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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

December 17, 2002

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

Re: New York State Health Insurance Program
Anesthesia Claims
Report 2000-S-40

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 major medical claims processed for the New York State Health Insurance Program's Empire Plan. The scope of our financial-related/compliance audit included medical claims of Empire Plan members for the three-year period ended December 31, 2001.

A. Background

The New York State Health Insurance Program (Program) provides hospital and surgical services and other medical and drug coverage to more than 790,000 active and retired State employees and their dependents. It also provides coverage for more than 376,000 active or retired employees of participating local government units and school districts, and dependents of such employees.

The Empire Plan (Plan) is the Program's primary health benefits plan, providing services to almost one million individuals in the Program at an annual cost of more than $2.5 billion. The Department of Civil Service (Department) contracts with United HealthCare (UHC) to administer the surgical/major medical portion of the Plan. During the year ended December 31, 2001, UHC approved over 9.6 million charges totaling more than $903 million and charged the State about $92 million for administrative and other related expenses.

According to generally accepted medical billing practices, including those contained in the National Correct Coding Guide published by Ingenix (formerly St. Anthony's Publishing Company) and guidelines published by the American Medical Association (AMA), anesthesiologists are reimbursed on the basis of a "global anesthesia care package." In this reimbursement methodology, an anesthesiologist receives a single global payment covering all the services generally provided by an anesthesiologist in connection with a surgical procedure, including all pre- and post-operative evaluation and management services, such as office visits, hospital visits and consultations. Since evaluation and management services are covered by the global payment, anesthesiologists should not be paid separately for these services.

B. Audit Scope, Objective and Methodology

We audited the Plan's payments to anesthesiologists for the three years ended December 31, 2001. The primary objective of our audit was to determine whether UHC erroneously made separate payments to anesthesiologists for evaluation and management services already covered by global payments. To identify such erroneous payments, we used computer-assisted audit techniques to review and assess all the payments made to anesthesiologists during the three-year period. We then selected a statistical sample from certain payments for detailed examination. In the course of this examination, we reviewed documentation maintained by UHC in relation to the payments and conducted interviews with officials at UHC and the Department.

We did our audit according to generally accepted government auditing standards. Such standards require that we plan and do our audit to adequately assess those Department and UHC operations included in our audit scope. Further, these standards require that we understand the internal control systems of the Department and UHC and that we review these entities' compliance with the 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.

Our consideration of the internal control structure at UHC addressed the controls over payments made to anesthesiologists. As is described in greater detail in the following section of this report, we identified certain weaknesses in these controls.

We use a risk-based approach when selecting activities to be audited. We therefore focus our audit efforts on activities that we have identified 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, 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.

C. Results of Audit

Because of weaknesses in UHC's claims processing system, some of the claims submitted by anesthesiologists for evaluation and management services were erroneously paid. The payments were erroneous because the services were covered by global payments made to anesthesiologists. We estimate that, during our three-year audit period, these erroneous payments totaled $366,036.

We provided preliminary reports of our audit findings to UHC officials and considered their comments in preparing this report. UHC officials agree that most of the payments questioned by our audit should not have been made. The officials informed us that they are reviewing the payments in our audit population and will remit recovered overpayments to the Plan. The officials also informed us that they have enhanced the company's claims processing system to prevent the payment of certain incorrect claims. The officials further stated that, to minimize other types of payment errors, they have provided additional training and claims review guidelines to their claims approvers.

As is described in detail later in this report, UHC officials expressed their belief that some of the payments questioned by us were not in fact erroneous, and should have been made. These payments were the result of a UHC policy that, while inconsistent with generally accepted medical billing practices, was based on advice from the company's medical consultant staff. However, Department officials agree with our position that the policy is not correct and the resulting payments should not have been made.

Erroneous Payments to Anesthesiologists for Evaluation and Management Services

According to generally accepted medical billing practices, anesthesiologists should not be paid separately for evaluation and management services that are covered by global anesthesiology payments. To determine whether any such payments were erroneously made during our three-year audit period, we used computer-assisted audit techniques to identify 15,049 payments for evaluation and management services, totaling $997,117, that may have been erroneous, because the payments appeared to be already covered by global payments to anesthesiologists.

To further evaluate the appropriateness of these payments, we used scientific sampling techniques to select a stratified sample of 133 of the payments. We then examined the supporting documentation relating to these payments. We determined that 87 of the 133 payments were appropriate because, generally, the payments reimbursed services that were not related to surgical procedures and, therefore, not covered by global payments to anesthesiologists. However, 46 of the 133 payments were not appropriate, because the payments were for evaluation and management services that were already covered by global payments to anesthesiologists.

