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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

March 25, 2004

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

Re: New York State Health Insurance Program
Duplicate Inpatient Claim Payments
Report 2002-S-42

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 (Plan). The scope of our performance audit included medical claims of Plan members for the three-year period ended December 31, 2002.

A. Background

The New York State Health Insurance Program (Program) provides hospitalization, surgical services, and other medical and drug coverage to more than 796,000 active and retired State employees and their dependents. It also provides coverage for more than 392,000 active and retired employees of participating local government units and school districts as well as their dependents.

The Empire Plan (Plan) is the Program's primary health benefits plan, providing services to about 1 million individuals at an annual cost of more than $2.9 billion. The Department of Civil Service (Department) contracts with United HealthCare to administer the medical/surgical and major medical portions of the Plan. During the year that ended on December 31, 2002, United HealthCare approved over 10.5 million charges totaling more than $1 billion and charged the State about $108 million for administrative and other related expenses.

The Department contracts with Empire Blue Cross and Blue Shield (Empire Blue Cross) to administer the hospitalization portion of the Plan. During the year that ended on December 31, 2002, Empire Blue Cross approved about 838,000 claims totaling more than $800 million and charged the State about $55 million for administrative and other related expenses.

Empire Blue Cross contracts with hospitals to provide the Plan's hospitalization and related-expense coverage. Prior to the inception of the Plan, Empire Blue Cross negotiated unique agreements, known as global reimbursement contracts, with most hospitals located in 15 southern

counties of New York State. In contrast to Empire Blue Cross' standard hospitalization contracts, these contracts provide for inpatient reimbursement rates that include coverage of certain physician services when they are rendered by radiologists, cardiologists, pathologists, and emergency medicine physicians.

Empire Blue Cross attempts to ensure that United HealthCare pays for these services properly by periodically providing the company with descriptions of the services included in its contracts. To prevent the inappropriate payment of global reimbursement claims, United Health Care incorporates the Blue Cross information into its own claim processing system.

Our prior audits (*Audit Report 93-S-49 - Inadequate Coordination of Benefits Resulted in $2.75 Million in Empire Plan Overpayments*, issued on June 17,1993; *and Audit Report 98-S-14 - Duplicate Inpatient Claim Payments Resulted in $3.77 Million in Empire Plan Overpayments,* issued on January 12, 2000), identified issues similar to those covered by our current audit and recommended improvements to the claims coordination process, such as improving training procedures and routine data exchanges, to ensure the proper payment of future claims. Our current audit shows that some improvements were made. However, some recommendations were not fully implemented. Therefore, United HealthCare continues to process improper payments.

B. Audit Scope, Objective, and Methodology

We audited United HealthCare's payments for hospital-related physician services during the three-year period ended December 31, 2002. The primary objective of our performance audit was to determine whether United HealthCare had made duplicate payments for physician services that were already included in Empire Blue Cross' hospital contract payments. To identify such instances of duplication, we used computer-assisted audit techniques to review and assess payments made to physicians during the audit period. We then selected a statistical sample from certain payments for detailed examination. During our examination, we reviewed documentation maintained by Empire Blue Cross and United HealthCare in relation to the payments, and conducted interviews with officials of both carriers.

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 carrier operations included in our audit scope. Further, these standards require that we understand the internal control systems of the Department and carriers 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.

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 to certain boards, commissions, and public authorities, some of who have minority voting rights. These duties may be considered

management 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

Because of weaknesses in United Health Care's claims processing system, certain claims submitted by physicians have been paid in error. The payments were based on claims for physician services that had already been covered by Empire Blue Cross hospital inpatient payments. We estimate that United HealthCare made erroneous payments totaling $2,403,724 during the audit period.

We provided a preliminary report of our audit findings to United HealthCare officials and considered their comments in preparing this report. Generally, the officials agreed with our findings. They informed us that they are reviewing the audit population, will remit recoveries to the Plan, and are taking the necessary steps to implement other recommendations.

Payments for Physician Services Already Included in Hospital Inpatient Payments

United HealthCare's management maintains a claims processing system that includes computerized and manual edits intended to ensure that claims are paid properly. A well functioning claims processing system includes edits that will detect and prevent duplicate payments by insurance carriers. The establishment of such edits requires adequate communication and data exchange among carriers. This is especially important because the Plan comprises multiple carriers with independent claim processing systems. However, we found that United HealthCare's manual edits do not always work as intended and that the Plan's carriers do not adequately exchange claims data. We also found that the Plan's providers do not always complete medical claim forms properly. As a result of these weaknesses, United HealthCare has made duplicate payments for physician services that were already included in Empire Blue Cross' hospital payments.

For the three-year period ended December 31, 2002, we identified 41,641 claims totaling $3,254,752 that may have been overpaid. United HealthCare officials cited reasons why some of these claims, such as claims for services provided by specialists other than radiologists, cardiologists, pathologists, and emergency medicine physicians, may be paid properly. We, therefore, reviewed a statistical sample of 212 claims with United HealthCare officials. They agreed that 131 of the 212-sampled claims had been paid improperly, since they had already been included in Empire Blue Cross' hospital payments. The officials provided us with the following information concerning the 131 claims:

- For 98 claims, improper payments were due to errors by approvers, who did not apply existing guidelines properly.

- For 33 claims, the information that United HealthCare officials relied on to adjudicate these charges was inaccurate. Although the patients had been hospitalized, the physicians had indicated on the claim forms that their services were provided in a non-inpatient setting. United HealthCare officials had not obtained the information from Empire Blue Cross (e.g., hospital inpatient data) that they would need to determine these patients had been hospitalized; therefore, their authorization to pay these charges was improper.

Based on the results of our review, we estimate with 95-percent confidence that United HealthCare improperly paid between $2,200,009 and $2,607,439 (with a mid-point of $2,403,724) for physician services that had already been covered by Empire Blue Cross' hospital payments.

Recommendations

1. *Review the population of questionable claims from which we estimated $2,403,724 was overpaid. Recover the costs of improperly-paid claims from the appropriate parties, and remit the recoveries to the Plan.*

2. *Analyze the approver errors made during the processing of claims that were subject to Empire Blue Cross' global reimbursement policy, and take appropriate corrective actions.*

3. *Instruct Plan providers in the proper completion of claims forms so that the service location is noted accurately.*

4. *Improve procedures for coordinating claims that are subject to Empire Blue Cross' global reimbursement policy. For example, data should be exchanged with Empire Blue Cross in a more-timely and routine manner.*

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

Very truly yours,

Frank J. Houston
Audit Director

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