MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF

MEDICAID PRACTITIONER FEE-FOR-SERVICE REIMBURSEMENT

DEPARTMENT OF COMMUNITY HEALTH

December 2013

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

391-0713-13

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
Medicaid Practitioner Fee-for-Service Reimbursement
Department of Community Health

Report Number:
391-0713-13

Released:
December 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 practitioner services. The Department of Community Health (DCH) is responsible for processing payment of Medicaid practitioner fee-for-service claims through its electronic claims processing system.

Audit Objective:

To assess the effectiveness of DCH's efforts to ensure proper payment of Medicaid practitioner fee-for-service claims as defined by selected DCH policies.

Audit Conclusion:

We concluded that DCH's efforts to ensure proper payment of Medicaid practitioner fee-for-service claims as defined by selected DCH policies were effective. However, we identified known improper practitioner fee-for-service payments of $1,456,000 ($465,000 General Fund/general purpose) and related improper capitated payments of $26,000 to $36,000 ($8,000 to $11,000 General Fund/general purpose). We noted five reportable conditions (Findings 1 through 5).

Reportable Conditions:

DCH did not have an edit in place in the Community Health Automated Medicaid Processing System (CHAMPS) to ensure proper payment of global services, physician administered injectable drugs and biologicals, and technical services based on place of service. As a result, DCH issued $978,000 (approximately $312,000 General Fund/general purpose) in improper payments during the audit period to providers for services provided to 8,657 beneficiaries at a facility place of service (Finding 1).

DCH had not properly established a control to ensure denial or recovery of practitioner fee-for-service claims for beneficiaries enrolled in a Medicaid Health Plan (MHP). As a result, DCH improperly paid $234,000 (approximately $75,000 General Fund/general purpose) to providers during the audit period for claims on behalf of 1,425 beneficiaries enrolled in an MHP at the date of service (Finding 2).

DCH had not properly established the incoming claim adjustment reason codes within an edit in CHAMPS to ensure proper denial of claims. As a result, DCH issued $116,000 (approximately $37,000 General Fund/general purpose) in payments during the audit period to

providers for claims that should have been denied by the CHAMPS incoming claim adjustment reason codes edit for services to 1,697 beneficiaries (Finding 3).

DCH did not prevent, detect, or recover duplicate practitioner payments. As a result, DCH issued $101,000 (approximately $32,000 General Fund/general purpose) in improper duplicate payments during the audit period to providers for practitioner services provided to 2,150 beneficiaries (Finding 4).

DCH's internal control did not prevent or detect payments made on behalf of beneficiaries that were assigned more than one Medicaid identification number. As a result, DCH issued $32,000 (approximately $10,000 General Fund/general purpose) in improper practitioner fee-for-service payments to providers during the audit period for claims on behalf of 118 beneficiaries with more than one Medicaid identification number. In addition, for 28 of the identified 118 beneficiaries for whom improper practitioner fee-for-service payments were made, we also determined that DCH issued multiple monthly capitated payments to MHPs for the same beneficiary totaling $26,000 to $36,000 (approximately $8,000 to $11,000 General Fund/general purpose) (Finding 5).

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Agency Response:

Our audit report contains 5 findings and 5 corresponding recommendations. DCH's preliminary response indicates that it agrees with all of the 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

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

December 18, 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 Medicaid Practitioner Fee-for-Service Reimbursement, Department of Community Health.

This report contains our report summary; a description; our audit objective, scope, and methodology and agency responses; comment, findings, recommendations, and agency preliminary responses; two exhibits, presented as supplemental information; and a glossary of abbreviations and terms.

