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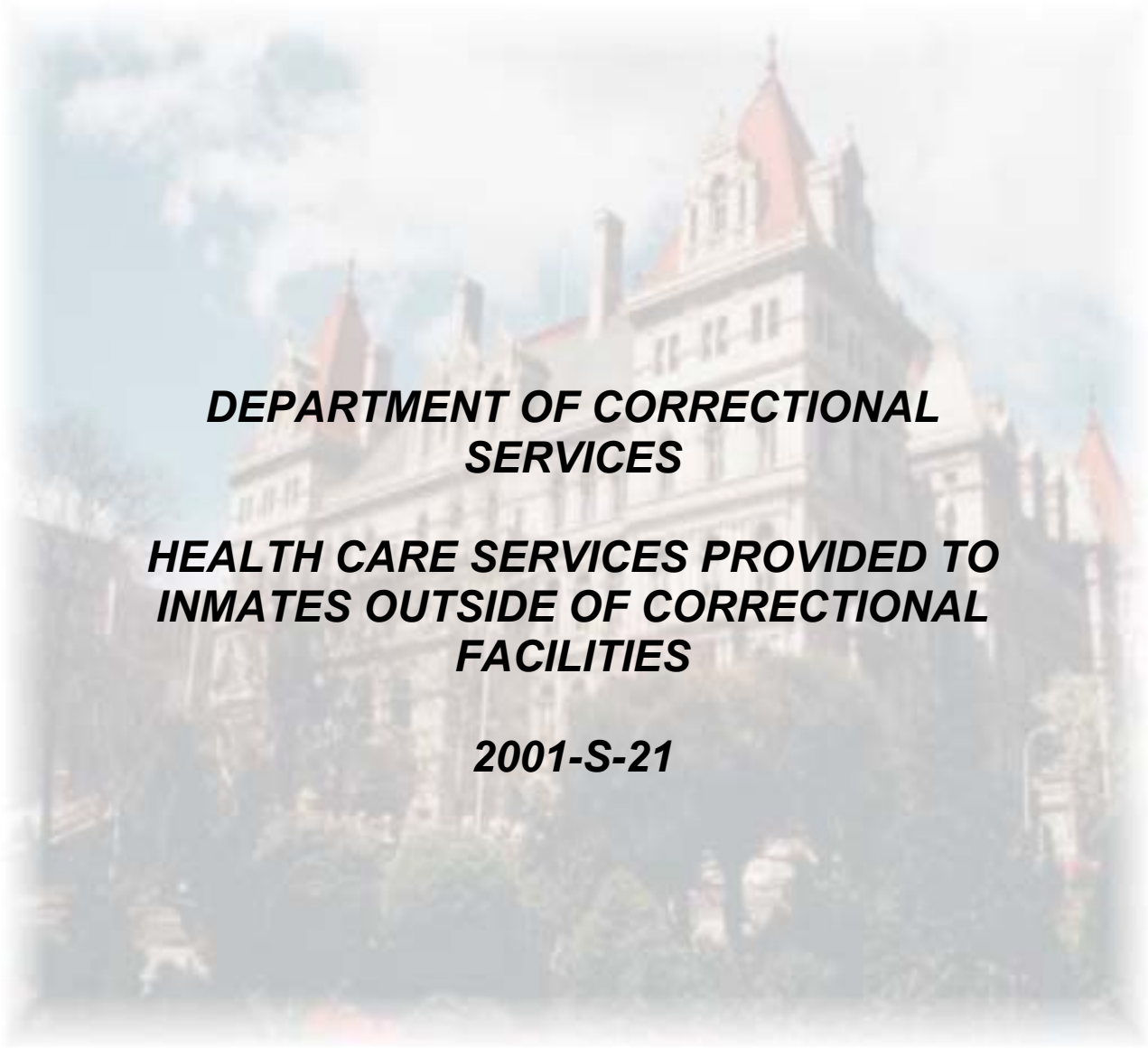

DEPARTMENT OF CORRECTIONAL SERVICES

HEALTH CARE SERVICES PROVIDED TO INMATES OUTSIDE OF CORRECTIONAL FACILITIES

2001-S-21

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STATE COMPTROLLER

Report 2001-S-21

Mr. Glenn S. Goord
Commissioner
New York State Department of Correctional Services
Building #2 – State Campus
1220 Washington Avenue
Albany, NY 12226-2050

Dear Mr. Goord:

The following is our audit report addressing the process used by the Department of Correctional Services in administering the health care services provided to inmates outside of correctional facilities.

This 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. Major contributors to this report are listed in Appendix A.

Office of the State Comptroller
Division of Management Audit
and State Financial Services

May 16, 2002

EXECUTIVE SUMMARY

DEPARTMENT OF CORRECTIONAL SERVICES
HEALTH CARE SERVICES PROVIDED TO INMATES OUTSIDE OF CORRECTIONAL FACILITIES

SCOPE OF AUDIT

The Department of Correctional Services (DOCS) is responsible for providing comprehensive health care services to about 71,000 inmates in 70 correctional facilities. The services may be provided by DOCS physicians at correctional facility infirmaries or by specialist physicians at hospitals and other outside medical facilities. All outside medical services are initiated by a referral from a facility physician. At the time of our audit, the bills for some outside medical services were still paid by contracted managed care providers, but DOCS was in the process of assuming the responsibility for making all such payments. Information about outside medical services is kept on a special automated information system (the FHS1 system) maintained by DOCS. For fiscal year 2000, the total cost to DOCS for all the medical services provided to inmates was about $187 million.

