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

DEPARTMENT OF HEALTH

MULTIPLE MEDICAID PAYMENTS TO CLINICS FOR SIMILAR SERVICES

REPORT 98-S-33

H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit and State Financial Services

Report 98-S-33

Antonia C. Novello, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
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Dear Dr. Novello:

The following is our report on multiple Medicaid payments for clinic services delivered to the same recipient on the same day.

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

September 24, 1999

Executive Summary

Department of Health
Multiple Medicaid Payments to Clinics for Similar Services

Scope of Audit

The New York State Department of Health (Health) administers the State's Medical Assistance Program (Medicaid), which was established in accordance with Title XIX of the Federal Social Security Act to provide medical assistance to needy people. Health's fiscal agent, Computer Sciences Corporation, uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims and pay health care providers for medical services rendered to eligible Medicaid recipients. Clinics are providers that deliver a wide variety of medical services, from treating viral infections to performing specific surgical procedures. Health regulations state that Medicaid will normally pay one clinic claim per recipient per day. Health has established payment rates for clinics to use in billing for general medical services, and other rates to use in billing for special program services.

Our audit addressed the following question about Medicaid's payment of multiple clinic claims for the period April 1, 1993 through December 31, 1998:

- Has Health established controls to ensure that MMIS does not make inappropriate multiple payments to clinics for similar services delivered to the same recipient on the same day?

Audit Observations and Conclusions

We found that Health has not established adequate controls to ensure that the multiple payments MMIS makes to clinic providers are not duplicate payments for similar services. Our analysis of clinic claims processed and paid during the period April 1, 1993 through December 31, 1998 determined that MMIS overpaid clinics as much as $36.4 million for similar services delivered to the same recipient on the same day. Health needs to investigate these claims and recover duplicate payments, establish controls to prevent and detect inappropriate payments, and clarify its billing instructions and guidelines for clinic providers.

Health regulations generally require that a clinic be reimbursed in one payment for all the services it delivers to a recipient on a single day. Accordingly, Health has established outpatient department and Products of Ambulatory Care (PAC) payment rates, both of which are all-inclusive

rates, as well as an emergency room payment rate to use in billing for general medical services. When Medicaid pays a clinic claim at an all-inclusive rate, it should generally not pay another clinic claim for the same recipient on the same day. Health has established payment policies to identify certain inappropriate combinations of payment rates, and developed related computer controls (combination edits) to prevent such inappropriate payments. However, we found that Health has not developed the combination edits necessary to prevent paying clinics twice for delivering the same or similar services to the same recipient on the same day. As a result, Medicaid overpaid clinics for general medical services a total of up to $24.9 million. Of this amount, about $8.3 million was paid to providers who billed claims twice: once at the outpatient rate, and again at the PAC rate. Medicaid also overpaid clinics up to $7.9 million by paying one claim at either the outpatient or PAC rate, and another claim with potentially the same diagnosis at the emergency room rate. In other instances, Medicaid paid a PAC claim as well as a separate claim for a service that should have been covered in the PAC rate. (See pp. 4-6)

As recipients' health needs change, Health develops new special programs and corresponding clinic reimbursement rates to deliver these program services. For example, Health has developed programs for the treatment of special illnesses, such as AIDS, and for the delivery of specific services, such as preventive care for low-income pregnant women. According to Health, which administers some of these special programs, and other State agencies that administer other programs, a clinic should generally submit one claim billed at the special program rate for all similar services it provides to a recipient on a single day. However, we found that Medicaid overpaid clinics for special program services by about $11.5 million because MMIS paid the clinics twice for similar services: once at the special program rate and again as a separately billed claim. (See pp. 6-10)

We recommend that Health investigate all the claims we identified and recover the overpayments. We further recommend that Health establish combination edits to prevent such overpayments in the future, perform routine audits to detect inappropriate multiple payments to clinics, and inform providers what constitutes a related illness for billing purposes.

