

*State of New York*  
*Office of the State Comptroller*  
*Division of Management Audit*

**DEPARTMENT OF HEALTH  
DEPARTMENT OF SOCIAL SERVICES**

**MEDICAID: MONITORING OF  
MULTIPLE BILLINGS BY PHYSICIANS**

**REPORT 95-S-49**



*H. Carl McCall*  
*Comptroller*



# State of New York Office of the State Comptroller

---

---

## Division of Management Audit

### Report 95-S-49

Barbara Ann DeBuono, M.D.  
Commissioner  
Department of Health  
Empire State Plaza  
Tower Building  
Albany, NY 12234

Mr. Brian J. Wing  
Acting Commissioner  
Department of Social Services  
40 North Pearl Street  
Albany, NY 12243

Dear Commissioners DeBuono and Wing:

The following is our report on the Departments of Health and Social Services' monitoring of multiple billings by Medicaid physicians.

This audit was performed pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law. Major contributors to this report are listed in Appendix A.

*Office of the State Comptroller  
Division of Management Audit*

**April 15, 1996**

---

---

# Executive Summary

---

---

## Department of Health

## Department of Social Services

# Medicaid: Monitoring of Multiple Billings By Physicians

---

---

### Scope of Audit

The Department of Social Services (Social Services) administers New York's Medicaid program, which provides medical assistance to needy people. Social Services contracts with a fiscal agent, Computer Sciences Corporation, to operate the Medicaid Management Information System (MMIS), a computerized payment and reporting system that processes payments to Medicaid providers. The Department of Health (Health) is responsible for establishing fees and developing medical policy under the State's Medicaid program. The MMIS pays health care physicians a fee for each covered medical service provided to eligible recipients. The amount of payment a physician receives from Medicaid is dependent on the procedure codes entered on the claim form. There are over 7,400 procedure codes that physicians may use to describe the services they have performed when billing Medicaid. Providers may perform multiple procedures during a patient visit and bill Medicaid for such procedures. The MMIS generally relies on providers to submit Medicaid billings that accurately reflect the type of services rendered. The MMIS utilizes computer controls (edits) to ensure that billings for multiple procedures are made according to Medicaid payment policy.

Our audit addressed the following questions relating to Medicaid payments during the 45 month period April 1, 1991 through December 31, 1994:

- ! Are the edits used by the MMIS to check Medicaid claims for inappropriate billings of multiple procedures effective?
- ! Have Health and Social Services established a means of monitoring multiple billings by Medicaid physicians?

---

### Audit Observations and Conclusions

We found that the State's Medicaid payment system provides some deterrence against inappropriate multiple billings. However, our audit revealed that the MMIS edits do not provide adequate safeguards against inappropriate billings for certain procedures that are frequently billed in conjunction with other procedures. In addition, Health and Social Services do not systematically review or target services billed in combination to ensure Medicaid multiple billings are proper. As a result, our audit identified more than \$6.9 million in potential overpayments related to multiple billings.

---

---

To determine the effectiveness of MMIS edits in preventing the inappropriate payment of multiple billings, we analyzed physician billings during our audit period for general medical procedures. We identified \$4.1 million in potential overpayments relating to the payment of various combinations of medical procedures for a single patient visit, excluding obstetrical services (see pp. 4-5). We also reviewed payments for obstetrical and related ancillary services relating to the same newborn delivery. At the time of our audit, there were no computer edits in place to prevent a physician from billing Medicaid more than once for services relating to the same newborn delivery. We identified potential overpayments totaling \$2.8 million for multiple billings of obstetrical and related ancillary services. We note that Social Services and Health officials took corrective action during our audit to prevent similar overpayments of obstetrical services in the future. (see pp. 7-10)

