Department of Health

Medicaid Program: Excessive Payments for Durable Medical Equipment Rentals

Report 2021-S-36 | April 2023

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objectives

To determine whether Medicaid managed care organizations inappropriately paid for durable medical equipment beyond allowed rental limits, and whether the Medicaid program could achieve cost savings by implementation of a rental cap on oxygen equipment. The audit covered the period from July 2016 to December 2021 for non-oxygen-related durable medical equipment rentals and September 2018 to December 2021 for oxygen-related durable medical equipment rentals.

About the Program

The Department of Health (Department) administers the State's Medicaid program. The Department uses two methods to pay for Medicaid services: fee-for-service (FFS) and managed care. Under the FFS method, the Department pays health care providers directly for services rendered to Medicaid recipients. Under managed care, the Department pays managed care organizations (MCOs) a monthly premium for each enrolled recipient and, in turn, the MCOs arrange for the provision of health care services that Medicaid recipients require and reimburse providers for those services.

Medicaid recipients receive necessary durable medical equipment (DME) as a benefit of the program. DME includes devices or equipment, such as wheelchairs or oxygen equipment, that can withstand repeated use and have been ordered by a practitioner in the treatment of a specific medical condition. Certain DME items are available to Medicaid recipients on a monthly rental basis, subject to certain limits (or caps). A special category of DME – oxygen equipment – is only available for rental and generally has no limit on the number of rental payments allowed. By comparison, under Medicare, oxygen equipment rentals are subject to a 36-month limit.

Key Findings

We identified overpayments totaling nearly $1.5 million for managed care DME rentals that exceeded MCOs' established monthly rental caps. For example, one MCO established a 10-month rental cap on apnea monitors, yet for one recipient the MCO paid $10,450 on 64 extra rental payments for a monitor beyond the 10-month cap. Furthermore, we estimated potential cost avoidance for the Medicaid FFS and managed care program of $8.6 million if the Department had adopted a similar policy to Medicare's 36-month cap on oxygen equipment rental payments.

Key Recommendations

- Review the identified overpayments and ensure appropriate recoveries are made.
- Advise MCOs to evaluate the feasibility of developing controls to identify and prevent DME overpayments.
- Formally assess Medicaid FFS and managed care policies regarding uncapped continuous rental payments for oxygen equipment to determine whether changes are necessary.

Office of the New York State Comptroller
Division of State Government Accountability

April 12, 2023

James V. McDonald, M.D., M.P.H.
Acting Commissioner
Department of Health
Corning Tower
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Albany, NY 12237

Dear Dr. McDonald:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Excessive Payments for Durable Medical Equipment Rentals*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

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Glossary of Terms

Term	Description	Identifier
Department	Department of Health	*Auditee*
CMS	Centers for Medicare & Medicaid Services	*Agency*
DME	Durable medical equipment	*Key Term*
eMedNY	The Department's Medicaid claims processing and payment system	*System*
FFS	Fee-for-service	*Key Term*
MCO	Managed care organization	*Key Term*
Noridian	Noridian Healthcare Solutions, LLC	*Key Term*
OMIG	Office of the Medicaid Inspector General	*Agency*

Background

The New York State Medicaid program is a federal, State, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2022, New York's Medicaid program had approximately 7.8 million recipients and Medicaid claim costs totaled about $74.6 billion. The federal government funded about 57.1% of New York's Medicaid claim costs, and the State and localities (the City of New York and counties) funded the remaining 42.9%.

The federal Centers for Medicare & Medicaid Services (CMS) oversees state Medicaid programs, and the State's Department of Health (Department) administers the program through its Office of Health Insurance Programs. The Department uses two methods to pay for Medicaid services: fee-for-service (FFS) and managed care. Under the FFS method, the Department, through its Medicaid claims processing and payment system (eMedNY), pays health care providers directly for eligible services rendered to Medicaid recipients. Under the managed care method, the Department pays managed care organizations (MCOs) a monthly premium for each enrolled recipient and, in turn, the MCOs arrange for the provision of health care services for Medicaid recipients and reimburse providers for those services. MCOs then submit claims (referred to as encounter claims) to the Department to inform it of each service provided to their enrollees.