Comments of Health Officials

Department of Health officials generally agree with our recommendations. Officials stated that they will investigate and recover any inappropriate payments and will work with the other State agencies to establish rate combination edits to prevent such inappropriate clinic payments in the future. To further improve controls, officials will review, and where necessary revise, billing instructions, and perform routine audits to detect inappropriate clinic payments for the same recipients on the same date of service.

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Introduction

Background

The New York State Department of Health (Health) administers the State's Medical Assistance Program (Medicaid), which was established in accordance with Title XIX of the Federal Social Security Act to provide medical assistance to needy people. Health's fiscal agent, Computer Sciences Corporation, uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims and pay health care providers for medical services rendered to eligible Medicaid recipients. The Department of Social Services administered the State's Medicaid program and operated MMIS through the fiscal agent until October 1, 1996, when Health assumed these responsibilities.

Health develops applicable medical standards and sets the payment rates at which MMIS reimburses medical providers, including clinics, for the services they render to Medicaid recipients. Clinics provide a wide variety of medical services, from treating viral infections to performing specific surgical procedures. Health regulations (Subpart 86-4 of Title 10) state that Medicaid will normally pay one clinic claim per recipient per day. To implement these regulations, Health has established payment rates for clinics to use in billing for general medical services: the outpatient department and Products of Ambulatory Care (PAC) rates, both of which are all-inclusive, and the emergency room rate. When Medicaid pays a clinic claim at an all-inclusive rate, it should generally not pay another claim from the clinic for the same recipient on the same day. Health has also established other payment rates that should be used to bill for treating persons with special illnesses, such as AIDS, or for delivering special program services, such as preventive care for low-income pregnant women.

Health does allow certain exceptions to the one-payment-per-day rule. For example, since a clinic could reasonably deliver outpatient services and unrelated emergency services to the same recipient on the same day, the provider could bill Medicaid for both these claims. Health has also set separate reimbursement rates for certain clinical specialties, such as hemodialysis, which are excluded from the PAC payment methodology. Health allows a clinic to bill a PAC claim and a claim for an "excluded" service rendered on the same day.

Providers who bill at the all-inclusive outpatient rate or at the emergency room rate receive the same amount of reimbursement, regardless of the services they perform. Health established the all-inclusive PAC payment

rates through Title 10 of the New York State Health Code, Rules and Regulations to help relate the amount of reimbursement to the levels of service and resources the provider used in carrying out a medical procedure. PAC payment methodologies base the reimbursement amount on factors such as the medical procedure performed, the recipient's diagnosis and any additional services performed.

Audit Scope, Objective and Methodology

We audited Health's policies and procedures relevant to controlling multiple Medicaid payments to the same clinic for the period April 1, 1993 through December 31, 1998. The objective of our performance audit was to determine if Health has controls that are adequate to prevent Medicaid from making inappropriate multiple payments to clinics for similar services provided to the same recipient on the same day. Our prior audit, entitled Medicaid Clinic and Emergency Room Claims Paid During A Recipient's Hospital Stay (Report 98-S-10, issued November 18, 1998), evaluated controls over payments made to clinics when recipients were hospitalized. This audit addresses multiple Medicaid payments to the same clinic for delivering similar services to the same recipient on the same day.

To accomplish our audit objective, we interviewed Health and other State officials, reviewed relevant Health records and reviewed related Medicaid payment policies and procedures. In addition, we used computer-assisted audit techniques to develop computer programs to extract and analyze clinic claims processed and paid by MMIS during the period April 1, 1993 through December 31, 1998. The purpose of this computer analysis was to determine whether Health has adequate controls to prevent making inappropriate multiple payments to clinics for similar services provided to the same recipient on the same day. Providers can sometimes select from a number of payment rates in billing for services, depending on the services delivered and other variables. To be conservative, we consistently used the lower payment rate available in calculating the amounts Health paid clinic providers for the duplicate claims we identified.

