MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES

DEPARTMENT OF COMMUNITY HEALTH

January 2013

THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

391-0717-12

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

– Article IV, Section 53 of the Michigan Constitution

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REPORT SUMMARY

Performance Audit
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
Department of Community Health (DCH)

Report Number:
391-0717-12

Released:
January 2013

Medicaid is a program that helps certain individuals and families with low incomes and limited resources pay for some or all of their medical bills. It provides coverage of a wide variety of medical services for eligible individuals, including DMEPOS. DCH is responsible for establishing the rates used to reimburse providers for DMEPOS provided to Medicaid eligible individuals and for processing payment of DMEPOS claims through its electronic claims processing system.

Audit Objective:

To assess the effectiveness of DCH's efforts to ensure proper payment as defined by selected DCH policies for DMEPOS.

Audit Conclusion:

We concluded that DCH's efforts to ensure proper payment as defined by selected DCH policies for DMEPOS were moderately effective. We identified known improper payments of $2,347,000 (approximately $691,000 General Fund/general purpose) and potential improper payments of up to $209,000 (approximately $61,000 General Fund/general purpose). We noted five reportable conditions (Findings 1 through 5).

Reportable Conditions:

DCH did not ensure proper payment of DMEPOS for dually enrolled beneficiaries. As a result, we identified $811,000 (approximately $240,000 General Fund/general purpose) in improper payments to DMEPOS providers during the audit period. Also, as a result, we identified potential improper payments of up to $209,000 (approximately $61,000 General Fund/general purpose) during the audit period (Finding 1).

DCH did not ensure that it prevented, detected, and recovered duplicate payments for DMEPOS. As a result, we identified $641,000 (approximately $189,000 General Fund/general purpose) in improper duplicate payments for DMEPOS claims during the audit period ($99,000 of the $641,000 and $29,000 of the $189,000 General Fund/general purpose are also included in Finding 4) (Finding 2).

DCH did not ensure proper payment for DMEPOS for beneficiaries residing in nursing facilities. As a result, we identified $476,000 (approximately $140,000 General Fund/general purpose) in improper payments to DMEPOS providers during the audit period (Finding 3).

DCH did not ensure proper payment for incontinence supplies. As a result, we identified $357,000 (approximately $104,000 General Fund/general purpose) in improper payments for incontinence supplies during the audit period (Finding 4).

DCH did not ensure proper payment for DMEPOS for beneficiaries enrolled in a Medicaid Health Plan (MHP). As a result, we identified $161,000 (approximately $47,000 General Fund/general purpose) in improper payments to DMEPOS providers during the audit period (Finding 5).

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Audit Objective:

To assess the effectiveness of DCH's process to establish rates consistent with applicable federal regulations, the Michigan Medicaid State Plan, and its policies for DMEPOS.

Audit Conclusion:

We concluded that DCH's process to establish rates consistent with applicable federal regulations, the Michigan Medicaid State Plan, and its policies for DMEPOS was moderately effective. We identified known improper payments of $997,000 (approximately $293,000 General Fund/general purpose) and potential improper payments of up to $1,600,000 (approximately $470,000 General Fund/general purpose). We noted three reportable conditions (Findings 6 through 8).

Reportable Conditions:

DCH did not ensure that it established Medicaid rates for DMEPOS consistent with its policy. As a result, DCH paid DMEPOS providers $983,000 (approximately $289,000 General Fund/general purpose) in excess of Medicare rates during the audit period (Finding 6).

DCH did not have written internal policies and procedures for establishing and periodically evaluating DMEPOS covered services and associated payment rates. As a result, DCH was unable to provide documentation supporting how the existing Medicaid DMEPOS payment rates were established and when DCH last updated or reviewed the payment rates (Finding 7).

DCH should consider establishing reduced payment rates for used durable medical equipment (DME). We estimate that DCH could have saved at least $14,000 (approximately $4,000 General Fund/general purpose) and at most $1,600,000 (approximately $470,000 General Fund/general purpose) during the audit period if it had developed used payment rates for DME items (Finding 8).

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Agency Response:

Our audit report contains 8 findings and 8 corresponding recommendations. DCH's preliminary response indicates that it agrees with all 8 recommendations.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: http://audgen.michigan.gov

Michigan Office of the Auditor General
201 N. Washington Square
Lansing, Michigan 48913

Thomas H. McTavish, C.P.A.
Auditor General

Scott M. Strong, C.P.A., C.I.A.
Deputy Auditor General

STATE OF MICHIGAN
OFFICE OF THE AUDITOR GENERAL
201 N. WASHINGTON SQUARE
LANSING, MICHIGAN 48913
(517) 334-8050
FAX (517) 334-8079

THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

January 3, 2013

Mr. James K. Haveman, Jr., Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Dear Mr. Haveman:

This is our report on the performance audit of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

This report contains our report summary; description; audit objectives, scope, and methodology and agency responses; comments, findings, recommendations, and agency preliminary responses; Medicaid expenditures and DMEPOS expenditures by category, presented as supplemental information; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's response subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Thomas H. McTavish, C.P.A.
Auditor General

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DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES
DEPARTMENT OF COMMUNITY HEALTH

SUPPLEMENTAL INFORMATION

GLOSSARY

Description

Medicaid is a program that helps certain individuals and families with low incomes and limited resources pay for some or all of their medical bills. The federal government established Medicaid under Title XIX of the Social Security Act.

The federal government establishes regulations, guidelines, and policy interpretations that describe the broad framework within which states can tailor their individual Medicaid programs. The states operate Medicaid programs according to the respective state rules and criteria that vary within this broad framework. In Michigan, the Medical Services Administration, Department of Community Health (DCH), administers Medicaid.

Medicaid is a joint federal and state funding effort. The federal government matches the funds that each state spends on Medicaid according to the state's federal medical assistance percentage (FMAP). Michigan's FMAP ranged from 65.79% through 75.57% during our audit period.

Pursuant to the Michigan Medicaid State Plan*, DCH provides coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). DCH processed payments totaling $181.6 million (approximately $53.4 million General Fund/general purpose) for DMEPOS claims during the period October 1, 2009 through June 30, 2012 (see supplemental information). A description of DMEPOS items follows:

- **Durable medical equipment** are those items that are U.S. Food and Drug Administration approved, can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and can be used in the beneficiaries' homes. Examples include hospital beds, wheelchairs, and ventilators.

- **Prosthetics** are devices used to artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body.

