Department of Health Care Services:

Although Notified of Changes in Billing Requirements, Providers of Durable Medical Equipment Frequently Overcharged Medi-Cal

June 2008 Report 2007-122

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June 17, 2008 2007-122

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Department of Health Care Services' (Health Care Services) Medi-Cal billing system, with particular emphasis on its billing instructions and coding for durable medical equipment (medical equipment).

This report concludes Health Care Services' policies and procedures regarding reimbursement methodologies for medical equipment generally agree with state laws, regulations, and federal program requirements. In addition, Health Care Services has adequately informed providers of the required procedures for calculating billings and reimbursements for medical equipment supplied to eligible beneficiaries, including changes to billing and reimbursement procedures and health care codes that have occurred since 2003.

Nonetheless, because Health Care Services has not identified a practical means to monitor and enforce its billing and reimbursement procedures, price controls enacted in 2003 have not met their intended purpose. During 2007 and 2008 Health Care Services conducted a limited review of 21 providers' billings for wheelchairs and their accessories with listed Medicare prices and found that the providers overbilled, and Health Care Services overpaid, about $1.2 million, or 25 percent of the $4.9 million those providers billed. Although Health Care Services has recovered almost $960,000 of the overpayments, it does not know the extent to which other providers may have also overbilled for medical equipment. Health Care Services intends to use postpayment audits to enforce its price controls for medical equipment; however, its current auditing efforts do not provide enough coverage of medical equipment reimbursements to effectively ensure providers' compliance with the billing procedures.

Respectfully submitted,

Elaine M. Howle

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State Auditor

Contents

Summary 1

Introduction 5

Audit Results
Requirements for Medical Equipment Billing and Reimbursement Are Anchored in Federal Program Requirements and State Law and Regulations 11

Health Care Services Adequately Notified Medical Equipment Providers of Changes to the Reimbursement Rates and Codes for Medical Equipment 13

Health Care Services Has No Practical Means to Effectively Monitor and Enforce Its Medical Equipment Reimbursement Rates 15

Current Auditing Efforts Do Not Ensure That Medical Equipment Providers Comply With the Billing and Reimbursement Procedures 21

Recommendations 24

Response to the Audit
Department of Health Care Services 27

California State Auditor's Comments on the Response From the Department of Health Care Services 31

Summary

Results in Brief

Medicaid, a federal program funded and administered in partnership with the states, provides health insurance to low-income families and to the aged, blind, and disabled. The Department of Health Care Services (Health Care Services) administers California's Medicaid program, the California Medical Assistance Program (Medi-Cal), which provides medical assistance to more than six million beneficiaries each month. In addition to covering health care needs, such as pharmaceuticals, physician services, and long-term care, Medi-Cal covers durable medical equipment (medical equipment) that licensed practitioners prescribe within the scope of their normal duties (for example, wheelchairs). According to reimbursement data maintained by Health Care Services, from October 1, 2006, through September 30, 2007, it reimbursed providers about $93 million for medical equipment supplied to Medi-Cal beneficiaries.

Health Care Services establishes the limits on payments, known as reimbursements, that providers of medical equipment receive under Medi-Cal. Through its Allied Health Provider Manual (provider manual) and monthly *Medi-Cal Update* bulletins, Health Care Services communicates information on reimbursement rates and the methodologies for calculating allowable reimbursements for various medical equipment. We found that Health Care Services' policies and procedures and the information in its provider manual regarding reimbursement methodologies for medical equipment generally agree with state law and regulations and federal program requirements. We noted, however, that the provider manual does not contain the current methodology for calculating reimbursements for speech-generating devices included in state law. In addition, federal program requirements and state law allow Health Care Services to establish some of the elements of the reimbursement procedures for medical equipment, such as development of the methodologies for calculating reimbursements. We found that Health Care Services gained the necessary federal approvals for its plan for implementing its Medi-Cal reimbursement methodologies and conferred with providers regarding the development of the reimbursement methodologies. Moreover, we reviewed its processes for informing providers of the Medi-Cal requirements for billing and reimbursements and found that Health Care Services has adequately informed providers of those requirements and significant changes.

Nonetheless, some providers have overbilled Medi-Cal, and Health Care Services has overpaid providers, $1.2 million for certain wheelchairs and wheelchair accessories with listed Medicare prices.

Audit Highlights . . .

Our review of the Department of Health Care Services' (Health Care Services) Medi-Cal billing system for durable medical equipment (medical equipment) found that:

- *Health Care Services' policies and procedures regarding reimbursement methodologies for medical equipment generally agree with state laws, regulations, and federal program requirements.*
- *Providers are adequately informed regarding changes in reimbursement methodologies and health care codes.*
- *Because Health Care Services has not identified a practical means to monitor and enforce its billing and reimbursement procedures, price controls enacted in 2003 have not met their intended purpose.*
- *Health Care Services conducted a limited review of providers and found that 21 providers overbilled, and Health Care Services overpaid, about $1.2 million, or 25 percent of the $4.9 million those providers billed.*
- *Although Health Care Services has recovered almost $960,000 of the overpayments, it does not know the extent to which other providers may have also overbilled for medical equipment.*
- *Although Health Care Services intends to use postpayment audits to enforce its price controls for medical equipment, its current auditing efforts do not provide enough coverage of medical equipment reimbursements to effectively ensure providers' compliance with the billing procedures.*

The primary cause of the overbillings is the providers' failure to adhere to the upper billing limit—a price limit provision Health Care Services includes in its billing and reimbursement procedures. The primary cause of the overpayments is that Health Care Services has not identified a practical means to effectively monitor and enforce its medical equipment billing and reimbursement procedures.

In 2003 Health Care Services implemented new price controls for reimbursing providers, establishing a means of calculating reimbursements based on the lowest of five options, including the upper billing limit. Intended to lessen the opportunity for fraud and abuse, the upper billing limit restricts a reimbursement to the lesser of the provider's net purchase price for the supplied medical equipment plus a markup of up to 100 percent or the provider's usual charge to the general public. The other options for calculating reimbursements include using the provider's cost according to its vendor's invoice, applying a variation of the listed Medicare price, or using a rate negotiated by Health Care Services and the provider.

However, as indicated by a small number of limited scope audits that Health Care Services conducted of billings that providers submitted from September 1, 2005, through August 31, 2006, the price controls have not met their intended purpose. In 2007 and 2008 Health Care Services conducted these audits of providers' billings for wheelchairs and wheelchair accessories with listed Medicare prices to determine whether the amounts billed complied with Health Care Services' billing and reimbursement procedures. It identified 43 providers, each of whom had billed more than $50,000 for a popular power wheelchair type. At the time of our fieldwork, Health Care Services had performed audits on 21 of the 43 providers and found that none had consistently complied with price controls when billing for medical equipment. In fact, the 21 providers overbilled, and Health Care Services overpaid, about $1.2 million, or 25 percent of the $4.9 million billed.

Although Health Care Services had recovered almost $960,000 of the overpayments from the 21 providers, it does not know the extent to which other providers may have overbilled for medical equipment. The health care codes assigned to the wheelchairs and wheelchair accessories it reviewed represent only 10 of the more than 400 health care codes. For perspective, the $4.9 million in reimbursements Health Care Services reviewed represents about 6.5 percent of the over $75 million reimbursed for all medical equipment with listed Medicare prices during federal fiscal year 2006–07. In addition, because Health Care Services has not yet reviewed billings for medical equipment without listed Medicare prices, including wheelchairs and wheelchair accessories, it does not know the extent to which those providers comply with the price controls and bill using the lowest billing rate option.

According to the response provided by the California Association of Medical Product Suppliers when Health Care Services was developing and implementing the upper billing limit, some providers viewed the price controls as burdensome and as requiring them to establish a unique business and accounting model expressly for Medi-Cal. The providers claimed that the model would have an adverse impact on their non-Medi-Cal business by affecting their calculated usual and customary charges.