In addition, during our audit, it came to our attention that Medicaid may be paying for Medicare Part B coinsurance for inappropriate multiple billings. Under Part B, Medicare pays for doctors' services, outpatient therapy, and many other professional services. Medicare recipients must pay a 20 percent coinsurance based on the approved Medicare charge. However, when a recipient is eligible for both Medicaid and Medicare, Medicaid is required to pay the physician for the coinsurance. Since Part B payments directly impact the State's Medicaid Program, Medicaid is at risk in the event that Medicare pays for inappropriate multiple billings. We determined that Medicaid may have paid \$473,800 in copayments relating to inappropriate multiple billings during the audit period. Social Services and Health officials need to review these payments and as appropriate refer the matter to the Federal Health Care Financing Administration for policy review under the Medicare Program. (see pp. 5-6)

We recommend that Health and Social Services officials review and recover, as appropriate, the potential Medicaid overpayments identified in our report. To prevent similar overpayments in the future, Social Services and Health officials need to establish a systematic method, such as postpayment reviews, to detect inappropriate multiple billed procedures. An appropriate Medicaid payment policy, along with the necessary MMIS edits, should be established to prevent future overpayments of multiple billings. (see p. 10)

---

## Comments of Officials

Health and Social Services officials generally agreed with our recommendations and have initiated steps to implement them.

---

---

---

# Contents

---

Introduction	Background . . . . .	1
	Audit Scope, Objectives and Methodology . . . . .	2
	Response of Agency Officials to Audit . . . . .	2
Monitoring of Multiple Billed Procedures	Medicaid Payment Controls . . . . .	3
	Multiple Surgical and Medical Procedures . . . . .	4
	Payments for Medicare Part B Coinsurance . . . . .	5
	Obstetrical Services . . . . .	6
Appendix A	Major Contributors to This Report	
Appendix B	Response of Department of Health Officials	
Appendix C	Response of Department of Social Services Officials	

---

The comments of Agency Officials are not available in an electronic format. Please contact our Office if you would like us to mail you a copy of the report that contains their comments.

---

---

# Introduction

---

## Background

The Department of Social Services (Social Services) administers New York's Medicaid program, which provides medical assistance to needy people. Social Services contracts with a fiscal agent, Computer Sciences Corporation, to process Medicaid claims and make payments to providers of medical services. This fiscal agent processes Medicaid claims and pays providers for medical services rendered to eligible Medicaid recipients through the Medicaid Management Information System (MMIS), a computerized payment and information system.

MMIS pays health care providers a fee for each covered medical service provided to eligible recipients. The Federal Health Care Financing Administration (HCFA) requires that the providers use HCFA's Common Procedure Coding System (HCPCS) to describe the service when billing Medicaid. HCPCS codes are based on the Current Procedural Terminology (CPT-4) procedures coding established by the American Medical Association. In addition to HCPCS codes, New York's Medicaid program utilizes special procedure codes relating to primary care programs that provide enhanced fees to physicians, such as the Preferred Physicians and Child Program (PPAC). Under the PPAC program, the State's Medicaid Program pays increased fees to providers who agree to provide medical care for children. The Department of Health (Health) is responsible for developing professional standards and setting Medicaid fees. Such fees are approved by the State's Director of the Budget. As part of this responsibility, Health staff in conjunction with their consulting medical professionals, determine the Medicaid policy regarding inappropriately billed multiple procedures.

There are over 7,400 procedure codes that physicians may use to describe the services they have performed when billing Medicaid. Providers may perform multiple procedures during a patient visit and bill Medicaid for such procedures. Generally, Social Services and Health rely on providers to submit accurate billings to MMIS that reflect the type of services rendered. The MMIS utilizes computer controls (edits) to ensure that multiple-billed procedures are made according to Medicaid payment policy. These edits check providers' claims to determine whether multiple procedures are billed appropriately.

Problems relating to multiple-billed procedures are common throughout the health care industry. For example, according to the U.S. General Accounting Office (GAO), the medical coding system is complicated, and providers who bill the Medicare Program often have difficulty identifying the codes that most accurately describe the services provided. Medicare is a health insurance program under Title XVIII of the Federal Social Security Act for people 65 or older and certain disabled people.

