social Security Act requires a state plan to meet certain requirements in setting payment amounts for covered Medicaid care and services. One of the requirements is that the state plan assures that payments are consistent with efficiency, economy, and quality of care.

The nursing home rate is based on actual cost data from 1983 trended forward to determine current year cost for most nursing homes. A limited number of nursing homes have a more recent base year due to a change in ownership, appointment of a receiver, complete replacement of the nursing facility building, or major reconstruction/renovation to conform to current codes. The nursing home rate is an all inclusive rate. However, the rate would not include any of the relatively new technology available to residents such as augmentative communication devices, which were not available at that time and therefore would not be included in the base year costs. According to Health officials, the nursing home, however, is expected to provide these services even though their rate does not include payment for the items since the rate paid to them is considered to be an all-inclusive rate to provide for the beneficiary's care.

## RECOMMENDATIONS

We recommend that Health:

- Refund \$606,403 to the Federal Government for its share of the identified overpayments;
- Ensure that DME providers bill the nursing home rather than Medicaid for services included in the nursing home rate by requiring the Medicaid reviewer, during their prior approval process, to determine whether Medicaid or the nursing home is responsible for payment;
- Issue guidance to DME providers specifying that augmentative communication devices are not custom-made and therefore, not separately billable to Medicaid for nursing home residents;
- Instruct DME providers not to refill any prescriptions without the beneficiary's or their representative's authorization, and;
- Prospectively, calculate Medicaid per diem rates to more closely reflect the changes in medical technology and nursing home operating costs.

## AUDITEE COMMENTS AND OIG RESPONSE

We are pleased that Health provided comprehensive comments, dated August 13, 2003 to our draft audit report. The full text of Health's comments is included as APPENDIX D.

### Health Comments

Health did not concur with our first recommendation to refund \$606,403 to the extent that this amount includes co-payments for services approved under Medicare Part B by the regional DME carrier. Health indicated that the State should not be required to return the Federal share of any co-payments approved under Medicare Part B.

Health officials indicated that they already use and will continue to use nursing home patient residency as a criterion for approving services to the extent that the information is available at the time of the review.

Health officials concurred with our third recommendation to issue guidance to DME providers specifying that augmentative communication devices are not custom-made and therefore, not separately billable to Medicaid for nursing home residents.

Health concurred with our fourth recommendation and they will prepare a Medicaid Update article reminding DME providers not to refill orders without the authorization of the beneficiary or their representative.

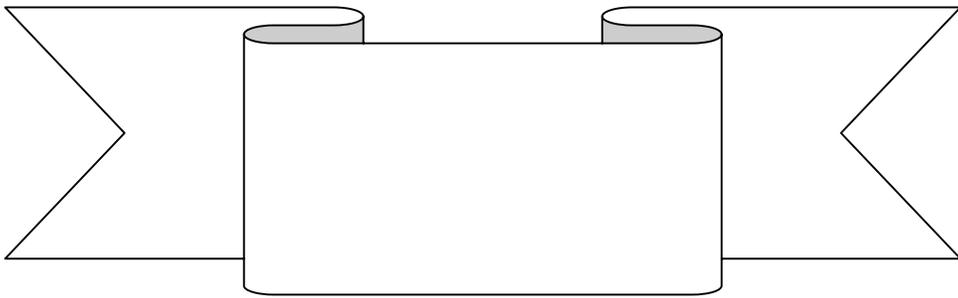
Health further indicated that the base year used to calculate Medicaid rates for most facilities is 1983 and current regulations prohibit recalculation of the Medicaid rates utilizing a new base year unless there has been a complete change in ownership, appointment of a receiver, complete replacement of the facility building or major construction/renovation to conform to current code. According to Health officials, this methodology was approved by CMS through a State Plan Amendment. Changes in operating costs due to changes in medical technology cannot be reimbursed due to these regulations. However, if a facility purchases major movable equipment as a result of changes in medical technology, they may receive reimbursement for that equipment prospectively when it is reported in the cost report.

### **OIG Response**

We are pleased that Health concurs with recommendations two, three and four. With respect to our first recommendation, in determining the universe of claims for this audit, all claims with a Medicare approved amount were eliminated from the sample frame. Consequently, the claims universe did not include any Medicaid co-insurance claims or co-payments. Therefore, we continue to recommend that NYS refund \$606,403 to the Federal Government. We assume that Health now concurs with this recommendation.

Health officials contend that prior approval staff uses nursing home residency as a criterion for approving services. However, we found that even when residency information was available, prior approval staff was allowing DME reimbursement when the patient was a nursing home resident. Specifically, 71 of the 120 claims in our sample had received prior approval from Health, yet 33 of these patients were residents of a nursing home at the time of the approval. Health officials acknowledged that they primarily look at the medical necessity documentation when approving services and do not necessarily look at the place of residency. We continue to recommend that Medicaid reviewers, during the prior approval process, be required to determine whether Medicaid or the nursing home is responsible for payment.