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 that are included in our audit scope. Further, these standards require that we understand the applicable internal control structure and 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 management's estimates,

decisions and judgments. 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 Health Officials to Audit

Draft copies this report were provided to Health officials for their review and comment. Their comments have been considered in preparing this report and are included as Appendix B.

In addition to the matters discussed in this report, we have also reported separately to Health officials about a number of other issues. While these are matters of lesser significance, officials should implement our recommendations related to these issues to improve the efficiency of Medicaid payment operations.

Within 90 days after 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 recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Multiple Medicaid Payments to the Same Clinic

Health's management is responsible for establishing and maintaining a system of internal controls to ensure the accurate payment of all Medicaid claims. To help fulfill this responsibility, Health has developed computer controls (edits) within MMIS to prevent or identify certain inappropriate payments. Certain edits, called combination edits, compare a claim's payment rate information with that of another claim the provider has submitted for services to the same recipient to determine whether MMIS should pay or deny the claim, or suspend it for further review. For example, if a provider performs related surgeries during the same operation, the provider should receive full payment for one of the surgeries and a partial payment for the other surgery. In this case, the combination edit will identify the related claims and prevent an overpayment to a provider.

As noted earlier, Health regulations generally require that a clinic be reimbursed at an all-inclusive payment rate for all the services it delivers to a Medicaid recipient on a single day. Accordingly, Health has established payment policies identifying certain inappropriate combinations of payment rates. However, Health has not established corresponding combination edits to prevent these inappropriate payments, or a review process to detect such inappropriate payments that have been already paid. To determine the effect of this absence of controls, we examined a total of 17.5 million claims submitted by clinics for the 69-month period April 1, 1993 through December 31, 1998. We found that MMIS inappropriately paid providers as much as $36.4 million for similar services delivered to the same recipient on the same day. Health should recover the overpayments made, establish effective combination edits to prevent such overpayments, and do routine audits to detect inappropriate clinic payments for the same recipient on the same day. Health should also establish a methodology to identify inappropriate combinations of payments that will result as new programs and payment rates are developed in the future.

Multiple Payments for General Outpatient Care

For the period April 1, 1993 through December 31, 1998, we found that Medicaid paid clinics a total of $24.9 million in inappropriate payments for general outpatient care claims billed at the outpatient, emergency room or PAC payment rates for services delivered to the same recipient on the same day. The immediate cause of these overpayments was the absence of a combination edit to detect duplicate claims or a control to prevent their payment. However, we found that other factors also contributed to Medicaid's overpayment of these claims: in one instance, there were

administrative delays in establishing PAC rates; in another instance, Health did not inform providers how to determine what constitutes a related illness for billing purposes. We list the duplicate payments we identified according to the type of inappropriate billing practice providers used, as follows:

- billing for two all-inclusive rates;
- billing for one all-inclusive rate plus an emergency room rate for a related illness; and
- billing a PAC claim plus a claim for another service.

Two all-inclusive rates

During our audit period, we found that MMIS paid about $8.3 million in duplicate payments to 38 clinics that were reimbursed for the same services twice: once at the all-inclusive outpatient rate and again at the all-inclusive PAC payment rate. Two New York City clinics accounted for over 70 percent of the identified overpayments. Health officials told us that these two clinics received authorization to use PAC rates after MMIS had paid the clinics at the outpatient rate. The clinics then billed for the same services at the PAC rate without repaying the reimbursements they had already received. After we contacted these two clinics, they repaid Medicaid for the $5.9 million they had received on these claims billed at the outpatient rate. Health still needs to recover the remaining $2.4 million in inappropriate payments from the remaining 36 clinics.

