Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ILLINOIS IMPROPERLY CLAIMED MEDICAID REIMBURSEMENT FOR OPTICAL SERVICES AND SUPPLIES

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Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

During a two-year period, Illinois claimed at least $488,000 for unallowable Federal Medicaid payments for optical services and supplies.

WHY WE DID THIS REVIEW

The State of Illinois, Office of the Auditor General, issued two reports on the Illinois All Kids Health Insurance program that identified potential control weaknesses that would allow optical services or supplies to be provided and paid for without adequate documentation. All Kids is an umbrella term used to describe health care provided to children eligible for Federal and State-only funded health programs by the Illinois Department of Healthcare and Family Services (State agency). The State agency claimed Medicaid optical services and supplies for Federal reimbursement through the same billing system as the State-only funded services and as a result, we determined it could result in possible unallowable Federal Medicaid payments.

Our objective was to determine whether the State agency claimed optical services and supplies for Medicaid reimbursement that complied with Federal and State requirements.

BACKGROUND

In Illinois, the State agency administers its Medicaid program in accordance with the Centers for Medicare & Medicaid Services approved State plan. The State plan establishes what services the Medicaid program will cover, including optical services and supplies for individuals under age 21.

States are required to provide early and periodic screening, diagnostic, and treatment (EPSDT) services to Medicaid-eligible individuals who are under the age of 21. These services under Medicaid must be medically necessary and supported by adequate documentation. According to Illinois Administrative Code, Illinois will pay for one eye exam per age period unless a second screening is medically necessary. Illinois will pay for all services or treatments which are medically necessary to correct or lessen health problems detected by the screening process, including eyeglasses. Also, the provider should repair eyeglasses by replacing either the damaged lens or the damaged frame when the other is still usable. Providers are required to retain medical records for six years from the date of service to receive Medicaid reimbursement from the State agency.

WHAT WE FOUND

Of the 658 total optical claims reviewed for the sampled 108 beneficiaries, we determined that the State agency properly claimed Medicaid reimbursement for 449 claims. However, the State agency claimed Federal Medicaid reimbursement for optical services and supplies that did not comply with Federal and State requirements for the remaining 209 claims provided to 28 beneficiaries totaling $6,452 ($3,138 Federal share). Specifically, these claims were not adequately supported by documentation.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $488,456 (Federal share) in Medicaid reimbursement for optical services and supply claims for 138,692 beneficiaries during the audit period. The State agency did not have adequate controls in place to ensure that claims for optical services and supplies complied with Federal and State requirements.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $488,456 to the Federal Government;
- use the results of this audit in its provider education activities related to adequate documentation for optical services and supplies; and
- include explicit documentation requirements under the EPSDT program at 89 Illinois Administrative Code section 140.485 to parallel the explicit documentation requirements at 89 Illinois Administrative Code section 140.417.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency, disagreed with our first recommendation, agreed with the second recommendation, and partially agreed with the third recommendation. The State agency provided an update effective July 1, 2012, to 89 Illinois Administrative Code section 140.417, which details the inclusion of children through age 20.

After considering the State agency's comments, we continue to recommend that the State agency refund to the Federal Government $488,456 for inadequately supported claims, use the results of this audit in its provider education activities related to adequate documentation for optical services and supplies, and include explicit documentation requirements under the EPSDT program at 89 Illinois Administrative Code section 140.485 to parallel the explicit documentation requirements at 89 Illinois Administrative Code section 140.417.

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INTRODUCTION

WHY WE DID THIS REVIEW

Illinois' Office of the Auditor General (OAG) issued two reports on the Illinois All Kids Health Insurance program[1] that identified potential control weaknesses that would allow optical services or supplies to be provided and paid for without adequate documentation. All Kids is an umbrella term used to describe health care provided to children eligible for Federal and State-only funded health programs by the Illinois Department of Healthcare and Family Services (State agency). The State agency claimed Medicaid optical services and supplies for Federal reimbursement through the same billing system as the State-only funded services and as a result, we determined these services could result in possible unallowable Federal Medicaid payments.

OBJECTIVE

Our objective was to determine whether the State agency claimed optical services and supplies for Medicaid reimbursement that complied with Federal and State requirements.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare and Medicaid Services (CMS) administers the program. Each State administers its own Medicaid program in accordance with a CMS-approved State plan. In Illinois, the State agency administers the Medicaid program. Although the State agency has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. Under Federal regulations, providers must agree to keep any records necessary to disclose the extent of services provided and any information related to claims for services provided (42 CFR § 431.107).