** See glossary at end of report for definition.*

- **Orthotics** are devices used to assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body.

- **Medical supplies** are those items that are required for medical management of the beneficiaries, are disposable or have a limited life expectancy, and can be used in the beneficiaries' homes. Examples include hypodermic syringes and needles, ostomy supplies*, and dressings necessary for the medical management of the beneficiaries.

Payment rates for DMEPOS items are established by DCH as a fee screen. A fee screen is an amount established by DCH that represents the maximum amount that Medicaid will pay for the service. According to the Michigan Medicaid State Plan, DCH uses Medicare prevailing fees, the resource-based relative value scale* and other relative value information, and other states' Medicaid fee screens and providers' charges as guidelines or reference in determining the maximum fee screens for individual items. Providers are reimbursed the lesser of the Medicaid fee screen or the provider's usual and customary charge minus any third party payment. The provider's usual and customary charge should be the fee most frequently charged to patients. The payment rate is uniform for private and governmental providers.

DCH is also responsible for processing payment of Medicaid DMEPOS claims through an electronic claims processing system called the Community Health Automated Medicaid Processing System (CHAMPS). DMEPOS providers submit electronic claims and paper claims, which are converted to electronic format, for processing. Claims processed through CHAMPS are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and a combination of service edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement. DCH processes claims and issues payments to providers by check or electronic funds transfer every week.

** See glossary at end of report for definition.*

Audit Objectives

Our performance audit* of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Department of Community Health (DCH), had the following objectives:

1. To assess the effectiveness* of DCH's efforts to ensure proper payment as defined by selected DCH policies for DMEPOS.

2. To assess the effectiveness of DCH's process to establish rates consistent with applicable federal regulations, the Michigan Medicaid State Plan, and its policies for DMEPOS.

Audit Scope

Our audit scope was to examine the program records, electronic paid claim data, and other records related to Medicaid durable medical equipment, prosthetics, orthotics, and supplies. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Our audit procedures, conducted from May through October 2012, generally covered the period October 1, 2009 through June 30, 2012.

We did not include within the scope of this audit the verification of Medicaid eligibility. Medicaid eligibility is determined by Department of Human Services local offices. Our financial audit, including the provisions of the Single Audit Act, of the Department of Community Health (391-0100-12) included verification of Medicaid eligibility within its scope and was issued in June 2012.

* *See glossary at end of report for definition.*

In our analysis of DMEPOS paid claims data related to both the first and second audit objectives, we excluded any DMEPOS paid claims that were granted prior authorization* by DCH. DCH requires that a provider obtain prior authorization for certain DMEPOS items before the item is provided to the beneficiary or, in the case of custom-fabricated items, before the item is ordered. Prior authorization is required for situations such as services that exceed quantity limits or established fee screens, medical need for an item beyond DCH's standards of coverage, and select procedure codes. DCH's prior authorization process entails manual review of the request by a medical professional, including review of the medical necessity of the service or product. We excluded DMEPOS paid claims data with prior authorization from our review as we focused our audit effort on other processes having a greater probability for needing improvement as identified through our preliminary review. During the audit period, DCH paid $181.6 million (approximately $53.4 million General Fund/general purpose) for DMEPOS claims, of which $93.1 million (51%) (approximately $27.4 million General Fund/general purpose) had DCH prior authorization and was excluded from our review.

As part of our audit, we prepared supplemental information that relates to our audit objectives. Our audit was not directed toward expressing a conclusion on this supplemental information and, accordingly, we express no conclusion on it.

Audit Methodology

We conducted a preliminary review of DCH's operations as they pertained to Medicaid DMEPOS claims to gain an understanding of its operations and to plan our audit. This included interviewing DCH management personnel; reviewing applicable laws, regulations, contracts, policies, and procedures, including appropriations acts and legislative boilerplate, the Michigan Medicaid State Plan, and the Medicaid Provider Manual*; examining reports from other external audits; and analyzing Medicaid DMEPOS paid claims data.

To accomplish our first objective, we performed various analyses of DMEPOS claims paid during the period October 1, 2009 through June 30, 2012. Our analyses were developed based on our understanding of limitations, restrictions, and other requirements imposed on DMEPOS claims by the Michigan Medicaid State Plan, the

* *See glossary at end of report for definition.*

Medicaid Provider Manual, contracts, and other federal or State laws and regulations. We also identified other overpayment risks through research of federal and other state audits of DMEPOS claims and developed data analysis techniques to determine if similar overpayments occurred. Our review was limited to selected DCH policies for DMEPOS, including policies regarding dually enrolled beneficiaries*; payments for beneficiaries enrolled in a Medicaid Health Plan or residing in a nursing facility; duplicate payments; and incontinence supplies*, including established monthly limits for incontinence supplies, payment of discounted prices through the DCH incontinence supply volume purchase contractor, required purchase of specific incontinence supplies through the DCH volume purchase contractor, and prior authorization of pediatric-sized diapers.

To accomplish our second objective, we reviewed applicable federal regulations, the Michigan Medicaid State Plan, and the Medicaid Provider Manual to obtain an understanding of applicable requirements. We obtained an understanding of DCH's process for establishing Medicaid DMEPOS rates through interviews with DCH Program Policy Division staff. We analyzed Medicaid DMEPOS rates to ensure that the rates were less than Medicare's established DMEPOS rates, as required by the Medicaid Provider Manual. We reviewed DCH's published Medicaid DMEPOS rate database to ensure that the list of covered procedure codes was complete.

When selecting activities or programs for audit, we use an approach based on assessment of risk and opportunity for improvement. Accordingly, we focus our audit efforts on activities or programs having the greatest probability for needing improvement as identified through a preliminary review. Our limited audit resources are used, by design, to identify where and how improvements can be made. Consequently, we prepare our performance audit reports on an exception basis.

Agency Responses

Our audit report contains 8 findings and 8 corresponding recommendations. DCH's preliminary response indicates that it agrees with all 8 recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan

** See glossary at end of report for definition.*

Financial Management Guide (Part VII, Chapter 4, Section 100) require DCH to develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

PROPER PAYMENT FOR DMEPOS

COMMENT

Background: We performed various analyses of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims paid during the period October 1, 2009 through June 30, 2012. Our analyses were developed based on our understanding of limitations, restrictions, and other requirements imposed on DMEPOS claims by the Michigan Medicaid State Plan, the Medicaid Provider Manual, contracts, and other federal or State laws and regulations.