One all-inclusive rate plus an emergency room rate for a related illness

Health's Medicaid billing instructions state that when a recipient is treated in a clinic's emergency room and outpatient department on the same day, Medicaid will pay for both services only if the services are for different illnesses. For our audit period, we found that Medicaid potentially paid clinics an extra $7.9 million because MMIS paid clinic outpatient or PAC claims, as well as emergency room claims, for the same recipient on the same day. For about $1.7 million of these potential overpayments, the emergency room and the outpatient department or PAC claim had the same (or a similar) diagnosis. For example, MMIS paid a clinic for an outpatient department claim and an emergency room claim, both stating a diagnosis of asthma, for the same recipient on the same day. For the remaining $6.2 million of potential overpayments, the claims had different diagnoses, but the recipients may have received related medical services. For example, the outpatient department claim contained the diagnosis of routine health care for a child while the emergency room claim diagnosis was a viral infection.

In the above cases, clinics may have billed Medicaid inappropriately because they did not know how Health defines a "related illness" for the purpose of billing for emergency room services. We found that Health has not given clinics instructions to explain what Health considers the same illness. Further, Health has not performed audits of clinics to ensure they understand the policy and are in compliance with the billing instructions. For the above claims, Health needs to determine whether it was proper to pay both claims by reviewing the clinic's medical records or by having medical professionals do a comprehensive evaluation of claim information.

PAC claim plus a claim for another service

Not all clinic services are covered by all-inclusive PAC payment rates. Health has set other reimbursement rates for clinical specialties, such as hemodialysis, which are specifically excluded from the PAC payment methodology. Therefore, Health allows a clinic to bill a PAC claim and a claim for an excluded service rendered on the same day. However, clinics are not permitted to submit both a PAC claim and a claim for other services that are not excluded (such as AIDS/HIV counseling, obstetrics, family planning, prenatal care and children's health care) for the same recipient on the same day. During our audit period, we found that clinics paid for delivering general medical services at the PAC rate were also paid for delivering "non-excluded" services to the same recipients on the same day, resulting in potential overpayments of $8.6 million.

We also found that clinics occasionally used the same diagnosis on one claim billed at the PAC rate and on another claim billed as an excluded service. We believe this suggests a duplicate payment was made, since the clinic was paid twice to deliver similar services. We found that MMIS made approximately $133,000 in potential duplicate payments on such claims paid during our audit period.

Multiple Payments for Special Programs

Health continually develops new special programs and clinic reimbursement rates as recipients' health needs change. Health sets payment policy for providers of special programs either unilaterally or in conjunction with other State agencies that administer the programs. For example, Health has established a series of unique payment rates to be used by clinics which specialize in treating recipients with AIDS. Providers should submit one claim billed at the special program payment rate for similar services it provides to a recipient on a single day. During our audit period, we found that Medicaid overpaid clinics by about $11.5 million because MMIS paid the clinic twice for providing special program services to the same recipient: once at the special program rate and again as a separately billed claim. We examined programs administered by Health,

as well as those administered by other State agencies. In each case, we confirmed the inappropriate billings with the officials responsible for establishing the program's billing policies.

Special Programs Administered by Health

We examined claims submitted by clinics that provide services to recipients in the following special programs administered by Health: the Early Intervention Program, the Child/Teen Health Plan, the Prenatal Care Assistance Program and AIDS Services. We also reviewed claims related to ambulatory surgery and the use of a hemodialysis-specific drug. Our analysis identified a total of $6.9 million in duplicate payments to clinics that provided these special program services.

Early Intervention Program

Health's Early Intervention Program identifies, tracks and screens children with disabilities who are three years old and under. Recipients receiving care under this program generally receive some type of therapy or training, such as speech or physical therapy. We found that clinics billed two separate claims for the same service, the first one at an outdated general visit rate, and again at Health's newer, more detailed, special program rate. For example, MMIS paid a clinic for a claim for speech and language services as well as another claim for a general visit where the clinic identified that speech training was rendered. During our audit period, we identified $2.6 million in multiple Early Intervention Program clinic payments, over 90 percent of which were attributable to two clinics.