Although Health stated it was unable to change the base year used for the rate calculation, there is no Federal regulation prohibiting such practice. Health could submit a State Plan Amendment to CMS to calculate the Medicaid rates on a more current base year. Section 1902(a)(30)(A) of the Social Security Act requires a State Plan to assure that payments are consistent with efficiency, economy, and quality of care. The NYS nursing home rate is an all-inclusive rate for services provided by the facility. For this all-inclusive rate to be consistent with economy and efficiency, it should include payment for all the necessary services and DME required by the beneficiary. Since the rate was established using 1983 cost data, it does not include any of the recent changes in medical technology and patient care that a nursing facility is required to provide to beneficiaries. We continue to recommend that Health prospectively calculate Medicaid per diem rates to more closely reflect the changes in nursing home costs.



## SAMPLING METHODOLOGY

### **Audit Objective:**

The objective of this review is to determine whether there were duplicate payments being made to ancillary service providers for durable medical equipment (DME) provided to residents of New York State nursing homes that would have been included in the nursing home's Medicaid reimbursement rate.

### **Population:**

The population will be all New York State DME claims that should have been in the all-inclusive nursing home rate for the period October 1, 1998 through September 30, 2001.

### **Sampling Frame:**

The sampling frame is an ACCESS file, extracted from the Medicaid Management Information System (MMIS), containing 24,276 DME claims which should have been claimed as part of the nursing home rate. The total Medicaid reimbursement for the 24,276 claims was \$4,808,413. We expect the sampling frame to be the same as the target population.

### **Sample Unit:**

The sampling unit will be an individual DME claim.

### **Sample Design:**

We used stratified random sample to evaluate the population of DME claims. To accomplish this, we separated the sampling frame into three strata as follows:

- Stratum 1: less than \$250.00 (21,678 claims)
- Stratum 2: \$250.00 to \$2799.99 (2,245 claims)
- Stratum 3: \$2800.00 and greater (353 claims)

### **Sample Size:**

A sample size of 120 claims will be selected as follows:

40 claims from the first stratum,  
40 claims from the second stratum,  
40 claims from the third stratum.

**Source of Random Numbers:**

The source of the random numbers will be the Office of Audit Services Statistical Sampling software, dated September 2001. We used the Random Number Generator for our stratified sample.

**Method of Selecting Sample Items:**

The DME claims on the computer file were numbered sequentially for each of the three strata. The random numbers selected for each of the strata were correlated to the sequential numbers assigned to each claim in the sampling frame. A list of the 120 sample items was then created.

**Characteristics To Be Measured:**

Sample DME payments will undergo review for validity, accuracy, and confirmation of the existence of Medicaid's obligation to the provider. Specifically, we will determine whether:

- The patient was a resident of a nursing home at the time the service was provided;
- Medicaid paid for the nursing home stay;
- The item billed was provided to the patient;
- The procedure code billed was the same as the procedure code received by the patient;  
and
- The amount billed by the provider was equal to the amount received by the patient.

**Estimation Methodology:**

We used the Department Health and Human Services, Office of Inspector General, OAS' variables appraisal program in RAT-STATS to appraise the sample results. We used the lower limit at the 90 percent confidence level to estimate the value of overpayments to nursing homes and the Medicaid program.

*STATISTICAL SAMPLING INFORMATION*

*Stratified Random Sample Results and Projections*

Stratum Number	Stratum Range	Population (Number Of Claims)	Population (Total Dollars Claimed)	Sample Size (Number Of Claims)	Sample Size (Total Dollars Claimed)	Sample Errors (Number Of Claims)	Sample Errors (Total Dollars)
1	\$.01 to \$249.99	21,678	\$1,256,617	40	\$1,857	20	\$1,062
2	\$250 to \$2,799.99	2,245	\$1,475,201	40	\$26,304	7	\$4,837
3	\$2,800 and greater	353	\$2,076,595	40	\$240,620	16	\$90,744
Total		24,276	\$4,808,413	120	\$268,781	43	\$96,643

Projection of Sample Results  
(Precision At The 90 Percent Confidence Level)

Upper Limit	\$ 2,082,941
Point Estimate	\$ 1,647,873
Lower Limit	\$ 1,212,805
Precision Percent	26.40

**DUPLICATE CLAIMS INFORMATION**

***Summary of Medicaid Potential Duplicate Payments By Provider***

<b>PROVIDER</b>	<b>RANDOM NUMBER</b>	<b>NUMBER OF CLAIMS</b>	<b>MEDICAID PAID</b>	<b>RECOMMENDED AMOUNT</b>	<b>DIFFERENCE</b>
01258199	16		\$6,340	0	6,340
01258199	25		4,010	0	4,010
01258199	95		7,530	0	7,530
01258199	154		7,890	0	7,890
01258199	162		6,695	0	6,695
00786269	33		7,400	0	7,400
00786269	141		7,839	0	7,839
00786269	196		8,080	0	8,080
00786269	214		7,789	0	7,789
00828428	264		3,186	0	3,186
00828428	269		6,159	0	6,159
00828428	273		3,977	0	3,977
00828428	290		3,650	0	3,650
00828428	293		3,078	0	3,078
00828428	302		2,842	0	2,842
00828428	346		4,280	0	4,280
01130189	1,802		2,750	0	2,750
01067110	699		435	0	435
01067110	701		435	0	435
01710470	4		358	0	358
01710470	24		373	0	373
02144503	1033		335	0	335
01226228	727		300	150	150
00975833	428		78	0	78
00975833	2604		86	0	86
00975833	3317		86	0	86
00975833	15883		20	0	20
01669718	7820		159	0	159
01799637	13944		150	10	140