Our review was limited to selected Department of Community Health (DCH) policies for DMEPOS, including policies regarding dually enrolled beneficiaries; payments for beneficiaries enrolled in a Medicaid Health Plan (MHP) or residing in a nursing facility; duplicate payments; and incontinence supplies, including established monthly limits for incontinence supplies, payment of discounted prices through the DCH incontinence supply volume purchase contractor, required purchase of specific incontinence supplies through the DCH volume purchase contractor, and prior authorization of pediatric-sized diapers.

We considered an improper payment to be any paid claim that was not in compliance with selected DCH policies for DMEPOS.

Audit Objective: To assess the effectiveness of DCH's efforts to ensure proper payment as defined by selected DCH policies for DMEPOS.

Audit Conclusion: We concluded that DCH's efforts to ensure proper payment as defined by selected DCH policies for DMEPOS were moderately effective. Our audit disclosed five reportable conditions* related to claims paid for dually enrolled beneficiaries, duplicate payments, claims paid for beneficiaries in nursing facilities, incontinence supplies, and claims paid for beneficiaries enrolled in an MHP (Findings 1 through 5).

FINDING

1. Claims Paid for Dually Enrolled Beneficiaries

   DCH did not ensure proper payment of DMEPOS for dually enrolled beneficiaries. As a result, we identified $811,000 (approximately $240,000 General Fund/general

* *See glossary at end of report for definition.*

purpose) in improper payments* to DMEPOS providers during the audit period. Also, as a result, we identified potential improper payments of up to $209,000 (approximately $61,000 General Fund/general purpose) during the audit period.

Medicaid provides coverage of a wide variety of medical services to eligible Medicaid beneficiaries, including DMEPOS claims. Many beneficiaries are eligible for both Medicare and Medicaid benefits and are referred to as "dually" enrolled.

Our review of payments made to DMEPOS providers during the audit period disclosed:

a. DCH paid DMEPOS providers $681,000 (approximately $200,000 General Fund/general purpose) for certain DMEPOS claims that were not granted prior authorization as required by DCH policy. These claims were submitted to Medicare on behalf of dually enrolled beneficiaries; however, because the claims were not reimbursed by Medicare, DCH policy required prior authorization for the claims.

   DCH requires that a provider obtain prior authorization for certain DMEPOS items before the item is provided to the beneficiary or, in the case of custom-fabricated items, before the item is ordered. Prior authorization is required for situations such as services that exceed quantity limits or established fee screens, medical need for an item beyond DCH's standards of coverage, and select procedure codes. DCH's prior authorization process entails manual review of the request by a medical professional, including review of medical necessity of the service or product. DCH policy contained in the Medicaid Provider Manual provides that the prior authorization requirement is waived for dually eligible beneficiaries if Medicare reimburses for its portion of the service; however, if Medicare does not reimburse for the service then prior authorization for certain DMEPOS items is still required.

b. DCH paid DMEPOS providers $130,000 (approximately $38,000 General Fund/general purpose) for dually enrolled beneficiaries with Medicare Part B coverage for which Medicare did not pay its portion for the Medicare covered DMEPOS item. Medicare either denied the claims or determined that the

* *See glossary at end of report for definition.*

services were not medically necessary. According to its policy, DCH should have rejected these claims for payment.

Medicare Part B covers certain DMEPOS, such as oxygen equipment, wheelchairs, prosthetic devices, surgical dressings, splints, casts, and braces, for dually enrolled beneficiaries. DCH policy contained in the Medicaid Provider Manual states that DCH will reject a claim for a beneficiary enrolled in Medicare Part B if Medicare has not paid the Medicare portion of a covered service.

c. DCH paid DMEPOS providers for dually eligible beneficiary claims that had not yet been paid by Medicare. As a result, we identified potential improper payments totaling up to $209,000 (approximately $61,000 General Fund/general purpose).

Because Medicaid is the payer of last resort, providers must submit claims to other insurers, including Medicare, before submitting claims to DCH for Medicaid payment. When a provider submits claims to DCH, providers often submit information on the claim to indicate how Medicare processed the claims. This information can be in the form of a claim adjustment reason code.

DCH paid DMEPOS providers $209,000 (approximately $61,000 General Fund/general purpose) for dually eligible beneficiary claims that had not yet been paid by Medicare. Our review showed that the providers had submitted the claims to Medicare; however, Medicare had not yet paid the claims because Medicare assigned a claim adjustment reason code to the claims requiring additional information or documentation before payment. If DCH had denied these claims pending Medicare's payment of the claim, it is likely that DCH's actual liability for the claims would amount to only a portion of the $209,000 (approximately $61,000 General Fund/general purpose) already paid.

DCH stated that it recognized this error before our review and had started taking steps to prevent future similar improper payments. DCH also stated that it was in the process of identifying and evaluating the inappropriately paid claims and planned to recover the funds.

RECOMMENDATION

We recommend that DCH ensure proper payment of DMEPOS for dually enrolled beneficiaries.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not always ensure proper payment of DMEPOS claims for dually enrolled beneficiaries:

a. DCH agrees that because these DMEPOS codes were not reimbursed by Medicare, prior authorization should have been obtained prior to reimbursement. However, DCH indicated that it has reviewed the identified claims and all of these claims were for appropriate DMEPOS services.

   DCH informed us that it will review existing DMEPOS coding to ensure that prior authorization edits for DMEPOS are appropriate, regardless of Medicare coverage.

b. DCH agrees that it did not always ensure proper payment of DMEPOS for dually enrolled beneficiaries with Medicare Part B coverage for claims submitted without any information from the primary payer, including claim adjustment reason codes.

   DCH indicated that it began reviewing suspended claims processing resolution instructions for specific claim adjustment reason codes in spring 2012. At that time, DCH indicated that it had implemented system changes for some of the claim adjustment reason codes and started work on modifications to edits for others. DCH stated that it expects to have all edits operational by the end of December 2012.

c. DCH agrees that it paid for some claims prior to Medicare reimbursement. DCH indicated that, in April 2012, it identified issues with claims processed with a specific claim adjustment reason code supplied by Medicare. DCH stated that payment was not processed by Medicare because the units billed exceeded Medicare payment rules or Medicare did not support the frequency of services billed. The claims were then submitted to Medicaid where they pended for manual review and were inappropriately forced for payment. DCH

stated that it subsequently changed the resolution instructions to force payment only when a Medicare payment is reported. DCH stated that it has identified claims affected by this change and is in the process of finalizing the claim adjustments for January 2013 processing.

