

STATE OF CONNECTICUT

September 13, 2001

**PERFORMANCE AUDIT
DEPARTMENT OF SOCIAL SERVICES
PROVIDER DOCUMENTATION
FOR THE FISCAL YEAR ENDED JUNE 30, 1999**

**AUDITORS OF PUBLIC ACCOUNTS
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EXECUTIVE SUMMARY

In accordance with the provisions of Section 2-90 of the Connecticut General Statutes, we have conducted a performance audit of provider documentation of home health providers and medical equipment, devices and supply (MEDS) providers providing goods and services in the Medicaid program. The conditions found and our recommendations are summarized below.

Practitioner Orders

For each item or service billed to the Medicaid program, MEDS providers must obtain a written order from a licensed practitioner. The provider must keep the practitioner's original prescription on file. The order should be sufficiently detailed to describe the goods or services required and include appropriate information on the diagnosis, quantity used, frequency of change and duration of need, if applicable.

Our audit identified numerous instances of old, missing, unoriginal or incomplete prescriptions on file with MEDS providers. We also noted that prescriptions for certain goods and services were routinely never written.

The Department should issue a policy transmittal to providers reiterating the need to have current and detailed prescriptions on file in support of goods and services rendered. The policy transmittal should emphasize the minimum elements required in a prescription. In addition, the Department should review its medical service policy to determine whether all goods and services should require a written order.

Evidence of Receipt for Goods and Services Rendered

Providers rendering goods and services are required to maintain fiscal and medical records that fully disclose services and goods rendered and/or delivered to clients. Medical service policy for MEDS providers do not prescribe the form in which providers must document receipt of goods by the recipient with the exception of delivered items. Thus, we determined that a recipient's signature evidencing receipt of a good obtained from a provider was reasonable to conclude that the recipient received the goods. We also accepted signatures of individuals signing on behalf of recipients other than the provider or their representatives.

Our audit identified numerous instances in which providers did not have documentation on file indicating receipt of goods or services by the Medicaid client. We also noted that medical service policy on documentation requirements for receipt of services only addressed delivered items.

The Department should issue a policy transmittal to providers reiterating the need to obtain signed receipts for goods or services provided to Medicaid clients. In addition, the Department should amend its medical service policy requiring that a signed receipt be

obtained for all MEDS provided to recipients.

Plans of Care – Duration of Home Health Aide Services

The basis from which all home health services are provided emanate from a plan of care established and approved by a physician. The physician orders on the plan of care indicate the type of services to be provided to the beneficiary, both with respect to the professional who will provide them and with respect to the nature of the individual services, as well as the frequency and the duration of the services.

Our review noted several plans of care did not specify the duration of home health aide visits.

The Department should issue a policy transmittal to home health agencies instructing them to specify the number of home health aide hours authorized in the plan of care.

Plans of Care – Physician Certification

Plans of care and any modifications must be signed and dated by the patient's physician within 21 days of the effective date of the original plan or modification.

Our review identified several instances in which the plan of care was not certified in a timely manner by the physician or was signed by the physician but not dated.

The Department should issue a policy transmittal to home health agencies reiterating to them the need to obtain timely and complete physician certifications on patient plans of care.

Claims Processing Edits and Controls – Hearing Aid Dealers

MEDS providers are enrolled in the Medicaid program under one of the following specialty categories: medical/surgical supplies; durable medical equipment; hearing aid dealers, orthotic/prosthetic devices or medical supply companies. Except for hearing aid dealers, the specialty categories do not have any licensing requirements.

We noted that payments for hearing aid purchase and repair procedure codes were made to MEDS providers enrolled in MEDS specialty categories other than hearing aid dealers.

The Department should incorporate the necessary edits in its claims processing system limiting the payment for hearing aids and related codes to only those MEDS providers enrolled as hearing aid dealers.

Unallowable Costs – Provider Audits

Data analysis is an essential tool for identifying potential errors in the Medicaid program. Data analysis should include a broad range of different analytical techniques in order to provide the broadest possible range of detection opportunities.