*DUPLICATE CLAIMS INFORMATION*

*Summary of Medicaid Potential Duplicate Payments By Provider*

<b>PROVIDER</b>	<b>RANDOM NUMBER</b>	<b>NUMBER OF CLAIMS</b>	<b>MEDICAID PAID</b>	<b>RECOMMENDED AMOUNT</b>	<b>DIFFERENCE</b>
01549417	441		80	0	80
01566485	17299		30	0	30
01566485	16582		46	0	46
01703433	15254		76	0	76
01762014	6612		35	0	35
	14961		27	0	27
01949646	18422		60	0	60
01077054	18124		50	0	50
01573899	16730		46	0	46
00778001	10740		45	30	15
01631121	4464		14	0	14
00321724	7123		12	0	12
01645550	8088		2	0	2
01428615	365		2	0	2

<sup>2</sup> Difference due to rounding



Coming Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.  
Commissioner

Dennis P. Whalen  
Executive Deputy Commissioner

August 13, 2003

Timothy J. Horgan  
Regional Inspector General for  
Audit Services  
DHHS OIG Office of Audit Services  
26 Federal Plaza  
Room 3900A  
New York, New York 10278

Dear Mr. Horgan:

Enclosed are the Department of Health's comments on the DHHS Draft Audit Report A-02-02-01025 "Review of New York Medicaid Nursing Home Ancillary and Durable Medical Equipment Payments."

Thank you for the opportunity to comment.

Sincerely,

  
Dennis P. Whalen  
Executive Deputy Commissioner

Enclosure

Department of Health  
Comments on the  
Department of Health and Human Services  
Office of the Inspector General  
Draft Audit Report A-02-02-01025  
Review of New York Medicaid Nursing Home  
Ancillary and Durable Medical Equipment Payments

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The following are the Department of Health's (DOH) comments in response to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) Draft Audit Report A-02-02-01025 "Review of New York Medicaid Nursing Home Ancillary and Durable Medical Equipment Payments."

**Recommendation #1:**

Refund \$606,403 to the Federal Government for its share of the identified overpayments.

**Response #1:**

The Department requests that the working papers associated with this audit be furnished so that we may determine whether the equipment, oxygen and supplies billed involved Medicaid co-insurance claims. Medicaid is required to make co-payments for services approved under Medicare Part B by the Region A DEMERC. To the extent that Medicare has approved Part B services on behalf of nursing home patients, the State should not be held liable to return the federal share of such co-payments. The Department disagrees with this recommendation to the extent that such co-payments form part of the \$606,403 refund recommendation.

**Recommendation #2:**

Ensure that DME providers bill the nursing home rather than Medicaid for services included in the nursing home rate by requiring the Medicaid reviewer, during their prior approval process, to determine whether Medicaid or the nursing home is responsible for payment.

**Response #2:**

To the extent that the information is available at the time of the review, prior approval staff has, in the past, and will continue, to use nursing home patient residence as a criterion for whether to approve the requested service.

**Recommendation #3:**

Issue guidance to DME providers specifying that augmentative communication devices are not custom-made and therefore, not separately billable to Medicaid for nursing home residents.

**Response #3:**

The Department concurs with this recommendation within the limitations described in our response to the two recommendations above.

**Recommendation #4:**

Instruct DME providers not to refill any prescriptions without the beneficiary's or their representative's authorization.

**Response #4:**

A Medicaid Update article will be prepared and issued which will remind medical equipment providers not to automatically refill fiscal orders (not prescriptions) without authorization from the beneficiary or their representative.

**Recommendation #5:**

In the future, calculate Medicaid per diem rates to more closely reflect the changes in medical technology and nursing home operating costs.

**Response #5:**

The methodology for the calculation of Medicaid rates for nursing facilities was approved by the Centers for Medicare and Medicaid through a State Plan Amendment. The base utilized to calculate Medicaid rates for most facilities is 1983. Regulations prohibit recalculation of Medicaid rates utilizing a new base year unless there has been a complete change in ownership, the appointment of a receiver, a complete replacement of the nursing facility building or major construction/renovation to conform to current codes.

If a facility purchases major movable equipment as a result of changes in medical technology, they may receive reimbursement for that equipment on a prospective basis, when it is reported in the certified cost report. Changes in operating costs due to changes in medical technology cannot be reimbursed due to the provisions of the regulations cited above.



This report was prepared under the direction of Timothy Horgan, Regional Inspector General. Other principal Office of Audit Services staff that contributed included:

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