Our audit addressed the following questions about the process used by DOCS in providing specialized health care services to inmates for the period April 1, 1999 through October 31, 2001:

- Are the services provided in a timely manner consistent with the referring physicians' guidelines with evidence of appropriate follow-up?

- Is the integrity of the data on the FHS1 system protected against unauthorized changes?

- Are the controls over the claim payment system sufficient to ensure that only proper payments are made to providers for authorized medical services that were actually provided?

AUDIT OBSERVATIONS AND CONCLUSIONS

We found that outside medical services are not always provided in a timely manner, and may not always be followed up on by the referring physicians. We also found that improvements are needed in the controls over the FHS1 system and the process used to pay bills for outside medical services.

We examined the records relating to 50 referrals for outside medical services made by physicians at five correctional facilities. We found that, in 9 of the 50 referrals, the requested medical services were not provided as soon as recommended by the referring physicians. Rather, the services were provided between 3 and 60 days later than was recommended. In such instances, the health of the inmates could be compromised, especially when the need for the services is urgent (as was the case in one of the nine referrals). (See pp. 5-7)

We also identified the need for improvement in other aspects of the referral process. For example, for 4 of the 50 referrals in our sample, the recommendations made by the referring physicians on referral forms were changed after the information on the forms was entered on the FHS1 system. While the reason for one of these changes was documented on the system, the reasons for the other three changes were not documented. As a result, there is less assurance that these changes were appropriate. We also found that, even though the referring physicians are required to follow up on the outside services, this follow-up was not documented in at least eight of the referrals in our sample. In addition, because completed referral forms were not always kept on file at the correctional facilities, there was less assurance that the referral information entered on the FHS1 system was accurate and complete. (see pp. 7-9)

DOCS relies on the information on the FHS1 system when scheduling inmates for outside medical services and verifying that these services were provided as intended. Therefore, it is imperative that the information on the system be adequately controlled. However, we found that certain improvements are needed if access to this information is to be appropriately restricted to authorized users only. We also found that improvements are needed in controls that help ensure the accuracy of information used in paying bills from medical service providers. (see pp. 11-15)

We examined the process used by DOCS in paying bills for outside medical services. We found that bills may be paid even when documentation is not submitted indicating that the services were actually provided to the inmate. As a result, DOCS is less likely to identify certain kinds of billing errors and more likely to make payments for services that were not provided. In our sample of 100 bills, we identified one bill in which payment had been authorized for services that were not provided. We also identified an overpayment that was caused by a DOCS error in calculating a reimbursement amount. (See pp. 17-20)

COMMENTS OF DOCS OFFICIALS

DOCS officials agreed with many of the report's recommendations and indicated steps being taken to implement them. For those recommendations that DOCS officials did not fully concur with, they generally indicated alternative measures being taken to satisfy the intent of the recommendation.

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INTRODUCTION

Background

The Department of Correctional Services (DOCS) is responsible for providing comprehensive health care services to approximately 71,000 inmates residing in more than 70 correctional facilities located throughout the State. The services may be provided by DOCS physicians who tend to inmates at correctional facility infirmaries, or they may be provided by specialist physicians who tend to inmates at hospitals, clinics and other medical facilities located outside correctional facilities (such as one of DOCS' four Regional Medical Units). For fiscal year 2000, the total cost to DOCS for all the medical services provided to inmates was about $187 million.

The inmate health care process begins at the infirmaries located in each correctional facility, where inmates receive primary health care services. If an inmate needs to be seen by an outside specialist, a referral form is completed by the facility physician. Information from this form, such as the description of the inmate's medical problem and the outside service sought to address the problem, is entered onto an automated information system for inmate health care services (the FHS1 system) by the facility's health service staff. At most facilities, this information is then transmitted electronically to a contracted managed care provider, who is responsible for determining whether the requested service is medically necessary. If the service is determined to be medically necessary, the managed care provider schedules and coordinates all needed outside services, and pays the bills submitted for these services.

At the correctional facilities in the two areas of the State not served by a contracted managed care provider (Western New York and part of the mid-Hudson region), the information from the referral form is transmitted to DOCS' Health Services Unit, located at the central office. These officials are responsible for determining whether the requested service is medically necessary. If the service is determined to be medically necessary, DOCS schedules and coordinates all needed outside services, and pays the bills submitted for these services.

In the past, all DOCS correctional facilities were served by managed care providers. However, DOCS is in the process of replacing these providers with outside contractors whose only responsibilities are to evaluate the medical necessity of referrals for outside services and to verify medical claims submitted. DOCS then assumes the responsibility for scheduling and paying for the services. DOCS officials told us they are making this change to improve their control over inmate medical costs. In their contracts with the managed care providers, the providers are paid a certain amount for each inmate in the managed care plan during the contract period. This amount is later adjusted based on the actual costs incurred.