States are required to provide early and periodic screening, diagnostic, and treatment (EPSDT) services to Medicaid-eligible individuals under the age of 21. Federal EPSDT guidelines require each State to make comprehensive and preventive child health services available at intervals which meet reasonable standards of medical and dental practice, as outlined in Sections 1902(a)(43) and 1905(r) of the Social Security Act (the Act). EPSDT guidelines require vision services to be provided at intervals that meet reasonable standards and at other intervals as medically necessary. At a minimum, vision services must include diagnosis and treatment for defects in vision, including eyeglasses (Section 1905(r)(2) of the Act).

[1] The OAG issued reports entitled "Program Audit of the Covering All Kids Health Insurance Program" in April 2011 and October 2012.

Illinois Optical Services and Supplies

The Illinois Medicaid State Plan authorizes all EPSDT services or treatments, which are medically necessary to correct health problems detected by the screening process, to be provided to individuals under age 21. EPSDT recipients receive eyeglasses and optical services based on the determinations of medical necessity. The services must be medically necessary and supported by documentation of the nature of the services provided.

The State agency will pay for one vision screening per age period, except when a second screening is determined to be medically necessary (Illinois Administrative Code Title 89, § 140.485(d)(4)). The State agency will pay for necessary medical care to correct defects and conditions, which are discovered or determined to have increased in severity by medical, vision, hearing or dental screening services (Illinois Administrative Code Title 89, § 140.485(d)(8)). Providers must comply with record requirements as set forth in section 140.28 (Illinois Administrative Code Title 89, § 140.485(g). Those record requirements state that a provider shall maintain professional records that relate to the quality of care given.

Providers must also document the care for which payment is claimed as required to be maintained by Federal and State laws. "Providers shall maintain…medical records for recipients of public assistance … for a period of six years from the date of service." (Illinois Administrative Code Title 89, § 140.28 (a)(2)(A) and (b)). In addition, according to Illinois *Handbook for Optometric Services, O-235.4 and O-235.5,* if one or both lenses are broken, but the frame is still usable, the lens or lenses are to be ordered. Likewise, a replacement frame may be covered only when the present frame is broken, and is non-repairable.

The State agency has an interagency agreement with the Illinois Department of Corrections (IDOC) for fabrication of all lenses, frames and frame parts. Payment for fabrication of eyeglasses and lenses is made by the State agency directly to the IDOC (Illinois Administrative Code Title 89, § 140.418).

HOW WE CONDUCTED THIS REVIEW

We limited our review to Medicaid optical claims paid during the two-year period July 1, 2010, through June 30, 2012. The State agency claimed about $15.6 million ($7.8 Federal share) for 558,738 optical claims for 138,692 Medicaid beneficiaries.[2] We reviewed a random sample of 108 beneficiaries with 658 optical claims, totaling $18,965 ($9,509 Federal share), during the audit period.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

[2] For this report, we define a beneficiary as a recipient, aged 18 and under with 3 or more optical claims for which the State agency received Medicaid reimbursement.

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.

Appendix A contains the details of our audit scope and methodology. Appendix B contains our sample design and methodology. Appendix C contains our sample results and estimates. Appendix D contains excerpts from the applicable Federal and State regulations.

FINDINGS

Of the 658 total optical claims reviewed for the sampled 108 beneficiaries,[3] we determined that the State agency properly claimed Medicaid reimbursement for 449 claims. However, the State agency claimed Federal Medicaid reimbursement for optical services and supplies that did not comply with Federal and State requirements for the remaining 209 claims provided to 28 beneficiaries totaling $6,452 ($3,138 Federal share). Specifically, these claims were not adequately supported by documentation.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $488,456 (Federal share) in Medicaid reimbursement for optical services and supply claims for 138,692 beneficiaries during the audit period. The State agency did not have adequate controls in place to ensure that claims for optical services and supplies complied with Federal and State requirements.