Medicaid recipients receive necessary durable medical equipment (DME) as a benefit of the program. DME includes devices or equipment, such as wheelchairs or oxygen equipment, that can withstand repeated use and have been ordered by a practitioner in the treatment of a specific medical condition. Certain DME items are available to Medicaid recipients on a monthly rental basis. Rental payment includes all necessary equipment, delivery, maintenance and repair costs, parts, supplies and services for equipment set-up, and replacement of worn essential accessories or parts. New York State's Medicaid regulations state that the total accumulated monthly rental charges for DME may not exceed the actual purchase price of the item. For most DME rental items, both FFS and MCO policies place limits (or caps) on the number of monthly rental payments – many items have 10-month caps, but certain items have higher coverage caps. When the monthly rental payment cap is reached but the item is still needed, it is generally considered purchased for the recipient and no additional rental payments are made.

Certain DME is available for continuous (i.e., uncapped) rental and is not purchasable. For example, oxygen equipment is allowed as a continuous rental based on medical necessity. Therefore, under Medicaid's current reimbursement practice, there is generally no limit on the number of rental payments made for these items under both FFS and managed care. By comparison, under Medicare – a federal health insurance program for people age 65 and older and for those under age 65 with certain disabilities – oxygen equipment rentals are subject to a 36-month limit.

The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. As such, it has a role in recovering inappropriate Medicaid payments for DME rental claims paid above the established limits.

Audit Findings and Recommendations

We identified $1.5 million in overpayments by MCOs for DME items that exceeded rental limits and/or were paid without proper authorization. This included nearly $1.3 million in overpayments for non-oxygen equipment and $200,657 for oxygen equipment (at one MCO that had a cap on this). We also identified $503,619 in questionable MCO payments for DME rental items that may have exceeded rental limits. Furthermore, certain aspects of MCOs' policies, such as allowing rental periods to restart whenever there is 60 days between rental payments or a change of provider, differ significantly from the Department's FFS policies. Lastly, we estimated potential cost avoidance for the Medicaid program of $8.6 million if the Department had adopted a similar policy to Medicare's 36-month cap on oxygen equipment rental payments rather than allowing continuous uncapped rentals of this equipment.

Rentals of Oxygen Equipment

There is an opportunity for Medicaid savings if the Department implemented certain policies similar to Medicare, including establishing a cap that limits the number of rental payments for oxygen-related equipment. For many types of DME, Medicaid limits the number of rental payments allowed. However, Medicaid recipients typically receive oxygen equipment as a continuous rental. For the period from September 2018 to December 2021, the Medicaid program paid about $50 million for oxygen and related equipment. This amount included nearly $8 million paid by FFS and about $42 million paid by MCOs for items such as stationary and portable oxygen concentrators as well as gaseous oxygen systems and oximeters.

Effective in 2006, CMS established a 36-month limit (cap) on monthly payments for stationary and portable oxygen equipment provided to Medicare recipients. Similar to Medicaid, Medicare's monthly rental payments to the supplier cover not only the oxygen equipment but also oxygen accessories and services such as tubing or a mouthpiece, oxygen contents, oxygen machine maintenance, oxygen machine servicing, and oxygen machine repairs. Furthermore, after 36 months of rental payments are made, Medicare suppliers are required to maintain the oxygen equipment (in good working order) and furnish the equipment and any necessary supplies and accessories for an additional 24 months at no extra cost. Replacement equipment, if needed, is provided after the useful life of the items, which is generally 60 months (5 years).

Based on a review of the Medicaid and Medicare rental policies related to oxygen equipment, we estimated potential cost avoidance if the Medicaid program adopted a policy similar to Medicare's 36-month cap. In total, we identified $8.6 million in Medicaid rental payments for stationary and portable oxygen equipment that exceeded the 36-month limit that Medicare uses – $1.3 million in FFS claims and $7.3 million in managed care encounter claims (see Table 1). These rental payments were made after the 36th monthly payment (Medicare's cap) and up through the 60th monthly rental payment (Medicare's end-of-useful-life policy).