## Audit Scope

---

## Objectives and Methodology

We have audited the MMIS controls over the payment of services with respect to multiple procedures performed during a single patient visit for the 45-month

---

period April 1, 1991 through December 31, 1994. The objectives of our audit were to (1) assess the effectiveness of edits used to check claims for inappropriate billings of multiple procedures and (2) determine how well Health and Social Services monitor inappropriate billings by Medicaid physicians. To accomplish our objectives, we reviewed records of Medicaid payments for physician services for our 45-month audit period. We also interviewed Health and Social Services officials and reviewed pertinent laws, regulations and Medicaid payment policy. In addition, we developed computer programs that identified all multiple billed procedures.

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 of Health and Social Services which are included within the audit scope. These standards require that we understand each department's internal control structure and compliance with those laws, rules, and regulations that are relevant to each department's operations which 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 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 those 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.

---

## Response of Agency Officials to Audit

Draft copies of this report were provided to Health and Social Services officials for their review and comment. Their comments, as appropriate, have been considered in preparing this report, and are included in Appendices B and C.

Within 90 days after the final release of this report, as required by Section 170 of the Executive Law, the Commissioners of Health and Social 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.

---

---

# Monitoring of Multiple Billed Procedures

---

---

## Medicaid Payment Controls

In order for Health and Social Services officials to be able to curb unnecessary and mistaken payments, they need to have the ability to analyze payment data. Health performs reviews of those physician claims that MMIS suspends for further review. These reviews are completed before the claim is paid, and are therefore referred to as prepayment reviews. As part of such reviews, Health may detect improperly billed procedure combinations. When this occurs, Health recommends additional MMIS edits to prevent future payment of similar occurrences. Another method for monitoring claims is called post-payment reviews. Such reviews are performed after a payment is made and are intended to alert officials of improper combination billings. To ensure that Medicaid billings are proper, Health and Social Services need to have the means to identify which procedures are billed to Medicaid for services rendered to a recipient on the same date of service. Our audit revealed that Health and Social Services do not systematically review services billed in combination that warrant further medical review. In the absence of such reviews, the Medicaid Program is lacking the necessary medical policy that is needed in order to effect MMIS prepayment edits.

In a May 1995 report entitled Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse, GAO reported that procedure code manipulation is a problem that exists in the nation's health care industry. In addition, GAO reported that: (1) due to the total number of medical procedures, there can exist millions of possible combinations that providers can bill using any number of procedure codes and (2) certain service combinations when billed for the same recipient are inappropriate and may be abusive in nature. Procedure combinations, or multiple billed procedures, relate to the payment of more than one procedure for a single patient visit.

To detect for inappropriately billed procedures, the MMIS utilizes a series of computerized edits. While it is difficult to estimate the full impact from the deterrence of the MMIS edits, it appears that existing Medicaid payment edits provide some safeguard against inappropriate billings. In addition, officials stated the presence of computerized controls serve as a deterrent against abusive billings. However, our audit found various control weaknesses associated with the MMIS edits that detect inappropriately billed multiple procedures.

---

## Multiple Surgical and Medical Procedures

The amount a physician is reimbursed depends on the procedure codes entered on the Medicaid claim form. To determine the effectiveness of such MMIS edits, we analyzed physician billings during our audit period for general medical procedures (excluding obstetrical services, which are discussed later in this report) that paid \$19.50 or more. We determined that this universe of payments totaled \$47.1 million and involved 32,900 unique procedure combinations. We limited our audit to procedure combinations with up to three procedures performed in a single patient visit and where the second and third procedures had an aggregate total payment of \$1,500 or more. These combinations totaled \$31.8 million and involved 1,219 unique procedure combinations. By applying these criteria, we were able to focus our limited audit resources on a small portion (3.7 percent or 1,219/32,900) of the universe of combinations, while still accounting for a significant portion (67.5 percent or \$31.8 million/\$47.1 million) of the dollars. With Health's assistance, we determined that in 306 combinations or 25 percent of the 1,219 combinations, Medicaid may have potentially overpaid \$4.1 million for the audit period, because providers inappropriately billed Medicaid using multiple procedures. The following are examples of the questionable procedure combinations:

- ! A provider billed Medicaid using the following procedure codes: code 57454 "endoscopy with biopsy(s) of the cervix and/or endocervical curettage" that paid \$73 and code 57505 "endocervical curettage" that paid \$30. The potential Medicaid overpayment in this combination is \$30.
  
