



RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

February 25, 2021

Ms. Simone Marstiller, Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Marstiller,

Enclosed is a six-month status report on the Auditor General's *Operational Audit of the Agency for Health Care Administration, Analysis of Selected Medicaid Claims Data*, Report No. 2021-013, issued August 2020. This status report is issued in accordance with the statutory requirement to report on corrective actions resulting from the Auditor General's recommendations six months from the report date.

If you have any questions about this status report, please contact Pilar Zaki, Audit Director at 412-3986.

Sincerely,

Mary Beth Sheffield
Inspector General

MBS/sgb

Enclosure: Six-Month Status Report on AG Report No. 2021-013

cc/enc: Joint Legislative Auditing Committee
Melinda Miguel, Chief Inspector General, EOG
Beth Kidder, Deputy Secretary, Division of Medicaid, AHCA
Pilar Zaki, Audit Director, Office of Inspector General, AHCA



**Agency for Health Care Administration
Auditor General Operational Audit 2019
Analysis of Selected Medicaid Claims Data (Report No. 2021-013)
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Finding No. 1:

Medicaid Claims Payments

Our audit found that Agency controls could be enhanced to better prevent or detect potential improper Medicaid claims payments.

As part of our audit, we analyzed selected FFS claims adjudicated during the period July 2017 through March 2019 and the encounter data for selected SMMC program claims billed during the period July 2017 through March 2019. The selected claim types included, but were not limited to, those for controlled substances prescriptions, human immunodeficiency virus (HIV) prescriptions, home health care visits, and dental services. Our analysis of the selected Medicaid claim types identified numerous claims, summarized in Table 1, that appeared to be contrary to State or Federal law, Agency rules or policies, or other guidelines, and, in some instances, indicative of potential fraud or abuse.

Recommendation:

We recommend that Agency management enhance FMMIS and MCO oversight controls to better prevent or detect potential improper Medicaid claims payments.

Agency Response as of February 25, 2021:

To prepare our initial response to the audit in August, we conducted an in-depth review of the claim information provided and determined that the FMMIS and Statewide Medicaid Managed Care plans paid in accordance with Agency policies. The Agency therefore disagrees with the audit findings and will not be implementing system updates. The following is a brief reiteration of our previous comments for each of the selected claim types identified in this finding.

Controlled Substances

Florida Medicaid maintains a number of safeguards through the utilization management process which includes automated and manual prior authorizations, step-edit criteria, and other system edits (quantity limits, age limits, etc.) to ensure appropriate prescribing practices or use of medication. Regarding the management of controlled substances, refills of OxyContin or any other control II substance is federally prohibited. Federal law requires a new prescription from the physician for OxyContin or oxycodone to be filled. Consultation with the prescriber is required in these instances. Additionally, statutory exemptions to prescriber enrollment requirements are applied by Florida Medicaid to ensure reimbursement for only medically necessary services.

HIV Prescriptions

Prior to the 2014 implementation of Statewide Medicaid Managed Care, the Agency implemented an automatic prior authorization (auto-PA) process to ensure Medicaid recipients obtaining HIV medications have an HIV medical claims diagnosis in their history. If the policy rules established by the automatic prior authorization criteria are not met, the submitted claim will deny and trigger a manual prior authorization review process for verification of consultation with a prescriber.

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Home Health Visits

Health plans provided justification on their system edits related to the specific claim samples in question and are conducting audits to identify any home health paid claims during an inpatient admission. The Agency also reviewed claim samples identified by the auditors and does not recommend system changes in the fee-for-service delivery system nor through the health plans.

Dental Services

Florida Medicaid dental services are provided through three Statewide Medicaid Managed Care Dental plans. Each plan has the flexibility and responsibility to apply medically appropriate utilization criteria for dental services. Root canal procedures require a prior authorization in fee-for-service Medicaid.

The Agency disagrees with the finding that the number of root canals performed in one date of service and the average length of time to perform a root canal are automatically grounds to identify overpayment by Medicaid. Such determinations require clinical review, and the Agency requested an expert analysis of these situations with licensed and practicing dentists within the Department of Health and the Medicaid dental plans.

The AG references the American Association of Endodontists as their source for the expected procedural time for a root canal appointment (90 minutes). However, this reference does not detail the various factors that may affect the overall root canal procedure time. These include primary versus permanent teeth, the location of a tooth, root structure, level of decay, compliance of the patient, level of anesthesia, etc. Therefore, the Agency does not find the AG's reference for root canal procedure time to be adequate or accurate, thus system updates are not necessary.

Agency Contact

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Agency Response as of August 27, 2020:

In response to the finding and recommendation above, the Agency for Health Care Administration provides the following information and analysis related to questioned claims associated with controlled substances, human immunodeficiency virus (HIV) prescriptions, home health visits, and dental services. Much of this information reiterates the Agency's previous response(s) to the AG detailing the appropriateness of the claim payments in question. Additionally, Agency review indicates that the FMMIS paid in accordance with Agency policies. However, should system/programmatic improvements be deemed necessary at any time, they will be made.

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Controlled Substances

Statutory exemptions [s. 409.913(8), F.S.] to prescriber enrollment requirements are applied by Florida Medicaid to ensure reimbursement for medically necessary services. These services may include (but are not limited to) prescribing by a non-enrolled board-certified specialist, by a Medicare enrolled prescriber for a dually eligible Medicare beneficiary, or by a non-enrolled prescriber for medically necessary service not otherwise reasonably available from an enrolled physician.