Providers selected for audit by the Department are primarily identified through the use of the claims processing surveillance utilization review subsystem (SURS). The SURS establishes baseline data enabling the department to identify unusual trends, changes in utilization over time, or schemes to inappropriately maximize reimbursement. While this profiling technique is a valid and acceptable detection methodology, it limits the Department's detection opportunities to only those providers identified as being outside the norm. We believe that incorporating some type of random sampling technique applied to all providers would increase the Department's detection opportunities.

The Department should incorporate the use of some type of random sampling methodology into its process of selecting medical providers to audit.

BACKGROUND INFORMATION

Medicaid is a jointly funded Federal-state health insurance program for eligible low income and medically needy people. States administer the program under a Medicaid State Plan approved by the Federal government. The Medicaid State Plan is a comprehensive written statement submitted by the state Medicaid agency describing the nature and scope of its Medicaid program. Within broad Federal rules, each state decides eligible groups, types and ranges of services, payment levels for services and administrative and operating procedures. The Department of Social Services administers the Medicaid program in Connecticut. The Department's Medicaid population receives their medical services through managed care or fee for service. The scope of this review covered fee for service only.

Medicaid fee for service operates as a vendor payment program, with the Department paying providers of medical services directly. Medical services are provided to an eligible beneficiary, normally without prior approval from the State. Medical service providers normally determine the scope and medical necessity of the services. With over 9,000,000 claims paid annually, the Medicaid program relies to a great extent on the integrity of its providers.

Providers submit claims to the Department's claims processing agent. The agent uses the Department's Medicaid Management Information System (MMIS) to process claims for most medical assistance services. MMIS is a computerized Medicaid benefit claims processing and information system. Medicaid receives claims for a variety of goods and services and uses automated computer edits as a check before payments are made to help ensure that claims are legitimate and billed by an eligible provider. However, the original detailed documentation that supports the claim is maintained in provider records and thus is not subject to payment processing edits and controls. While paid claim audits are performed by the Department's Quality Assurance Unit as part of their provider audit program, the sheer volume of claims makes it impossible to perform detailed checks on a significant portion of them.

Audit Objectives, Scope, and Methodology

The Auditors of Public Accounts, in accordance with Section 2-90 of the Connecticut General Statutes, are responsible for examining the performance of State entities to determine their effectiveness in achieving expressed legislative purposes. We conducted a performance audit of provider documentation of home health providers and medical equipment, devices and supply (MEDS) providers providing goods and services in the Medicaid program in accordance with Generally Accepted Government Auditing Standards. The objectives of our audit were to determine whether medical goods and services provided on behalf of program recipients were: (1) actually performed or provided; (2) allowable goods or services; (3) consistent with the recipient's medical diagnosis or condition as disclosed in the medical record; (4) in compliance with laws and regulations of the program and; (5) necessary and reasonable.

To achieve our audit objectives, we relied on computer-processed data produced by the Department's MMIS. We determined the validity and reliability of this computer-processed data by direct tests of the supporting data. Based on these tests, we conclude that the data are sufficiently reliable to be used in meeting our audit objectives.

We reviewed supporting documentation for 40 claims paid to home health providers and 40 claims paid to MEDS providers between July 2000 and September 2000, respectively. The total number of claims paid during this period to these provider types totaled 92,000. The claims were randomly selected from a quarterly report of Medicaid payments produced by the Department's Management Information Systems Unit on behalf of the Auditors. The source for the number of paid claims was taken from MMIS report HMMR486T. This data was not verified for accuracy and completeness.

Our initial sample of MEDS provider payments yielded 36 "valid" payments from the 52 payments in the report. Sixteen payments were not used and dropped from our sample. Payments to 14 providers consisted of crossover claims only. Crossover claims are claims paid by Medicaid on behalf of Medicaid clients who have Medicare insurance. These claims represent coinsurance or deductible amounts not paid by Medicare. Prior to October 1, 2000, claim information relative to crossover claims did not identify medical procedures performed and thus were not included in our review. One payment was made to an out-of-state provider that would have required us to travel to this provider to review supporting documentation. One payment was dropped because of its low dollar value (\$1.43).