Table 1 – Rental of Oxygen Equipment With Potential Cost Avoidance

Procedure Code	Item Name	Managed Care Payments	Potential Managed Care Cost Avoidance	FFS Payments	Potential FFS Cost Avoidance	Total Payments	Total Potential Cost Avoidance
E1390	Oxygen concentrator, single delivery	$31,784,686	$6,366,393	$5,739,709	$957,522	$37,524,395	**$7,323,915**
E0431	Portable gaseous oxygen system	4,014,222	626,603	786,762	169,134	4,800,984	**795,737**
E0445	Oximeter	3,079,955	169,064	471,048	–	3,551,003	**169,064**
E0471	Respiratory assist device, bi-level pres. (non-invasive)	960,005	33,329	237,047	68,020	1,197,052	**101,349**
E1392	Portable oxygen concentrator, rental	1,543,928	76,339	411,917	21,060	1,955,845	**97,399**
E0424	Stationary compressed gaseous oxygen system, rental	252,121	42,305	46,529	19,092	298,650	**61,397**
K0738	Portable gas oxygen system	256,601	25,733	28,124	–	284,725	**25,733**
E0439	Stationary liquid oxygen system, rental	20,945	7,095	16,916	11,600	37,861	**18,695**
E0434	Portable liquid oxygen system, rental	5,068	1,339	6,780	3,600	11,848	**4,939**
Totals		**$41,917,531**	**$7,348,200**	**$7,744,832**	**$1,250,028**	**$49,662,363**	**$8,598,228**

Further, during our comparison of Medicaid and CMS-published Medicare rental reimbursement rates for oxygen-related DME, we noted certain disparities. For example, the Medicaid monthly rental reimbursement rate for procedure code E1392 (portable oxygen concentrator) was $195 per month throughout our audit scope, with no limit placed on the number of rental payments. Meanwhile, this same item was reimbursed by Medicare at rates ranging from $39 to $72 per month, with a 36-month limit on payments.

Department officials indicated that, while they use various Medicare policies as guidance for establishing State Medicaid policy, there is no State or federal mandate requiring a rental cap on Medicaid oxygen equipment or the adoption of Medicare's limits. However, they stated they will review the Medicare policy for any information that would potentially provide cost savings to the Medicaid program while maintaining the same level of service for recipients.

Department officials also stated that no analysis had been conducted in recent years to determine a cost basis of the Medicaid fees for oxygen and related equipment

in support of the current continuous uncapped rental policy. Therefore, there is no assurance that the continuous rentals of oxygen equipment have been in compliance with Medicaid regulations requiring that total rental payments not exceed the actual purchase price of the item.

MCO Overpayments for Oxygen Equipment

One MCO in our review had a 36-month limit for oxygen equipment similar to Medicare's policy. However, we identified instances where it appeared that the MCO incorrectly paid for oxygen equipment rental claims in excess of its 36-month limit. Based on our analysis and discussions with MCO officials, we identified a total of $200,657 in overpayments for oxygen equipment rentals where claims exceeded the MCO's set 36-month cap, and some claims for oxygen equipment that were paid without proper authorization.

Recommendations

1. Formally determine whether it is efficient and appropriate under managed care to require a cap on the number of rental payments for oxygen-related equipment. If deemed appropriate, work with stakeholders to implement policy changes.
2. Formally re-evaluate the existing policies for paying FFS DME rental claims for oxygen-related equipment, including an evaluation of the appropriateness of the uncapped continuous rental policy and the Medicaid reimbursement fees. If deemed appropriate, implement policy and claims processing changes.
3. Follow up with the MCO that made payments in excess of its policy limits on oxygen equipment to ensure that the $200,657 is reviewed and recovered, as appropriate.

Capped DME Rental Claims

Medicaid recipients also receive other DME items through monthly rentals that are subject to payment limits (or caps) determined by the individual MCOs for each DME rental item. These limits may be the same as the Department's FFS limits, but in some cases the MCOs' limits are different.

Medicaid regulations for DME state that the total accumulated monthly rental charges may not exceed the actual purchase price of the item. We surveyed five MCOs about their DME rental policies, including the maximum number of monthly rental payments allowed. Four of the five MCOs' rental limits (e.g., 10-month caps for most items) were similar to that of the Department's FFS limits. The remaining MCO's DME rental limits were not similar to the FFS policy. In addition, four MCOs allowed a new rental period to begin when there was either a gap in service, such as a period of 60 days without any rental payments (two MCOs) or a change in the DME provider (two MCOs) – neither of which are consistent with the FFS policy.