- ! Another provider billed Medicaid using the following procedure codes: code 70480 "computerized axial tomography" and code 70450 "computerized axial tomography, head or brain." Medicaid paid a total of \$192 for the two procedures: \$120 for procedure 70450 and \$72 for procedure 70480. In this instance, Medicaid may have overpaid \$72 for the second procedure.

In both instances, based on their initial review, Health officials determined that the procedures, when billed in combination, were possibly inappropriate. Table 1 details the top five questionable combinations that were included in the potential \$4.1 million overpayment.

**Table 1**  
**Top Five Questionable Procedure Combinations**  
**Billed by Same Physician, for a Single Patient Visit**

<b>First Procedure And Description</b>	<b>Second Procedure And Description</b>	<b>Third Procedure And Description</b>	<b>Potential Overpayment</b>
<i>93320</i> Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	<i>93307</i> Echocardiography, real-time with image documentation (2D) with or without M-mode recording; complete		\$1,115,700
<i>93320</i> Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	<i>93307</i> Echocardiography, real-time with image documentation (2D) with or without M-mode recording; complete	<i>W5016</i> Medicaid Preferred Physicians and Child Program office visit	\$220,200
<i>76857</i> Echography, pelvic (non-obstetric), B-scan and/or real time with image documentation; limited or follow-up	<i>76805</i> Echography, pregnant uterus, B-scan and/or real time with image documentation; complete (complete fetal and maternal evaluation)		\$99,100
<i>76770</i> Echography, retroperitoneal, B-scan and/or real time with image documentation; complete	<i>76700</i> Echography, abdominal, B-scan and/or real time with image documentation; complete		\$77,400
<i>74160</i> Computerized axial tomography, abdomen; with contrast material	<i>72193</i> Computerized axial tomography, pelvis; with contrast materials		\$72,800

These potential overpayments occurred because the MMIS does not have established prepayment edits to evaluate such billing combinations. In addition, as mentioned previously, neither Health nor Social Services has a means to systematically review combination procedures paid by the Medicaid Program on a postpayment basis. As previously noted, during the course of our audit, Health officials advised us that they believed these combinations were possibly inappropriate. However, before they establish MMIS edits to prevent future payments, they need to refer the combinations in question to their medical professionals for policy review.

## **Payments for Medicare Part B Coinsurance**

During our audit, it came to our attention that Medicaid may be inappropriately paying for Medicare Part B coinsurance. Under Part B, Medicare pays for doctors' services, outpatient therapy, and many other services. Medicare recipients must pay a 20 percent coinsurance based on the approved Medicare charge. However when a recipient is dually eligible under Medicaid and Medicare, Medicaid is required to pay the physician for the coinsurance.

---

Since Part B payments directly impact the State's Medicaid Program, Medicaid is at risk in the event that Medicare pays for inappropriate procedure combinations. In the previously mentioned report, GAO found that Medicare is overpaying providers for improperly billed procedure combinations because the Medicare Program has invested limited resources to identify such payments. In conjunction with Health officials, we determined that in 76 combinations, Medicaid may have inappropriately paid \$473,800 in copayments for the audit period. In addition, based on information entered by providers on their Medicaid claims, Medicare paid \$2.3 million for such procedures. Health officials informed us that such procedures need to be further reviewed by their medical consultants. In the interest of curtailing inappropriate payments by State and Federal funding sources, Health should make a determination as to the appropriateness of the 76 combinations and refer the results of their review to the Federal Health Care Financing Administration.