The sample was further modified because no purchases of durable medical equipment (DME) transactions were initially selected. We randomly de-selected 4 diaper payments to drop from our sample. This type of supply, procedure codes A7973A, A7976A, A7977A and A7978A represented 14 of the 36 transactions originally selected. Our intention was to select a better mix of transactions that would include some purchases of durable medical equipment. In order to select these transactions, we referred to MMIS report HMMR388T as of September 30, 2000. This report provides a

monthly cumulative provider ranking based on the number of paid details on claims. The report contains information on the average payment paid to the ranked providers. Rankings are produced for the various categories of providers. We selected six providers with the highest average payment for the DME goods category. From these six, we selected claims paid to three of these providers. We randomly selected provider payment periods and claims between July and September of 2000. A total of eight claims were selected from these providers to bring the total number of claims to 40. The data contained on this report was not verified for accuracy and completeness.

In performing the audit, we reviewed applicable laws and regulations, the Medicaid State Plan, medical services policy, provider manuals, paid claims information, medical record documentation and conducted interviews with the Department's Medical Utilization Review and Policy Units. Based on the results of our review and interviews, we developed audit criteria to use to determine whether provider documentation met the objectives of our audit.

Home Health Services

The basis from which all home health services are provided emanate from a plan of care established and approved by a physician. Plans of care must be reviewed as often as the severity of the patient's condition requires, but at least every 60 days for patients receiving one or more skilled services. The original plan and any modifications must be signed and dated by the patient's physician within 21 days of the effective date of the original plan or modification. Services include skilled services such as nursing and therapeutic services and home health aide services. Home health aide services are hands on personal care of the beneficiary or services that are needed to maintain the beneficiary's health or to facilitate treatment of the beneficiary's illness or injury. The physician orders on the plan of care indicate the type of services to be provided to the beneficiary, both with respect to the professional who will provide them and with respect to the nature of the individual services, as well as the frequency and the duration of the services.

Services performed are documented in various ways depending on the type of service provided. Skilled nursing and therapeutic services are documented in the form of clinician notes or standardized medical forms. The notes or forms include dates of service and signatures of the individual performing the services. Home health aide services are documented on activity sheets prepared by home health aides. The activity sheet indicates the dates of service, specific services provided and the duration of the services. The sheets are signed by the home health aide and the beneficiary of the service.

For each of the 40 home health agency claims in our sample we reviewed recipient plans of care, clinical notes, home health aide activity sheets and other medical record documentation to determine that (1) a signed plan of care was on file covering the period of the service; (2) the plan of care was signed and dated in a timely manner by the physician; (3) the procedure performed as claimed was performed in the frequency and duration in which it was ordered in the plan of care; (4) skilled nursing and therapy services were supported by clinical notes or other medical record documentation

indicating services performed and dates of service and; (5) home health aide services were supported by activity sheets signed by the home health aide and the beneficiary of the services indicating services performed and their duration and the dates of such services.

In addition, we arranged with the Department's Utilization Review Team supervisor, who is a registered nurse, to review the plans of care and medical record documentation. The purpose of this audit step was to determine whether the services authorized in the plan of care were necessary and reasonable based upon the recipient's medical diagnosis or condition.

Medical Equipment, Devices and Supplies

For each item or service billed to the Medicaid program, MEDS providers must obtain a written order from a licensed practitioner. The provider must keep the practitioner's original prescription on file. The order should be sufficiently detailed to describe the goods or services required and include appropriate information on the diagnosis, quantity used, frequency of change and duration of need, if applicable. Information supporting the need for the prescription is contained in medical records maintained by the practitioner on each beneficiary.