According to the chief deputy director of health care programs (chief deputy director), Health Care Services expects providers to bill for medical equipment at the appropriate rates. Thus, it does not require providers to submit documents that would show they billed at the lowest of the billing options for medical equipment with a listed Medicare price. In addition, the chief deputy director stated that Health Care Services does not require providers to submit invoices because it does not intend to review them during claims processing to ensure compliance with the billing procedures. According to the chief deputy director, for a billing that a provider submits electronically, Health Care Services has no automated method for auditing the claim to determine the relationship between the billed amount and the invoiced amount.

The chief deputy director stated that, at the time Health Care Services was implementing the new reimbursement rates, including the upper billing limit, it was also imposing major rate reductions to medical equipment, such as wheelchairs and wheelchair accessories. He stated that Health Care Services was very concerned about affecting the ability of Medi-Cal beneficiaries to access the wheelchairs they needed. Health Care Services decided not to require invoices for wheelchairs or wheelchair accessories without listed Medicare prices because of the burden it would place on providers to submit two sources of documentation. In federal fiscal year 2006–07, wheelchairs and wheelchair accessories without listed Medicare prices made up more than $8 million in reimbursements. According to the chief deputy director, Medi-Cal continuously receives complaints from providers about excessive paperwork requirements, and Health Care Services is concerned that increasing the billing requirement from one form of documentation to two might lead some providers to stop supplying wheelchairs and wheelchair accessories to beneficiaries who need them.

Nonetheless, audits performed by Health Care Services in 2007 and 2008 revealed that the providers it reviewed billed for most of the wheelchairs and wheelchair accessories they supplied at the maximum listed Medicare prices, not the significantly lower amounts the upper billing limit would have produced. The chief deputy director told us that Health Care Services has always

intended to use postpayment audits to monitor and enforce its medical equipment billing and reimbursement procedures, including the upper billing limit. However, because medical equipment reimbursements make up a relatively small portion of total Medi-Cal payments—0.8 percent according to the 2006 payment error study Health Care Services conducted—auditing efforts do not provide enough coverage of medical equipment reimbursements to effectively ensure compliance.[1] Moreover, perceiving a high cost and a low potential for benefits from the effort, Health Care Services focused its audits in 2007 and 2008 on medical equipment that represented only 10 of the more than 400 health care codes and reviewed a provider only if it had billed more than $50,000 from September 1, 2005, through August 31, 2006, for only one wheelchair type. However, using that methodology excluded some providers from a monitoring device intended to ensure that they adhere to price controls.

Recommendations

To better ensure its provider manual represents a comprehensive guide for medical equipment providers, Health Care Services should include the current methodology for calculating reimbursements for speech-generating devices.

To maintain control over the cost of reimbursements, Health Care Services should develop an administratively feasible means of monitoring and enforcing current Medi-Cal billing and reimbursement procedures for medical equipment. If unsuccessful, Health Care Services should consider developing reimbursement caps for medical equipment that are more easily administered.

If Health Care Services continues using audits to ensure that providers comply with Medi-Cal billing procedures for medical equipment, including the upper billing limit, it should design and implement a cost-effective approach that adequately addresses the risk of overpayment and ensures all providers are potentially subject to an audit, thereby providing a deterrent to noncompliance.

Agency Comments

Health Care Services states that it appreciates the work performed by the Bureau of State Audits and provides comments on the draft report beginning on page 27.

[1] The payment error study is released annually by Health Care Services in an effort to detect, identify, and prevent fraud and abuse of Medi-Cal funds.

Introduction

Background

Medicaid is a federal program funded and administered in cooperation with the states to provide health insurance to low-income families, the aged, blind, and persons with disabilities. The Department of Health Care Services (Health Care Services) administers California's Medicaid program, the California Medical Assistance Program (Medi-Cal), which will provide medical assistance to an estimated monthly average of 6.59 million eligible beneficiaries in fiscal year 2007–08. In addition to covering health care needs—like pharmaceuticals, physician services, and long-term care—Medi-Cal covers durable medical equipment (medical equipment) that licensed practitioners prescribe as part of their normal duties. Medical equipment includes wheelchairs, bathroom equipment, hospital beds, speech-generating devices, oxygen and respiratory equipment, and blood glucose monitors. The text box lists the four Medi-Cal eligibility criteria state law specifies for medical equipment. As shown in Table 1 on the following page, according to reimbursement data maintained by Health Care Services, from October 1, 2006, through September 30, 2007, it reimbursed almost $93 million for medical equipment supplied to Medi-Cal beneficiaries; 56 percent of that was for wheelchairs and wheelchair accessories.

Medi-Cal Eligibility Criteria for Medical Equipment

- Can withstand repeated use.
- Serves a medical purpose.
- Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital abnormality.
- Is appropriate for use in or out of the patient's home.

Source: California Code of Regulations, Title 22, Section 51160.

For fiscal year 2007–08, the State's General Fund provided roughly 40 percent of Health Care Services' budget for Medi-Cal expenditures, with the remainder consisting of federal funds and other state funds. Medi-Cal services are coordinated through 12 divisions and two offices within Health Care Services. Health Care Services processes claims submitted by Medi-Cal providers, reviews and updates changes to allowable medical equipment codes, and conducts audits of providers and claims. At the local level, Medi-Cal relies on local county welfare or social service departments to make beneficiary eligibility determinations. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), reviews and approves California's plan outlining how the State will administer Medi-Cal.

Table 1
Medical Equipment Reimbursements Paid With Medi-Cal Funds
Federal Fiscal Year 2006–07

TYPE OF EQUIPMENT	AMOUNT PAID	PERCENTAGE
Wheelchairs and accessories	$52,374,082	56%
Oxygen and related equipment	18,747,514	20
Miscellaneous	6,055,994	6
Bathroom equipment	4,238,961	5
Hospital beds	3,372,060	4
Bedsore preventive care	2,719,338	3
Infusion equipment and supplies	2,229,338	2
Patient lifts	1,502,140	2
Ambulatory	835,016	1
Speech-generating devices	797,581	1
Totals	**$92,872,024**	**100%**

Source: Medi-Cal data from the Department of Health Care Services' Medi-Cal Management Information System for health care codes identified as medical equipment in the Medi-Cal provider manual as of December 2007

Note: Because we were unable to obtain assurance of the completeness of the claims data used to develop the reimbursements information included in this table, we assessed the data to be of undetermined reliability. As a result, the reimbursements information presented in the table may be misstated.

Medi-Cal Billing Procedures and Reimbursement Rates

Reimbursements—that is, payments to providers for supplying medical equipment—are determined using a system designed by both the federal and state governments. CMS maintains a standardized system of health care codes, called the Healthcare Common Procedure Coding System, that all states must use primarily to identify products, supplies, and services, including medical equipment, and to ensure that claims are processed in a consistent and orderly manner. Health Care Services maintains a system of reimbursement rates and procedures for medical equipment that it makes available through its Allied Health Provider Manual (provider manual).

Legislation passed in 2003 and the related regulation created the current reimbursement methodology used by Medi-Cal for calculating all medical equipment reimbursement rates and implemented a price control through a provision known as the upper billing limit. The changes are contained in recently enacted legislation that Health Care Services crafted as part of its effort to curb Medi-Cal fraud and abuse in medical equipment reimbursements. Specifically, state law now requires Health Care Services to reimburse providers using the lesser amount that results

from several methodologies for calculating reimbursement, including the upper billing limit. The current reimbursement rates are divided into two major categories—medical equipment with a listed Medicare price and those without. Reimbursements are then based on various options that involve the provider's net purchase price (the invoice amount adjusted for reductions known at the time of the billing) plus a percentage markup, a percentage of the listed Medicare price for California, a contracted price, or a percentage of the manufacturer's suggested retail price.

Before the current reimbursement methodology was established in 2003, the method for establishing reimbursement rates for medical equipment generally consisted of the provider's estimated acquisition cost plus an allowable percentage markup. According to Health Care Services, it became aware that providers were billing the maximum allowable reimbursement rate for products they obtained at amounts substantially below the estimated acquisition cost, or the weighted average of the negotiated contract price. Health Care Services sought to resolve that issue by requiring providers of medical equipment and certain other items to bill based on net purchase price plus a set percentage markup of up to 100 percent.

