

## SURS and PA Overview

### I. What is SURS?

SURS - Surveillance/Utilization Review Section

"The Medicaid agency must implement a statewide surveillance and utilization control program that Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments." 42 CFR 456.23 and 456.3

We accomplish by:

- Performing retrospective review of paid claims billed by medical providers and recovering overpayments (average of 260 cases opened annually)
- Educating medical providers; and,
- Prior authorizing durable medical equipment (DME) and some medical/surgical procedures

11 SURS PA staff, including one (1) FTE Supervisor

### Providers and Claims

91 Provider types, 97 Specialty Provider types

ACS (Medicaid Fiscal Agent) processes approximately 556,000 claims per month (6,667,000+ per year) and must do so in a timely and efficient manner.

Claims processing system includes numerous edits to identify most billing errors. However, it cannot detect all errors. (eg. Major issue is the generation of appropriate documentation completed prior to a provider's submission of a claim)

**37.85.414 MAINTENANCE OF RECORDS AND AUDITING** (1) All providers of service must maintain records which fully demonstrate the extent, nature and medical necessity of services and items provided to Montana Medicaid recipients which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. These records must be retained for a period of at least 6 years and 3 months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later.

### Retrospective Reviews

Although Medicaid providers are required to maintain records for 6 year and 3 months, the average retrospective period is 3 to 4 years.

ALL paid claims are subject to retrospective review and possible recovery of overpayments (may include prior authorized claims).

Referrals may be received from:

- providers
- clients
- program officers
- other agencies
- legislators
- private citizens
- OmniAlert (fraud detection system) and/or QueryPath (claims warehouse)

If the SURS Unit finds that providers have billed or been paid inappropriately for services, the overpayment will be recovered. [ARM 37.85.406 (9) & (10)]

The SURS Unit may withhold payment or suspend/terminate Medicaid enrollment if the provider has failed to abide by the terms of the State law. [53-6-111 MCA; ARM 37.85.513; ARM 37.85.501]

Cases of suspected fraud will be referred to the Department of Justice.

**Notables:**

"If it isn't documented, it didn't happen."

It is the responsibility of the provider to be knowledgeable about sections of the A.R.M. that relate to their provider type and/or services provided and to follow current laws and regulations. (Training and information available to all providers.)

**II. Federal Requirements**

States are required to have a post-payment review process for Medicaid paid claims (42 CFR 456).

States are required by law to refund the federal share of Medicaid overpayments to providers (42 CFR 433). In accordance with Title XIX of the Social Security Act, as outlined in 42 CFR 433, a State has 60 days from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 60 days, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has

been discharged in bankruptcy or is otherwise uncollectible (i.e., they have gone out of business).

### III. What is Prior Authorization?

Specific Durable Medical Equipment (DME) and Medical Procedures are subject to a Medical Necessity Review prior to authorizing payment for the service.

Each review is conducted on the merits of the individual case.

#### DME Prior Authorization Includes:

- All wheelchairs (including rentals)
- All hospital beds (including rentals)
- All shower commode chairs (including rentals)
- Pulse oximeters (including rentals)
- Apnea monitors (including rentals)
- C-PAPs and BIPAPs (Respiratory Assist Devices)
- Insulin Pumps
- Passive Motion Exercise Device daily rentals for any use other than total knee
- Passive Motion Exercise Device daily rentals for any use greater than 30 days
- Bone Growth Stimulators
- Vest Airway Clearance System
- Wound Vac rental
- Group II & Group III Pressure Reducing Surface rental
- Speech Generating Devices and Accessories
- Standing Frames
  
- Any claim line item where the Medicaid fee is equal to or greater than \$1,000.00

#### DME PA Documentation required

- The correct Certificate of Medical Necessity, completed, signed and dated by the doctor;
- Prescription with diagnosis and length of need;
- Prior Authorization Request Form which will provide the correct codes and billing information;
- Manufacturer's suggested list price (itemized);
- Warranty information; and,
- Therapy assessment may be required to justify medical need to assure that the item is the least costly alternative that will meet the client's medical needs.