Providers rendering goods and services are required to maintain fiscal and medical records that fully disclose services and goods rendered and/or delivered to clients. Medical service policy for MEDS providers do not prescribe the form in which providers must document receipt of goods by the recipient with the exception of delivered items. Thus, we determined that a recipient's signature evidencing receipt of a good obtained from a provider was reasonable to conclude that the recipient received the good. We also accepted signatures of individuals signing on behalf of recipients other than the provider or their representatives.

Payment of MEDS goods and services by the Department is based on its fee schedule. The fee schedule indicates the maximum amount the Department will pay for an item or service. Procedure codes for repair services and certain durable medical equipment purchases do not indicate a fee amount. Pricing for these services are based on the provider's usual and customary charge to the public. The provider is responsible to maintain documentation on the pricing of these procedure codes. In addition, all applicable warranties must be used to repair or replace durable medical equipment and hearing aids before the Department will pay for repairing or replacing them.

Individuals eighteen years of age and over who have been identified as having a hearing loss must receive a medical evaluation by a licensed physician prior to receiving a hearing aid. The purpose of the medical evaluation is to ensure that all medically treatable conditions that may effect hearing are identified and treated first. Results of the medical evaluation must be in writing and be on file with the hearing aid dealer.

We reviewed medical and fiscal records of MEDS providers for the practitioner's original prescription for goods or services and for recipient signatures evidencing receipt of those goods or services. We also reviewed medical record documentation of the prescribing practitioner to determine whether the prescribed good/service was consistent with the recipient's medical condition as disclosed in the medical record.

Some procedure codes in our audit sample were for hearing aid batteries or repair services. For these codes, we applied the same audit steps noted above except that we did not review medical records to determine medical necessity. Relative to repair services, we reviewed provider records for warranties on the equipment or device to determine whether the repair work was covered under a warranty and documentation supporting the pricing of the repair. For hearing aid purchases, we reviewed hearing aid dealer records for medical evaluations and the dealer's purchase invoice for the dispensed hearing aid.

Results of Review

Findings developed in response to our audit objectives are presented below.

Item No. 1 Practitioner Orders

Our review of 40 MEDS provider claims for practitioner orders identified 30 instances in which orders were either: not on file with the MEDS provider (7); not current (3); not originals (4); not detailed enough to determine either the diagnosis, quantity required, frequency of change or duration (4). We also noted for certain types of goods or services, orders were routinely never written (12). Essentially all (11) of the goods or services for which prescriptions were not written involved the purchase, repair and servicing of hearing aids.

Except for the missing orders not on file with the providers, we believe the above occurred because of a general lack of understanding amongst providers of medical service policy relative to what constitutes an acceptable prescription and the policy itself. The incidence of exceptions in this area supports this conclusion. Relative to policy, we noted that, while policy required a prescription for all items be on file with the MEDS provider, it was not specific as to what information was required. The Department is currently in the process of amending its MEDS regulations and has added language stating the minimum elements required for prescriptions.

The effect of missing, old, unoriginal or incomplete prescriptions lessens the Department's assurance that goods and services are reasonable and medically necessary.

Relative to the lack of prescriptions for hearing aid goods and services, several hearing aid dealers indicated that prescriptions were not required for these types of services and that it was not the industry's practice to write orders for such services. The dealers felt that it would be administratively burdensome to write orders for these services especially for hearing aid batteries that are dispensed frequently.

Although hearing aid dealers appear to be providing necessary goods and services to Medicaid clients, the process in which they provide such goods and services does not comply with Department policy.

The Department should issue a policy transmittal to providers reiterating to them the need to have current and detailed prescriptions on file in support of goods and services rendered. The policy transmittal should emphasize the minimum elements required in a prescription. In addition, the Department should review its medical service policy to determine whether all goods and services should require a written order. (See Recommendation 1.)

Agency Response:

“We are in agreement with the recommendation. The Department intends to send a provider bulletin reiterating the need to have current and detailed prescriptions on file that should support the services being provided. The Department had emphasized this point at the March provider workshop and will also emphasize this issue at the next quarterly MEDS provider workshop.”