Another significant change in the medical equipment billing procedures brought certain state practices into compliance with federal law. In November 2004 Health Care Services implemented coding changes instituted by CMS in response to a provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requiring that code sets be created and distributed for medical concepts, diagnoses, and procedures. The health care codes that CMS originally established in 1978 make up the standardized coding system for specific health care items and services; the coding system is necessary to ensure that Medi-Cal and other programs process insurance claims in an orderly and consistent manner. However, between 1978 and 1996, state Medicaid agencies employed procedure codes on a strictly voluntary basis. The passage of HIPAA made the use of certain health care codes for transactions involving medical equipment mandatory.

Health Care Services' Monitoring of State and Federal Funds

State law requires Health Care Services to ensure accountability for state and federal funds by performing audits of Medi-Cal providers. The law also requires Medi-Cal providers to maintain accounting records documenting the costs of purchasing, assembling, and performing other activities related to acquiring and selling products for which they receive reimbursements through

Medi-Cal. If a Medi-Cal medical equipment provider is audited by Health Care Services and has a complaint or otherwise disagrees with the outcome of the audit, that provider has the right to appeal the audit findings.

Scope and Methodology

The Joint Legislative Audit Committee requested the Bureau of State Audits to conduct an audit of Health Care Services' Medi-Cal billing system with particular emphasis on the billing instructions and coding for medical equipment.

To determine whether Health Care Services' policies and procedures and the information in its provider manual regarding Medi-Cal medical equipment reimbursements comply with federal and state laws and regulations, we reviewed the relevant laws and regulations. We obtained Health Care Services' state plan for implementing Medi-Cal and determined it was approved by CMS. Further, we compared Health Care Services' policies, procedures, and provider manual to the federal and state laws and regulations and the approved state plan.

To determine if its billing and coding practices comply with the provisions of HIPAA and other relevant federal and state laws related to health care codes, we reviewed the medical equipment codes Health Care Services publishes in its provider manual as well as relevant state laws and regulations. Additionally, we performed procedures to determine whether Health Care Services has established a plan to annually update medical equipment health care codes to remain in compliance with the HIPAA code provisions.

To determine whether Health Care Services effectively informed providers of the changes in its medical equipment billing procedures, we reviewed documents regarding its regulatory notices and monthly *Medi-Cal Update* bulletins sent to medical equipment providers. We reviewed the regulatory notifications sent to several providers and their representatives as well as the letters sent to Health Care Services by providers concerned with the changes to medical equipment reimbursement in state law and regulations. We assessed whether Health Care Services adequately notified providers of changes to its medical equipment billing procedures and took action in response to public comment from the provider community.

To determine whether Health Care Services reimbursed providers for medical equipment accurately and in compliance with applicable laws, we reviewed public notices and its policies and

procedures for reimbursing medical equipment providers paid with Medi-Cal funds. We then reviewed a sample of 30 reimbursements for medical equipment items without listed Medicare prices to determine whether Health Care Services accurately calculated reimbursements at the lowest allowable rates.

To assess the accuracy of reimbursements for medical equipment with listed Medicare prices, we relied on audits conducted by Health Care Services to determine if providers complied with billing procedures and received payments calculated in accordance with payment limitations. We reviewed 50 claims sampled by Health Care Services to determine whether we agreed with calculations regarding the reimbursements.

Electronic Data Systems (EDS), the contractor Health Care Services uses to process Medi-Cal reimbursements, classifies Medi-Cal claims for reimbursement into several categories, including medical, inpatient, and outpatient. To determine which types of claims contained reimbursements for medical equipment, we obtained data for all Medi-Cal claims paid during federal fiscal year 2006–07. Government auditing standards issued by the U.S. Government Accountability Office require us to assess the reliability of computer-processed data we use in our reports unless it is used only for background purposes. The data contained seven categories, or types of claims. Except for medical type claims—a subset of this data—we used the Medi-Cal claims paid during federal fiscal year 2006–07 solely for the purpose of background information. Thus, we did not assess the reliability of this data.

The medical type claims contained the majority of reimbursements for the health care codes we identified as medical equipment. As such, we used these claims to provide information on the amount paid for medical equipment by Medi-Cal during federal fiscal year 2006–07, the amount reimbursed for all medical equipment associated with and without listed Medicare prices, the amount reimbursed by type of medical equipment, and to select a sample of medical equipment reimbursements without listed Medicare prices for additional review. To assess the reliability of these claims, we performed electronic testing of selected data elements to ensure they contained logical values and tested the accuracy of the data by tracing a sample of records to supporting documentation.

We were unable to obtain assurance regarding the completeness of the medical type claims reimbursed by Medi-Cal during federal fiscal year 2006–07. Because we were unable to obtain assurance regarding the completeness of the data, we assessed it to be of undetermined reliability for the purposes of providing information on the amounts and classifications of medical equipment

reimbursed by Medi-Cal during federal fiscal year 2006–07. Because we could not obtain assurance regarding the completeness of the data we received, the amounts of medical type claims for medical equipment reimbursed by Medi-Cal during federal fiscal year 2006–07 included in our report may be understated.

In addition, we attempted to evaluate the existence of fraud in Medi-Cal claims by using recipient identification information to determine whether recipients had obtained medical equipment for which they were not eligible. However, using the data Health Care Services provided in February 2008 we found that the recipient identification information provided to us had inaccurate values. EDS indicates that it incorrectly extracted the data from its records. After repeated attempts beginning in March 2008 to resolve the accuracy issues with the original data, in mid-May 2008 Health Care Services offered to provide corrected data. However, the corrected data was not available in time for us to verify its accuracy and perform our planned procedures before issuing this report. Thus, we assessed the data to be not sufficiently reliable for the purposes of determining if recipients had obtained medical equipment for which they were not eligible.

Audit Results

Requirements for Medical Equipment Billing and Reimbursement Are Anchored in Federal Program Requirements and State Law and Regulations

The billing and reimbursement procedures that providers follow when billing the California Medical Assistance Program (Medi-Cal) for medical equipment are based on a reimbursement structure defined by federal requirements and a pricing methodology developed by the Department of Health Care Services (Health Care Services). The federal agency responsible for overseeing state Medicaid programs, the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), has approved the reimbursement methodology used by Health Care Services. Its medical equipment health care codes also satisfy the provisions in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) related to code sets.

Additionally, Health Care Services followed appropriate notification guidelines when creating the upper billing limit and complied with state law regarding medical equipment reimbursement rate methodologies. Health Care Services also notified medical equipment providers of changes to billing and coding procedures through monthly provider bulletins. Finally, Health Care Services continuously updated its Allied Health Provider Manual (provider manual) to incorporate changes to its billing and reimbursement procedures and sent those updates to medical equipment providers as another means of notifying them.

Medical Equipment Billing and Coding Procedures Used by Health Care Services Comply With Federal Requirements

California administers Medi-Cal in accordance with a state plan approved by CMS. The state plan describes the nature and scope of Medi-Cal and serves as a contractual agreement between the State and the federal government. A state plan or an amendment to it will become effective unless CMS sends the State a notice of disapproval or a request for additional information. According to Health Care Services' legislative coordinator, CMS can deny state plan amendments but usually works with Health Care Services in constructing amendments that conform to federal guidelines. In October 2003 Health Care Services sent an amendment to CMS that incorporated changes to the Medi-Cal reimbursement methodology for medical equipment. CMS approved a revised amendment in June 2007 that lists the current provisions of state law concerning Medi-Cal reimbursements for medical equipment and includes references to and a description of the upper billing limit.