OPTICAL SERVICES AND SUPPLIES WERE NOT ADEQUATELY SUPPORTED

Optical Supplies Not Supported

For 204 sampled optical claims, totaling $6,358 ($3,091 Federal share), providers did not adequately document medical records for optical supplies provided. State regulations specify that the optometrist must maintain professional records that relate to the quality of care given and document the care for which payment is claimed. Under Federal regulations, providers must agree to keep any records necessary to disclose the extent of services provided and any information related to claims for services provided.

Eyeglass Replacement Not Supported

For four sampled optical claims, totaling $76 ($38 Federal share), providers did not furnish adequate documentation to justify full replacement of both the frame and lenses. Under Federal and State requirements, services must be medically necessary and supported by adequate documentation to be allowable. Providers must agree to keep any records necessary to disclose the extent of services provided and any information related to claims for services provided. According to State agency policies, if one or both lenses are broken, but the frame is still usable, only the lens or lenses are to be ordered. Likewise, a replacement frame may be covered only when the present frame is broken.

[3] A single beneficiary has multiple claims, each claim was assessed individually.

Additional Eye Exam Not Supported

For one sampled optical claim, totaling $18 ($9 Federal share), the provider failed to document the need for more than one eye exam per year. State regulations allows for one eye examination per year unless the optometrist documents the need for the additional examination.

RECOMMENDATIONS

We recommend that the State agency:

- refund $488,456 to the Federal Government;
- use the results of this audit in its provider education activities related to adequate documentation for optical services and supplies; and
- include explicit documentation requirements under the EPSDT program at 89 Illinois Administrative Code section 140.485 to parallel the explicit documentation requirements at 89 Illinois Administrative Code section 140.417.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The State agency's comments, excluding technical comments we addressed as appropriate, are included as Appendix E. In summary, the State agency disagreed with our first recommendation, agreed with the second recommendation, and partially agreed with the third recommendation. The State agency provided details of the age requirement added to 89 Illinois Administrative Code section 140.417 that was updated effective July 1, 2012, to include children through age 20. After reviewing the State agency's written comments, we maintain that our findings and recommendations are valid.

REFUND TO THE FEDERAL GOVERNMENT

The State agency disagreed that it did not have adequate claim documentation. Specifically, the State agency said it maintained copies of the Optical Prescription Orders (OPO) to support the medical necessity of the claims, thus the claims are supported and allowable.

We agree that the State agency maintaining copies of the OPO, supports medical necessity of the claims; however, as stated on numerous occasions, we were unable to obtain support from the provider's medical records to verify the accuracy of the OPO.

STATISTICAL SAMPLING

The State agency does not concur with the use of extrapolation relating to the testing results in our review. More specifically, it says the results noted at individual providers can't be

extrapolated over each stratum's population as each provider has their own set of internal procedures over Medicaid claims. The State agency expressed concerns about the methodology and the statistical validity of the amount extrapolated. Because of these and other methodology concerns, the State agency said it was unable to accept the repayment projection of $488,456.

The use of statistical sampling to determine improperly claimed reimbursement amounts in Medicaid is well established and has repeatedly been upheld on administrative appeal within the Department and in Federal courts.[4]

Regarding the State agency's objections to our statistical sampling and extrapolation methodology, the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.[5] We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

INCLUDE DOCUMENTATION REQUIREMENTS IN CRITERIA

The State agency partially concurred with including explicit documentation requirements under the EPSDT program at 89 Illinois Administrative Code section 140.485 to parallel the explicit documentation requirements at 89 Illinois Administrative Code section 140.417. The State agency said it updated 89 Illinois Administrative Code section 140.417, effective July 1, 2012, to include children through age 20.

Although the State agency updated 89 Illinois Administrative Code section 140.417 to include children through age 20, our recommendation specifically notes documentation requirements be made to 89 Illinois Administrative Code section 140.485, which would include optometrists documenting the reason for eyeglass replacement (i.e. lost, stolen and/or change in prescriptions).

[4] *See Illinois Physicians Union v. Miller,* 675 F.2d 151 (7th Cir. 1982); *Georgia v. Califano*, 446 F. Supp. 404 (N.D. Ga. 1977); *Services, Rosado v. Wyman*, 437 F.2d 619, 627-628 (2d Cir. 1970), aff'd, 402 U.S. 991 (1970).

[5] *See Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transyd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); Maryland, DAB No. 2090 (2007).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For the audit period July 1, 2010, through June 30, 2012, we limited our review to Medicaid payments that the State agency made to optical providers for services and supplies to Medicaid beneficiaries as authorized under the State plan. We excluded beneficiaries with fewer than three claims as well as any providers that are currently under investigation by the State or Federal government.