The bills for the outside services paid by DOCS are submitted to the DOCS Budget and Finance Office. Information from the bills is entered on the FHS1 system and is verified by staff in the DOCS Division of Health Services. The staff visually match the provider and date of service on the bill to the information on the corresponding medical referral. If the inmate's medical appointment took place as scheduled, the bill is approved for payment. If the inmate stayed overnight in a hospital or clinic, the days billed by the hospital or clinic are matched against DOCS information about the location of inmates to verify that the inmate was in fact checked out of the correctional facility on the dates of service. If a billed service cannot be verified by the Division of Health Services, Division staff are to contact the health services staff at the appropriate correctional facility to determine whether the medical services were provided as indicated on the bill. Once a service is verified, the Budget and Finance Office determines how much the provider should be paid on the basis of pre-established contract rates for certain providers or Medicaid rates for other providers.

The FHS1 system was developed in 1995 to track the phases of the specialized outside health care services provided to inmates, beginning with the assessment of need for specialized care by the facility physician and the initiation of the medical referral. In March 2000, DOCS also began using this system in its verification and payment of medical bills submitted by service providers, and is planning on expanding the system's capabilities to include other functions.

Audit Scope, Objectives and Methodology

We audited selected aspects of the process used by DOCS in administering the health care services provided to inmates outside of correctional facilities for the period April 1, 1999 through October 31, 2001. The objectives of our performance audit were to determine: (1) whether services were provided in a timely manner consistent with the referring physicians' guidelines with evidence of appropriate follow-up; (2) whether controls are in place to protect the integrity of the data on the FHS1 system; and (3) whether the controls over the claim payment system are sufficient to ensure that only proper payments are made to providers for authorized medical services that were actually provided. To accomplish our objectives, we interviewed managers and staff at the DOCS Central Office and at selected correctional facilities. We also reviewed DOCS policies, directives and procedures; visited selected correctional facilities; reviewed a sample of paid bills for outside medical services; tested other transactions; and observed operations at the Central Office and selected facilities.

We conducted 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 which are included in our audit scope. Further, these standards require that we understand DOCS' internal control structure and its compliance with those laws, rules and regulations that are relevant to the operations 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 such other auditing procedures as 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.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on operations that have been identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, finite audit resources are used to identify where and how improvements can be made. Thus, little audit effort is devoted to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an

"exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Internal Control and Compliance Summary

Our consideration of the internal control structure focused on the process used by DOCS in administering the health care services provided to inmates outside of correctional facilities. We identified weaknesses in controls relating to the medical referral process, information on the FHS1 system, and payment of bills for outside medical services that should be addressed by officials at the DOCS Central Office and the individual facilities reviewed. These matters are presented throughout the report.

Response of DOCS Officials to Audit

A draft copy of this report was provided to DOCS officials for their review and comment. Their comments were considered in the preparation of this report, and are included as Appendix B.

DOCS officials agreed with many of the report's recommendations and indicated steps being taken to implement them. For those recommendations that DOCS officials did not fully concur with, they generally indicated alternative measures being taken to satisfy the intent of the recommendation.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Correctional Services shall report to the Governor, the State Comptroller and 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 therefor.

MEDICAL REFERRAL PROCESS

The process of obtaining outside medical services for inmates is initiated by a referral form. If the process is to function as intended, the information placed on the referral form by the facility physician needs to be entered on the FHS1 system promptly, accurately and completely. We reviewed certain aspects of the referral process at five correctional facilities: Arthur Kill, Fishkill, Green Haven, Sing Sing and Taconic. These facilities were among those with the highest level of referral activity.

We visited these five facilities during the months of July and August 2001, and, at each facility, selected ten referrals from the FHS1 system for specialized medical appointments that were recently completed. For these 50 referrals, we attempted to compare the information on the FHS1 system to the information on the actual referral forms. The objectives of our review were to determine whether:

- the information written on the referral forms by the referring physicians was accurately entered on the FHS1 system, and

- the services requested by the referring physicians were provided to the inmates within the timeframes indicated by the referring physicians.

In addition, we reviewed the completed referral forms for compliance with certain DOCS requirements. We found that improvements are needed in a number of aspects of the referral process, as the services in our sample were not always provided within the timeframes indicated by the referring physicians, the reasons for certain discrepancies between the referral forms and the information on the FHS1 system were not always documented, the referring physician's follow-up on the requested services was not always documented, and 13 of the 50 referral forms in our sample were not on file at the facilities.

Timeliness of Care

When an inmate is referred for outside medical services, the facility physician assigns an urgency level to the services on the basis of his or her medical judgment of the inmate's condition. The urgency level indicates how soon the services should be provided to the inmate. The possible urgency levels and the related timeframes (which are indicated on the referral form) are as follows:

Urgency Level	Timeframe
Emergency	24 Hours
Urgent	5 days
Soon	14 days
Routine	30 days
Assigned	on a specified date; usually after 30 days

As is shown in the following table, in nine of the 50 referrals in our sample, the requested medical services were not provided within the timeframes indicated by the referring physicians. Rather, the services were provided 3 to 60 days later than requested:

Inmate	Type of Service	Urgency Level	Days Late
A	Physical therapy	routine	51
B	Chemotherapy	soon	7
C	Cardiovascular surgery	urgent*	3
D	Cardiology testing	routine	11
E	Pulmonary procedure	soon*	6
F	Ophthalmology	assigned	21
G	Head MRI	routine	3
H	Ear, nose and throat surgery	routine*	25
I	Pap smear	routine	61

**The urgency level as indicated on the referral form.*

As is discussed later in this report, in these instances, the urgency level indicated on the referral form differed from the urgency level indicated by the FHS1 system, and the reason for the difference was not documented. For example, a pap smear

was requested on April 2, 2001 for inmate I. Since an urgency level of "routine" was assigned by the referring physician, the procedure should have been performed by May 2; however, the procedure was not performed until July 2, which was 61 days later than requested. In this instance, the reason for the delay was indicated on the FHS1 system (the provider was not available until July 2). However, in seven of the remaining eight cases, no reason for the delay in services was indicated on the system. We noted that, in two of these cases, the information on the referral form was not promptly entered on the FHS1 system, which may have contributed to the delay in treatment. For example, the information on inmate D's referral form was entered on the FHS1 system six days after the referral form was completed by the referring physician.

When needed medical services are not provided in a timely manner, the health of the inmates needing the services could be compromised, especially when the need for the services is urgent, such as cardiovascular surgery. While all nine of these outside services were scheduled by a contracted managed care provider, DOCS is responsible for monitoring the contractor's performance to ensure that services are provided in a timely manner. Correctional facility officials are also responsible for ensuring that referral forms are promptly entered on the FHS1 system.

For 13 of the 50 referrals in our sample, the referral form was not on file at the correctional facility, as will be discussed in a subsequent section. We examined the remaining 37 referral forms that were on file and found that, on four of the forms, the urgency level indicated by the referring physician differed from the urgency level indicated on the FHS1 system. In one of the four referrals, the reason for the change was documented on the FHS1 system (the provider was not available within the requested time frame). However, in the other three referrals (which are indicated by an asterisk in the preceding table), the reason for the change was not documented on the system. In all three instances, the urgency level on the FHS1 system was lower (i.e., less urgent) than the urgency level indicated by the referring physician. For example, on May 7, 2001, a facility physician requested ear, nose and throat surgery for inmate H, and assigned an urgency level of "routine" (within 30 days, or by June 7) to the request. However, according to the information on the FHS1 system, the urgency of the service had been downgraded to "assigned," and the procedure was not

performed until July 2, 2001, which was 25 days later than requested by the facility physician.

While it is possible that the urgency of these services was downgraded by the managed care providers in accordance with the terms of the managed care contracts, the reason for such changes should be documented on the FHS1 system to provide assurance that the changes are justified. In response to our preliminary findings, DOCS officials indicated that they will take steps to better document changes in the urgency level of requested outside medical services.

Follow-Up by Facility Physicians

According to DOCS procedures, when an inmate receives outside medical services, the referral form should be brought along and presented to the outside physician after the services are provided. The outside physician should complete the bottom portion of the form, describing the nature of the treatment, and the form should be brought back to the facility with the inmate. The facility physician is then expected to review and sign the referral form in the space provided to approve any treatment initiated by the outside physician and initiate any other follow-up action that may be required. According to the DOCS Health Services Policy Manual, "When the Consultation Form [referral form] is received at the facility health unit, the facility physician reviews the form, signing and dating the form in the rectangular box at the form's bottom right hand corner."

However, in 8 of the 37 sampled referral forms that were on file at the facilities, the facility physician had not signed the referral form in the space provided for follow-up review. As a result, there is less assurance in these instances that the physician did in fact review the treatment provided by the outside physician to ensure that it was appropriate or did in fact initiate any needed follow-up treatment. In response to our preliminary findings, DOCS officials advised they will take steps to monitor facility physicians' follow-up of outside medical services.

Retention of Referral Forms

The referral process is designed as an internal control to ensure that necessary specialized medical services are

properly authorized and scheduled accordingly. It is important to maintain proper documentation to provide assurance that a control system is functioning as intended. In the absence of such documentation, breakdowns in the system (such as unauthorized medical treatment or delays in necessary treatment) are less likely to be detected.

However, for 13 of the 50 referrals in our sample, the referral form was not on file at the correctional facility. Three of the missing forms were not in the inmates' medical folders, which is where they were maintained by the facilities. The other ten forms were not available because the Taconic Correctional Facility did not keep the original referral forms with the inmate's medical records; instead, this facility used information printed from the FHS1 system. In the absence of these forms, we were unable to verify that the information on the FHS1 system for these 13 referrals was consistent with the information written on the referral forms by the facility physicians. As a result, there is less assurance that the outside medical services provided to these 13 inmates were authorized and appropriate.

The referral process would be better controlled if the referral information were entered directly on the FHS1 system by the facility physicians, thereby establishing automatically accountability over the referrals. In addition, delays in entering the information on the system should be reduced, and the likelihood of data entry errors would be reduced. The use of passwords by the physicians would provide assurance that only authorized referrals were entered on the system. If the process is not automated, referral forms should be logged or sequentially numbered to improve accountability over the referral process. DOCS officials advised us they are considering a system in which referral information would be entered directly on the system by the physicians.