In addition, Health Care Services has adopted health care codes issued by CMS to comply with HIPAA's code provisions. As required by HIPAA, Health Care Services has implemented the health care codes created by CMS and uses those codes when reimbursing medical equipment providers under Medi-Cal. To remain HIPAA compliant, Health Care Services must periodically update its health care codes for medical equipment. According to its HIPAA coordinator, Health Care Services conducts an annual update of the provider manual it uses to inform medical equipment providers of its Medi-Cal billing procedures and health care codes. Using the new health care codes CMS distributes annually, Health Care Services sends providers updates to the provider manual that list new health care codes that have been added, obsolete codes that have been deleted, codes that have undergone descriptor or other changes, and previously invalid codes that have been reactivated.

Reimbursement Rates and Methodologies Used by Health Care Services Generally Agree With State Law

The billing procedures outlined in the provider manual generally agree with current state law and regulations.

Health Care Services adequately notified providers of the implementation of amended billing and reimbursement procedures, including implementing the upper billing limit as an emergency regulation. The upper billing limit became effective as an emergency regulation on March 1, 2003, and as a permanent regulation when the Office of Administrative Law approved it in April 2004. The Office of Administrative Law ensures that regulations proposed by state agencies are clear, necessary, and legally valid. Health Care Services also updated its provider manual to reflect changes to reimbursements for medical equipment. The manual instructs providers on the current policies and procedures of Health Care Services. The billing procedures outlined in the provider manual generally agree with current state law and regulations. We noted, however, that the provider manual does not contain the current methodology for reimbursing speech-generating devices included in state law.

As part of the notification process, Health Care Services sent a notice regarding a public hearing on the changed billing and reimbursement procedures and received numerous written and oral responses from providers. Providers were concerned about several aspects of the upper billing limit. One major concern was the vague definition of "net purchase price." In its initial form, the regulation on the upper billing limit stated that providers must bill the lesser of their usual charges to the general public or the net purchase price of an item plus a markup of no more than 100 percent, but it did not include a clear definition of net purchase price. In reviewing providers' written responses to Health Care Services' notice of

public hearing, we found that some providers wondered about including rebates or discounts based on volume or other factors such as prompt payment in the net purchase price. Other providers questioned whether the net purchase price should include payment penalties or interest charged to providers.

Further, some providers expressed concern that the regulation would have adverse effects on other segments of their business by eliminating their ability to establish a usual and customary rate for medical equipment. At least one provider and a representative from the California Association of Medical Product Suppliers stated that the upper billing limit would require them to bill amounts unique to Medi-Cal, effectively making providers unable to establish usual and customary charges for items not billed to Medi-Cal.

In response to providers' comments, Health Care Services made numerous changes to the upper billing limit when it redrafted the regulation.

In response to providers' comments, Health Care Services made numerous changes to the upper billing limit when it redrafted the regulation in February 2004. The redrafted emergency regulation added language that clarified the term net purchase price as the actual cost to the provider to purchase the item from the vendor, including any rebates, refunds, or discounts known by the provider at the time of billing. Additionally, the regulation contained a provision stating that the net purchase price does not include costs associated with late payment penalties, interest, or inventory costs incurred by the provider. Further, the regulation incorporated language specifying labor charges for the assembly of custom wheelchairs. Health Care Services appears to have actively responded to providers' comments when it redrafted the regulation.

Health Care Services Adequately Notified Medical Equipment Providers of Changes to the Reimbursement Rates and Codes for Medical Equipment

Based on our review of monthly provider bulletins issued by Health Care Services, from 2003 to 2007 Health Care Services published 30 *Medi-Cal Update* bulletins informing medical equipment providers of changes in the health care codes and reimbursement rates for medical equipment that resulted from changes in the law and regulations. Those bulletins contained information regarding policy or regulation changes, implementation dates, or training opportunities for medical equipment providers. In addition, Health Care Services published a notice to providers, a notice to the general public, and a notice in the California Regulatory Notice Register (published weekly by the Office of Administrative Law) to make interested parties aware of the public comment period and provide further information on changes related to the health care codes and reimbursement rates for medical equipment.

Health Care Services also notifies providers, within a reasonable time, of changes in the billing and reimbursement rates through its provider manual and monthly bulletins. When providers first enroll in Medi-Cal, they receive an enrollment letter from Health Care Services that, among other things, informs them that the provider manual is their primary source of information. The letter instructs new providers to read and update their manual promptly to ensure that they have the most current information, including updates to billing and coding procedures. Lastly, the letter informs new providers that the provider manual is updated through monthly *Medi-Cal Update* bulletins. These bulletins also include notices for billing seminars, clarification on additional medical equipment issues, and other information of importance to Medi-Cal providers.

For example, the monthly provider bulletins sent between March 2003 and August 2004 mentioned the regulation establishing the upper billing limit on six occasions. Revised provider manual pages issued from June 2003 through September 2004 mentioned the regulation and how it would affect the existing medical equipment reimbursement methodology. In March 2003, when the upper billing limit became effective, a *Medi-Cal Update* bulletin informed providers of its scope and intent. Three months later, Health Care Services issued the first in a series of replacement pages for the provider manual addressing the upper billing limit. Between March 2003 and December 2004, Health Care Services issued nine provider bulletins that contained revised manual pages referencing the regulation when outlining billing procedures for medical equipment. Currently, the provider manual references the upper billing limit in many locations. For example, in the section titled "Durable Medical Equipment: An Overview," the provider manual states that claims for medical equipment and accessories must not exceed an amount that is the lesser of the usual charges made to the general public or the net purchase price of the item, which must be documented in the provider's books or records, plus a markup of no more than 100 percent. Replacement manual pages sent to providers between 2003 and 2004 evidence the addition of the upper billing limit to the reimbursement methodology for medical equipment.

Taken as a whole, we believe the bulletins and instructions included in the provider manual are clear and accurate.

We did note two instances when Health Care Services incorrectly informed providers regarding new reimbursement methodologies: a letter sent to providers in June 2004 failed to alert them to the upper billing limit when discussing the reimbursement methodologies for items with listed prices, and a *Medi-Cal Update* bulletin released in September 2004 did not include the upper billing limit when discussing revised reimbursement methodologies for items without listed Medicare prices. However, taken as a whole, we believe the bulletins and instructions included in the provider manual are clear and accurate.

Health Care Services provided adequate notification to providers of its intention to eliminate certain medical equipment health care codes and implement other codes. State law gives Health Care Services the option of making changes to health care codes by publishing them in the California Regulatory Notice Register, releasing updates to the provider manual, or distributing a similar publication. When preparing to eliminate health care codes that are not HIPAA compliant, Health Care Services published a notice of general public interest in the California Regulatory Notice Register and made the appropriate changes to the provider manual. In an effort to educate providers about upcoming changes in health care codes, Health Care Services also issued a notice to Medi-Cal medical equipment providers in June 2004.

Health Care Services Has No Practical Means to Effectively Monitor and Enforce Its Medical Equipment Reimbursement Rates

Despite the efforts of Health Care Services to inform providers of the allowable reimbursement methodologies for medical equipment products, providers often do not bill at the allowable amounts. Moreover, because Health Care Services does not adequately monitor providers' billings and enforce the price controls in its billing and reimbursement procedures, providers have overbilled and Health Care Services has overpaid for such medical equipment.

The primary cause of the overbillings is providers' failure to adhere to the upper billing limit—one of the price controls Health Care Services implemented in 2003. As discussed earlier, the upper billing limit restricts reimbursements to the lesser of the provider's usual charges to the public or the net purchase price for medical equipment supplied plus a markup of no more than 100 percent. Intended to prevent and curtail fraud and abuse, the price controls have not been effective, as indicated by recent Health Care Services audits of providers' billings for the period of September 1, 2005, through August 31, 2006. In turn, Health Care Services has overpaid these providers because it has not identified and implemented a practical method for monitoring and enforcing their compliance with its medical equipment billing and reimbursement procedures.

Intended to prevent and curtail fraud and abuse, the price controls have not been effective, as indicated by recent Health Care Services' audits of providers' billings.