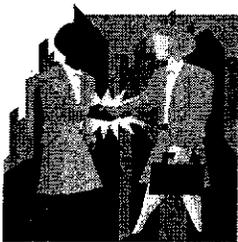
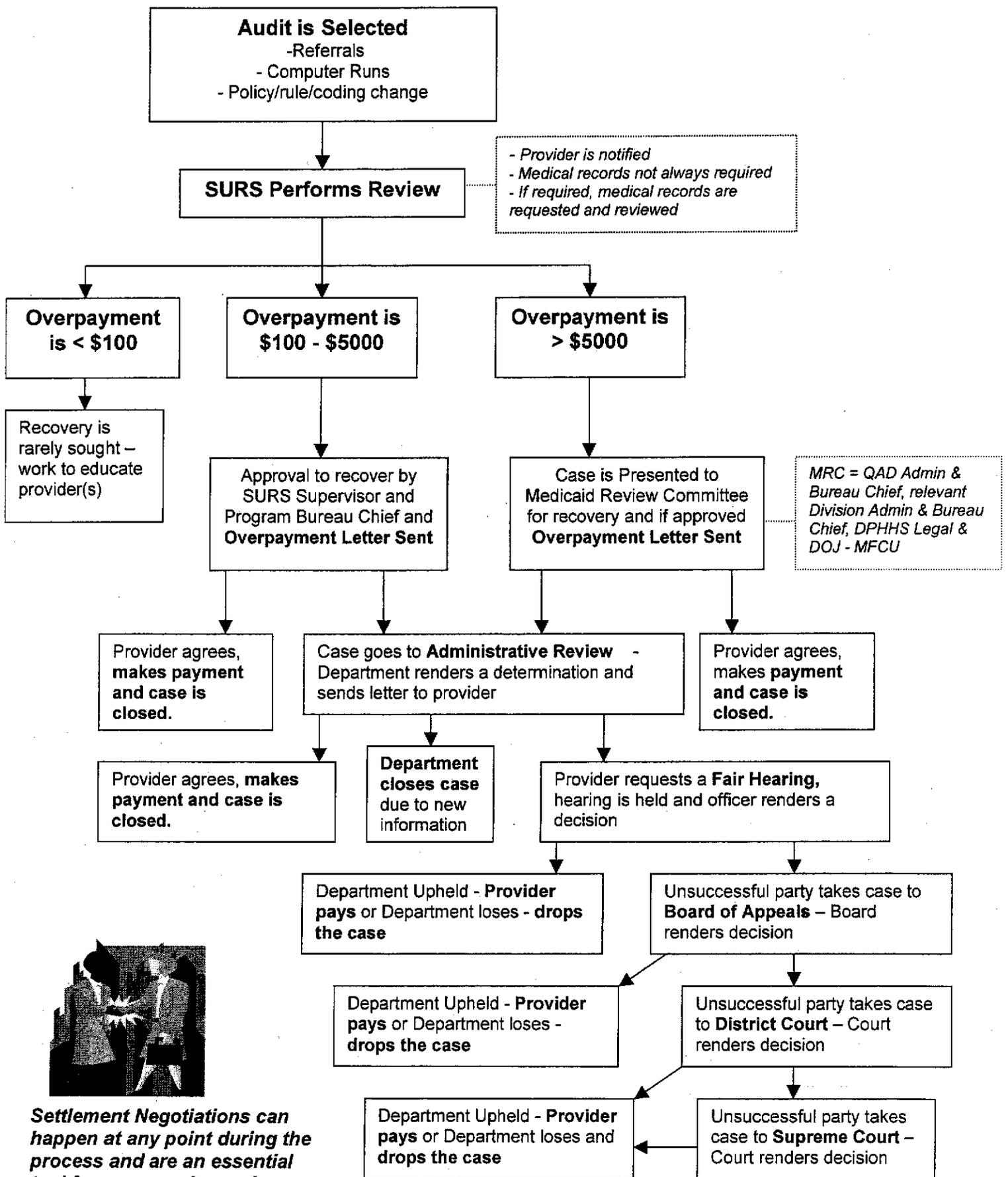
**Medical Procedure Prior Authorization**