The agency preliminary responses were taken from the agency's response at the end of 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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MEDICAID PRACTITIONER FEE-FOR-SERVICE REIMBURSEMENT
DEPARTMENT OF COMMUNITY HEALTH

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 practitioner services. DCH established practitioner billing, reimbursement, and coverage policy in its Medicaid Provider Manual*, which defines practitioner services as services provided by physicians, oral-maxillofacial surgeons, doctors of podiatric medicine, medical clinics, physical therapists, certified nurse-midwives, certified registered nurse anesthetists, anesthesiologist assistants, and nurse practitioners. DCH reimburses practitioners for services such as office visits, emergency department visits, and physician administered injectable drugs and biologicals. DCH processed payments totaling $397.8 million ($127.0 million General Fund/general purpose) for practitioner fee-for-service claims during the period October 1, 2010 through June 30, 2013 (see supplemental information).

DCH is responsible for processing payment of Medicaid practitioner fee-for-service claims through its electronic claims processing system called the Community Health Automated Medicaid Processing System (CHAMPS). Providers submit electronic claims and paper claims, which are converted to electronic format, for processing.

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

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.

Audit Objective

The objective of our performance audit* of Medicaid Practitioner Fee-for-Service Reimbursement, Department of Community Health (DCH), was to assess the effectiveness* of DCH's efforts to ensure proper payment of Medicaid practitioner fee-for-service claims as defined by selected DCH policies.

Audit Scope

Our audit scope was to examine the program records, electronic paid claim data, and other records related to Medicaid practitioner fee-for-service claims. 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 conclusion based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusion based on our audit objective. Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered the period October 1, 2010 through June 30, 2013.

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 State of Michigan Single Audit (000-0100-13) included verification of Medicaid eligibility within its scope and was issued in June 2013.

In our analysis of practitioner paid claim data, we excluded any practitioner paid claims that were granted prior authorization* by DCH. DCH requires that a provider obtain prior authorization for certain practitioner services before the service is provided to the beneficiary. Prior authorization is required for certain procedure codes, procedures that are normally noncovered but may be medically necessary, and referrals for elective services by out-of-State nonenrolled providers. DCH's prior authorization process entails manual review of the request by a medical professional, including review of medical necessity of the service. We excluded practitioner paid claim data with prior

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

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 $397.8 million ($127.0 million General Fund/general purpose) for practitioner fee-for-service claims, of which $5.6 million (1.4%) ($1.8 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 objective. 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 practitioner fee-for-service claims to gain an understanding of its operations and to plan our audit. This included interviewing DCH management personnel; reviewing applicable laws, regulations, 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 practitioner fee-for-service paid claim data.

To accomplish our objective, we performed various analyses of practitioner fee-for-service claims paid during the period October 1, 2010 through June 30, 2013. Our analyses were developed based on our understanding of limitations, restrictions, and other requirements imposed on practitioner claims by the Michigan Medicaid State Plan, the Medicaid Provider Manual, and other federal or State laws and regulations. We also identified other overpayment risks through research of federal and other state audits of practitioner claims and developed data analysis techniques to determine if similar overpayments occurred. Our review was limited to selected DCH policies for practitioner fee-for-service services, including policies regarding:

- Community Health Automated Medicaid Processing System (CHAMPS) rate type category assignment.

- Payment of duplicate practitioner fee-for-service claims submitted for dually enrolled* (Medicare and Medicaid) beneficiaries.

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

- Payment of duplicate practitioner fee-for-service claims based on a match of 16 claim elements.

- Payment of duplicate practitioner fee-for-service claims to individual and group providers.

- Payment of practitioner fee-for-service claims for gender specific services.

- An incoming claim adjustment reason codes edit.

- Medically unlikely edits.

- Payment of practitioner fee-for-service claims after established procedure code end dates.

- Payment of practitioner fee-for-service claims for one frequency limit.

- Payment of practitioner fee-for-service claims after recorded CHAMPS date of death.

- Payment of practitioner fee-for-service claims and related capitated payments for beneficiaries with multiple Medicaid identified numbers.

- Payment of practitioner fee-for-service claims for beneficiaries enrolled in a Medicaid Health Plan or residing in a nursing facility.

- Payment of practitioner fee-for-service claims within established dosage limitations for long-acting risperidone.

- Professional, technical, and global component service place of service edits.