For example, in 2007 the Medical Review Branch of Health Care Services began conducting audits of providers that supplied wheelchairs and wheelchair accessories with listed Medicare prices. Health Care Services allows providers of medical equipment with listed Medicare prices, including wheelchairs and their accessories, to bill for the items without submitting vendors' invoices or pages from the manufacturers' catalogs showing providers billed at the

lowest rates allowed by the billing procedures. Reimbursement procedures for medical equipment with or without listed Medicare prices are shown in Table 2.

Table 2
Methodology for Calculating Reimbursements for Purchases of Medical Equipment With and Without Listed Medicare Prices

MEDICAL EQUIPMENT WITH LISTED MEDICARE PRICES IS REIMBURSED AT THE LESSER OF THE FOLLOWING:	MEDICAL EQUIPMENT WITHOUT LISTED MEDICARE PRICES IS REIMBURSED AT THE LESSER OF THE FOLLOWING:	REIMBURSEMENT FOR ALL MEDICAL EQUIPMENT SUPPLIES AND ACCESSORIES (OTHER THAN WHEELCHAIR ACCESSORIES) BILLED TO THE MEDI-CAL PROGRAM MUST BE THE LESSER OF THE FOLLOWING:
• The upper billing limit (the lesser of the net purchase price plus a markup of up to 100 percent or the usual charges made to the general public). • 80 percent of the lowest maximum allowance for California established by Medicare for California or 100 percent for wheelchairs, wheelchair accessories, and speech-generating devices. • A contracted price plus a percentage markup to be established by Health Care Services.	• The upper billing limit (the lesser of the net purchase price plus a markup of up to 100 percent or the usual charges made to the general public). • A contracted price plus a percentage markup to be established by Health Care Services. • The actual acquisition cost plus a markup established by Health Care Services (currently 67 percent). • The manufacturer's suggested retail purchase price documented on a catalog page showing a date before June 1, 2006, and reduced by 20 percent (or 15 percent for a wheelchair or wheelchair accessory if the provider employs or contracts with a qualified rehabilitation professional). • A price established through product-specific cost containment developed with the provider.	• The upper billing limit (the lesser of the net purchase price plus a markup of up to 100 percent or the usual charges made to the general public). • The acquisition cost plus a markup of 23 percent.

Sources: California Welfare and Institutions Code, Section 14105.48, and the Department of Health Care Services' Medi-Cal provider manual.

Health Care Services identified 43 providers—each of whom, according to the chief of the Medical Review Section, billed in excess of $50,000 for a popular type of power wheelchair during the period September 1, 2005, through August 31, 2006, as those it would audit. As of the end of our fieldwork (April 2008), Health Care Services had completed audits of 21 of those providers. The completed audits revealed that none of the providers had consistently complied with the price controls when billing for medical equipment. In fact, the 21 providers had overbilled, and Health Care Services had overpaid, a total of about $1.2 million, or roughly 25 percent of the $4.9 million these 21 providers billed during that period. The chief told us Health Care Services planned to begin the audits for the remaining 22 providers by May 2008.

Although Health Care Services has recovered almost $960,000 of the $1.2 million in overpayments made to the 21 providers, it does not know the extent to which other providers may have overbilled for medical equipment. For example, the health care codes assigned to the wheelchairs it reviewed represent only 10 of the more than 400 health care codes. For perspective, the $4.9 million Health Care Services reviewed represents about 6.5 percent of the over $75 million in reimbursements for all medical equipment with listed Medicare prices during federal fiscal year 2006–07. In addition, because Health Care Services has not yet expanded its audits to include billings for wheelchairs and wheelchair accessories without listed Medicare prices, it does not know the extent to which providers that supply that type of medical equipment comply with the price controls. Further, Health Care Services does not require that medical equipment providers submit documentation—in particular, vendors' invoices—that would allow it to calculate the correct payment amount for medical equipment with listed Medicare prices or wheelchairs and accessories without listed Medicare prices. As a result, we were not able to determine or estimate the amount of possible overpayments resulting from providers' noncompliance with the upper billing limit regulation.

Although Health Care Services has recovered almost $960,000 of the $1.2 million in overpayments made to 21 providers, it does not know the extent to which other providers may have overbilled for medical equipment.

We also reviewed a sample of 30 paid reimbursements for medical equipment without listed Medicare prices. For the 20 wheelchair accessories in that sample, we could not determine whether Health Care Services reimbursed providers at the lowest allowable rates because it does not require providers to submit invoices with their wheelchair claims. For the remaining 10 claims we reviewed, which were for medical equipment other than wheelchairs, such as humidifiers and bath chairs, we found that Health Care Services paid the lowest allowable amount, consistent with its policies and state law.

Providers Do Not Adhere to Price Controls in the Reimbursement Methodology When Billing for Medical Equipment

According to the response provided by the California Association of Medical Product Suppliers, when Health Care Services was developing and implementing the upper billing limit, some providers viewed the price controls as burdensome to administer and requiring that they establish a unique business and accounting model expressly for Medi-Cal. The providers claimed that the costly and administratively convoluted model would have an adverse impact on their non-Medi-Cal business by affecting their calculated usual and customary charges.

During the public comment period, another individual provider stated that the upper billing limit could eliminate a provider's ability to establish a usual and customary rate. According to the provider, the upper billing limit would force providers to bill amounts unique to Medi-Cal, effectively removing their ability to establish usual and customary charges for items offered for sale, regardless of the payment source. The provider further noted that Medicare and other payers require providers to bill their usual and customary rates.

Audits revealed that providers Health Care Services reviewed billed for most wheelchairs they supplied at the maximum listed Medicare price, not the significantly lower amount the upper billing limit would have produced.

Nevertheless, audits revealed that providers Health Care Services reviewed billed for most wheelchairs they supplied at the maximum listed Medicare price, not the significantly lower amount the upper billing limit would have produced. Our review of billings for medical equipment, including wheelchairs and their accessories without listed Medicare prices, indicated that typically a provider charged the manufacturer's suggested retail price without sufficient evidence to support it was the lowest-priced option.

Health Care Services Does Not Monitor Providers' Billings and Enforce the Price Controls in Its Reimbursement Methodology

Health Care Services does not effectively monitor providers' billings to verify compliance with its billing and reimbursement procedures, nor does it require providers to submit the documents needed to verify compliance, including vendors' invoices. According to the chief deputy director of health care programs (chief deputy director), Health Care Services does not require providers to submit invoices because it did not intend to review them during claims processing; rather, it uses postpayment audits to ensure compliance with billing procedures. According to the chief deputy director, when providers submit billings electronically, Health Care Services has no automated method for determining the relationship between the billed amount and the invoiced amount. The only way it can determine a provider's usual charge to the public is through a review of the provider's financial records, the chief deputy director said. He further stated that because Health Care Services processes more than $300 million a week in Medi-Cal payments for medical services and products, it would be a massive and costly undertaking to review every claim to see if the provider followed the billing and reimbursement procedures. Moreover, he stated that the volume of claims from Medi-Cal providers compels Health Care Services to anticipate that providers who bill for medical equipment follow the rules established. In February 2008 and May 2008, Health Care Services issued bulletins reminding providers of the upper billing limit for medical equipment.

According to the chief deputy director, at the time Health Care Services was implementing the new reimbursement rates, including the upper billing limit, it was imposing major rate reductions to medical equipment, such as wheelchairs. He stated that Health Care Services was very concerned about affecting the ability of beneficiaries to get access to wheelchairs. According to the chief deputy director, if Health Care Services began requiring providers to submit the documentation the department needs to verify that the claims submitted represent the lowest allowable rates, it would produce two negative outcomes: (1) the verification process would greatly increase costs and (2) the increased administrative burden on the providers might cause some to stop providing medical equipment to Medi-Cal beneficiaries, and possibly reduce the beneficiaries' access to wheelchairs and wheelchair accessories. Currently, according to the provider manual, a provider submitting a Medi-Cal reimbursement claim for medical equipment with a listed Medicare price does not have to include an invoice.

