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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

December 7, 2006

Antonia C. Novello, M.D, M.P.H, Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Medicaid Payments to
Signature Health Center, LLC
Report 2006-S-59
(Revised)

Dear Dr. Novello:

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, we audited selected Medicaid payments to Signature Health Center, LLC for the period January 1, 2001 through May 31, 2006. (This report was revised to include subsequent information provided after the initial report was issued.)

A. Background

The New York State Department of Health (Department) administers the State's Medicaid program, established by Title XIX of the federal Social Security Act to provide medical assistance to needy individuals. Some of the State's Medicaid recipients are also covered by Medicare and are referred to as dual-eligibles. By law, Medicaid is the payer of last resort and as such, it is the responsibility of medical providers to exhaust all other medical coverage before billing Medicaid.

Signature Health Center, LLC (Signature) is a diagnostic and treatment center with offices in the Bronx and Hempstead, New York. Signature offers a wide variety of medical services including orthopedic, chiropractic, gynecological, podiatric, and general medicine. Between January 1, 2001 and May 31, 2006, Signature received payment for nearly 195,000 Medicaid claims totaling $25 million.

During our review of Medicaid payments, we identified several billing abnormalities by Signature. These included:

- large quantities of seemingly unnecessary services to individual patients,
- practitioners billing for services that would add up to more than 24 hours per day,
- repeated instances where duplicate claims were submitted for payment,
- claims billed at higher than allowable rates.

On February 10, 2006, we notified Signature of our intent to audit its Medicaid billings based on our preliminary findings. Signature denied our auditors access to their records. After successful litigation, OSC auditors began their onsite review on May 15, 2006.

Based on the findings identified by the State Comptroller's Office and its own independently derived findings, the Office of the Medicaid Inspector General (OMIG), issued a letter on June 21, 2006 terminating Signature's participation in the Medicaid program effective August 21, 2006. In addition to what we identified, the OMIG termination letters found Signature was billing Medicaid for services ordered by non-enrolled providers, made false statements on ownership applications, and offered patients excessive services. In addition, the OMIG letter raised quality of care issues related to Signature's services.

B. Audit Scope, Objectives, and Methodology

We audited selected Medicaid payments made to Signature for the period January 1, 2001 through May 31, 2006. We conducted our audit according to generally accepted government auditing standards. Our original audit objectives were to determine whether Medicaid overpaid Signature for recipients who were eligible for both Medicare and Medicaid, and whether Signature providers prescribed medications outside of their medical specialties. We also initially sought to determine if Signature was billing for excess numbers of services and if services were being over utilized.

Following the release of the OMIG's termination letter, we limited our audit scope to determining whether Signature inappropriately billed for recipients who were eligible for both Medicaid and Medicare (dual-eligible) and whether providers prescribed medication outside of their specialty.

To accomplish our audit objectives, we analyzed Signature's Medicaid claim data, reviewed applicable sections of federal and State laws and regulations, and examined the Department's billing policies and procedures relevant to our audit scope. In addition, we interviewed officials from Signature and the Department. We also selected a judgmental sample of 125 of Signature's Medicaid claims and supporting medical records for recipients who qualified for dual-eligibility. Further, we obtained and examined detailed Medicare payments to Signature during the period January 1, 2001 through May 31, 2006.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system;

preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members, some of who have minority voting rights, to certain boards, commissions, and public authorities. These duties may be considered management's functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

C. Results of Audit

We conclude that Signature over billed Medicaid for many patients who were dual-eligible at the time of their service. This resulted in actual overpayments of about $831,000 and estimated potential overpayments of another $455,000. This matter was referred to the Office of the New York State Attorney General for investigation. Additionally, we identified a number of instances where podiatrists working at Signature prescribed medications which appeared to be outside their specialty. We referred this matter separately to the State Education Department's Office of Professional Discipline.

1. Overpayments for Dual-Eligible Recipients

By law, Medicaid is the payer of last resort on all medical claims. In New York State, it is the responsibility of the Medicaid provider to determine whether a recipient has applicable Medicare or other third-party medical coverage and bill such insurance resources before billing Medicaid. For patients eligible for both Medicare and Medicaid (dual-eligible), Medicare is normally responsible for paying 80 percent of the amount approved for a procedure. The 20 percent difference between the Medicare amount approved and paid for a procedure is referred to as the "coinsurance amount." Medicaid is typically responsible for paying a provider only 20 percent of the coinsurance amount. However, for some providers, Medicaid is required to pay the entire coinsurance amount or even a higher amount. Providers such as Signature are required to enter, on the Medicaid claim, the amount Medicare approves and pays for services they provided. According to Department officials, Signature is only entitled to the coinsurance amount on claims for dual-eligible recipients.