FINDING

2. Duplicate Payments

DCH did not ensure that it prevented, detected, and recovered duplicate payments for DMEPOS. As a result, we identified $641,000 (approximately $189,000 General Fund/general purpose) in improper duplicate payments for DMEPOS claims during the audit period.

DCH processes provider claims through its electronic claims processing system, Community Health Automated Medicaid Processing System (CHAMPS). DCH has edits in CHAMPS set to deny duplicate payments and suspend suspected duplicate payments for manual review. We performed a data match of DMEPOS claims paid during the audit period to identify duplicate payments. Our review disclosed:

a. DCH issued $341,000 (approximately $100,000 General Fund/general purpose) in duplicate payments to the same provider that submitted a claim multiple times with a different modifier.

   Providers can submit a field on claims called a modifier, which is a standardized two-digit code that describes the provided service in more detail. Examples of common modifiers are rental (RR), dressing for one wound (A1), orally administered (B0), and replacement of a part (RB). Some modifiers are informational, while other modifiers affect the reimbursement amount for the claim.

   DCH stated that it had existing edits in place; however, the edits did not take modifiers into consideration.

b. DCH issued $137,000 (approximately $40,000 General Fund/general purpose) in duplicate payments for overlapping dates of service. In these instances, two or more claims have date of service ranges that encompass the same date(s) of service.

   DCH stated that these claims were suspended for DCH manual review prior to payment; however, the claims were incorrectly processed by DCH's manual reviewers because of an error in its internal manual review instructions. DCH stated that it implemented revised internal manual review instructions in April 2012 to ensure appropriate manual review and payment processing.

c. DCH issued $121,000 (approximately $36,000 General Fund/general purpose) in duplicate payments to the same provider that submitted duplicate claims with different National Provider Identifier (NPI) numbers ($99,000 of the $121,000 and $29,000 of the $36,000 General Fund/general purpose are also included in Finding 4, part b.).

   Providers must submit their NPI number on all claims in order to obtain reimbursement. Some organization healthcare providers are made up of components that furnish different types of healthcare or have separate physical locations where healthcare is furnished. These organizations may have more than one NPI number.

   DCH's CHAMPS edit suspended suspected duplicate claims for manual review. During the audit period, DCH's internal procedures instructed the manual reviewer to force payment of a claim if the provider NPI number on the claim did not match the provider NPI number on the suspected duplicate. DCH's internal procedures did not require the reviewer to perform additional review or research to determine if the suspected duplicate claims were from the same provider.

d. DCH issued $42,000 (approximately $12,000 General Fund/general purpose) in duplicate payments to the same provider for the same date of service, beneficiary, and good or service.

DCH stated that these claims were suspended for DCH manual review prior to payment; however, the claims were incorrectly processed by DCH's manual reviewers.

RECOMMENDATION

We recommend that DCH ensure that it prevents, detects, and recovers duplicate payments for DMEPOS.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not always prevent, detect, and correct duplicate payments for some DMEPOS:

a. DCH agrees that some duplicate claims with different modifiers were inadvertently reimbursed. DCH indicated that a systems change request has been submitted to modify existing edits to take into consideration modifiers; implementation is expected during summer 2013. Subsequent to implementation, DCH stated that it will identify the impacted claims and process recoveries.

b. DCH agrees that some claims with overlapping dates of service were incorrectly processed. DCH informed us that, in April 2012, it identified changes within the resolution instructions that impacted the outcome of claims processed for overlapping dates of service. DCH stated that the resolution instructions were then clarified to ensure appropriate manual review and processing. In addition, DCH informed us that, once the system change request identified in part a. has been implemented, it will reprocess all affected claims and recoupment will occur if necessary.

c. DCH agrees that some duplicate claims were inappropriately reimbursed. DCH stated that it does not have an edit in place to deny or suspend claims for the same date of service, same procedure, with a different NPI because policy allows for payment to different providers rendering the same procedure on the same day. DCH informed us that a change request to revise edits to deny claims with different NPIs has been submitted and is scheduled for implementation in summer 2013. In addition, DCH informed us that it has

revised its internal manual review procedures to appropriately address suspended claims. Subsequent to implementation of the revisions, DCH stated that it will identify the impacted claims and process recoveries.

d. DCH agrees that these claims were inappropriately processed by DCH's manual reviewers. DCH informed us that it will periodically perform a quality review of manually processed claims and retrain staff where necessary. In addition, DCH informed us that it will identify the impacted claims and process recoveries.

FINDING

3. Claims Paid for Beneficiaries in Nursing Facilities

DCH did not ensure proper payment for DMEPOS for beneficiaries residing in nursing facilities. As a result, we identified $476,000 (approximately $140,000 General Fund/general purpose) in improper payments to DMEPOS providers during the audit period.

Medicaid beneficiaries with long-term care needs may reside in Medicaid-certified nursing facilities. DCH reimburses nursing facilities for Medicaid eligible residents through an established per diem rate. The per diem rate is intended to provide reimbursement for a wide range of services that are provided to the beneficiary on a daily basis, such as nursing care, administrative services, food, and many medical supplies.

DCH's policy contained in its Medicaid Provider Manual states that nursing facilities and DMEPOS providers may not bill for items or services covered by the per diem rate. DCH's policy refers DMEPOS providers to its DMEPOS database and instructs providers that the database will indicate which items are covered by the per diem rate.

Our review disclosed that DCH paid DMEPOS providers $476,000 (approximately $140,000 General Fund/general purpose) on behalf of beneficiaries residing in

nursing facilities for DMEPOS procedure codes that were included in the nursing facility per diem rate. Specifically, our review disclosed:

a. DCH did not have a process in place to identify and recover claims paid on behalf of beneficiaries that were retroactively recorded in CHAMPS as residing in nursing facilities. As a result, DCH did not identify and recover $449,000 (approximately $132,000 General Fund/general purpose) paid to DMEPOS providers on behalf of beneficiaries residing in nursing facilities for DMEPOS procedure codes that were included in the nursing facility per diem rate.