We applied the rental policies of the five MCOs we surveyed to their DME encounter claims for the period from July 2016 to December 2021. We then selected samples of recipient and procedure code combinations that appeared to exceed each MCO's rental payment limits and sent the associated claims to the MCOs for their review. The MCOs responded that DME rental claims were inappropriately paid for 38 of 41 sampled recipient and procedure code combinations (see Table 2). The rental items on the improperly paid claims included items such as parenteral nutrition infusion pumps, continuous positive airway pressure (CPAP) machines, hospital beds, and standard wheelchairs. For example, one MCO paid $10,450 in rental claims that exceeded the 10-month rental limit for an apnea monitor for one recipient. Although the rental limit and purchase price were both met at the 10th monthly rental payment, the MCO paid 64 additional claims for the item.

Table 2 – Sample Overpayments by MCO

MCO	Sample Size*	No. of Sample Units With Overpayments	Sampled Amount	Confirmed Sample Overpayment
A	15	15	$44,173	$41,493
B	10	10	29,635	29,635
C	9	9	24,257	24,257
D	1	1	2,796	2,796
E	6	3	3,047	856
Totals	**41**	**38**	**$103,908**	**$99,037**

*The sample unit is a combination of recipient and procedure code.

In total, for the period July 2016 to December 2021, we found that these MCOs paid 23,574 claims, totaling about $1.3 million, for DME rentals that exceeded the established rental payment limits and/or were not properly authorized (see Table 3). MCOs should report the details of such cases of waste to OMIG to ensure appropriate recoveries are made.

Table 3 – Total Overpayments by MCO

MCO	Overpayments	No. of Claims
A	$868,921	15,225
B	274,462	5,851
C	119,155	1,831
D	13,904	260
E	7,870	407
Totals	**$1,284,312**	**23,574**

Officials at one MCO stated that the overpayments identified were due to a configuration error in its claims processing system, which did not accurately count the number of rental payments in its history. The MCO is now in the process of changing and testing the system configurations to ensure the appropriate limits are in place, and has implemented a claims review process to ensure medical necessity.

The Payment Integrity team at the MCO will also review and recover overpaid claims in accordance with its recovery policy. Another MCO cited similar errors and omissions from its claims processing system as the cause of the overpayments, and stated that this issue was resolved to prevent future overpayments. A third MCO stated that the payments identified in the sample were paid with incorrect or exhausted rental authorizations, and it is currently discussing appropriate controls that can be implemented to prevent future overpayments. The fourth MCO indicated that equipment was replaced for three of the six recipient and procedure code combinations sampled and therefore the claims were appropriate. The remaining three of six sample items at this MCO had certain claims inappropriately paid due to provider billing errors and incorrect authorizations. The fifth MCO improperly paid claims for one DME procedure code because of a system configuration error. The MCO officials stated they are working on correcting the system issue. We found that neither the Department nor OMIG monitored whether the MCOs appropriately paid for DME, and OMIG's DME audits historically have focused on FFS claims rather than managed care claims.

We also analyzed the claims for the remaining MCOs not included in our survey of five MCOs. Since the rental limits were unknown for these MCOs, we compared the encounter claims with the FFS rental limits to identify payments above the limit. In addition, we assessed the effects of rental policies similar to those of the surveyed MCOs, which allow for the start of a new rental period when there is either a gap in service of more than 60 days or a change in provider. We identified $270,706 in questionable payments when rental period restarts were allowed, but this amount increased to $503,619 when the Department's FFS rental limits were applied to the claims without restarting rental periods due to gaps of 60 days or changes in provider.

Recommendations

4. Review the $1.3 million in overpayments identified for DME rental claims and ensure recoveries are made, as appropriate.
5. Monitor MCOs' DME rental claims for overpayments, including a review of the $503,619 identified, and take appropriate corrective steps, including ensuring recoveries are made.
6. Advise MCOs to evaluate the feasibility of developing controls to identify and prevent the types of DME rental overpayments identified by the audit, and take steps to ensure corresponding corrective actions are implemented.
7. Formally determine the appropriateness of certain MCOs' policies that allow payments for a new rental period whenever there is a 60-day gap in rental payments or a change in provider. If deemed inappropriate, work with stakeholders to implement policy changes.