- Includes surgeries/procedures that are considered cosmetic, such as breast reduction mammoplasty, Botox and Myobloc injections (Cleft lip repair does **not** require prior authorization.)
- PET scans
- Category III (T codes) Emerging Technology

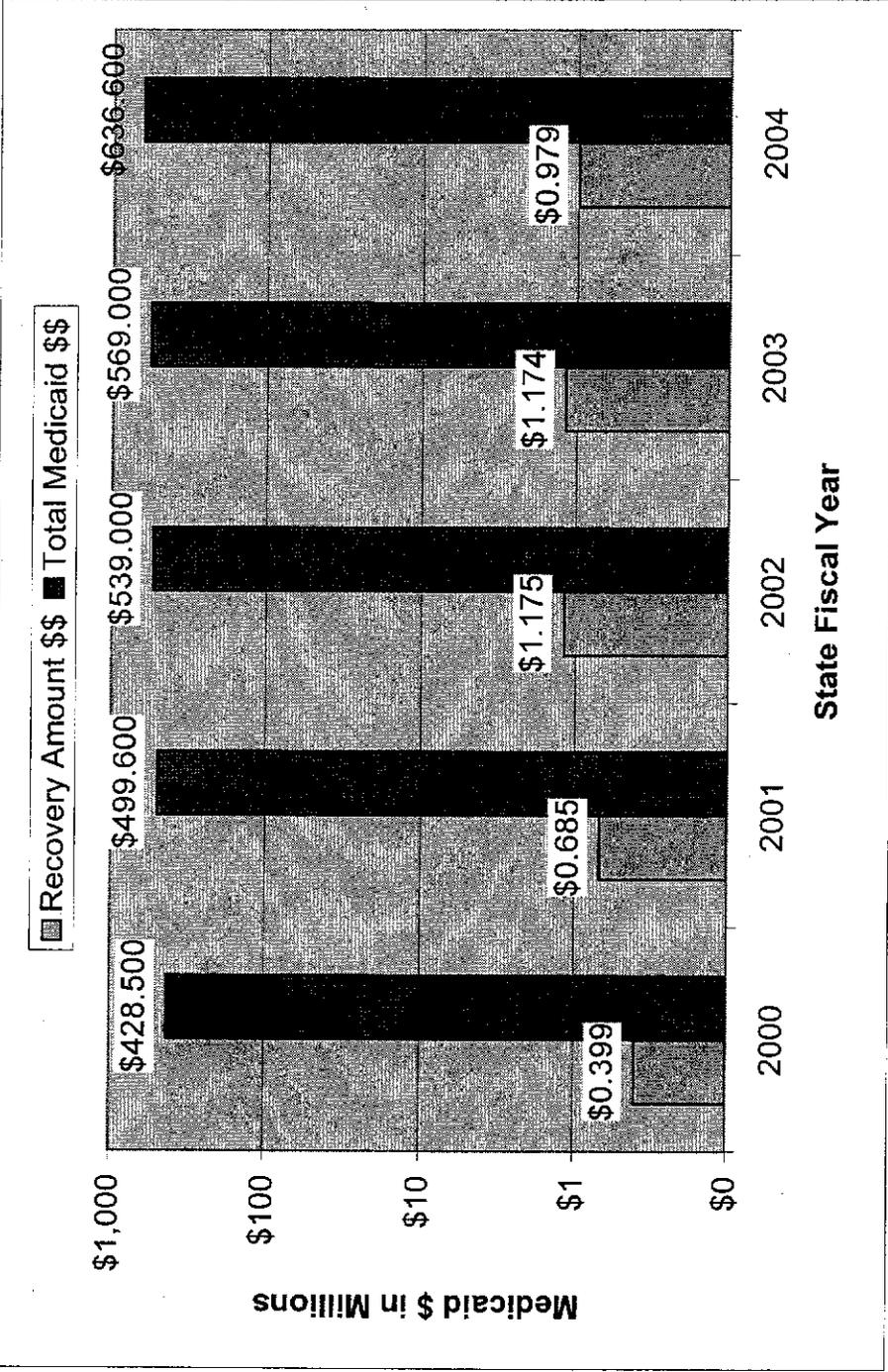
**Medical Procedure PA Documentation required**

- Provider must determine the applicable criteria;
- Provide a letter of medical necessity from the doctor and any additional documentation that will support the medical necessity for the procedure (i.e., any conservative treatment tried and failed).
- Pictures may be required.