Recommendations

1. Take steps to improve the extent to which outside medical services are provided to inmates within the time frames indicated by facility physicians. One way to accomplish this objective would be, when feasible, to send inmates to other clinics when the contracted providers are unable to accommodate the inmates within the requested time frames.

Recommendations (Cont'd)

2. If the urgency level of an outside medical service is changed from the level indicated by the referring facility physician, document the reason for the change.

3. Monitor facilities' compliance with the requirement that the referring physician sign the referral form after the outside service is provided.

4. Consider the feasibility of establishing a process in which the referring facility physician enters referral information directly on the FHS1 system. If this is not feasible, improve accountability over the referral forms by having them logged or pre-numbered.

CONTROLS OVER INFORMATION ON THE FHS1 SYSTEM

DOCS relies on the information on the FHS1 system when scheduling inmates for outside medical services and verifying that these services were provided as intended. Therefore, it is imperative that the information on the system be adequately controlled. We evaluated the adequacy of the controls over this information. We found that certain improvements are needed if access to the information is to be appropriately restricted to authorized users only. Improvements are also needed in controls that help ensure the accuracy of information used in paying bills from medical providers. Additional improvements are needed if the design of the FHS1 system is to be adequately documented.

System Design and Development

The design and development of, and subsequent changes to, an automated data processing system like the FHS1 system should be thoroughly documented. In the absence of such documentation, the individuals responsible for operating and modifying the system may not be able to obtain a complete and accurate understanding of the system, and as a result, the system may not be able to function as effectively and efficiently as possible.

We found that DOCS has maintained extensive supporting documentation for changes made to the original design of the FHS1 system. However, DOCS has maintained little supporting documentation for the original design and development of the system and related software applications. For example, DOCS was unable to provide us with detailed system specifications and/or a diagram of the system. If key system employees were to leave DOCS or become unavailable, the continued operation of the system could be placed at risk. We therefore recommend that DOCS document the design of the FHS1 system.

Access to Information

The DOCS Central Office appoints a Computer Security Coordinator at each correctional facility who acts as a liaison with the DOCS Division of Management Information Systems and oversees the day-to-day security of the computer system at the facility. The Division of Management Information Systems maintains a listing of all the individuals who are authorized to use DOCS computer systems. Each Computer Security Coordinator is responsible for conducting an annual review of the portion of the listing relating to his or her facility to identify individuals who should be added or deleted.

However, when we reviewed the DOCS listing of authorized users as of May 3, 2001, we identified about 300 individuals who, according to the listing, had not logged on to the FHS1 system for nearly one year or longer. Some of these individuals had not logged on the system for more than three years. We determined that most of these individuals were no longer working for DOCS, and therefore, their user IDs should have been removed from the listing. Since their user IDs were not removed from the listing, we conclude that many of the Computer Security Coordinators have not been performing their annual review of the listing of authorized users and DOCS Central Office has not monitored compliance with this requirement. As a result, dozens of unauthorized individuals may have access to the information on the FHS1 system, which includes confidential health-related information about inmates.

In response to our preliminary findings, DOCS officials indicated that their Security Unit developed a new reporting tool to assist the Computer Security Coordinators in their annual review of the listing of authorized users. In addition, a new quarterly procedure has been implemented to remove user IDs that have not been used or updated in one year.

Access controls are designed to protect data in a computer system against unauthorized use and to prevent unauthorized changes to data and computer applications. The FHS1 is maintained on a mainframe computer, which has controls in place (login and password requirements) to provide appropriate security for system access. However, we found that certain comment fields used by DOCS Division of Health Services staff when verifying bills from medical providers can be altered by personnel in the DOCS Budget and Finance Office. Since the

personnel in the Budget and Finance Office are responsible only for entering the billing information that is to be verified by the Division of Health Services, they should not be able to alter information entered by Division of Health Services staff. Generally, to ensure that data integrity is maintained, an individual's access should be restricted to the functions which pertain to his or her responsibilities.

The FHS1 system is designed to log out a user after a period of inactivity, usually 15 minutes. This control prevents the unauthorized use of the system from terminals when a logged-in user steps away from the terminal. We noted, however, that this control has not been activated at all correctional facilities. At three of the seven terminals we tested: AK SS GH at six correctional facilities and the Central Office, the system did not automatically log off a user after a specified period of time. At such terminals, the system is vulnerable to access by unauthorized individuals.

In response to our preliminary findings, DOCS officials stated that a change to the FHS1 system will be implemented allowing users to edit only comment fields specific to their own area. They also stated that DOCS is in the process of converting all of its users to a more secure sign-on method that would automatically sign off users after a period of inactivity.

Accuracy of Information

Good internal control procedures require that appropriate measures be taken to ensure the accuracy and reliability of data. When a computer system is involved, there should be sufficient data entry controls in place to ensure the accuracy and completeness of data during its entry into the computer application system. For instance, editing and validating controls assess the data as they are being entered into the computer or immediately thereafter. These controls test each item entered for reasonableness as to dates, completeness and duplicates. Data failing any of the tests would be rejected or placed into a suspense file until corrected.

A computerized bill payment system should contain edits to check for the validity of information included on the bill. For the FHS1 system, such edits could validate a patient's age or gender; determine whether a bill may have already been paid based on a particular individual, type and date of service; or

ascertain whether an amount being entered for a particular service is reasonable.