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 improvement can be made. Consequently, we prepare our performance audit reports on an exception basis.

Agency Responses

Our audit report contains 5 findings and 5 corresponding recommendations. DCH's preliminary response indicates that it agrees with all of the recommendations.

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

COMMENT, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

PROPER PAYMENT FOR PRACTITIONER SERVICES

COMMENT

Background: The Department of Community Health (DCH) processed payments totaling $397.8 million ($127.0 million General Fund/general purpose) for practitioner fee-for-service claims during the period October 1, 2010 through June 30, 2013 (see supplemental information). We performed various analyses of these claims. Our analyses were developed based on our understanding of limitations, restrictions, and other requirements imposed on practitioner fee-for-service claims by the Michigan Medicaid State Plan, the Medicaid Provider Manual, and other federal or State laws and regulations.

Our review was limited to selected DCH policies for practitioner fee-for-service services, including policies regarding:

- Community Health Automated Medicaid Processing System (CHAMPS) rate type category assignment.

- Payment of duplicate practitioner fee-for-service claims submitted for dually enrolled (Medicare and Medicaid) beneficiaries.

- Payment of duplicate practitioner fee-for-service claims based on a match of 16 claim elements.

- Payment of duplicate practitioner fee-for-service claims to individual and group providers.

- Payment of practitioner fee-for-service claims for gender specific services.

- An incoming claim adjustment reason codes edit.

- Medically unlikely edits.

- Payment of practitioner fee-for-service claims after established procedure code end dates.

- Payment of practitioner fee-for-service claims for one frequency limit.

- Payment of practitioner fee-for-service claims after recorded CHAMPS date of death.

- Payment of practitioner fee-for-service claims and related capitated payments for beneficiaries with multiple Medicaid identified numbers.

- Payment of practitioner fee-for-service claims for beneficiaries enrolled in a Medicaid Health Plan (MHP) or residing in a nursing facility.

- Payment of practitioner fee-for-service claims within established dosage limitations for long-acting risperidone.

- Professional, technical, and global component service place of service edits.

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

Audit Objective: To assess the effectiveness of DCH's efforts to ensure proper payment of Medicaid practitioner fee-for-service claims as defined by selected DCH policies.

Audit Conclusion: We concluded that DCH's efforts to ensure proper payment of Medicaid practitioner fee-for-service claims as defined as selected DCH policies were effective.

Our audit conclusion was based on our audit efforts as described in the audit scope and audit methodology sections and the resulting reportable conditions* noted in the comment, findings, recommendations, and agency preliminary responses section.

We noted five reportable conditions in 5 of the 14 selected policy areas reviewed. In our professional judgment, these matters were less severe than a material condition* but still represented opportunities for improvement in DCH's internal control over proper Medicaid practitioner fee-for-service payments. The five reportable conditions related to

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

place of service edit, claims paid for beneficiaries enrolled in an MHP, incoming claim adjustment reason codes, duplicate payments, and multiple Medicaid identification numbers (Findings 1 through 5).

We applied our audit procedures via queries to the entire population of practitioner fee-for-service payments processed during our audit period, which totaled $397.8 million ($127.0 million General Fund/general purpose). We concluded that the identified improper practitioner fee-for-service payments totaling $1,456,000 ($465,000 General Fund/general purpose) (0.4%) represent total known improper payments for the selected policy areas. Also, we noted improper capitated payments related to fee-for-service beneficiaries of $26,000 to $36,000 ($8,000 to $11,000 General Fund/general purpose). In addition, we evaluated qualitative factors, such as the lack of known instances of fraud, beneficiary safety and access to medical care, and public perception of the program, and nothing came to our attention that would have a significant impact on our conclusion.

In reaching our conclusion, we considered the five reportable conditions that related to 5 of the 14 policy areas subject to audit, the known improper payments of less than 1% of total practitioner fee-for-service payments, and the absence of other significant qualitative factors. We believe that the results of our audit efforts provide a reasonable basis for our audit conclusion for this audit objective.

