H. CARL MCCALL
STATE COMPTROLLER

A.E. SMITH STATE OFFICE BUILDING
ALBANY, NEW YORK 12236

STATE OF NEW YORK
**OFFICE OF THE STATE COMPTROLLER**

October 25, 2000

Mr. Channing Wheeler
Chief Executive Officer
United HealthCare Service Corporation
450 Columbus Boulevard
Hartford, CT 06115-0450

Re: New York State Health Insurance Program
Duplicate Outpatient Claim Payments
Report 99-S-11

Dear Mr. Wheeler:

According 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 audited selected medical claims processed on behalf of the New York State Health Insurance Program's Empire Plan (Plan). The scope of our financial-related/compliance audit was a review of claims paid by United HealthCare Service Corporation (United HealthCare) during the three-year period ended December 31, 1998.

## A. Background

The New York State Health Insurance Program (Program) provides coverage for hospitalization, surgical services and other medical expenses for over 766,000 active and retired State employees and dependents. The Program also covers over 359,000 active and retired employees and dependents of local governmental units and school districts that elect to participate. The Department of Civil Service (Department) contracts with insurance carriers to provide all aspects of health insurance coverage, and is responsible for managing and administering the Program. The Empire Plan (Plan) is the Program's primary health benefit plan, providing services at a total annual cost exceeding $1.9 billion. United HealthCare provides the Plan's medical/surgical and major medical coverage. During the three-year period ended December 31, 1999, United HealthCare paid over 23 million claims totaling over $2.1 billion and charged the Plan over $266 million in administrative expenses. Empire Blue Cross Blue Shield (Empire Blue Cross) provides the Plan's hospitalization coverage. During the three-year period ended December 31, 1999, Empire Blue Cross paid over 2 million claims totaling over $1.5 billion and charged the Plan over $74 million in administrative expenses.

Empire Blue Cross contracts with hospitals to provide the Plan's hospitalization and related expense coverage. Prior to the 1986 inception of the Plan, Empire Blue Cross negotiated unique contracts (global reimbursement contracts) with all but a few hospitals located in the lower 15 counties of New York State. These contracts differ from Empire Blue Cross' standard hospitalization contracts in that the outpatient reimbursement rates include coverage for certain outpatient-related physician services when rendered by radiologists, cardiologists, pathologists and emergency medicine physicians. In 1997 Empire Blue Cross entered into new global reimbursement contracts with its downstate member hospitals. The new contracts include services provided by the above specialists. However, such services must be provided in an emergency room setting. In addition, Empire Blue Cross signed a global reimbursement contract with an additional hospital not previously reimbursed in this manner. Overall, the 1997 global reimbursement contracts resulted in minimal changes from the existing contracts.

To ensure that United HealthCare does not pay for physician services already included in the global reimbursement contracts, Empire Blue Cross has periodically provided United HealthCare with information describing the services included in these contracts. United HealthCare uses this information to develop its own claim processing policies and procedures to prevent the inappropriate payment of global reimbursement claims.

In 1998, United HealthCare participated in a "1997 Global Reimbursement Project" to identify 1997 charges that it paid which were already included in Empire Blue Cross' hospital payments. Empire Blue Cross provided United HealthCare with claims data to facilitate this project. Improper charges that United HealthCare recovered through this project were excluded from our report.

In our prior audit report, which was issued on June 17, 1993 (Report 93-S-49 - Inadequate Coordination of Benefits Resulted in $2.75 Million in Empire Plan Overpayments), we identified issues similar to those covered by our current audit. In this prior audit, we detailed the specific services included in these global reimbursement contracts. We also recommended improvements to the claims coordination process such as continuous communication and routine data exchange between carriers, to ensure the proper payment of future charges. However, our subsequent audit report 98-S-14 (Duplicate Inpatient Claims, issued on January 12, 2000) documented that our recommendations to improve the claims coordination process were not fully implemented and few additional corrective actions were taken in the nearly six years since our 1993 report was issued. Our current audit indicates that these conditions still have not improved.

## B. Audit Scope, Objectives and Methodology

We audited United HealthCare's payments of outpatient-related physician services during the three-year period ended December 31, 1998. The primary objective of our financial-related/compliance audit was to determine whether duplicate payments were made for physician services that were already included in Empire Blue Cross' hospital outpatient payments.

We designed computer programs to identify payments for outpatient-related physician services that appear to be already included in Empire Blue Cross' hospital outpatient payments. However, our review of these payments was limited because United HealthCare officials were unable to provide us with pertinent computerized data. For example, the data provided by United HealthCare does not contain provider specialty information which is critical in determining whether separate payments for services are appropriate.

We provided United HealthCare officials with a random sample of charges for selected providers. To determine if the charges for these providers were duplicate payments we reviewed these charges with United HealthCare officials. We also discussed any charges requiring payment policy clarification with Empire Blue Cross officials.

We did our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations that are included within our audit scope. Further, these standards require that we understand the internal control structure and review compliance with the laws, rules and regulations that are relevant to the operations that are included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying other auditing procedures we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

Our consideration of the internal control structure at United HealthCare focused on the control procedures for paying hospital-related claims. Our audit identified improvements needed in the area, which we further describe in the "Payments for Services Already Included in Hospital Outpatient Payments" section of this report.