We reviewed the list of edits incorporated into the FHS1 system to evaluate the validity of claim data from medical providers. Based on conversations with officials in charge of other major medical claim payment systems as well as a review of edits contained within these systems, we identified additional edits that could be useful to DOCS in preventing overpayments and payments for services that were not provided. These include edits for checking whether a patient's age is consistent with a given procedure; whether a procedure is valid for the place of service; whether the service provider is ineligible to provide a particular category of service; whether a procedure is valid based on the gender of the recipient; and whether a procedure is consistent with the diagnostic code on the bill.

One particular edit used in the medical industry is a check for reasonableness of the Diagnostic Regional Group (DRG) code, which bases hospital reimbursement on the type of treatment provided and the costs incurred by the hospital. Certain DRGs represent longer hospital stays and thus are reimbursed at a much higher cost. If a hospital bills for services using a higher DRG than necessary, its bill will be inflated. A computerized DRG edit checks for the reasonableness of the code based upon the diagnosis. DOCS officials told us they manually check for the reasonableness of DRGs. However, a computerized edit would be more reliable in identifying potentially unreasonable DRGs. In response to our preliminary findings, DOCS officials indicated that, while it would not be feasible for them to incorporate additional edits into the claims payment system, they will consider purchasing DRG Grouper software that will verify the accuracy of the DRG code.

Output controls in automated systems ensure that transactions are entered and processed as expected. A generally accepted output control is a batch control, which ensures processing reliability by generating batch control totals that are reconciled with the entered data. However, no such control is used in the FHS1 system at any of the correctional facilities we visited. As noted earlier in this report, referral forms may become lost or misplaced. For as long as these forms continue to be the source of the referral information that is entered on the FHS1 system, batch controls could help provide assurance that every

referral form submitted for data entry is entered and accounted for.

Recommendations

5. Document the design and development of the FHS1 system.

6. Establish controls which prevent unauthorized users from accessing the FHS1 system. Deny access to users who have not used the system for an extended period of time.

7. Establish controls that restrict FHS1 system users to the functions in the system that are needed to perform their duties.

8. Establish controls which log off users of the FHS1 system after a designated period of inactivity.

9. Add automated edits to the FHS1 system that enhance the system's ability to identify possible errors in the billing information entered on the system.

10. Establish batch controls over referral forms for as long as such forms are the source of the referral information that is entered on the FHS1 system.

PAYMENT OF BILLS FOR OUTSIDE MEDICAL SERVICES

We examined the process used by DOCS in paying bills for outside medical services. We found that bills may be paid even when documentation is not submitted indicating that the services were actually provided to the inmate. As a result of this control weakness, DOCS is less likely to identify certain kinds of billing errors and more likely to make payments for services that were not provided. We also identified an overpayment that was caused by a DOCS error in calculating a reimbursement amount.

Documentation of Medical Services

It is a general practice for hospitals and other providers to prepare written reports describing the results of surgical and diagnostic procedures, such as CAT scans, MRIs, and X-rays. To provide assurance that an inmate's scheduled medical procedure was provided as intended, the medical unit at the correctional facility where the inmate is housed is responsible for receiving this written medical report before the bill for the procedure is authorized for payment.

Beginning with claims paid (or approved for payment) on July 1, 2001 and working back chronologically until the desired number of claims were chosen, we selected 100 claims of $500 or more for specialized medical services rendered between January 1 and June 30, 2001. The claims related to services provided to inmates at five correctional facilities in the Mid-Hudson region where DOCS pays directly for these services: Coxsackie, Eastern, Greene, Sullivan and Woodbourne. We also compared these 100 bills to the referral information on the FHS1 system to determine whether the services billed were consistent with the services requested on the referral forms.

We found that, for all 100 bills, the services billed were consistent with the services requested on the referral forms. However, for 23 of the 100 bills, the written medical report was not in the inmate's medical file. The amount paid or approved for payment on these 23 bills totaled $33,200, as follows:

Bill	Facility	Date of Service	Type of Service	Amount Paid/Approved
1	*Coxsackie*	2/27-3/9/01	Therapy radiology	$ 1,295
2		3/9-4/4/01	Port films	764
3		6/6/01	Stress test; myocardial study	666
4		5/25/01	Oncology	2,989
5		4/25/01	Mediatostomy/exploration transthoracic	945
6		5/21-23/01	CPR (inpatient)	2,332
7	*Eastern*	4/26/01	Anesthesiology	630
8		6/8/01	Surgical Pathology/Hemorrhoidectomy	1,467
9	*Greene*	6/21/01	Hallux valgus	686
10		5/21/01	Excision-surgical arms & legs-lipoma	1,391
11		5/17/01	RPRblepharot; leva resect; ext approach	674
12		5/16-19/01	Closed liver biopsy (inpatient)	8,076
13		5/16/01	MRI, w/o contrast followed by contrast	997
14		4/26/01	Bronchoscopy, Diag. mediastinotomy	930
15		4/27/01	Mediatonoscopy/biopsy	675
16		5/18/01	Surgical pathology/biopsy	1,076
17		5/29/01	Biometry ultrasound-echo mode	617
18	*Woodbourne*	5/18/01	Colonoscopy flex to splenic flexur	787
19		5/21/01	Hernia repair	675
20		5/21/01	Hernia repair	537
21		5/21/01	Hernia repair	1,581
22		5/30/01	Podiatry	1,438
23	*Sullivan*	5/31/01	Mammography & MRI	1,972
	TOTAL			**$33,200**