Health Care Services also decided not to require invoices for wheelchairs or wheelchair accessories without listed Medicare prices because of the burden it would place on providers to furnish two sources of documentation. According to the chief deputy director, the burden would take the form of excessive paperwork that might discourage provider participation if required. Table 3 on the following page shows the documents Health Care Services directs medical equipment providers to submit with claims for reimbursement and those we believe it needs to contain claim costs. According to the chief deputy director, Health Care Services already receives numerous complaints from Medi-Cal providers about excessive paperwork requirements, and requiring two sources might unnecessarily increase the risk that some providers would decide not to supply wheelchairs to beneficiaries who need them.

Health Care Services also decided not to require invoices for wheelchairs or wheelchair accessories without listed Medicare prices because of the burden it would place on providers to submit two sources of documentation.

However, to ensure that it reimburses for wheelchairs and their accessories at the lowest rates, Health Care Services needs to at least review the invoice from the provider's supplier and a retail price from the manufacturer's catalog. In fact, the provider manual states that for any item of medical equipment without a listed Medicare price, except a wheelchair or an accessory to it, a provider submitting a claim for reimbursement must include both an invoice and a catalog page. However, a claim for reimbursement for a wheelchair or accessory without a listed Medicare price need only include a catalog page listing the manufacturer's suggested retail price, according to the provider manual.

Table 3
Medical Equipment Provider Reimbursement Documentation

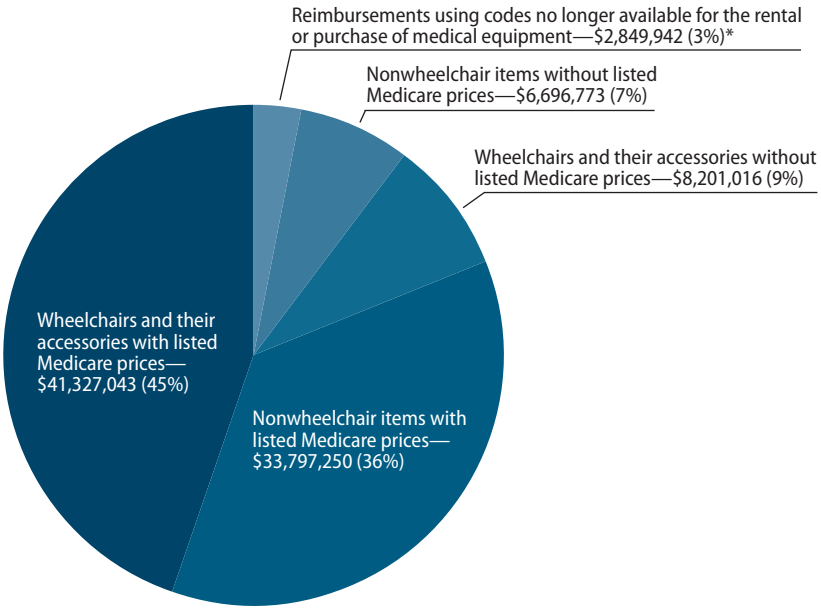
TYPE OF MEDICAL EQUIPMENT	DOCUMENTATION PROVIDER MUST SUBMIT WITH CLAIM	DOCUMENTATION HEALTH CARE SERVICES* NEEDS TO ENSURE CLAIMS ARE PAID AT LOWEST RATE
Wheelchair or wheelchair accessory with a listed Medicare price	None.	• Invoice with provider's cost. • Evidence of provider's usual charge made to the general public.
Wheelchair or wheelchair accessory without a listed Medicare price	Catalog page with manufacturer's suggested retail price (MSRP).	• Invoice with provider's cost. • Evidence of provider's usual charge made to the general public. • Catalog page with MSRP. • Evidence that the provider employs or contracts with a qualified rehabilitation professional.
Medical equipment other than wheelchair or wheelchair accessory with a listed price	None.	• Invoice with provider's cost. • Evidence of provider's usual charge made to the general public.
Medical equipment other than wheelchair or wheelchair accessory without a listed price	• Invoice with provider's cost. • Catalog page with MSRP.	• Invoice with provider's cost. • Catalog page with MSRP. • Evidence of provider's usual charge made to the general public.

Sources: Department of Health Care Services' provider manual and California Welfare and Institutions Code, Section 14105.48.

* The Department of Health Care Services is responsible for reimbursing providers for medical equipment supplied to Medi-Cal eligible individuals.

The five options for calculating reimbursement for items without listed Medicare prices are found in state law (see Table 2 on page 16). However, lacking invoices submitted with claims for wheelchair items without listed Medicare prices, Health Care Services cannot calculate two of the five allowable options for determining the lowest reimbursement rate. Specifically, Health Care Services cannot determine whether the invoice price plus a 67 percent markup results in a lower reimbursement rate than does the catalog price minus 20 percent (or 15 percent if the provider contracts or employs a qualified rehabilitation professional). Based on our review of paid claims data for federal fiscal year 2006–07, reimbursements for wheelchairs without a listed Medicare price totaled more than $8 million and represented 55 percent of all payments for items without a listed Medicare price. Therefore, reimbursements that are not calculated at the lowest allowable rate for this type of medical equipment can result in significant overpayments. The Figure shows the reimbursements Health Care Services made to providers in federal fiscal year 2006–07 for wheelchairs and other medical equipment with and without listed Medicare prices.

Figure
Medical Equipment Reimbursements With and Without Listed Medicare Prices
Federal Fiscal Year 2006–07



Source: Medi-Cal data from the Department of Health Care Services' Medi-Cal Management Information System for health care codes identified as medical equipment in the Medi-Cal provider manual as of December 2007.

Note: Health Care Services classifies Medi-Cal claims for reimbursements into several categories. The amounts presented are for medical claims only. In addition, because we were unable to obtain assurance of the completeness of the claims data used to develop the reimbursements information included in the figure, we assessed the data to be of undetermined reliability. As a result, the reimbursements information presented in the figure may be misstated.

* Reimbursements not identified in the Medi-Cal provider manual as with or without Medicare prices because these health care codes were not available for the rental or purchase of medical equipment as of December 2007.

Current Auditing Efforts Do Not Ensure That Medical Equipment Providers Comply With the Billing and Reimbursement Procedures

According to the chief deputy director, Health Care Services has always intended to use postpayment audits to monitor and enforce billing and reimbursement procedures, including the upper billing limit. However, because medical equipment reimbursements make up a relatively small portion of total Medi-Cal payments—0.8 percent, according to the 2006 payment error study—we believe that auditing efforts do not provide enough coverage of medical equipment reimbursements to effectively ensure compliance. The chief of its Medical Review Branch told us that Health Care Services does not have the resources to audit every provider in the State, so priority for audits is given to providers who deviate from normal utilization patterns as detected through electronic data processing, the random claims review process, or complaints.

According to the chief of the Medical Review Section-North, its random claims review process currently examines 100 randomly selected Medi-Cal claims on a weekly basis, with a focus on claims submitted by physicians and pharmacy providers. The chief told us that the random-claims sampling process is an additional layer of review beyond the automated checks and edits in the claims-processing system and gives all paid claims an equal chance to be selected for review. According to the chief of the Medical Review Branch, when Health Care Services' staff spot an issue, they analyze whether it has statewide implications; if staff determine that the dollar amounts are material, they initiate statewide audits, as was done for the wheelchair reimbursements.

As previously described, Health Care Services focused its audits on providers that billed more than $50,000 each for a wheelchair with a listed Medicare price from September 1, 2005, through August 31, 2006. Although less than half of these audits were complete at the end of our fieldwork, the audits were successful in identifying overpayments to providers totaling $1.2 million, or about 25 percent of the amounts the 21 providers that had been audited at that point had billed for wheelchairs. However, the audited claims represent just $4.9 million in total reimbursements. To provide context for the portion of the medical equipment tested compared to the universe of paid medical equipment claims, in federal fiscal year 2006–07 Health Care Services paid about $93 million for medical equipment claims.

Although less than half of these audits were complete at the end of our fieldwork, they were successful in identifying overpayments to providers totaling about $1.2 million, or about 25 percent of the amounts the 21 providers had billed for the wheelchairs.