   DCH had an edit in its electronic claims processing system, CHAMPS, that was set to deny claims for certain procedure codes when the beneficiary resides at a nursing facility at the date of service. However, DCH stated that CHAMPS allowed for these claims to be paid because the beneficiary was not listed in CHAMPS as residing in a nursing facility at the time the claim was paid. After the DMEPOS claim was paid, CHAMPS was updated to reflect that the beneficiary was in fact residing in a nursing facility at the date of service.

b. DCH did not ensure that the edits in CHAMPS contained all the procedure codes included in the nursing facility per diem rate. As a result, DCH improperly paid $27,000 (approximately $8,000 General Fund/general purpose) to DMEPOS providers on behalf of beneficiaries residing in nursing facilities for DMEPOS procedure codes that were included in the nursing facility per diem rate.

   Using the October 2009 DMEPOS database, we applied the nursing home per diem field indicators to the payments during our audit period and estimated that DCH paid DMEPOS providers an additional $27,000 (approximately $8,000 General Fund/general purpose) on behalf of beneficiaries residing in nursing facilities for DMEPOS procedure codes that were included in the nursing facility per diem rate.

c. DCH did not inform providers which DMEPOS procedure codes were included in the nursing facility per diem rate.

Our review disclosed that, for 30 of 33 months in the audit period, DCH's DMEPOS database did not contain a field to indicate whether a procedure code was covered by the nursing facility per diem rate. As a result, it was not clear to providers which items could be billed for beneficiaries in a nursing home.

DCH updated the DMEPOS database in October 2012 to include a field that indicates whether a procedure code was covered by the nursing facility per diem rate.

RECOMMENDATION

We recommend that DCH ensure proper payment for DMEPOS for beneficiaries residing in nursing facilities.

AGENCY PRELIMINARY RESPONSE

DCH agrees that some DMEPOS claims for beneficiaries residing in nursing facilities were paid inappropriately:

a. DCH agrees that, for some beneficiaries, DMEPOS claims were reimbursed prior to the beneficiaries' level of care being changed to the nursing facility level of care. DCH indicated that it will determine the feasibility of including DMEPOS claims affected by level of care changes in the established post payment recovery process. In addition, DCH informed us that it will identify the impacted claims and process recoveries.

b. DCH agrees that edits for some procedure codes were not set appropriately. DCH indicated that the majority of these codes were corrected in CHAMPS in July 2012; with the exception of one code which was nationally end dated in December 2009. In addition, DCH informed us that it will identify the impacted claims and process recoveries.

c. DCH agrees that it did not inform nursing facility providers which DMEPOS procedures codes are included in the nursing facility per diem rate. DCH informed us that it recognized the importance of this column to the nursing facility providers and, as noted in the finding, has reestablished the field in the database.

FINDING

4. Incontinence Supplies

DCH did not ensure proper payment for incontinence supplies. As a result, we identified $357,000 (approximately $104,000 General Fund/general purpose) in improper payments for incontinence supplies during the audit period.

Through a competitive bid process, the State of Michigan awarded a volume purchase contract for select incontinence supplies to receive bulk price discounts on items such as diapers, pull-ons, catheters, sanitary wipes, and underpads. DCH policy contained in the Medicaid Provider Manual requires that beneficiaries obtain select incontinence supplies from the volume purchase contractor.

Our review of incontinence supply claims paid during the audit period disclosed:

a. DCH did not ensure that select incontinence supplies were purchased through the DCH volume purchase contractor as required by its policy. Instead, the supplies were obtained from other incontinence supply providers, resulting in $141,000 (approximately $41,000 General Fund/general purpose) in payments in excess of the discounted price offered by the volume purchase contractor. DCH policy specifies that certain incontinence supplies, such as diapers, pull-ons, and underpads, must be obtained through the volume purchase contractor.

   DCH stated that it does not have an edit in CHAMPS to deny claims that are not billed in accordance with this policy.

b. DCH paid its volume purchase contractor for duplicate incontinence supply claims totaling $100,000 (approximately $29,000 General Fund/general purpose).

   As discussed in Finding 2, part c., providers must submit their NPI number on all claims in order to obtain reimbursement. Some organization healthcare providers may have more than one NPI number.

   DCH's volume purchase contractor for incontinence supplies had two separate NPI numbers. One of its NPI numbers was intended to be used for claims

billed under the incontinence supplies volume purchase contract. The other NPI number was intended to be used for services and supplies not covered under the contract. However, our review found that the volume purchase contractor submitted and DCH paid for identical claims, with the only difference on the claims being the volume purchase contractor's NPI numbers. DCH stated that these claims were paid because the NPI numbers were not the same on both claims and it did not have an automated edit to detect such instances.

c. DCH did not pay the bulk discount price to its volume purchase contractor for certain incontinence supplies resulting in $96,000 (approximately $28,000 General Fund/general purpose) in payments in excess of the available discounted price.

As mentioned in part a. of this finding, DCH's volume purchase contractor for incontinence supplies had two separate NPI numbers: one was intended to be used for claims billed under the incontinence supplies volume purchase contract and the other NPI number was intended to be used for services and supplies not covered under the contract. DCH did not have a process in place to ensure that incontinence supply items covered by the contract were billed under the NPI number associated with the contract and, as a result, DCH paid a higher, nondiscounted rate for the incontinence supplies.

d. DCH did not ensure that it granted required prior authorization for claims paid to its volume purchase contractor for $11,000 (approximately $3,000 General Fund/general purpose) of pediatric-sized diapers for beneficiaries over the age of 13.

DCH requires that a provider obtain prior authorization for certain DMEPOS items before the item is provided to the beneficiary or, in the case of custom-fabricated items, before the item is ordered. DCH's prior authorization process entails manual review of the request, including review of the medical necessity of the service or product.

DCH's volume purchase contract for incontinence supplies states that pediatric-sized diapers require prior authorization if the beneficiary is age 13 or over.

e. DCH did not ensure that it paid for incontinence supplies within monthly limits established in its policy, resulting in $9,000 (approximately $3,000 General Fund/general purpose) in improper payments.

   DCH policy and the volume purchase contract contain monthly limits for incontinence supplies.

   DCH stated that it has an edit in CHAMPS to deny claims in excess of established limits, but the edit was not active at the date the claims were paid.

RECOMMENDATION

We recommend that DCH ensure proper payment for incontinence supplies.