While it is possible that some of these missing medical reports were received by the facilities but were subsequently misfiled, it is likely that many of the missing medical reports were never received. As a result, it is likely that many, and perhaps all, 23 bills were approved for payment even though DOCS lacked assurance that the services were provided as indicated on the bills. For example, in the fourth bill in the preceding table,

$2,989 was paid for oncology services. The Division of Health Services approved this payment because the date of service on the bill matched the appointment date recorded on the FHS1 system (May 25, 2001). However, there was no medical report in the inmate's medical file indicating that oncology services were provided to the inmate. In the absence a medical report confirming that the scheduled services were in fact provided, DOCS increases its risk of making payments for services that were not provided.

One such payment was approved in response to one of the bills (#23) listed on the preceding table. In this instance, an inmate at Sullivan Correctional Facility was diagnosed with decreased vision and glaucoma, and was scheduled to receive an MRI of the brain. The medical provider submitted a bill totaling $1,972, which included charges for a mammography in addition to the MRI. DOCS Division of Health Services staff approved payment for both services because the date of the services on the bill (May 31, 2001) matched the date of the scheduled appointment. After we reviewed the inmate's medical file and spoke with facility officials, we determined that a mammography was not performed for this inmate. If the Division of Health Services relied on a medical report in its verification of such bills, it could have detected this error.

On October 9, 2001, we requested DOCS officials to provide us with the missing medical reports for the other 21 bills in our sample. Absent these bills, we have limited assurance that the services were actually provided.

DOCS officials told us they believe that requiring medical providers to submit formal written reports before claims are paid would significantly delay the payment of bills. However, we note that the California Department of Corrections requires medical providers to submit medical reports or other such documentation with their bills. Since medical providers are readily able to produce such documentation shortly after services are rendered, requiring such documentation should not delay the payment process.

Calculation of Payment Amount

Once a bill for outside medical services is approved for payment by the Division of Health Services, the Budget and Finance Office determines how much the provider should be

paid on the basis of pre-established contract rates for certain providers or Medicaid rates for other providers. We reviewed 27 of the 100 bills in our sample to determine whether the amounts approved for payment were correct. We found that one of the bills was overpaid by $764, as a hospital was paid $1,966 when it should have been paid $1,202 for the services that were provided.

This overpayment was caused by an error in applying a formula used to determine the amount a hospital should be paid for an inpatient hospital stay. DOCS uses a prescribed form called a DRG Worksheet for Maximum State Reimbursement to determine such payments. In this instance, a DOCS clerk placed information on the incorrect lines of the form, which resulted in the computation of an incorrect reimbursement amount. DOCS officials told us they have initiated the process of recovering this overpayment.

We note that the DRG Worksheets for several other bills in our sample were missing required information, such as the number of days the inmate was in the hospital and the established standards for the range and average length of hospital stay for the kind of treatment provided to the inmate. All of this information is used to calculate the reimbursement amount. While overpayments did not result from these particular errors of omission, such errors could cause overpayments in other instances. We recommend that DOCS officials instruct Budget and Finance Office staff in the proper use of DRG Worksheets.

Recommendations

11. Prior to approving payment, verify billed services against medical reports or other documentation from the medical provider indicating that the services were actually provided.

12. Obtain medical reports for the 21 instances where documentation of services provided were missing.

    (As of March 10, 2002, DOCS was able to provide us with four of the requested reports.)

13. Recover the overpayment of $764.

Recommendations (Cont'd)

14. Provide Training to Budget and Finance Office staff regarding the proper completion of DRG Worksheets.

MAJOR CONTRIBUTORS TO THIS REPORT

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Appendix A

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ALBANY, N.Y. 12226-2050

GLENN S. GOORD
COMMISSIONER

April 26, 2002

Mr. William P. Challice
Audit Director
Office of the State Comptroller
Division of Management Audit &
State Financial Services
123 William Street, 21st Floor
New York, New York 10038

Re: **Draft Audit of the Department of Correctional Services Managed Care Program FHS1, Report 2001-S-21**

Dear Mr. Challice:

In accordance with Section 170 of the Executive Law and in response to your correspondence of March 21, 2002, attached is the Department's reply to the Draft Audit of the Department of Correctional Services Managed Care Program FHS1, Report 2001-S-21.

We have complied with the provisions of the Budget Policy and Reporting Manual, item B-410 by forwarding two copies of this response to the Division of the Budget on April 19, 2002.

God Bless America,

Glenn S. Goord
Commissioner

Attachment

Appendix B

DEPARTMENT OF CORRECTIONAL SERVICES
MANAGED CARE PROGRAM FHS1 – 2001-S-21

Recommendation #1:

Take steps to improve the extent to which outside medical services are provided to inmates within the time frames indicated by facility physicians. One way to accomplish this objective would be, when feasible, to send inmates to other clinics when the contracted providers are unable to accommodate the inmates within the requested time frames.