After taking into account the exclusions above, we determined that the State processed and paid 558,738 Medicaid claims for 138,692 beneficiaries totaling $15,555,003 ($7,795,921 Federal share) for optical services and supplies during the audit period. We reviewed a random sample of 108 beneficiaries.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we limited our internal control review to the objective of our audit.

We conducted fieldwork from December 2013 through June 2014 at the State agency and at various optical offices.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, requirements, and guidance;
- held discussions with State agency officials to gain an understanding of the State agency's optical program;
- obtained Medicaid paid claims for optical services and supplies from July 1, 2010, through June 30, 2012, from the State agency;
- identified the sampling frame of 138,692 beneficiaries with 558,738 Medicaid claims totaling $15,555,003 ($7,795,921 Federal share);
- selected a random sample of 108 beneficiaries from our sampling frame and, for each claim, obtained and reviewed the provider's documentation to determine whether the beneficiary's services and/ or supplies were in accordance with Federal and State requirements;
- used the results of the sample to estimate the unallowable Federal Medicaid reimbursement (Appendix D); and
- discussed our results with the State agency.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and 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.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of beneficiaries aged 18 and younger with 3 or more optical service and/or supply claims provided from July 1, 2010, through June 30, 2012, for which the State agency claimed Federal Medicaid reimbursement.

SAMPLING FRAME

The sampling frame was a data file provided by the State agency containing Medicaid payments during the audit period for the State agency's optical program. We excluded beneficiaries with fewer than 3 claims as well as any providers that are currently under investigation by the State or Federal government. After the exclusions, the sampling frame was 138,692 beneficiaries with 3 or more paid optical service and/or supply claims during the audit period, totaling $15,555,003 ($7,795,921 Federal share).

SAMPLE UNIT

The sample unit was a beneficiary and all optical services and supplies provided to them during the audit period.

SAMPLE DESIGN

We used a stratified random sample, as follows:

- Stratum 1: 115,088 beneficiaries with 3 to 5 claims, totaling $11,109,733
- Stratum 2: 23,596 beneficiaries with 6 to 19 claims, totaling $4,439,040
- Stratum 3: 8 beneficiaries with 20 or more claims, totaling $6,230

SAMPLE SIZE

We selected a sample of 108 beneficiaries, as follows:

- 70 beneficiaries from stratum 1
- 30 beneficiaries from stratum 2
- 8 beneficiaries from stratum 3

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software, RAT-STATS.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the sample units in each stratum. After generating 70 random numbers for Stratum 1 and 30 for Stratum 2, we selected the corresponding frame items. We selected all 8 frame items for Stratum 3.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the unallowable Federal Medicaid reimbursement paid by applying the applicable Federal Medical Assistance Percentages to the payments for optical services and supplies that we determined did not comply with Federal and State requirements.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results: Total Amounts

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Beneficiaries for Optical Services and Supplies that were Unsupported	Value of Optical Services and Supplies that were Unsupported
1	115,088	$11,109,733	70	$7,230	6	$353
2	23,596	4,439,040	30	5,505	14	1,464
3	8	6,230	8	6,230	8	4,635
Total	**138,692**	**$15,555,003**	**108**	**$18,965**	**28**	**$6,452**

Sample Results: Federal Share Amounts

Stratum	Frame Size	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Beneficiaries for Optical Services and Supplies that were Unsupported	Value of Optical Services and Supplies that were Unsupported (Federal Share)
1	115,088	$5,568,092	70	$3,626	6	$177
2	23,596	2,224,705	30	2,759	14	637
3	8	3,124	8	3,124	8	2,324
Total	**138,692**	**$7,795,921**	**108**	**$9,509**	**28**	**$3,138**

Estimated Unallowable Costs

(Limits Calculated for a 90-Percent Confidence Interval)

	Total Amount	Federal Share
Point Estimate	$1,737,439	$795,333
Lower Limit	1,087,560	488,456
Upper Limit	2,387,318	1,102,210

APPENDIX D: FEDERAL AND STATE REQUIREMENTS FOR OPTICAL SERVICES AND SUPPLIES

FEDERAL REQUIREMENTS FOR EPSDT SERVICES

Pursuant to section 1902(a)(43) of the Act, States must make comprehensive and preventive child health services available to Medicaid-eligible individuals under the age of 21 at intervals which meet reasonable standards of medical and dental practice.