In regard to the management of controlled substances, refills of OxyContin or any other control II substance is federally prohibited. Federal law requires a new prescription from the physician for OxyContin or oxycodone to be filled. Consultation with the prescriber is required in these instances.

In addition, Florida Medicaid maintains a number of other safeguards through the utilization management process which includes automated and manual prior authorizations, step-edit criteria, and other system edits (quantity limits, age limits, etc.) to ensure appropriate prescribing practices or use of medication.

HIV Prescriptions

The Agency has implemented an automatic prior authorization (Auto-PA) process to ensure Medicaid recipients obtaining HIV medications have an HIV medical claims diagnosis in their history. The Auto-PA process has been in effect since prior to the 2014 implementation of Statewide Medicaid Managed Care. If the policy rules established by the automatic prior authorization criteria are not met, the submitted claim will deny and trigger a manual prior authorization review process for verification of consultation with a prescriber. This is to prevent delays in access to medication determined necessary to control the HIV infectious disease process by promoting 100% adherence to the prescription. This strategy prevents HIV transmission, slows or halts progression of disease, and reduces occurrence of comorbid complications.

Home Health Visits

The Agency reviewed claim examples across the two topics identified by the auditors. The below details information for each instance for which claims were provided. The Agency does not recommend system changes in the fee-for-service delivery system nor through the health plans. The health plans have provided justification on their system edits and specific claim examples in question by the auditor.

More than Three Home Health Visits - Per the Home Health Visits Coverage policy, Florida Medicaid reimburses for up to three intermittent home health visits per day for non-pregnant recipients age 21 and older. It was asked that the Agency review four claims in which it appears that payments were made in excess of this policy.

Response after Agency review:

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All four of the claims submitted for Agency review are encounter claims. This means that these recipients are enrolled in a managed care plan. In accordance with the [Home Health Visit Services Coverage Policy](#), managed care plans must comply with the coverage requirements outlined in the policy, unless otherwise stated in the contract with the Agency. The plans are not allowed to be more restrictive than the coverage policy.

Plans are permitted to be more expansive in coverage than the Agency. These claims were encounter claims; as such the managed care plans may exceed the limits of the coverage policy.

Recipients under Inpatient Care - *Thirty claims were identified having had a home health visit paid for while the recipient was under inpatient care at a hospital or nursing home/facility. It was asked that a detailed explanation along with any applicable supporting documentation be provided.*

Response after Agency review:

The Agency was asked to review thirty claims. Please see the detailed review below:

Encounter Claims:

Twenty of the claims were encounter claims from a recipient enrolled in a managed care plan. The plans' coverage may be more expansive than the coverage policy. Seven health plans were contacted about the 20 encounter claims. Because prior authorization was in place for the home health services, clean claims did pay. Identifying home health claims that were paid for dates of service when a member was inpatient must be done as retro-payment review. For the claims identified by the AG, the plans will be reaching out to the home health providers to request documentation and then take appropriate action.

These claims were encounter claims and as such health plans may exceed the limits of the coverage policy. Additionally, it is likely the home health visit claim was made prior to the hospital or nursing facility claim was filed with the health plan.

Fee-for-Service Claims:

Ten claims are fee-for-service claims. Prior authorization is required for home health visits. This is one of the mechanisms the state uses to apply utilization management of home health services. Providers obtain authorization every 60 days. However, when the prior authorization is approved it is not possible to predict health emergencies or natural disasters that may result in an inpatient stay.

One of the 10 claims coincides with the disaster grace period for Hurricane Irma (9/7/17– 9/21/17). During the disaster grace period, all prior authorization requirements

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were waived. Reimbursement was provided for services provided in good faith to eligible Florida Medicaid Recipients.

The remaining nine out of ten fee-for-service claims were paid prior to the implementation of [electronic visit verification \(EVV\)](#). With the implementation of EVV the Agency has greater controls over the location in which services are delivered. The vendor now has more detailed claims information which helps contribute to the management of home health visit claims.

Dental Services

The Agency provided the auditors with a plan review of each dental claim in question, as well as health plan contract details to describe the flexibilities health plans have. The Agency asserts that multiple root canals on one date of service is not in conflict with the Agency's policies or any conflict with scope of practice/standards of care.

The Agency reimburses for medically necessary services for children in accordance with the coverage policy and fee schedule. Additionally, the Agency complies with the National Correct Coding Initiative which details when billing for specific procedure codes are prohibited. In regard to the number of procedures performed in a single day, that would need to be determined by the healthcare practitioner who has knowledge of the impact of the services to the recipient. For instance, where the recipient requires anesthesia, it is common practice to perform as many procedures as can be safely administered in order to avoid having to anesthetize the patient again at a later date.

It is not appropriate for the Agency to limit the number of root canals a recipient under the age of 21 years may receive on one date of service due to multiple factors:

- *The Agency follows national correct coding system edits and limitations in accordance with federal guidance and the dental code book.*
- *The Agency does not regulate scope of practice nor standards of care.*
- *Parental consent, parental choice (e.g., due to need to take time off or work or to arrange transportation), and medical necessity may dictate multiple services to be performed on the same date of service, including evidence-based quadrant dentistry by specific local anesthetic area.*
- *The majority of dental services are managed by dental plans, with their own utilization management and review practices.*

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