Child/Teen Health Plan

The goal of the Child/Teen Health Plan (C/THP) is to provide assistance in diagnosing and treating physical and mental problems in persons under the age of 21. According to Health officials, clinics should not be reimbursed for C/THP services and an outpatient department service provided to a recipient on the same day. We found that MMIS paid about $2 million in potentially duplicate clinic claims which resulted from clinics billing for C/THP services at the special program rate, and again at the outpatient rate.

Prenatal Care Assistance Program

The Prenatal Care Assistance Program (PCAP) provides prenatal care for pregnant low-income women who are not otherwise eligible for Medicaid. PCAP provides for services such as prenatal care visits, laboratory services and referrals for other services. In the claims we examined, we found Medicaid overpaid clinics by $1.1 million because it paid clinics at the PCAP rate as well as at another rate for providing similar services.

AIDS Services

Health's AIDS Institute coordinates the State's response to the HIV/AIDS epidemic. The AIDS Institute provides Federal and State funds for this population's clinical care through special enhanced Medicaid payment rates. A clinic is entitled to receive only one payment per recipient per day for providing similar services. However, we found that Medicaid paid an additional $900,000 to clinics that billed twice, at different payment rates, for delivering similar HIV/AIDS services to the same recipient on the same day.

Product of Ambulatory Surgery Rates

Health developed the Product of Ambulatory Surgery (PAS) payment rates to pay for surgical procedures performed by a clinic on an outpatient basis. The PAS payment process classifies surgical procedures into various groups by illness or medical specialty. Health has set all-inclusive PAS payment rates for each group. Therefore, it is inappropriate for a clinic to bill Medicaid for more than one PAS procedure within the same group for the same recipient on the same day. Health established edits within MMIS to prevent such inappropriate payments as the result of our prior audit (Report 92-S-54, issued September 17, 1992). However, in the time between our identification of such overpayments in the prior audit, and Health's implementation of the edit, MMIS paid an additional $240,000 in such inappropriate claims.

Epogen Treatments

Hemodialysis is a type of medical procedure that cleans the blood of a person with various degrees of kidney failure. Patients who receive hemodialysis services also receive epogen, a drug which treats the anemia associated with kidney failure. However, since only hemodialysis patients receive epogen, a clinic should not be reimbursed for epogen unless it performs a hemodialysis service. During our audit period, we found that Medicaid incorrectly paid about $74,000 to clinics for epogen for recipients who had not received hemodialysis services.

Special Programs Administered by Other Agencies

We examined claims submitted by clinics that provide services to recipients in the following special programs administered by other State agencies individually, or in conjunction with Health: the School and Preschool Supportive Services Programs, substance abuse treatment services, psychiatric services and developmental disabilities services. Our analysis identified a total of $4.6 million in duplicate payments to clinics that provided these special program services.

School and Preschool Supportive Services Programs

Health and the State Education Department jointly developed the School and Preschool Supportive Services Programs to provide school districts and counties with Medicaid reimbursement for certain diagnostic and health support services for students or preschoolers who have, or are suspected of having, disabilities. These services include physical and occupational therapy as well as psychological counseling. During our audit period, we found clinics billed twice for providing similar services to the same recipients on the same days, resulting in about $1.5 million in duplicate payments. For example, a clinic that received a payment for a "psychological evaluation," as well as for a "psychological evaluation with a social history," received a duplicate payment, since both claims include the same services. Over 60 percent of the inappropriate payments we identified are attributable to two clinics.

Substance Abuse Treatment

Under the direction of the Office of Alcoholism and Substance Abuse Services (OASAS), clinics treat Medicaid recipients for alcohol or drug addiction. We found that Medicaid may have overpaid such clinics by about $1.46 million in multiple substance abuse clinic claims during our audit period. Over 40 percent of the identified inappropriate payments are attributable to two clinics. These two clinics are no longer eligible to participate in Medicaid because of prior fraudulent billing practices. OASAS officials agree the above clinic payments were questionable. However, these officials stated their belief that the overpayments made will not be definitely recoverable unless qualified medical personnel review recipients' medical records.