We use a risk-based approach when selecting activities to be audited. This approach focuses on those operations that we identify through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, we use finite audit resources to identify where and how improvements can be made. Thus, we devote little audit effort to reviewing operations that may be relatively efficient or effective. As a result, we prepare our audit reports on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

## C. Results of Audit

We found that United HealthCare officials need to improve the company's procedures for coordinating with Empire Blue Cross to pay outpatient-related charges. As a result of these procedural weaknesses, we found that United HealthCare paid 29,097 charges totaling $1,603,768 that were potentially duplicate payments (payments for physician services that were already included in Empire Blue Cross' hospital outpatient payments).

We provided a preliminary report of our audit findings to United HealthCare officials. We considered their comments in preparing this report. United HealthCare officials informed us that they have begun to review this population and as of September 11, 2000, have identified 3,304 charges totaling $163,080 that they deem recoverable. In addition, these officials have identified 9,495 charges totaling $360,980 that were correctly paid. A significant portion of these charges were correctly paid because the providers' specialties were not applicable to the global reimbursement contracts. At the conclusion of our audit, United HealthCare officials informed us that they are still reviewing about $1 million in potentially duplicate overpayments. Additionally, United HealthCare officials informed us that their recovery process has been hampered because the findings data we provided did not include certain information such as patients' names, hospital account numbers and providers' specialties. However, the information we provided United HealthCare is based on the electronic claims history data that United HealthCare provided us before the start of the audit. This data lacks the items that United HealthCare officials stated they need to expedite their recovery process. Most notably, the lack of provider specialty data has required United HealthCare staff to research the company's individual provider files to determine whether the providers in our findings population actually specialized in medical fields included in the global reimbursement contracts.

**Payments for Services Already Included in Hospital Outpatient Payments**

United HealthCare's management maintains a claim processing system which includes edits to ensure that claims are properly paid. A properly functioning claims processing system should include edits to detect and prevent duplicate payments among insurance carriers. Establishment of such edits requires adequate communication and data exchange among carriers. Such communication and exchange is especially important in the Plan, which is comprised of multiple carriers with independent claim processing systems. We found that United HealthCare's claims processing edits and other coordination provisions are not adequate. As a result, United HealthCare made duplicate payments for physician services that were already included in Empire Blue Cross' hospital outpatient payments. As also detailed in audit report 98-S-14, the following are key reasons why United HealthCare made separate, and therefore, duplicate payments.

- Claim approvers are not adequately trained to prevent the improper payment of globally reimbursable charges. We found that approvers paid charges although these charges should not have been paid according to United HealthCare's own global reimbursement guidelines.

- United HealthCare's process to prevent payment of global reimbursement charges is predominantly manual and, thus, is subject to human error. We found that United HealthCare's edit system includes only one automated edit designed to identify such charges; this edit flags only charges for emergency services. These charges, once flagged, are still subject to a manual review process, which can result in improper payments. United HealthCare officials responded that they can not implement automated edits to apply provisions to only a fraction of the population (i.e., charges affected by global reimbursement). However, United HealthCare's automated edit system applies provisions to other isolated portions of the population. For example, the system automatically

reimburses providers at rates based on geographic service location. In addition, United HealthCare officials indicated that they are working with Empire Blue Cross officials to obtain hospital emergency room data for all claims. This data could serve as a basis for developing edits specifically designed to prevent the payment of these improper charges.

- United HealthCare improperly paid claims because the physicians indicated that the medical services had been provided in an office, rather than the hospital outpatient department. This situation emphasizes the need for improved procedures for exchanging data between the Plan's carriers.

- Even though Empire Blue Cross had provided the necessary information, United HealthCare's global reimbursement guidelines were incomplete.

## Recommendations

1. *Review the claims in the audit population. Recover payments made for physician services that were already included in the Empire Blue Cross' hospital outpatient payments and remit these recoveries to the Plan.*

2. *Evaluate and improve training procedures related to global reimbursement issues to minimize approver payment errors.*

3. *Improve procedures for coordinating claims affected by Empire Blue Cross' global reimbursement policy. For example, confirm existing global reimbursement guidelines with Empire Blue Cross officials and exchange data with Empire Blue Cross on a timely and routine basis.*

4. *Consider additional computerized edits to identify potential payment errors. For example, develop edits to flag claims with certain medical procedures, provider specialty and location information. Additionally, consider matching claims with outpatient data obtained from Empire Blue Cross.*

Major contributors to this report were Lee Eggleston, Ronald Pisani, Dennis Buckley, Douglas Abbott and Lei Zhang.

We would appreciate receiving your response to the recommendations made in this report within 90 days, indicating any action planned or taken to implement them.

We wish to express our appreciation to the management and staff of United HealthCare for the courtesies and cooperation extended to our auditors during this examination.

Yours truly,

Kevin M. McClune
Audit Director

cc: Robert Brondi, Division of the Budget
George Sinnott, Department of Civil Service
M. Laurie Wasserstein, United HealthCare Service Corporation
Dr. Michael A. Stocker, Empire Blue Cross Blue Shield
Josephine Hargis, Empire Blue Cross Blue Shield