While these audits show that providers frequently do not follow the requirements for the upper billing limit when billing for wheelchairs or wheelchair accessories, according to the chief of the Medical Review Branch, Health Care Services does not plan to expand its auditing efforts to include other items or providers. The chief also stated that when Health Care Services completes its audits of wheelchair providers, it will allocate its audit resources to the annual payment error study. The chief told us that Health Care Services could not make any decision to expand the audits of billing and reimbursement procedures until audit resources free up.

Moreover, according to the chief of the Medical Review Branch, Health Care Services limited its audits to those providers that billed more than $50,000 each from September 1, 2005, through August 31, 2006, for only one wheelchair type because of the high costs and limited benefits of such audits. However, this audit methodology excludes some providers from a potential audit when they bill less than $50,000 for that specific code, thus excluding them from the deterrent of not complying with the reimbursement methodology a potential audit can provide. In addition, as

previously discussed, current auditing efforts of Health Care Services have covered only 10 of the more than 400 health care codes regarding medical equipment with a listed price.

Although Health Care Services' audits have been effective in identifying noncompliance among some providers, without expansion to other providers the current audit strategy will not result in an effective long-term approach to enforcing the upper billing limit on reimbursements for medical equipment. The high rate of overpayments identified in just the limited number of audits Health Care Services did perform—more than $1.2 million—suggests that an expanded audit effort could yield similar results.

The high rate of overpayments identified in just the limited number of audits Health Care Services did perform suggests that an expanded audit effort could yield similar results.

In addition to randomly reviewing Medi-Cal reimbursement claims, Health Care Services annually conducts a payment error study, citing that controlling fraud, waste, and abuse in publicly funded health care programs requires continuous assessment to monitor emerging trends and to make informed decisions on the allocation of fraud control resources. The primary objective of the annual study is to identify where Medi-Cal is at greatest risk for payment errors. However, because of the relatively small size of Medi-Cal payments representing reimbursements for medical equipment—0.8 percent of the total claims—the reimbursements received little coverage in the most recent study, issued in 2006. In fact, of the 1,147 sample items reviewed from the period April 1, 2006, through June 30, 2006, for the 2006 study, only 50 represented medical equipment reimbursements. Among those 50 reimbursements, Health Care Services found three payment errors: one involving medical necessity, another for an ineligible provider, and the third for a policy violation. The 2006 payment error study concluded that 97.8 percent of the amounts paid from the sample were accurate. Because this conclusion is in stark contrast with the results of Health Care Services' audits performed in 2007 and 2008 that focused strictly on payments for wheelchairs with listed Medicare prices, the annual payment error study does not appear to be an effective means of monitoring and enforcing the medical equipment billing and reimbursement procedures.

State law allows providers to appeal the findings of audits Health Care Services conducts. According to the deputy director of the Audits and Investigations Unit, two of the 21 medical equipment providers Health Care Services audited in 2007 and 2008 have appealed their audit findings and repayment demands. When we asked about the potential impact of such appeals on other audits, the deputy director indicated that all appeals stand alone, and any outcome would not affect the findings of any other audit that focuses on the upper billing limit. According to our legal counsel,

under state law the outcomes of the two audit appeals would not affect future audits unless Health Care Services took the necessary procedural steps to designate the decisions as precedent setting.

Recommendations

To better ensure its provider manual represents a comprehensive guide for medical equipment providers, Health Care Services should amend the manual to include the current methodology for calculating reimbursements for speech-generating devices.

To maintain control over the cost of reimbursements, Health Care Services should develop an administratively feasible means of monitoring and enforcing current Medi-Cal billing and reimbursement procedures for medical equipment. If unsuccessful, Health Care Services should consider developing reimbursement caps for medical equipment that are more easily administered.

If Health Care Services continues using audits to ensure that providers comply with Medi-Cal billing procedures for medical equipment, including the upper billing limit, it should design and implement a cost-effective approach that adequately addresses the risk of overpayment and ensures that all providers are potentially subject to an audit, thereby providing a deterrent for noncompliance.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of the report.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

Date: June 17, 2008

Staff: Norm Calloway, CPA
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Aaron Fellner, MPP

For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at (916) 445-0255.

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(Agency response provided as text only.)

Department of Health Care Services
1501 Capitol Avenue, Suite 71.6001, MS 0000
Sacramento, CA 95899-7413

June 4, 2008

Elaine M. Howle*
State Auditor
California Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) has prepared its response to the draft report entitled "Department of Health Care Services: Although Notified of Changes in Billing Requirements, Some Providers of Durable Medical Equipment Frequently Overcharged Medi-Cal," report number 2007-122. The DHCS appreciates the work performed by the Bureau of State Audits and the opportunity to respond to the draft report.

Please contact Stan Rosenstein, Chief Deputy Director, Health Care Programs, at (916) 440-7400 if you have any questions.

Sincerely,

(Signed by: Stan Rosenstein for)

Sandra Shewry
Director

Enclosure

* California State Auditor's comments begin on page 31.

Response to the Bureau of State Audits'
Draft Audit Report

"Department of Health Care Services:
Although Notified of Changes in Billing Requirements, Some Providers of
Durable Medical Equipment Frequently Overcharged Medi-Cal"

Recommendation: To better ensure its provider manual represents a comprehensive guide for medical equipment providers, Health Care Services should amend the manual to include billing procedures for speech-generating devices.

(1) **Response:** Billing procedures for Speech Generating Devices (SGD) are located in the Allied Health Provider Manual, Part 2 - Billing and Policy, under the Durable Medical Equipment and Medical Supplies (DME) section, page titled "spe dev." The Fiscal Intermediary and Contracts Oversight Division is currently drafting an operating instruction letter (OIL) to instruct Electronic Data Systems to add additional language regarding billing requirements and reimbursement to this section.

Recommendation: To maintain control over the cost of reimbursements, Health Care Services should develop an administratively feasible means of monitoring and enforcing current Medi-Cal billing and reimbursement procedures for medical equipment. If unsuccessful, Health Care Services should consider developing reimbursement caps for medical equipment that are more easily administered.

Response: Through the Department's Medi-Cal Fiscal Intermediary, Electronic Data Systems, the current Medi-Cal claims processing system incorporates over 1000 system edits and audits which are applied against all claims. California has more edits and audits than most other Medicaid programs and the commercial vendors who sell these controls. Medi-Cal processes over $300 million a week in payments and it would be a massive and costly undertaking to review every claim and the documentation to see if the providers are following Med-Cal's billing and reimbursement procedures. The Department must set-up procedures that are administratively feasible and balance cost-effectiveness and access to care. Consequently, besides using edits and audits within the claims processing system, the most appropriate way to validate whether
(2) providers are following the procedures is through post-payment reviews. The Department uses a variety of post-payment audits to monitor and enforce its medical equipment billing and reimbursement procedures. The imposition of reimbursement caps would not be practical, since they would drive pricing
(3) up to the maximum (i.e. the cap). Setting a reasonable cap in the current State budget environment would most likely lead to access to care problems by limiting the number of providers willing to participate.

Recommendation:

If Health Care Services continues using audits to ensure that providers comply with Medi-Cal billing procedures for medical equipment, including the upper billing limit, it should design and implement a cost-effective approach that adequately addresses the risk of overpayment and ensure all providers are potentially subject to an audit, thereby providing a deterrent to noncompliance.