Item No. 2 Evidence of Receipt for Goods and Services Rendered

Our review of 40 MEDS provider claims for evidence that Medicaid beneficiaries received goods or services identified 23 instances in which providers did not have on file the beneficiary’s or a representative’s signature indicating receipt of the goods or services.

Reasons given by providers for not obtaining beneficiary signatures included being too busy to obtain a signature when beneficiaries came to pick up the goods or that no one was available to sign for the goods delivered to the beneficiary’s home. We noted for some goods and services (i.e. hearing aid batteries/repairs) that it was not the practice of providers to obtain signatures from recipients at all.

We believe that some of the problem may be attributed to medical service policy. Policy in effect during our audited period did not specify the type of documentation a provider was required to obtain when providing goods and services. The one exception was for durable medical equipment delivered to recipients, in which case policy requires providers to obtain a recipient signature for the delivered goods. This requirement has been added to the Department’s amended regulations for medical and surgical supplies and orthotic and prosthetic devices. However, we believe the Department should extend this policy to include all goods and services provided, whether delivered to, or picked up by, the recipient.

The effect of not obtaining signatures from recipients for goods and services rendered by providers lessens the Department’s assurance that the goods or services were actually provided or performed.

The Department should issue a policy transmittal to providers reiterating the need to obtain signed receipts for goods or services provided to Medicaid clients. In addition, the Department should amend its medical service policy requiring that a signed receipt be obtained for all MEDS goods and services provided to recipients. (See Recommendation 2.)

Agency Response:

“We are not in agreement with this recommendation. The Department recently addressed this issue when the regulations were revised for DME, medical and surgical supplies and orthotic and prosthetic devices. It was determined that a signature is

necessary when goods are delivered (sent to a client). The Department's policy requires a prescription for all services including repairs and it is felt that it is sufficient to require providers to have a signature on file for items that are delivered."

Auditors' Concluding Comments:

The Department's revised regulations do not address provider documentation requirements relative to goods picked up by recipients.

Item No. 3 Plans of Care – Duration of Home Health Aide Services

Our review of 47 plans of care identified 10 instances in which the plan of care identified the need for home health aide services but did not indicate the duration of the home health aide visits in terms of the number of hours required. The number of plans of care reviewed was greater than the number of claims sampled (40) because some dates of service on the sampled claim covered two plans of care.

Physician orders for home health aide services indicated a range of visits for a given period of time. For example, plan of care orders for home health aide services would be written for 1 to 3 times per week for 9 weeks. While this range of visits would be appropriate for skilled services such as nursing or therapy, it is insufficient to document the extent of home health aide services. The reason it is insufficient is that skilled services are paid for on a per visit basis without regard to the actual time spent to provide the service versus home health aide services which are paid for on an hourly basis.

We believe the cause for this can be attributed to the practice of some physicians and home health agencies to denote the frequency and expected duration of services in terms of a range of visits.

The effect of not indicating the duration of home health aide services increases the risk that home health aide services may be provided in excess of required amounts.

The Department should issue a policy transmittal to home health agencies instructing them to specify the number of home health aide hours authorized in the plan of care. (See Recommendation 3.)

Agency Response:

"We are in agreement with the recommendation. We intend on sending a provider bulletin reiterating the need to specify in the plan of care the number of home health aide hours authorized."

Item No. 4 Plans of Care – Physician Certification

Our review of 47 plans of care identified six instances in which the plan of care was not certified in a timely manner by the physician and seven instances in which the physician signed the plan of care but did not date it.

The number of days in which the plan of care was certified late in each of the instances was 4, 5, 101, 134 and 289 days. In the remaining instance, a signature stamp was used to certify the plan of care.

We were informed by home health agencies that getting certified plans of care in a timely manner from physicians can sometimes be delayed. Relative to certifications not being dated, it appeared to us that the home health agencies were not concerned with the absence of a date.

The effect of late or incomplete physician certifications lessens the Department's assurance that services provided by the home health agency are necessary and reasonable.