# SURS Review Process



**Settlement Negotiations can happen at any point during the process and are an essential tool for compromise and case resolution.**



**Department of Public Health and Human Services**  
**Testimony on HB 469 – Revise Medicaid Payment Laws**  
**House Business and Labor**

**2/7/05**

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE COLLECTION OF PAYMENTS IN THE MEDICAID PROGRAM PREVIOUSLY MADE BY THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO HEALTH CARE PROVIDERS; AUTHORIZING THE DEPARTMENT TO COLLECT PREVIOUS PAYMENTS MADE TO A PROVIDER BECAUSE OF PROVIDER FRAUD OR ABUSE; PROHIBITING THE DEPARTMENT FROM COLLECTING PAYMENTS MADE AS A RESULT OF DEPARTMENTAL OR PROVIDER ERROR; PROVIDING THAT INTEREST ACCRUES ON A PAYMENT MADE BECAUSE OF FRAUD OR ABUSE FROM THE DATE ON WHICH THE PAYMENT WAS MADE BY THE DEPARTMENT; PROHIBITING THE DEPARTMENT FROM SUSPENDING PAYMENTS TO A MEDICAID PROVIDER AT CERTAIN TIMES; PROHIBITING THE DEPARTMENT FROM COLLECTING PAYMENTS PRIOR TO A HEARING REQUESTED BY THE PROVIDER; AND AMENDING SECTION 53-6-111, MCA."

House Bill 469 would amend 53-6-111, MCA, to PROHIBIT THE DEPARTMENT of PUBLIC HEALTH AND HUMAN SERVICES FROM COLLECTING PAYMENTS MADE AS A RESULT OF DEPARTMENTAL OR PROVIDER ERROR..." The Department is currently able to collect previous payments to a provider "...to which the provider was not entitled, regardless of whether the incorrect payment was the result of department or provider error or other cause..." The Department also makes interim payment for cost-based services and determines and adjusts this payment based on facility cost reports retrospectively (an example of this type of payment would be the cost settlement process with 40 Critical Access Hospitals.) The proposed changes on page 1, lines 26 through 30 and page 2, line 1 - would restrict recovery of overpayments in either case unless fraud or abuse is present.

Because most providers who receive an overpayment of Medicaid funds do not engage in actual fraud or abuse, passage of HB 469 would not require them to repay Medicaid funds they were not entitled to. The result would be a negative impact on the state's general fund of more than \$2.7 million over the coming biennium (see fiscal note for further detail).

Technically, a state does not have to participate in the Medicaid program. For practical reasons, however, all states do participate because they are able to draw down significant federal match to pay for the health care needs of their low-income, aged, and disabled populations. In Montana, this federal match will be approximately \$.71 for every \$1 spent in SFY 2006 and 2007.

Because Montana has chosen to participate in Medicaid, there are certain federal requirements that we must comply with. We are required to have a post-payment review process for Medicaid paid claims. This requirement is found at 42 CFR 456. The Surveillance & Utilization Review Section (SURS) within the Quality Assurance Division of the Department of Public Health and Human Services carries out this post-payment function for the state of Montana. SURS is mandated to "safeguard against unnecessary and inappropriate use of Medicaid services and against excess payments."

Montana is furthermore required by federal law to refund the federal share of Medicaid overpayments to providers. We have 60 days from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the state is made. Our federal partners have verified that if HB 469 should pass, the state would still be required to repay the federal share of any Medicaid overpayment identified. This is regardless of whether the provider actually pays the state.