Response:

Inmates are scheduled into available clinics dependent upon their medical urgency levels. Schedulers work with facility physicians on a daily basis to triage patients into available clinic slots according to this criteria. As with community patients, it is not always possible to obtain an appointment as quickly as we would like due to the limited availability of some specialists. Whenever an extended wait for an evaluation is deemed to be medically unacceptable, either the patient is transferred to a facility in another region or sent to an area emergency room.

Recommendation #2:

If the urgency level of an outside medical service is changed from the level indicated by the referring facility physician, document the reason for the change.

Response:

Referrals that cannot be scheduled within the requested time frame are pended and a discussion occurs between the referring physician and the scheduler regarding the wait time for the next available clinic. At no time will we permit a nurse scheduler to unilaterally change a patient's urgency level.

Recommendation #3:

Monitor facilities' compliance with the requirement that the referring physician sign the referral form after the outside service is provided.

Response:

We concur and will reiterate this to our physicians. A monitoring process will be incorporated into the Division's existing Quality Improvement Program.

Recommendation #4:

Consider the feasibility of establishing a process in which the referring facility physician enters referral information directly on the FHS1 system. If this is not feasible, improve accountability over the referral forms by having them logged or pre-numbered.

Response:

We concur and will work with our physicians to accomplish. An FHS1 change request providing for "Referral Entry by Physicians" is in the queue of existing requests. Form accountability is addressed in the response to item 10.

Recommendation #5:

Document the design and development of the FHS1 system.

Response:

DOCS follows a Systems Development Methodology based on standard information systems procedures. In developing the Health Services System (FHS1), many hours were spent analyzing the processes followed by DOCS facility and Central Office staff prior to creating a formal system design document and presenting it to the Health Services Division for comment and approval. Their recommendations were then incorporated into the design, the system programmed and final approval obtained during a "walk-through" of the system prior to implementation. Following implementation, extensive supporting documentation for all changes made to the system is maintained in the DOCS Change Management system, but not reflected in the original design documents. Therefore, we disagree with the need for and value of stopping work on our current projects and documenting this system as specified.

Recommendation #6:

Establish controls which prevent unauthorized users from accessing the FHS1 system. Deny access to users who have not used the system for an extended period of time.

Response:

As noted in the audit report, we have established controls that prevent unauthorized users from accessing the FHS1 system. The reporting tool has been implemented to assist Computer Security Coordinators in their review of authorized users. We have also implemented the quarterly procedure to delete user ids from the authorized user file that have not been updated or signed on into the production system in one year.

Recommendation #7:

Establish controls that restrict FHS1 system users to the functions in the system that are needed to perform their duties.

Response:

DOCS is making changes in FHS1 to include a complete electronic audit trail of claim comments and prevent the modification of comments entered by other users. These changes were implemented on April 9, 2002.

Recommendation #8:

Establish controls which log off users of the FHS1 system after a designated period of inactivity.

Response:

As noted in the audit report, controls have been established to log off users after a period of inactivity. The conversion to the more secure signon/logoff procedure is on schedule and will be completed statewide.

Recommendation #9:

Add automated edits to the FHS1 system that enhance the system's ability to identify possible errors in the billing information entered on the system.

Response:

These edits are currently being performed manually by verification staff as part of the process when verifying a claim for payment. It would not be feasible at this time to invest the additional time and resources that would be needed to gather and maintain the data required to incorporate these edits into the claim entry process of the FHS1 system.

Recommendation #10:

Establish batch controls over referral forms for as long as such forms are the source of the referral information that is entered on the FHS1 system.

Response:

Assuming "Referral Form" references the DOCS "Request and Report of Consultation" form (3194), the optimal way of assuring that every "form submitted for data entry is entered and accounted for" is to document the FHS1 generated referral number on the form itself, and file a copy of the entered form in the Inmate's Ambulatory Health Care Record consistent with Health Services' Policy 4.05.

Recommendation #11:

Prior to approving payment, verify billed services against medical reports or other documentation from the medical provider indicating that the services were actually provided.

Response:

As discussed with OSC auditors during the closeout meeting, this is not feasible. This recommendation would require that verification of services be done at the facility level where the medical records of inmates are stored. We believe that our automated FHS1 scheduling system which links clinic appointments by specialty with date of service to be an appropriate documentation system and allows for a centralized oversight and prompt payment to providers for services rendered.

Recommendation #12:

Obtain medical reports for the 21 instances where documentation of services provided were missing.

Response:

All 21 records were obtained and verified. In all instances, service was provided as stated.

Recommendation #13:

Recover the overpayment of $764.00.

Response:

A credit for the overpayment was applied to voucher #0114399 which was paid on November 6, 2001.

Recommendation #14:

Provide training to Budget and Finance Office staff regarding the proper completion of DRG Worksheets.

Response:

OSC noted that the DRG's sampled included several DRG worksheets which were missing required information such as the inmate's length of hospital stay, as well as established standards for the range and average length of hospital stay based on the diagnosis. Even without this information no overpayment was made on any of the sample claims reviewed. The required information is verified when auditing claims, as the reimbursement rate cannot be calculated without this information. Audit clerks have been instructed to record this information on the DRG worksheet when calculating future payments.