FINDING

1. Place of Service Edit

   DCH did not have an edit in place in CHAMPS to ensure proper payment of global services, physician administered injectable drugs and biologicals, and technical services based on place of service.

   DCH issued $978,000 (approximately $312,000 General Fund/general purpose) in improper payments during the audit period to providers for services provided to 8,657 beneficiaries at a facility place of service.

   Some services are divided into a professional component and a technical component for coverage purposes. A global service includes both the technical resources necessary to perform the procedure, such as office overhead, equipment, supplies, and staff, and the professional services provided by the physician, such as interpretation of results and preparation of a report of findings.

DCH's Medicaid Provider Manual states that Medicaid covers practitioner global services and technical services in a non-facility place of service, such as a physician's office, rather than a facility place of service, such as a hospital. Also, DCH's Medicaid Provider Manual states that Medicaid covers injectable drugs and biologicals administered by a physician in a non-facility place of service, rather than a facility place.

DCH stated that a place of service edit was not in place, but that it is currently developing the edit.

RECOMMENDATION

We recommend that DCH implement an edit in CHAMPS to ensure proper payment of global services, physician administered injectable drugs and biologicals, and technical services based on place of service.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not have an edit in place in CHAMPS to ensure proper payment of global services, physician administered injectable drugs and biologicals, and technical services based on place of service. DCH informed us that an edit has been developed for the purpose of place of service editing; however, the disposition of this edit is currently set to "informational" as DCH works to ensure that it is functioning consistent with policy and is compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements. In order to fully implement place of service editing, DCH indicated that it has begun the extensive process of associating places of service with each procedure code in the CHAMPS Reference File which will be necessary to correctly adjudicate claims. Subsequent to full implementation of place of service editing, DCH indicated that it will investigate the feasibility of recovering the payments identified.

FINDING

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

DCH had not properly established a control to ensure denial or recovery of practitioner fee-for-service claims for beneficiaries enrolled in an MHP.

DCH improperly paid $234,000 (approximately $75,000 General Fund/general purpose) to providers during the audit period for fee-for-service claims on behalf of 1,425 beneficiaries enrolled in an MHP at the date of service.

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. DCH's Medicaid Provider Manual states that practitioner services must be covered by MHPs. Because practitioner services must be covered by MHPs and reimbursement would be factored into the monthly capitated rate, DCH should not reimburse providers for practitioner services billed for beneficiaries enrolled in an MHP.

DCH stated 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 stated that, after the 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 properly establish a control to ensure denial or recovery of practitioner fee-for-service claims for beneficiaries enrolled in an MHP.

AGENCY PRELIMINARY RESPONSE

DCH agrees that its controls did not ensure denial of all applicable practitioner fee-for-service claims for beneficiaries in an MHP. DCH informed us that it will investigate the feasibility of recovering the remaining payments identified and, if appropriate, including them in the post payment recovery process.

In addition, subsequent to the Office of the Auditor General's data extraction for this audit, DCH indicated that it processed claim voids that affected $44,634 of the claims noted in the finding.

FINDING

3. Incoming Claim Adjustment Reason Codes

DCH had not properly established the incoming claim adjustment reason codes within an edit in CHAMPS to ensure proper denial of claims.

DCH issued $116,000 (approximately $37,000 General Fund/general purpose) in payments during the audit period to providers for claims that should have been denied by the CHAMPS incoming claim adjustment reason codes edit for services to 1,697 beneficiaries.

Federal regulations require that all identifiable financial resources (e.g., Medicare, insurance plan or carrier, and commercial carrier) be utilized prior to expenditure of Medicaid funds. DCH's Medicaid Provider Manual also states that Medicaid providers must utilize other payment sources to their fullest extent prior to filing a claim with DCH. Medicaid is not liable for payment of services denied because coverage rules of the primary health insurance were not followed.