---

## Obstetrical Services

The American Medical Association (AMA) has designated certain obstetrical procedures as global, which include a range of ancillary services such as antepartum care, newborn deliveries and postpartum care. Global obstetrical codes 59400 and 59510 include this full range of services, and providers should bill Medicaid only once for such services, at the end of postpartum care. In addition, the AMA has designated separate obstetrical procedures that are not as comprehensive as the global services, but include components of the global procedures. Generally, these procedures are billed by physicians who did not solely provide the full range for obstetrical care during a Medicaid recipient's pregnancy. For example, the AMA has designated a separate procedure (59409) for newborn delivery only.

When billing Medicaid for obstetrical services, the physician should record the proper procedure code describing the service performed. For example, if the physician billed Medicaid using the global procedure, the physician should not bill Medicaid for separate components already included in the global Medicaid fee. Our review of payments for obstetrical and related ancillary services found that physicians were inappropriately billing Medicaid. At the time of our audit, there were no computer edits in place to prevent a physician from billing Medicaid more than once for services relating to the same newborn delivery.

---

## Duplicate Payments for the Same Newborn Delivery

Using computer programs that we developed, we analyzed physician payments for obstetrical services related to newborn deliveries for the procedures listed in the following table. For these services listed, Medicaid paid 376,600 claims totaling \$237.7 million during the 45-month period ended December 31, 1994.

**Table 2**  
**Obstetrical Services**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>Medicaid Fees</b>
59400	Routine, obstetric care including antepartum care, vaginal delivery and postpartum care	\$1,037
59409	Delivery only	\$ 630
59410	Delivery including postpartum care	\$ 679
59510	Routine obstetrical care including antepartum care, cesarean delivery, and postpartum care	\$1,037
59514	Cesarean delivery only	\$ 685
59515	Cesarean delivery including postpartum care	\$ 734

For example, if an obstetrician performs a routine delivery, he/she should bill Medicaid using procedure 59409. If, in addition to the delivery, the same provider performs antepartum care before the baby is born and postpartum care after the delivery, then the provider should bill the global obstetrical procedure code 59400. However, the provider should not bill both procedures since procedure 59400 includes the services performed under procedure 59409.

According to Health officials, when billing for delivery services listed in Table 2, physicians may bill only one procedure code for a single delivery.

Using criteria developed in conjunction with Health officials, we developed computer programs to identify all instances where a physician billed Medicaid more than once during a three month period for the same delivery, using the procedure codes listed in the preceding table. Our computer matches identified overpayments for obstetrical services (relating to single births) totaling \$1.7 million. The following table presents a summary of the overpayments.

**Table 3**  
**Summary of Obstetrical Services Overpayments**

Duplicate Claims	Overpayments	Number of Claims
Billed by the Same Physician	\$779,046	1,216
Billed by Different Physician(s) - Same Provider Group	258,033	347
Billed by Different Physicians, No Group Affiliation	668,411	1,038
<b>Total Overpayments</b>	<b>\$1,705,490</b>	<b>2,601</b>

The following is an example of the types of improper claims billed to Medicaid:

- ! A provider billed Medicaid procedure code 59400 (a routine delivery including antepartum and postpartum care) on two separate claims for the same delivery (single birth) and received two payments each of \$1,037. One claim was billed to Medicaid with a service date of January 21, 1993 and the second claim was billed with a service date of February 22, 1993. By recording different service dates on the claims, the claim was not identified as a duplicate billing by the MMIS duplicate payment edit. Medicaid overpaid the provider \$1,037.