We visited Signature and reviewed 125 of their Medicaid claims for services provided to recipients that were dual-eligible. Of the 125 claims reviewed, we found 99 (79 percent) were overpaid. Each overpayment was caused by Signature reporting inaccurate Medicare payment information on its Medicaid claim. Specifically, for 90 of the 99 overpayments, Signature reported that Medicare did not pay or approve any amount. However, for these claims, we found that Signature did bill Medicare, and Medicare did approve and pay Signature for the claim. For the remaining nine overpayments, Signature incorrectly entered the Medicare billed amount for the service instead of the Medicare approved amount, on the Medicaid claim. The amount a provider bills for a service is often much higher than the amount Medicare approves and pays for that service. Using the Medicare billed amount instead of the Medicare approved amount when billing Medicaid inappropriately increases the coinsurance amount and the corresponding Medicaid payment.

For 25 of the 125 claims, we could not conclude whether there were actual overpayments because either the recipient's Medicare coverage was in question or we had not confirmed whether Signature had billed Medicare for the claim. For one claim, we found no exception.

Based on these findings, we expanded our tests and obtained Signature's Medicare payments for the period January 1, 2004 to May 31, 2006. We compared these payments to Signature's Medicaid claims to determine whether Signature was overpaid by Medicaid. We found that Signature received $831,000 in overpayments from Medicaid, most of which were caused by Signature's failure to report, or Signature under-reporting Medicare receipts on its Medicaid claim. In addition, we estimate Signature would have received approximately $455,000 in overpayments for the period January 1, 2001 through December 31, 2003, based on the identified error rates. We did not obtain Signature's Medicare billing records before 2004 and therefore, could not confirm this estimate. However, our analysis of billings in the earlier period revealed many of the same patterns we saw in the more recent Medicaid billings.

2. Prescriptions Outside the Prescribing Practitioners' Specialty

According to Article 141 of the New York State Education Law, podiatrists are only allowed to diagnose, treat, operate, and prescribe for any disease, injury, deformity or other condition of the foot. However, we found two podiatrists working for Signature were prescribing medication that did not appear to relate to the foot. In total, we identified 154 prescriptions ordered by these podiatrists that do not appear appropriate, including prescriptions for drugs used to treat acid reflux, elevated cholesterol, depression, erectile dysfunction, schizophrenia, sleep disorders, and other conditions. When we questioned the medical director of Signature on this practice, he stated a provider would sometimes do this as a service to the patient. For instance, if a podiatrist sees a patient who complains of a problem unrelated to the foot, the podiatrist may write a prescription for the patient's problem (unrelated to the foot) without requiring the patient to see another practitioner. We question the appropriateness of this practice and we referred this matter separately to the New York State Education Department for further investigation.

Recommendation

Investigate and recoup overpayments made to Signature for dual-eligible recipient claims.

We provided a draft copy of this report to Department officials for their review and comment. Department officials agreed with our recommendation. A complete copy of the Department's response is included as Appendix A.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendation contained herein, and if the recommendation was not implemented, the reasons therefor.

Major contributors to this report were Kenneth Shulman, Robert Wolf, Dennis Graves, Joseph Nopper, and Andrea Inman.

We appreciate the courtesies and cooperation extended to our auditors during the audit.

Very truly yours,

Steven E. Sossei
Audit Director

cc: Lisa Ng, Division of the Budget
Thomas Howe, Department of Health

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

September 5, 2006

Steven E. Sossei
Audit Director
Office of the State Comptroller
110 State Street
Albany, New York 12236

Dear Mr. Sossei:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report (2006-S-59) on "Medicaid Payments to Signature Health Center, LLC".

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix A

cc: Mr. Charbonneau
Mr. Griffin
Mr. Howe
Ms. Napoli
Ms. O'Connor
Mr. Reed
Mr. Seward
Mr. Wing

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2006-S-59 on
"Medicaid Payments to Signature Health, LLC"

The following are the Department of Health's (DOH) comments concerning the recommendations contained in the Office of the State Comptroller's (OSC) draft audit report (2006-S-59) on "Medicaid Payments to Signature Health, LLC".

Recommendation #1:

Investigate and recoup overpayments made to Signature for dual-eligible recipient claims.

Response #1:

In addition to terminating Signature Health Center, LLC's participation in the Medicaid program, the Department's Office of the Medicaid Inspector General (OMIG) is currently conducting a billing audit of Signature. OMIG will investigate the payments identified by the audit and establish recoveries where appropriate. Termination may affect collection of the amounts identified. However, there is currently a 100% Medicaid withhold in effect as well as a significant number of pended claims, both of which may allow the Department to recoup a significant portion of such payments.