Other insurer assigned claim adjustment reason codes are submitted on the Medicaid claim to DCH and are considered by DCH in determining Medicaid's liability for the claim. When a claim has certain other insurer assigned claim adjustment reason codes, DCH will deny the claim line because the other insurer assigned claim adjustment reason code indicates that the provider did not meet the primary health insurer's coverage rules.

DCH stated that, in September 2011, it implemented a CHAMPS system enhancement. After the system enhancement, the start and end dates related to certain claim adjustment reason codes were not being properly captured, causing DCH's edit to improperly approve payment.

RECOMMENDATION

We recommend that DCH properly establish the incoming claim adjustment reason codes within the edit in CHAMPS to ensure proper denial of claims.

AGENCY PRELIMINARY RESPONSE

DCH agrees that start and end dates related to certain claim adjustment reason codes (CARC) were not being properly captured, causing a DCH claim edit to improperly approve payment.

DCH informed us that it created a CHAMPS system enhancement in September 2011 to resolve the issue removing the claim adjustment reason codes from the CHAMPS hard-coded logic and creating a Claim Processing Editing Group within

CHAMPS to allow DCH to maintain and control the claim adjustment reason codes. DCH indicated that this allows it to ensure the claim adjustment reason codes within the edit parameters are denying claim lines appropriately. DCH also indicated that it has identified the associated improper payments on the claim lines noted and will process claim adjustments for recoupments.

FINDING

4. Duplicate Payments

DCH did not prevent, detect, or recover duplicate practitioner payments.

DCH issued $101,000 (approximately $32,000 General Fund/general purpose) in improper duplicate payments during the audit period to providers for practitioner services provided to 2,150 beneficiaries. The identified duplicate claims matched on 16 claim elements, including billing provider, rendering provider, beneficiary, procedure code, diagnosis codes, service date(s), and place of service.

DCH's Medicaid Provider Manual states that claims processed through CHAMPS are edited for many parameters, including claim duplication.

DCH stated that its CHAMPS edit failed to work as intended in certain duplicate claim scenarios. For example, DCH stated that its duplicate editing electronic grids have proven to be more restrictive than DCH had intended, causing some duplicate claims to go undetected. In other scenarios, the CHAMPS edit was not set up to identify the duplicate claims scenarios.

RECOMMENDATION

We recommend that DCH prevent, detect, and recover duplicate practitioner payments.

AGENCY PRELIMINARY RESPONSE

DCH agrees that some improper duplicate payments were issued to providers for practitioner services. DCH indicated that CHAMPS performs duplicate claim checks; however, defects in the editing prevented appropriate denials in some cases. DCH also indicated that deficiencies in existing edits were resolved and that more efficiencies were identified and are currently being pursued to prevent

and detect future duplicate payments. In addition, DCH indicated that it is investigating the feasibility of recovering the duplicate payments identified in the audit.

FINDING

5. Multiple Medicaid Identification Numbers

DCH's internal control did not prevent or detect payments made on behalf of beneficiaries that were assigned more than one Medicaid identification number.

DCH issued $32,000 (approximately $10,000 General Fund/general purpose) in improper practitioner fee-for-service payments to providers during the audit period for claims on behalf of 118 beneficiaries with more than one Medicaid identification number. In these instances, DCH had already made a monthly capitated payment to an MHP under one of the beneficiaries' Medicaid identification numbers, but continued to pay practitioner fee-for-service claims under the beneficiary's other Medicaid identification number(s).

For 28 of the identified 118 beneficiaries for whom improper practitioner fee-for-service payments were made, we also determined that DCH issued multiple monthly capitated payments to MHPs for the same beneficiary totaling $26,000 to $36,000 (approximately $8,000 to $11,000 General Fund/general purpose). For example, DCH made MHP capitated payments to the two different MHPs for 8 consecutive months for one beneficiary under two different Medicaid identification numbers totaling $6,000 and $6,000, respectively, in addition to improper practitioner fee-for-service payments.