When the results from our sample are statistically projected to the 15,049 selected payments (totaling $997,117) to anesthesiologists during the three-year period, it can be estimated with 95 percent confidence that between $273,976 and $458,096 (with a midpoint of $366,036) of the payments were inappropriate because they were already included in the global payments to anesthesiologists.

We determined that the inappropriate payments were made for a number reasons. For example, while UHC's claims processing system includes computerized and manual controls that are intended to provide reasonable assurance that claims are properly paid, these controls did not always work as intended. In some instances, automated controls for preventing inappropriate payments were overriden by UHC claims approvers and claims were inappropriately paid. In other instances, computerized controls had not been developed to prevent the payment of certain types of erroneous claims. In other instances, UHC incorrectly authorized the payment of a certain type of claim.

Following is a summary of the reasons for the 46 inappropriate payments identified by our examination of the 133 payments in our statistical sample:

- In 23 of the payments, either computerized controls had not been developed to prevent the payment of certain types of erroneous claims or, to a lesser extent, incorrect decisions were made by UHC claims approvers when they processed the claims. UHC officials agree that the 23 claims should not have been paid, because the evaluation and management services in the claims were covered by global payments that were made to the anesthesiologists.

- In 11 of the payments, the claim was paid because the doctor who provided the evaluation and management services was not the same doctor who administered the anesthesia for the surgical procedure. However, we determined that, in all 11 instances, the different doctors belonged to the same provider group specializing in anesthesiology. According to billing guidelines published by the McGraw-Hill Healthcare Management Group (Relative Value for Physicians), doctors in the same provider group specializing in the same medical field are considered to be the same doctor for billing purposes. Therefore, the 11 separate claims for evaluation and management services should not have been paid. In response to our preliminary report, UHC officials informed us that they have enhanced their claims processing system to prevent the payment of such claims, and they will pursue the recovery of the claims identified in our audit.

- In 7 of the payments, the separate claim for evaluation and management services was paid because the services were provided more than one day before or more than one day after the administration of the anesthesia. UHC officials informed us that they use this "one-day rule" on the advice of the company's medical consultant staff. However, according to generally accepted medical billing practices, evaluation and management services are included in the global anesthesia care package and should not be paid separately regardless of when these services occur. Department officials concur with this position and agree that the "one-day rule" is not correct. As a result, the seven claims should not have been paid.

- In 4 of the payments, the separate claim for evaluation and management services was paid because Medicare was the primary payer of benefits for the recipient. In such instances, UHC pays the remainder of the Medicare-approved amount without applying its own payment guidelines. However, this practice is not appropriate, as we noted in a prior audit report addressing the New York State Health Insurance Program (Report 95-S-88 issued on April 14, 1997 and a related management letter issued to the Department on the same date). As we stated in that report, Medicare's claims processing system cannot always be relied on

to identify claims that should not be paid. If UHC had applied its own payment guidelines to the four claims, they would not have been paid.

- In 1 of the payments, a separate claim for evaluation and management services was paid because UHC combined this claim with a claim for other services provided by the anesthesiologist, and compared the combined total to the reasonable and customary fee for the global anesthesia care package. Since the combined total was less than the reasonable and customary fee, UHC paid both claims. However, this method of evaluating the claim for evaluation and management services is not appropriate. According to generally accepted medical billing practices, anesthesiologists should not be paid separately for evaluation and management services that are covered by global anesthesiology payments. Since the evaluation and management services in this claim were covered by a global payment, the claim should not have been paid, and any consideration of the reasonable and customary fee is irrelevant to this determination. In our prior audit report (Report 95-S-88 and related management letter), we also noted that reasonable and customary fees were sometimes applied inappropriately by UHC in its processing of claims.

Recommendations

1. *Review the population of 15,049 questionable payments made to anesthesiologists from which we estimated that $366,036 was overpaid. Identify the payments that should not have been made, recover these payments from the appropriate parties, and remit the recoveries to the Plan.*

2. *Analyze the errors made by the automated claims processing system in processing claims from anesthesiologists and develop the appropriate automated controls.*

3. *Evaluate the company's "one-day rule" and other payment policies for anesthesia-related claims, and make the revisions necessary to bring the policies into compliance with generally accepted medical billing practices.*

4. *Analyze the errors made by claims approvers in processing claims from anesthesiologists and take appropriate corrective actions.*

Major contributors to this report were Ronald Pisani, Dennis Buckley and Craig Coutant.

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 UHC for the courtesies and cooperation extended to our auditors during this audit.

Yours truly,

Kevin M. McClune
Audit Director

cc: George Sinnott, Department of Civil Service
Deirdre A. Taylor, Division of the Budget
Donna Pooley, United HealthCare