Audit Scope, Objectives, and Methodology

The objectives of our audit were to determine whether Medicaid MCOs inappropriately paid for DME beyond allowed rental limits and whether the Medicaid program could achieve cost savings by implementation of a rental cap on oxygen equipment. The audit covered the period from July 2016 to December 2021 for non-oxygen-related DME rentals and September 2018 to December 2021 for oxygen-related DME rentals.

To accomplish our audit objectives and assess related internal controls, we interviewed officials and gathered information from the Department, the five surveyed MCOs, and CMS' FFS Medicare DME claims processing contractor, Noridian Healthcare Solutions, LLC (Noridian). We examined the relevant Department and MCO Medicaid policies and procedures, and reviewed applicable federal and State laws, rules, and regulations. We interviewed OMIG officials to gain an understanding of their audit efforts related to our audit objectives. We used data from the Medicaid Data Warehouse and information from eMedNY to identify DME rental claims paid on behalf of Medicaid recipients; we determined that the data from these systems were sufficiently reliable for the purposes of this audit.

For the capped DME rental analysis, we surveyed five MCOs about their DME rental policies, including the maximum number of monthly rental payments allowed for DME items. We selected DME encounter claims for procedure codes that were subject to the MCOs' rental limits. We removed claims for recipients with Medicare Part B coverage and claims where third-party insurance payments were indicated. In addition, we removed all claims paid for DME purchases and repairs. Next, we compared the total number of rental payments for each recipient and procedure code to the established limit (cap) of each procedure code to determine the amount paid in excess of the stated limits, after also applying each MCO's rental period restart policy. We provided samples of claims identified to five MCOs for their review. We judgmentally selected our samples based on procedure codes with high total paid amounts in excess of each MCO's stated rental policy limits, and then we chose recipients with high total paid amounts for each MCO and procedure code selected. The sample unit was a combination of recipient and procedure code. Because the samples were judgmentally selected, the results cannot be projected to the population as a whole.

For the analysis of oxygen equipment rentals, we selected FFS and encounter claims for portable and stationary oxygen equipment that were not subject to any rental limits (i.e., uncapped). We removed claims for recipients with Medicare Part B coverage and/or claims where third-party insurance payments were indicated. We obtained and reviewed the Medicare oxygen equipment rental policy and procedures information from Noridian. We then determined the number of Medicaid claims paid in excess of Medicare's 36-month cap policy to identify the total potential cost avoidance if the policy had been in place for Medicaid.

We provided a sample of oxygen equipment rental claims for review to one MCO that used a 36-month cap on oxygen equipment rentals. These claims were judgmentally selected based on procedure codes with high total paid amounts in excess of the MCO's stated rental limits, and then we chose recipients with high total paid amounts

for each procedure code selected. The sample unit was a combination of recipient and procedure code. Because the samples were judgmentally selected, the results cannot be projected to the population as a whole.

We shared our methodology and findings with officials from the Department and OMIG during the audit for their review.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our 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.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of the Department's oversight and administration of Medicaid DME rental services.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of the report. In their response, Department officials generally concurred with the audit recommendations and indicated certain actions have been and will be taken to address them. We address certain remarks in our State Comptroller's Comment, embedded within the Department's response.

Within 180 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Agency Comments and State Comptroller's Comment

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Acting Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

March 14, 2023

Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2021-S-36 entitled, "Medicaid Program: Excessive Payments for Durable Medical Equipment Rentals."

Thank you for the opportunity to comment.

Sincerely,

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
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Department of Health Comments to Draft Audit Report 2021-S-36 entitled, "Medicaid Program: Excessive Payments for Durable Medical Equipment Rentals" by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Draft Audit Report 2021-S-36 entitled, "Medicaid Program: Excessive Payments for Durable Medical Equipment Rentals" by the Office of the State Comptroller (OSC).

Recommendation #1:

Formally determine whether it is efficient and appropriate under managed care to require a cap on the number of rental payments for oxygen-related equipment. If deemed appropriate, work with stakeholders to implement policy changes.