Once an applicant's Medicaid eligibility is established, the Bridges Integrated Automated Eligibility Determination System* (Bridges) application assigns a Medicaid identification number to uniquely identify the beneficiary within Medicaid. We identified instances in which more than one Medicaid identification number was associated with the same social security number, resulting in multiple payments for the same beneficiary.

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

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. DCH's Medicaid Provider Manual states that practitioner services must be covered by MHPs. Because practitioner services must be covered by MHPs and reimbursement would be factored into the monthly capitated rate, DCH should not reimburse providers for practitioner services billed for beneficiaries enrolled in an MHP.

DCH stated that it has a daily automated edit in CHAMPS to identify possible duplicate Medicaid identification numbers on the incoming Bridges eligibility file; however, the edit criteria has not been reviewed for adequacy since CHAMPS's implementation.

RECOMMENDATION

We recommend that DCH implement internal control to prevent and detect payments made on behalf of beneficiaries that were assigned more than one Medicaid identification number.

AGENCY PRELIMINARY RESPONSE

DCH agrees that its internal control did not prevent or detect payments made on behalf of beneficiaries assigned more than one Medicaid identification number.

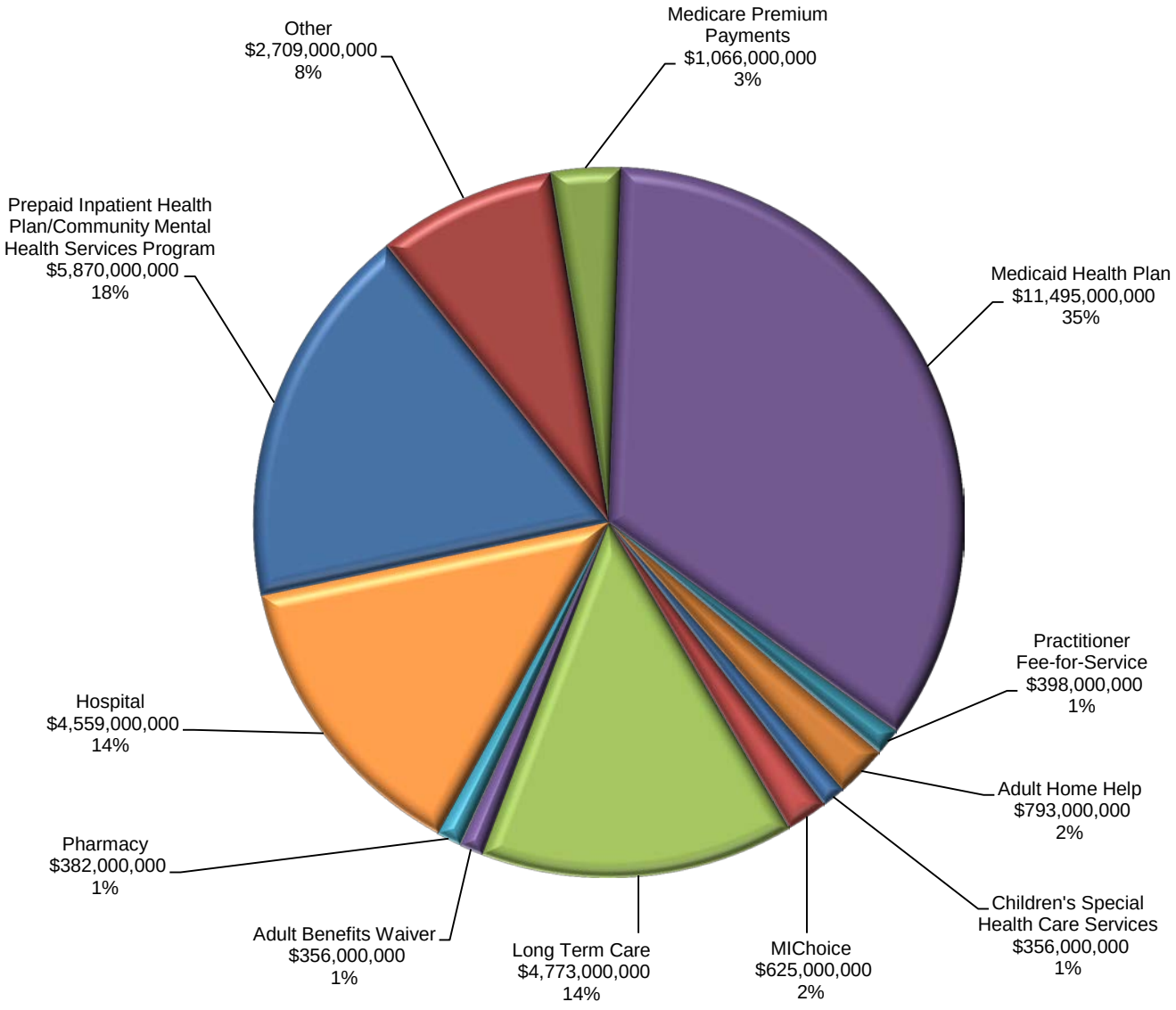
DCH informed us that it will work with DHS on all remaining duplicates identified in the finding to identify where the error occurred and correct the eligibility record. In addition, DCH indicated that it will review existing CHAMPS edit criteria and determine if any changes in the criteria are warranted.