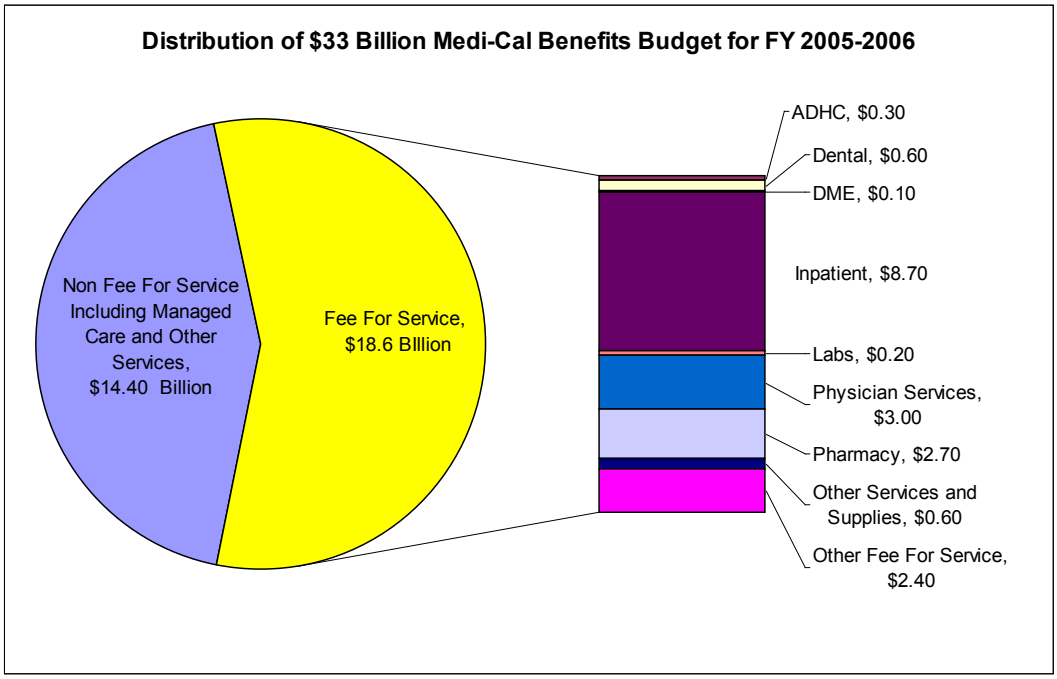
Response:

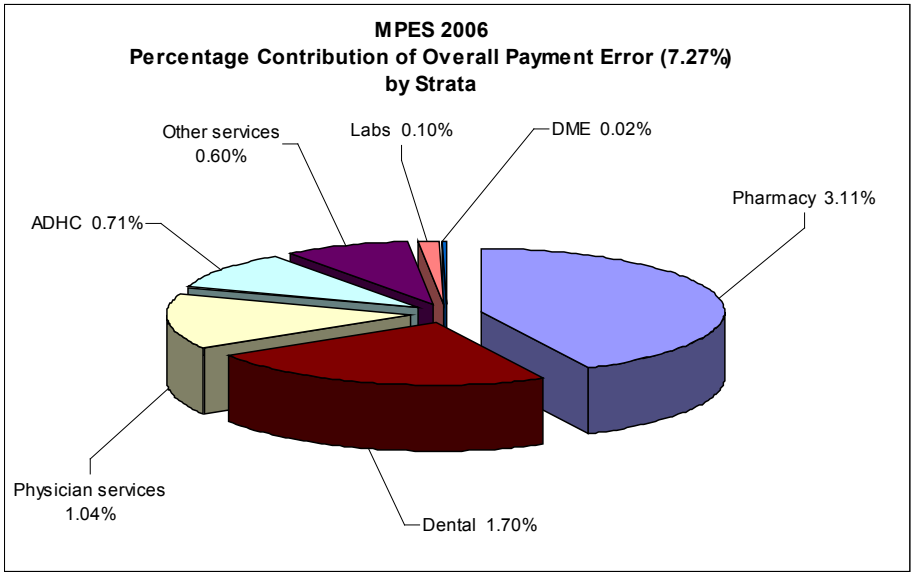
In recent years Audits and Investigations (A&I) has added a new tool to help detect fraud, waste and abuse. The California Department of Health Care Services (DHCS) is currently conducting the fourth annual Medi-Cal Payment Error Study (MPES). The purpose of the MPES is to identify where the Medi-Cal program is at greatest risk for payment errors and determine how best to deploy Medi-Cal anti-fraud resources. (4)

In the recently published MPES 2006, the Department focused on potential payment errors in durable medical equipment (DME) by reviewing a statistically valid, random sample of DME claims. For the claims reviewed, the payment error rate for DME was .02 percent. DME represented the smallest percent of the total Medi-Cal error dollars associated with the MPES 2006 study period - April 1, 2006 through June 30, 2006 (see chart below). And, in addition, speech generating device dollars ($341,017) represented only about one percent of the DME stratum.

DHCS has completed three MPES and over 18,500 Random Claims Reviews and has documented an upper billing limit (UBL) error issue only once. Based on our experience, UBL errors are not a significant risk factor for the Medi-Cal program overall. The following charts show that the total DME expenditures are low, as well as the percentage of DME contribution to the overall MPES 2006 error of 7.27 percent. (4)

The following chart shows DME expenditures in relation to the entire Medi-Cal program.





Lastly, A&I recently reviewed all 864 currently active DME providers in order to confirm that they have an established place of business and are legitimate Medi-Cal providers. Again, this review did not show that DME providers are a significant risk to the program. This review supplemented A&I's Medical Review Branch's ongoing antifraud reviews of DME providers. This report is currently being finalized and will be made available to the Bureau of State Audits upon its release. (4)

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE DEPARTMENT OF HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on the response to our audit report from the Department of Health Care Services (Health Care Services). The numbers below correspond to the numbers we have placed in the margin of Health Care Services' response.

Health Care Services is correct in clarifying that the Durable Medical Equipment and Medical Supplies section of its Allied Health Provider Manual (provider manual) contains billing procedures for speech-generating devices. Additional billing information for speech-generating devices is contained in the section of the provider manual regarding speech therapy. However, neither of these two sections contains the current methodology for determining reimbursement that was implemented with legislation passed in 2003. As such, Health Care Services incorrectly implies that those two sections of its provider manual require only "additional language". They need to be re-written to reflect the current billing and reimbursement procedures contained in the law regarding speech-generating devices. We modified the language on pages 1 and 12 of our report and the recommendations to reflect that Health Care Services' provider manual does not contain the current methodology for calculating reimbursements for speech-generating devices included in state law. (1)

We appreciate Health Care Services' assertions that its electronic claims processing system incorporates edits and audits of all claims; Medi-Cal processes over $300 million a week in payments; and it would be a massive and costly undertaking to review every claim and the documentation to see if providers follow Medi-Cal billing and reimbursement procedures. Nonetheless, we were asked to review only the durable medical equipment (medical equipment) portion of those payments. And, as we describe on page 15 of our report, although intended to prevent and curtail fraud and abuse, the current price controls over reimbursements for medical equipment have not been effective because providers do not bill at allowable amounts and Health Care Services does not adequately monitor providers' billings and enforce the price controls. In fact, as we discuss on pages 22 through 23 of the report, based on audits conducted in 2007 and 2008 by Health Care Services of just 21 providers of wheelchairs, overpayments to the providers, when aggregated, totaled $1.2 million or 25 percent of the amounts billed. (2)

③ We question Health Care Services' statement that setting a reasonable cap on reimbursements in the current state budget environment would most likely lead to access to care problems by limiting the number of providers willing to participate. It seems more likely that unreasonable reimbursement caps would lead to access to care problems in any state budget environment.

④ Health Care Services overstates the effectiveness of its annual Medi-Cal Payment Error Study (payment error study) in identifying billing concerns with medical equipment. Health Care Services reports that from its last three annual payment error studies, involving over 18,500 randomly selected Medi-Cal claims, it identified only one upper billing limit issue. However, as we discuss on pages 22 through 23 of the report, in 2007 and 2008 when Health Care Services conducted a review focused on just 21 providers of wheelchairs with a listed Medicare price, it found that none of the providers had consistently complied with Health Care Services' billing and reimbursement procedures. In fact, the 21 providers had overbilled, and Health Care Services overpaid, about $1.2 million, or 25 percent of the $4.9 million billed. Despite its success in identifying overpayments from these types of audits, as we explain on page 22 Health Care Services does not plan to expand these types of audits to include other providers or other types of medical equipment, citing that it could not make any decisions regarding expansion of the audits until the current annual payment error study is completed.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press