Psychiatric Services

The Office of Mental Health uses clinics to foster the recovery of individuals with psychiatric illness. During our audit period, we found that Medicaid overpaid such clinics by about $960,000 in multiple mental health claims. Most of the overpayments occurred when a clinic inappropriately billed for the same services at two completely different payment rates: one a fee-for-service rate and the other a managed care rate. Since a clinic bills for its services to a recipient at either one rate or the other, the second claim represents a duplicate payment.

Developmental Disabilities

The Office of Mental Retardation and Developmental Disabilities (OMRDD) administers clinic programs which treat recipients with developmental disabilities. Generally, OMRDD's payment policy limits Medicaid reimbursement to a clinic to one visit per recipient per day. We found that Medicaid overpaid clinics by about $700,000 during our audit

period because clinics billed twice for the same recipient (e.g., a general visit and a visit for a particular service) in the same day.

Recommendations

1. Investigate and recover all inappropriate payments to clinics that received payment for the same recipient on the same day.

2. Implement controls to prevent MMIS from inappropriately paying multiple claims for similar services to a clinic for the same recipient for the same day.

3. Do routine audits to detect inappropriate clinic payments for the same recipient on the same day.

4. Clarify Health's billing instructions regarding the appropriateness of multiple billings for the same date of service, and define what constitutes "related illness" for billing purposes.

5. Establish a methodology to routinely identify the inappropriate combinations of payments that will result as new programs are developed in the future.

Major Contributors to This Report

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September 16, 1999

William Clynes
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Dear Mr. Clynes:

The Department of Health has reviewed your draft audit report relating to the Multiple Payments for the Same Service (98-S-33). Our comments are noted on the attached. Thank you for the opportunity to comment at this stage in the audit process.

Very truly yours,

Dennis P. Whalen
Executive Deputy Commissioner

enclosure

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
98-S-33 Entitled
"Multiple Medicaid Payments to
Clinics for Similar Services

The following are the Department of Health's (DOH) comments in response to Draft Audit Report 98-S-33 entitled "Multiple Medicaid Payments to Clinics for Similar Services".

Recommendation #1: Investigate and recover all inappropriate payments to clinics that received payment for the same recipient on the same day.

Response #1: The Department's Office of Medicaid Management (OMM) will investigate and recover any inappropriate payments.

Recommendation #2: Implement controls to prevent MMIS from inappropriately paying multiple claims for similar services to a clinic for the same recipient for the same day.

Response #2: OMM and the individual state agencies (Offices of Mental Health, Alcoholism and Substance Abuse Services and Mental Retardation and Developmental Disabilities) have reviewed the combinations identified in the audit report and will establish rate combination edits to prevent inappropriate combinations of clinic claims where feasible.

It should be noted that the Department, with the approval of the Division of the Budget, initially developed a set of clinic rates for the Early Intervention Program; however, it became necessary to increase the number of rate codes to better identify the early intervention services being provided. From July 1, 1995 to March 31, 1996 both sets of rates were active on the MMIS file. The Department took corrective action and end-dated the initial set of rates, effective March 31, 1996.

Recommendation #3: Do routine audits to detect inappropriate clinic payments for the same recipient on the same day.

Response #3: OMM will perform routine audits to detect inappropriate clinic payments for the same recipient on the same date of service.

Recommendation #4: Clarify Health's billing instructions regarding the appropriateness of multiple billings for the same date of service, and define what constitutes "related illness" for billing purposes.

Response #4: OMM will review billing instructions to providers and, where necessary, revise instructions and provide clarification on the appropriateness of multiple clinic billings for the same date of service and what constitutes "related illness".

Recommendation #5: Establish a methodology to routinely identify the inappropriate combinations of payments that will result as new programs are developed in the future.

Response #5: As new programs are developed, OMM will analyze combination payments to ensure that inappropriate combinations won't take place.