DCH also informed us that, in March 2013, DHS implemented additional monitoring procedures to identify and correct duplicate records.

SUPPLEMENTAL INFORMATION

MEDICAID PRACTITIONER FEE-FOR-SERVICE REIMBURSEMENT
Department of Community Health (DCH)

Medicaid Expenditures by Category
October 1, 2010 Through June 30, 2013



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

MEDICAID PRACTITIONER FEE-FOR-SERVICE REIMBURSEMENT
Department of Community Health

Practitioner Fee-for-Service Expenditures by Service Type
October 1, 2010 Through June 30, 2013

Practitioner Service Type	Total Expenditures
Evaluation and management	$ 190,751,524
Drugs administered other than oral method	56,595,657
Radiology	36,121,286
Medicine	28,534,226
Maternity care/delivery	17,997,409
Anesthesia	12,766,257
Musculoskeletal system	9,117,448
Digestive	8,448,553
Cardiovascular system	6,598,227
Integumentary system	6,054,817
Pathology and laboratory	5,119,218
Nervous system	5,036,847
Other	3,251,724
Female genital system	2,743,781
Respiratory system	2,233,630
Eye and ocular adnexa	1,937,400
Urinary system	1,826,580
Male genital system	1,073,353
Auditory system	704,607
Hemic/Lymphatic	463,586
Endocrine system	166,526
Mediastinum	152,178
Operating microscope	62,699
Grand total	$ 397,757,532

Source: Prepared by the Office of the Auditor General using practitioner fee-for-service paid claim data from the Community Health Automated Medicaid Processing System (CHAMPS).

GLOSSARY

Glossary of Abbreviations and Terms

Bridges Integrated Automated Eligibility Determination System (Bridges)	An automated, integrated service delivery system for Michigan's cash assistance, medical assistance, food assistance, child care assistance, and emergency assistance programs.
CHAMPS	Community Health Automated Medicaid Processing System.
CMS	Centers for Medicare and Medicaid Services.
DCH	Department of Community Health.
dually enrolled beneficiaries	Individuals who are concurrently enrolled in both Medicare and Medicaid.
effectiveness	Success in achieving mission and goals.
FMAP	federal medical assistance percentage.
improper payment	Any paid claim that was not in compliance with selected DCH policies for practitioner services.
material condition	A matter that, in the auditor's judgment, is more severe than a reportable condition and could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.
Medicaid Provider Manual	The manual maintained by DCH that contains coverage, billing, and reimbursement policies for Michigan's Medicaid program.
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.
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. Prior authorization is required for certain procedure codes, procedures that are normally noncovered but may be medically necessary, and referrals for elective services by out-of-State nonenrolled providers. DCH requires that a provider obtain prior authorization for certain practitioner services before that service is provided to the beneficiary.
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.

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