AGENCY PRELIMINARY RESPONSE

DCH agrees that some incontinence supplies were not reimbursed according to established Medicaid policy:

a. DCH agrees that some incontinence supplies were not purchased through the DCH volume purchase contractor. DCH stated that Medicaid Payments staff, along with Program Policy Division staff, will review existing policy and the volume purchase contract to clarify exceptions to the volume purchase contract. Upon clarification, DCH informed us that it will analyze the claims identified and determine if existing edits require modifications. In addition, DCH informed us that it will identify any inappropriate payments and present the analysis to management so that a resolution decision can be made.

b. DCH agrees that during the audit period the quantity edits were not working as intended. DCH indicated that a system change request to revise the quantity edits has been submitted; implementation is expected in summer 2013. Subsequent to implementation of the revisions, DCH informed us that it will identify the impacted claims and process recoveries.

c. DCH agrees that some incontinence supplies were not purchased through the DCH volume purchase contractor NPI. DCH stated that DCH Medicaid Payments staff, along with Program Policy Division staff, will review existing policy and the volume purchase contract to clarify exceptions to the volume

purchase contract. Upon clarification, DCH informed us that it will analyze the claims identified and determine if existing edits require modifications. In addition, DCH indicated that it will identify any inappropriate payments and present the analysis to management so that a resolution decision can be made.

d. DCH agrees that some incontinence supplies were purchased without prior authorizations. DCH stated that Medicaid Payments staff, along with Program Policy Division staff, will review existing policy to clarify requirements in the volume purchase contract. Upon clarification, DCH informed us that it will determine if existing edits require modifications. In addition, DCH indicated that it will identify any inappropriate payments and present the analysis to management so that a resolution decision can be made.

e. DCH agrees that, during the audit period, the quantity edits were not working as intended. DCH stated that modifications were made to existing edits and a change request to implement additional editing has been submitted and is scheduled for implementation in summer 2013. Subsequent to implementation of the revisions, DCH informed us that it will identify the impacted claims and process recoveries.

FINDING

5. Claims Paid for Beneficiaries Enrolled in a Medicaid Health Plan (MHP)

DCH did not ensure proper payment for DMEPOS for beneficiaries enrolled in an MHP. As a result, we identified $161,000 (approximately $47,000 General Fund/general purpose) in improper payments to DMEPOS providers during the audit period.

DCH pays MHPs a capitated amount, or rate, per month per eligible Medicaid beneficiary for the healthcare services that it provides to each enrolled Medicaid beneficiary regardless of the frequency, extent, or kind of services provided to each Medicaid beneficiary. DCH policy contained in the Medicaid Provider Manual states that DMEPOS must be covered by MHPs. Because DMEPOS must be covered by MHPs and reimbursement would be factored into the monthly capitated rate, DCH should not reimburse providers for DMEPOS items billed for beneficiaries enrolled in an MHP.

We compared DCH's DMEPOS paid claims data to beneficiary enrollment information and found that DCH paid DMEPOS providers $161,000 (approximately $47,000 General Fund/general purpose) on behalf of beneficiaries enrolled in an MHP at the date of service.

DCH had an edit in CHAMPS that was set to deny DMEPOS claims when the beneficiary was enrolled in an MHP at the date of service. However, when we presented DCH with our results, DCH stated that it suspected that CHAMPS allowed these claims to be paid because the beneficiary was not listed in CHAMPS as being enrolled in an MHP at the time the claim was paid. DCH suspects that, after the DMEPOS claim was paid, CHAMPS was updated to reflect that the beneficiary was, in fact, enrolled in an MHP at the date of service.

RECOMMENDATION

We recommend that DCH ensure proper payment for DMEPOS for beneficiaries enrolled in an MHP.

AGENCY PRELIMINARY RESPONSE

DCH agrees that the identified DMEPOS items should have been reimbursed to the providers by the MHP. However, DCH stated that these claims were paid because the beneficiaries had not yet been enrolled in the MHP at the time of reimbursement. DCH informed us that, in some instances, it retroactively enrolls a beneficiary into an MHP; this sometimes causes reimbursement for items under the fee-for-service arrangement in the interim until the beneficiary's MHP benefit is changed in CHAMPS.

DCH informed us that it will analyze the claims and determine the appropriate disposition. In addition, DCH indicated that it will determine the feasibility of including DMEPOS claims in the established MHP post payment recovery process.

PROCESS TO ESTABLISH RATES FOR DMEPOS

COMMENT

Audit Objective: To assess the effectiveness of DCH's process to establish rates consistent with applicable federal regulations, the Michigan Medicaid State Plan, and its policies for DMEPOS.

Audit Conclusion: We concluded that DCH's process to establish rates consistent with applicable federal regulations, the Michigan Medicaid State Plan, and its policies for DMEPOS was moderately effective. Our audit disclosed three reportable conditions related to Medicaid rates in excess of Medicare rates, policies and procedures, and payment rates for used DMEPOS (Findings 6 through 8).

FINDING

6. Medicaid Rates in Excess of Medicare Rates

DCH did not ensure that it established Medicaid rates for DMEPOS consistent with its policy. As a result, DCH paid DMEPOS providers $983,000 (approximately $289,000 General Fund/general purpose) in excess of Medicare rates during the audit period.

The Medicaid program is jointly administered by the federal government, through the Centers for Medicare and Medicaid Services (CMS), and the states. CMS also administers the Medicare program to serve the medical needs of the elderly. Annually, CMS prepares a fee schedule for DMEPOS provided under the Medicare program. DCH policy contained in the Medicaid Provider Manual states that Medicaid DMEPOS rates may not exceed those paid by Medicare. Also, its policy states that DCH will adjust its Medicaid fee schedule when Medicare rate changes result in noncompliance with this requirement.

Our review disclosed that DCH's Medicaid DMEPOS rate exceeded Medicare's rate for two DMEPOS procedure codes. We determined that DCH paid providers $983,000 (approximately $289,000 General Fund/general purpose) in excess of Medicare's rate for 13,749 individual claims on behalf of 2,362 beneficiaries during the audit period. Of the total $983,000 in excessive payments, $885,000 (90%) (approximately $260,000 General Fund/general purpose) related to a single procedure code for children's medical tubing.

DCH stated that its Medicaid rate exceeded Medicare's rate for the children's medical tubing procedure code to help ensure proper medical treatment of youth Medicaid beneficiaries. The Medicare reimbursement rate was approximately $87 less for the medical tubing than the Medicaid rate. DCH indicated that it was concerned that suppliers would not continue to provide the medical tubing at the lower cost. DCH was unable to get CMS to increase the Medicare rate for the medical tubing. Instead, CMS informed DCH that Medicaid rates are set by the states and, when a state has policies that require Medicaid reimbursement to be linked to Medicare reimbursement, it is up to the states to modify their policies if the states want to change their reimbursement policies for items such as the children's medical tubing. DCH did not revise its policy.