In addition, the state would not realize our share of an overpayment recovery, resulting in lost revenue to the general fund. In other words, if a SURS audit identifies an overpayment of \$100, it would negatively impact the state general fund by \$100. We would have to "issue a check" to the federal government for approximately \$71, and the general fund would lose the \$29 recovery the state is entitled to.

Beyond the immediate fiscal impact to the general fund, the Department believes that HB 469 is bad public policy. The bill proposes that only overpayments made as a result of abuse or fraud on the part of a provider could be collected from that provider. Fraud is a high standard to prove. It involves purposeful or knowing conduct or omission. As such, it is a criminal offense under the Montana statutes (53-6-155(7), MCA). Passage of HB 469 would ensure that providers who are paid incorrectly by the state or who bill incorrectly get a free ride at the expense of other Montana taxpayers.

As an example, let's imagine that a provider regularly gets paid \$1000 for a service that he provides. He gets his check from Medicaid next week, however, and based on a computer programming error, the payment is \$10,000 instead of \$1000. If he doesn't want to refund that money, he doesn't have to. It was the state's mistake and it is not collectible under HB 469. A mistake in payment to one provider would result in a fairly minimal impact to the state Medicaid program. If a hundred providers are paid before the error is found, though, the impact becomes \$900,000.

Let's take another scenario. The provider hires a new billing agent. The billing agent, who has no previous experience, looks at the codes available and bills all visits using XYZ code. This code pays \$20 more than the ABC code that the provider's previous billing agent used. XYZ is a legitimate code for this provider type, and so when the bill is submitted, it is paid. The provider sees 100 Medicaid clients a month. Two years from now, the Department performs a

retrospective review of the code XYZ to make sure it is being billed correctly. The Department examines the provider's medical records to see if they support billing XYZ code and determines that the wrong code has been used. The provider has been overpaid by \$48,000 (24 months x \$2000/month). Again, under HB 469, the provider owes nothing even though he billed using an incorrect code. It doesn't meet the definition of "fraud". He didn't intentionally try to get something he wasn't entitled to. He thought he was billing correctly.

You may be thinking to yourself, it doesn't seem fair to recover from a provider after he has been paid. Why doesn't the state just make the correct payment in the first place? In the vast majority of cases, we do. Our post payment recoveries average 2/10 of one percent of the total Medicaid payments in a year. In a budget that is estimated at \$636.6 million for SFY 2004, this small percentage that we recover is still a lot of money.

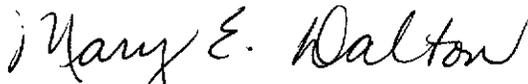
Currently, the state pays 6.6 million Medicaid claims annually. As I just said, the vast majority of these claims pay correctly. This is both because most providers bill correctly and because we have various edits in place that prevent things such as paying for a male pregnancy or a well-child visit for an eighty-year old. No computerized billing system, however, can detect whether a provider has chosen the wrong code in a particular circumstance if the code is appropriate for that provider. We could place more "hoops" in our system by requiring more prior authorization or pre-payment review. While this would reduce our post-payment recovery rate even further, we believe that it is a poor way to do business. Pre-payment review and prior authorization would require the state to match medical records to the claim before we paid it. Pre-payment review is very effective in limited circumstances but it would be cost prohibitive to both the provider and the state if it were used non-judiciously. It would end up punishing the vast majority of providers who bill correctly. It would be a step back in time, in terms of claims processing, of probably 30 or 40 years and would very likely result in a mass exodus from the Medicaid program. It is simply not a viable alternative. Overuse

of either pre-payment or prior authorization in claims processing is like killing a mosquito with a cannon.

So, to summarize.....

- HB 469 creates a system where there is no accountability for a provider who bills incorrectly as long as no intentional fraud occurs.
- The SURS post-payment review process is federally mandated. This federal mandate continues even if HB 469 passes.
- The state is required to repay the federal share of any overpayments identified, regardless of whether we collect from the provider.
- The cost to the general fund should HB 469 pass, will be at least \$2.7 million over the biennium.

Therefore, the Department respectfully requests that the Committee does not pass HB 469.



Mary E. Dalton, Administrator

Quality Assurance Division