Pursuant to section 1905(r)(2) of the Act, vision services provided under EPSDT must be provided at intervals that meet reasonable standards and at other intervals as medically necessary. At a minimum, vision services must include diagnosis and treatment for defects in vision, including eyeglasses.

FEDERAL REQUIREMENT FOR RECORD RETENTION

Pursuant to 42 CFR section 431.107, providers must agree to keep any records necessary to disclose the extent of services provided and any information related to claims for services provided under the Plan.

STATE REQUIREMENTS FOR RECORD RETENTION

Pursuant to 89 Illinois Administrative Code, section 140.28:

a) Providers shall maintain in the regular course of business any and all professional records that relate to the quality of care given by the provider or that document the care for which payment is claimed, including medical records for applicants and recipients of public assistance.

b) The business and professional records required to be maintained shall be kept in accordance with accepted business and accounting practice and shall be legible. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period the records must be retained until the audit is completed and every exception resolved.

STATE REQUIREMENTS FOR OPTMETRIC SERVICE UNDER EPSDT

Pursuant to 89 Illinois Administrative Code, section 140.485(d)(4):

A) The Department will pay for vision screening services, and diagnosis and treatment for defects in vision, including glasses.

B) The periodicity schedule for vision screenings is contained in Section 140.488. The Department will pay for one vision screening per age period, except when a second screening is determined to be medically necessary.

Pursuant to 89 Illinois Administrative Code, section 140.485(d)(8):

> The Department shall pay for necessary medical care (see section 140.2), diagnostic services, treatment or other measures medically necessary (e.g., medical equipment and supplies) to correct or ameliorate defects, and physical and mental illnesses and conditions which are discovered or determined to have increased in severity by medical, vision, hearing or dental screening services.

Pursuant to 89 Illinois Administrative Code, section 140.418:

All lenses, frames and frame parts shall be obtained from IDOC laboratory. Payment for fabrication of eyeglasses shall be made by the Department of Public Aid directly to the IDOC.

Pursuant to Illinois *Handbook for Optometric Services, section O-235.4, Replacement of Broken Lenses:*

If one or both lenses are broken, but the frame is still usable, the lens or lenses are to be ordered from IDOC by completing an OPO and a claim containing a charge for the service fee, and sending both documents to the Department. The OPO must identify the frame for which IDOC is being asked to fabricate a new lens or lenses. The new lens or lenses will be sent directly to the provider for insertion into the frame.

Pursuant to Illinois *Handbook for Optometric Services, section O-235.5, Frame, Frame Parts and Repairs:*

Only IDOC frames are covered by the Department. A replacement frame may be covered only when the present frame is broken, and is non-repairable, or has been lost. In instances where it is evident that the repair of an existing frame is less costly than providing a new frame, and when such repairs provide a serviceable frame for the patient, consideration is to be given to repairing the existing frame. New frame parts, including fronts, temples, etc., are covered when used to repair an existing frame.

STATE REQUIREMENTS FOR LIMITATIONS ON OPTOMECTRIC SERVICES

Pursuant to Illinois Administrative Code, section 140.417:

Payment for the following optometric services and material shall be made subject to the following limitations:

a) Payment shall be made for single vision lenses only when the following conditions are met:

1) The power is at least 0.75 diopters in either the sphere or cylinder component; or

2) The difference between the old and new prescription is at least 0.75 diopters in either the sphere or cylinder component.

b) Payment shall be made for bifocal lenses only when the following conditions are met:

1) For first bifocals, the power of the bifocal addition is at least 1.00 diopter.

2) For a change in bifocal lenses, the poser of the bifocal addition is changed by at least 0.50 diopters or the distance power represents a change of at least 0.75 diopters.

c) Payment shall be made for more than one examination per year only when the vendor documents the then need for the additional examination.

d) Payment shall be made for more than one pair of eyeglasses or set of lenses per year only when the physician or optometrist documents:

1) that:
A) the most recent pair of eyeglasses or set of lenses was lost or destroyed for reasons beyond the control of the recipient; or

B) there is a change in the prescription that meets the requirements in subsection (a)(2) or (b)(2) of this Section; and

2) that the additional pair is medically necessary.