The Department should issue a policy transmittal to home health agencies reiterating to them the need to obtain timely and complete physician certifications on patient plans of care. (See Recommendation 4.)

Agency Response:

“We are in agreement with the recommendation. We intend on sending a provider bulletin reiterating the need for the original plan of care and any modifications to be signed and dated by the patient's physician within 21 days. This includes plans of care for skilled services such as nursing and therapeutic services and also home health aide services.”

Item No. 5 Claims Processing Edits and Controls - Hearing Aid Dealers

We noted that payments for hearing aid purchase and repair procedure codes were made to MEDS providers enrolled in MEDS specialty categories other than hearing aid dealers.

MEDS providers are enrolled in the Medicaid program under one of the following specialty categories: medical/surgical supplies; durable medical equipment; hearing aid dealers, orthotic/prosthetic devices or medical supply companies. Except for hearing aid dealers, the specialty categories do not have any licensing requirements.

The above condition was able to occur because medical criteria edits in the claims processing system does not limit payment for these codes to the hearing aid specialty and will pay for these codes to any of the specialty types within the MEDS group.

This condition lessens the Department's assurance that payments are made only to qualified providers.

The Department should incorporate the necessary edits in its claims processing system limiting the payment for hearing aids and related codes to only those MEDS providers enrolled as hearing aid dealers. (See Recommendation 5.)

Agency Response:

“We are in agreement with this recommendation. The Department will update the MMIS to allow only hearing aid dealers to bill Medicaid for hearing aids.”

Item No. 6 Unallowable Costs – Provider Audits

We noted several other instances of noncompliance, the types of which were not as widespread as those identified in Item Numbers 1 and 2 above, yet warranted that we report these instances. We have related the instances of noncompliance to the number of cases examined and have quantified the instances of noncompliance in terms of unallowable costs.

Our review of 353 activity sheets prepared by home health agencies in support of home health aide services noted the following exceptions:

- The starting and/or ending time for five home health aide visits were not recorded on activity sheets preventing us from determining the duration of the home visit (\$202).
- Services performed in two instances were not allowable. For one visit, only homemaker services were provided. In order to be an allowable service the homemaker services must be provided in connection with personal hands on care to the client. For the other visit, services were performed outside of the home. To be allowable, services must be performed in the client’s home (\$41).
- Twelve activity sheets were not signed by the home health aide and/or the beneficiary of the service indicating receipt of services (\$436).
- The number of hours of home health aide services provided to one client exceeded the number of hours authorized in the plan of care (\$10).
- The duty checklist on one activity sheet was incomplete (\$20).

Our review of 40 MEDS provider claims identified the following noncompliance or questionable practices:

- One provider billed the Department for the purchase of a body binaural hearing aid. However, the supporting documentation for the claim indicated that a less expensive behind the ear monaural hearing aid was actually dispensed. This same provider also did not have on file documentation indicating that a medical evaluation had been performed and that he had received payment for the aid prior to dispensing it to the recipient (\$929).

- One provider informed us that he routinely bills and receives payment for hearing aids prior to dispensing the aids. Two claims were paid to this provider in our sample. For one of the claims the provider signed the delivery receipt on behalf of the client (\$831).
- Services were not rendered for one claim in our sample. The provider informed us that the claim selected in our sample was filed in error. However, the provider did not prepare a paid claim adjustment report as required by the Department (\$1,090).
- Our review of one claim for hearing aid repairs disclosed that the provider billed the department for the repair service despite the hearing aid being covered under warranty. When we inquired as to why the Department was billed for this service we were informed that it was the provider's practice to charge for the service whether under warranty or not (\$200).

The above instances of noncompliance or questionable practices are repeatedly identified in provider paid claim audits performed by the Department's Quality Assurance Unit. However, the likelihood of the above providers being selected for audit by Quality Assurance is very low.