RECOMMENDATION

We recommend that DCH ensure that it establishes Medicaid rates for DMEPOS consistent with its policy.

AGENCY PRELIMINARY RESPONSE

DCH agrees that Medicaid rates should be established for DMEPOS consistent with policy. However, DCH indicated that, in some instances, it grants exceptions to the Medicaid rate if it believes that a patient's access to care would be impeded. DCH stated that these exceptions require prior authorization and are closely monitored.

DCH indicated that it reviews DMEPOS rates on an annual basis and provides recommendations to decrease any rates that exceed Medicare reimbursement. However, DCH stated that exceptions to reimbursement will continue to occur so that DCH can ensure that beneficiaries are provided the appropriate care. DCH informed us that it is reviewing current Medicaid Provider Manual language to determine if this exception process needs to be more clearly defined in existing policy.

FINDING

7. Policies and Procedures

DCH did not have written internal policies and procedures for establishing and periodically evaluating DMEPOS covered services and associated payment rates.

As a result, DCH was unable to provide documentation supporting how the existing Medicaid DMEPOS payment rates were established and when DCH last updated or reviewed the payment rates.

Written policies and procedures help ensure that employees have detailed knowledge of their responsibilities and serve as a basis to ensure that employees consistently and properly conduct program operations.

The Michigan Medicaid State Plan states that payment rates for medical supplies are established as a fee screen, which is the maximum amount that Medicaid will pay for the good or service. The Michigan Medicaid State Plan further states that DCH will use the Medicare prevailing fees, the resource-based relative value scale and other relative value information, and other states' Medicaid fee screens and providers' charges as guidelines or reference in determining the maximum fee screens for individual items.

DCH did not develop written policies and procedures to indicate the frequency, timing, actions, approval process, documentation requirements, and other considerations necessary for establishing and periodically evaluating DMEPOS covered services and payment rates.

RECOMMENDATION

We recommend that DCH develop written internal policies and procedures for establishing and periodically evaluating DMEPOS covered services and associated payment rates.

AGENCY PRELIMINARY RESPONSE

DCH agrees that written internal policies and procedures have not been developed and that existing division practices need to be formalized.

DCH indicated that Medicaid rates are developed based upon several methods established in the State Plan, the Medicaid Provider Manual, Policy bulletins, and legislative and administrative directives. DCH stated that databases are published for providers to use as a reference tool only. DCH indicated that providers are instructed that the written policy supersedes any information published in the

provider database. DCH informed us that Program Policy Division staff are formalizing existing practices for incorporation into a DMEPOS policies and procedures manual.

FINDING

8. Payment Rates for Used DMEPOS

DCH should consider establishing reduced payment rates for used durable medical equipment* (DME). Establishing reduced payment rates would result in savings to the State and federal government. We estimate that DCH could have saved at least $14,000 (approximately $4,000 General Fund/general purpose) and at most $1,600,000 (approximately $470,000 General Fund/general purpose) during the audit period if it had developed used payment rates for DME items.

DME items can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and can be used in the beneficiary's home. Generally, DME will be purchased when a beneficiary requires the equipment for an extended period of time. If DME items are purchased, DCH's policy contained in the Medicaid Provider Manual requires that the provider indicate whether the DME item provided is new or used, as appropriate. Providers make this indication by submitting an indicator field on its claims; a "UE" indicator denotes a used item and a "NU" indicator denotes a new item.

Our review disclosed that DCH had not developed reduced payment rates for used DME items, although it requires providers to indicate whether the DME item is new or used when it submits DME claims. Instead, DCH pays providers the same fee screen amount regardless of whether the item is new or used.

Our research showed that CMS has developed reduced payment rates for used DME items for the Medicare program. CMS's payment rates for used DME items are, on average, 25% less than the price of new items. Also, our research showed a number of other states' Medicaid programs had developed reduced payment rates for used DME items. Our review of three other states' payment rates showed

* *See glossary at end of report for definition.*

that payment rates for used DME items ranged from 25% to 50% less than the price of new items. Further, our review showed:

a. DCH reimbursed DMEPOS providers a total of $57,000 (approximately $17,000 General Fund/general purpose) during the audit period for DME items that providers indicated were used. Assuming a 25% reduced payment rate for used DME items (based on Medicare reduced payment rates for used DME items), we estimate that DCH could have saved $14,000 (approximately $4,000 General Fund/general purpose) if it had developed and applied used payment rates.

b. DCH reimbursed DMEPOS providers $6,497,000 (approximately $1,900,000 General Fund/general purpose) during the audit period for claims relating to 293 procedure codes that could involve used equipment. We estimated that DCH could have developed used payment rates for these 293 DME procedure codes, based on our comparison of DCH procedure codes to Medicare procedure codes for which Medicare had established used payment rates. However, because providers did not indicate whether the DME item was new or used, it was not possible to determine the portion of the $6,497,000 (approximately $1,900,000 General Fund/general purpose) that could have been for used DME items and, therefore, could have been paid at a reduced rate. Assuming a 25% reduced payment rate for used DME items (based on Medicare reduced payment rates for used DME), if 100% of these claims were for used DME items, we estimate that DCH could have saved at most $1,600,000 (approximately $470,000 General Fund/general purpose).