We provided Health and Social Services officials with detailed information on the overpayments, which included one provider with possible Medicaid billing abuses. We noted this provider often billed Medicaid two claims for a single delivery, and we determined this provider was overpaid \$111,777. We provided Social Services officials with this information for their review and as necessary, for referral to the Attorney General for Medicaid Fraud. Social Services officials stated they were: (1) examining this provider's Medicaid claims; (2) performing statewide audits of obstetrical services provided by outpatient clinics; and (3) initiating a review of obstetrical services billed to Medicaid on a fee-for-service basis by physicians. They believe that their review will encompass similar payments that we referred to them for recovery.

The overpayments we identified occurred because the MMIS did not have edits to identify inappropriate claims for single births. However, prior to the completion of our field work, we noted that Health officials proposed edits related to obstetrical services, and such edits were implemented within the MMIS. We also note that during our audit, Social Services notified obstetrical providers through the Medicaid Update newsletter as to the correct Medicaid

billing policy involving the use of the maternity procedure codes. We commend both Health and Social Services officials for their quick action to curb future recurrence of similar overpayments.

## Ancillary Services

Global obstetrical procedure codes 59400 (routine obstetric care including antepartum care, vaginal delivery and postpartum care) and 59510 (routine obstetric care including antepartum care, cesarean delivery and postpartum care) include most of the maternity care needed during a pregnancy. Generally, a physician who renders global care should bill Medicaid once (depending on the type of delivery performed) at the end of postpartum care. Using computer programs we developed, we evaluated the extent that ancillary services were billed in addition to the global obstetrical services for the same newborn delivery. We requested Health officials to review these ancillary services and determine whether Medicaid should have paid for such services in addition to the global payment. As a result, we found Medicaid potentially overpaid \$1.1 million for 58,022 claims. For example, in one case, Medicaid paid a provider \$1,037 for a global obstetrical procedure (59400) and an additional \$279 for nine claims billed separately for antepartum care (W0003). According to Health officials and based on the description of the global services defined by the AMA, this billing combination does not appear to be valid because global procedure 59400 includes antepartum care. Table 4 illustrates the top five ancillary procedures billed in combination with the global obstetrical procedure.

**Table 4**  
**Top Five Ancillary Services Billed In Addition to the Global Procedure**

<b>Procedure Code And Description</b>	<b>Potential Overpayments</b>	<b>Number of Procedures</b>
<i>W0003</i> Antepartum care only, subsequent; separate procedure	\$288,300	8,899
<i>59420</i> Antepartum care only; separate procedure, initial	\$154,600	2,758
<i>99214</i> Detailed history exam; decision moderately complex	\$80,500	4,142
<i>59050</i> Fetal monitoring during labor by consultant physician	\$42,800	2,875
<i>90060</i> Intermediate service in office; established patient	\$38,800	3,526

---

Health and Social Services officials need to establish Medicaid payment policy, which clarifies the billing for medical procedures in combination with other procedures. Health officials informed us they plan to further investigate these payments.

### **Recommendations**

To Social Services and Health:

1. Examine the feasibility of establishing a systematic method such as postpayment reviews, similar to the computer analysis tools used in our audit, to detect inappropriate multiple billed procedures.
2. Perform a medical review of the potentially inappropriate procedure combinations identified in our report and establish a Medicaid payment policy along with the necessary MMIS edits to prevent payment of any combinations deemed to be inappropriate.
3. Review and recover the Medicaid overpayments identified in the report, as appropriate:
  - ! potential overpayments related to multiple surgical and medical procedures totaling \$4.1 million;
  - ! duplicate Medicaid payments for the same newborn delivery totaling \$1.7 million;
  - ! ancillary services billed in conjunction with global obstetrical services amounting to \$1.1 million.
4. Review the 76 procedure combinations relating to Medicaid payments (\$473,800) for Medicare Part B coinsurance, and as appropriate, refer any inappropriate combinations to the Federal Health Care Financing Administration for policy review under the Medicare Program.

---

---

# Major Contributors to This Report

---

David DeStefano  
Frank Houston  
Kevin McClune  
Lee Eggleston  
Douglas Coulombe  
Warren Fitzgerald  
Dominick DiFiore  
Paul Bachman