Providers selected for audit are primarily identified through the use of the claims processing surveillance utilization review subsystem (SURS). The SURS establishes baseline data enabling the department to identify unusual trends, changes in utilization over time, or schemes to inappropriately maximize reimbursement. While this profiling technique is a valid and acceptable detection methodology, it limits the Department's detection opportunities to only those providers identified as being outside the norm. We believe that incorporating some type of random sampling technique applied to all providers would increase the Department's detection opportunities. This approach is crucial to identify providers who ascertain Department strategies for targeting corrective actions and who seek to avoid scrutiny.

The Department should incorporate the use of some type of random sampling methodology into its process of selecting medical providers to audit.

Agency Response:

“The Medicaid program has approximately 9,000 active providers. Payments to these providers exceed two billion dollars annually. The Medical Audit Unit has twenty auditors charged with the responsibility of identifying overpayments to these providers. For the fiscal year ended June 30, 2001, the Medical Audit Unit reviewed \$246,500,000 in paid claims and identified \$19,400,000 in overpayments. The limited resources available to audit annual payments exceeding two billion dollars require an audit strategy to maximize the effectiveness of each audit. The use of SURS data is a tremendous aide in helping to identify providers with a high probability of overpayments. Analysis of SURS data is not the only method utilized for selecting providers to audit, for example,

the audits of the Home Care Program for Elderly are selected utilizing a strata of total payment; small, medium and large.

We continue to believe that the use of SURS to select providers for audit optimizes our ability to maximize recoveries of overpayments. However, there may be some deterrent value in performing a limited number of randomly selected audits each year. Therefore, we will institute a program where some providers will be chosen for audit using a random selection method.”

RECOMMENDATIONS

1. **The Department should issue a policy transmittal to providers reiterating the need to have current and detailed prescriptions on file in support of goods and services rendered. The policy transmittal should emphasize the minimum elements required in a prescription. In addition, the Department should review its medical service policy to determine whether all goods and services should require a written order.**

Comment:

Our audit identified numerous instances of old, missing, unoriginal or incomplete prescriptions on file with MEDS providers. We also noted that prescriptions for certain goods and services were routinely never written.

2. **The Department should issue a policy transmittal to providers reiterating the need to obtain signed receipts for goods or services provided to Medicaid clients. In addition, the Department should amend its medical service policy requiring that a signed receipt be obtained for all medical equipment, devices and supplies (MEDS) provided to recipients.**

Comment:

Our audit identified numerous instances in which providers did not have documentation on file indicating receipt of goods or services by the Medicaid client. We also noted that medical service policy on documentation requirements for receipt of services only addressed delivered items.

3. **The Department should issue a policy transmittal to home health agencies instructing them to specify the number of home health aide hours authorized in the plan of care.**

Comments:

Our review noted several plans of care did not specify the duration of home health aide visits.

4. **The Department should issue a policy transmittal to home health agencies reiterating to them the need to obtain complete and timely physician certifications on patient plans of care.**

Comments:

Our review noted several plans of care that were not certified in a timely manner by physicians or included certifications that were not dated by the physician.

- 5. The Department should incorporate the necessary edits in its claims processing system limiting the payment for hearing aids and related codes to only those MEDS providers enrolled as hearing aid dealers.**

Comment:

We noted that payments for hearing aid purchase and repair procedure codes were made to MEDS providers enrolled in MEDS specialty categories other than hearing aid dealers.

- 6. The Department should incorporate the use of some type of random sampling methodology into its process of selecting medical providers to audit.**

Comment:

Providers selected for audit by the Department are primarily identified through the use of the claims processing surveillance utilization review subsystem (SURS). The SURS establishes baseline data enabling the department to identify unusual trends, changes in utilization over time, or schemes to inappropriately maximize reimbursement. While this profiling technique is a valid and acceptable detection methodology, it limits the Department's detection opportunities to only those providers identified as being outside the norm.

CONCLUSION

In conclusion, we wish to express our appreciation of the courtesies shown to our representatives during the course of our audit. The assistance and cooperation extended to them by the Department of Social Services and medical providers in making their records readily available and in explaining transactions greatly facilitated the conduct of this examination.

Joseph Faenza
Associate Auditor

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