RECOMMENDATION

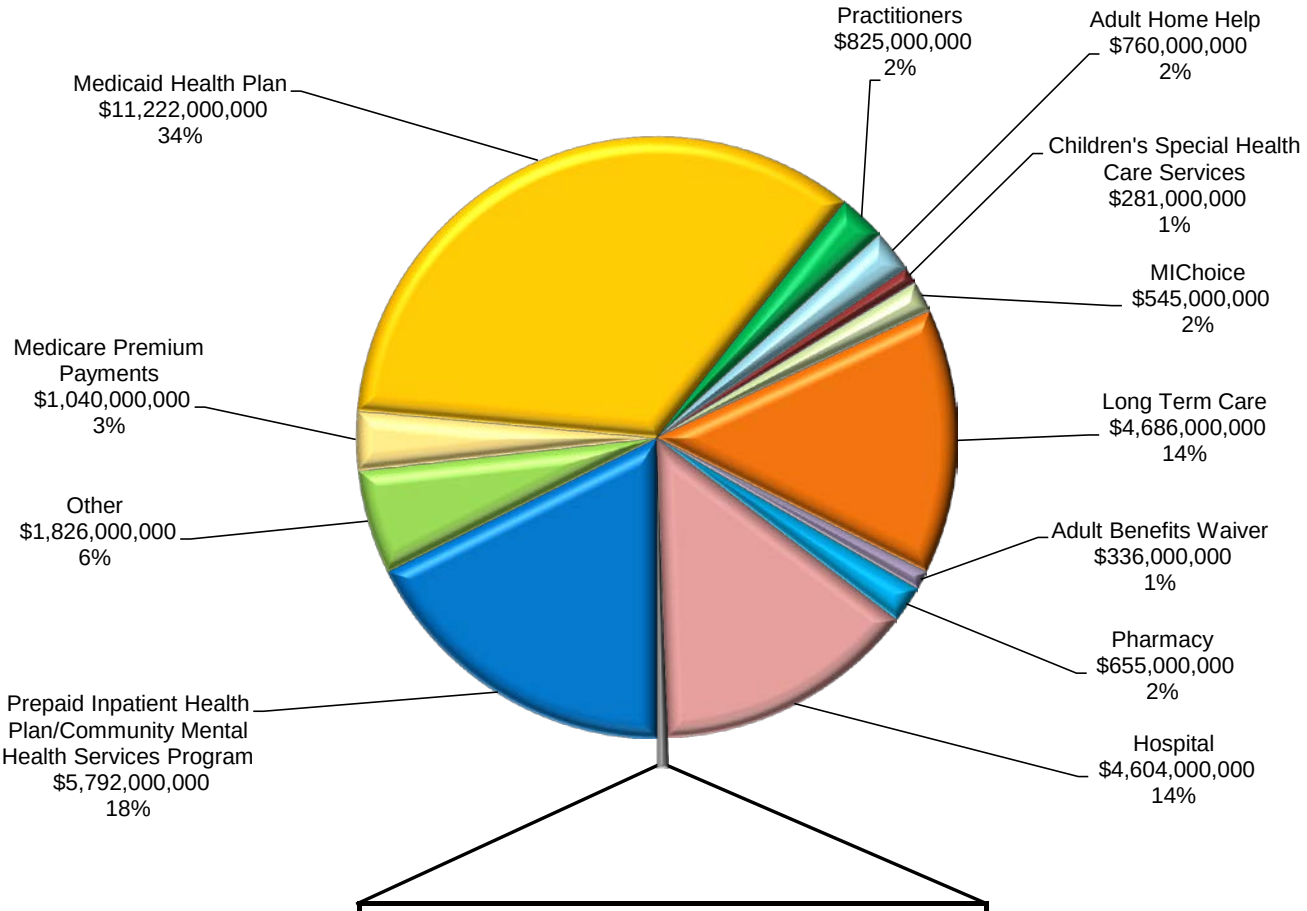
We recommend that DCH consider establishing reduced payment rates for used DME.

AGENCY PRELIMINARY RESPONSE

DCH agrees to consider establishing reduced payment rates for used DME. DCH stated that Medicaid policy does not allow for reduced payment rates for used DME. However, DCH informed us that its staff will examine the finding further and determine the overall cost benefit.

SUPPLEMENTAL INFORMATION

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)
Department of Community Health (DCH)
Medicaid Expenditures and DMEPOS Expenditures by Category
October 1, 2009 Through June 30, 2012



Durable Medical Equipment, Prosthetics, Orthotics, and Supplies			
Durable medical equipment	$	53,400,000	30%
Incontinence supplies		47,300,000	26%
Medical supplies		27,400,000	15%
Enteral and parenteral nutrition		27,300,000	15%
Prosthetics and orthotics		11,600,000	6%
Wheelchairs		6,600,000	4%
Infusion therapy		6,000,000	3%
Other		2,000,000	1%
Total	**$**	**181,600,000**	**1%**

Source: Prepared by the Office of the Auditor General using data from the State's accounting system and DCH.

GLOSSARY

Glossary of Acronyms and Terms

CHAMPS	Community Health Automated Medicaid Processing System.
CMS	Centers for Medicare and Medicaid Services.
DCH	Department of Community Health.
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies.
dually enrolled beneficiaries	Individuals who are concurrently enrolled in both Medicare and Medicaid.
durable medical equipment (DME)	Those items that are U.S. Food and Drug Administration approved, can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and can be used in the beneficiaries' homes. Examples include hospital beds, wheelchairs, and ventilators.
effectiveness	Success in achieving mission and goals.
enteral nutrition	Nutrition administered by tube or orally into the gastrointestinal tract.
FMAP	federal medical assistance percentage.
improper payment	Any paid claim that was not in compliance with selected DCH policies for DMEPOS.
incontinence supplies	Items used to assist individuals with the inability to control excretory functions, such as diapers, pull-ons, catheters, sanitary wipes, and underpads.

Medicaid Provider Manual	The manual maintained by DCH that contains coverage, billing, and reimbursement policies for Michigan's Medicaid program.
medical supplies	Those items that are required for medical management of the beneficiaries, are disposable or have a limited life expectancy, and can be used in the beneficiaries' homes. Examples include hypodermic syringes and needles, ostomy supplies, and dressings necessary for the medical management of the beneficiaries.
MHP	Medicaid Health Plan.
Michigan Medicaid State Plan	A document that defines how Michigan will operate its Medicaid program. The Michigan Medicaid State Plan addresses the areas of State program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement and is approved by the CMS.
NPI	National Provider Identifier.
orthotic	Devices used to assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body.
ostomy supplies	Products necessary to maintain and care for a temporary or permanent stoma and include, but are not limited to, belts, barriers, adhesive remover, filters, and pouches. A stoma is an opening from either the digestive system or urinary system.
parenteral nutrition	Nutrition provided intravenously.
performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance

	and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.
prior authorization	The process by which a medical professional performs a manual review of a provider's request, including review of the medical necessity of the service or product. Providers request prior authorization for services that exceed quantity limits or established fee screens, for medical need for an item beyond DCH's standards of coverage, and for select procedure codes. DCH requires that a provider obtain prior authorization for certain DMEPOS items before the item is provided to the beneficiary or, in the case of custom-fabricated items, before the item is ordered.
prosthetic	Devices used to artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the audit objectives; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.
resource-based relative value scale	A scale of national uniform relative values for all physicians' services. The relative value of each service must be the sum of relative value units representing physicians' work, practice expenses net of malpractice expenses, and the cost of professional liability insurance.

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