Response #1:

While the Department does use Medicare policies as guidance for establishing state Medicaid policy, there is no state or federal mandate that requires the Department to adopt federal policy. Medicaid services a different mix of medical acuity, age range and service needs compared to the largely geriatric population serviced by Medicare. The Department has determined that the current reimbursement for oxygen services meets the needs of Medicaid members but will re-review the Medicare policy for any changes that would potentially provide cost saving measures while maintaining the level of oxygen services for Medicaid members.

If the conclusions from the re-review result in a change in the Medicaid fee for service reimbursement methodology, the Department will consider whether to seek authority to direct Medicaid managed care plans to adopt such a methodology.

Recommendation #2:

Formally re-evaluate the existing policies for paying FFS DME rental claims for oxygen-related equipment, including an evaluation of the appropriateness of the uncapped continuous rental policy and the Medicaid reimbursement fees. If deemed appropriate, implement policy and claim processing changes.

Response #2:

The Department has concerns with the methodology used to determine projected cost savings for FFS oxygen rentals. The methodology did not take into consideration that the monthly rental is all-inclusive of supplies and oxygen contents in the rental fee. Other insurances, such as Medicare, reimburse providers for all supplies, as well as oxygen contents, outside of the oxygen rental fees.

State Comptroller's Comment – As stated in the audit report on page 7, similar to Medicaid, Medicare's monthly rental payments for stationary and portable oxygen equipment cover not only the oxygen equipment but also oxygen accessories and services such as tubing or a mouthpiece, oxygen contents, oxygen machine maintenance, oxygen machine servicing, and oxygen machine repairs. Furthermore, after 36 months of rental payments are made, Medicare suppliers are required to maintain the oxygen equipment (in good working order) and furnish the equipment and any necessary supplies and accessories for an additional 24 months at no extra cost.

The recommendation also did not take into consideration that oxygen usage in FFS Medicaid is most often a life sustaining service, rather than a supplemental service as found in other insurance programs. These factors, along with no federal or state mandate to adopt Medicare policies in Medicaid, are sufficient reasons to keep the continuous oxygen rental fees in place. Taking this information into consideration, the Department agrees to conduct an analysis of the oxygen rental policy to assess whether any cost savings would be realized while maintaining the life-sustaining support that Medicaid families rely upon under the current fee structure.

Recommendation #3:

Follow up with the MCO that made payments in excess of its policy limits on oxygen equipment to ensure that the $200,657 is reviewed and recovered, as appropriate.

Response #3:

In collaboration with the Department, the Office of the Medicaid Inspector General (OMIG) is performing analysis on the identified claims, as well as the methodology OSC used to calculate the potentially inappropriate overpayments. OMIG's audit process accounts for the fact that providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. Thus, OMIG's analysis will include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #4:

Review the $1.3 million in overpayments identified for DME rental claims and ensure recoveries are made, as appropriate.

Response #4:

In collaboration with the Department, OMIG is performing analysis on the identified claims, as well as the methodology OSC used to calculate the potentially inappropriate overpayments. OMIG's audit process accounts for the fact that providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. Thus, OMIG's analysis will include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #5:

Monitor MCOs' DME rental claims for overpayments, including a review of the $503,619 identified, and take appropriate corrective steps, including ensuring recoveries are made.

Response #5:

In collaboration with the Department, OMIG is performing analysis on the identified claims, as well as the methodology OSC used to calculate the potentially inappropriate overpayments. OMIG's audit process accounts for the fact that providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. Thus, OMIG's analysis will include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #6:

Advise MCOs to evaluate the feasibility of developing controls to identify and prevent the types of DME rental overpayments identified by the audit and take steps to ensure corresponding corrective actions are implemented.

Response #6:

The Department will advise MCOs to evaluate the feasibility of developing controls to identify and prevent overpayments.

Recommendation #7:

Formally determine the appropriateness of certain MCOs' policies that allow payments for a new rental period whenever there is a 60-day gap in rental payments or a change in provider. If deemed inappropriate, work with stakeholders to implement policy changes.

Response #7:

In order to implement this recommendation, the Department will need to contract with a vendor with subject matter expertise in the topic area to formally review and determine the appropriateness of certain MCOs DME payment policies for new rental periods whenever there is a gap in rental payments or a change in provider.

Contributors to Report

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