ALAN G. HEVESI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

April 5, 2005

Mr. Tracy Bahl
Chief Executive Officer
United HealthCare
Floor 35
1114 Avenue of the Americas
New York, NY 10036

Re: New York State Health Insurance Program
Outpatient-Related Services
Report 2004-S-12

Dear Mr. Bahl:

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 four-year period ended December 31, 2003.

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 396,000 active or retired employees of participating local government units and school districts and dependents of such employees.

The Department of Civil Service (Department) contracts with United HealthCare (UHC) to administer the medical/surgical and major medical portions of the Plan, and with Empire Blue Cross and Blue Shield (Empire Blue Cross) to administer the hospitalization portion of the Plan.

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 contracts (global reimbursement contracts) with all but a few hospitals located in the State's lower 15 counties. These contracts differ from Empire Blue Cross' standard hospitalization contracts in that the outpatient reimbursement rates include coverage for certain physician services when rendered by radiologists, cardiologists, pathologists and emergency physicians.

To ensure that UHC properly pays for these physician services, Empire Blue Cross has periodically provided UHC with information identifying the hospitals affected by global reimbursement policy and the services included in these contracts. UHC uses this information to develop its own claim processing policies and procedures for preventing the inappropriate payment of global reimbursement claims.

B. Audit Objective and Methodology

The primary objective of our audit was to determine whether UHC erroneously paid physicians for services that were already included in Empire Blue Cross' hospital outpatient payments.

To accomplish our audit objective, we electronically matched Empire Blue Cross out patient claim data with UHC medical claim data to identify a population of potential duplicate billings. Because some of the electronic information, such as the providers' specialties or locations of service, was either missing or inaccurate, we drew a statistical sample from our population of potential duplicate billings. We reviewed the sampled items with Empire Blue Cross and UHC officials to estimate the amount of overpayments in the population of potential duplicate billings.

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.

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

Due to weaknesses in UHC's claims processing system, certain claims submitted by physicians were erroneously paid. The erroneous claims were paid for physician services that had been already included in Empire Blue Cross's hospital outpatient payments. We estimate that, during the audit period, UHC made erroneous payments totaling $889,240.

We provided a preliminary report of our audit findings to UHC officials and considered their comments in preparing this report. Generally, UHC officials agreed with our findings. The officials informed us that they have recovered about $63,000 of the $889,240 we identified, and they are continuing to review the population of questionable claims. The officials also stated that they have taken steps to implement our other recommendations.

Payments for Services Already Included in Hospital Outpatient Payments

UHC's management maintains a claims processing system, which includes manual edits intended to ensure that claims are properly paid. Such a system, if functioning properly, should include edits to detect and prevent duplicate payments among insurance carriers. Establishment of these edits requires adequate training of claim payment personnel and adequate communication among carriers. This is especially important since the Plan is comprised of multiple carriers with independent claim processing systems. However, we found that UHC's manual edits do not always work as intended. We also found that certain claim payment errors resulted because Plan's providers do not always properly complete medical claim forms. As a result, UHC made duplicate payments for physician services that were already included in Empire Blue Cross' hospital outpatient payments.

For the three-year period ended December 31, 2003, we identified 14,341 claims totaling $1,031,775 that were potentially overpaid. UHC officials cited reasons why some of these claims may be paid properly, including services provided by specialists other than radiologists, cardiologist, pathologists and emergency physicians. We reviewed 169 claims and we estimate with 95 percent confidence that, UHC improperly paid between $821,409 and $957,070 (with a mid-point of $889,240) for physician services that had already been included in Empire Blue Cross' hospital payments.

Of the 169 sampled claims, UHC officials agreed that 147 were improperly paid, and provided the following information about them:

- For 113 claims, we found that improper payments were due to errors by approvers who did not properly apply existing guidelines.

- For 34 claims, we found that the information that UHC officials relied on to adjudicate these charges was inaccurate. For some claims, although patients were treated in the emergency room, the physicians indicated on the claim forms that services were provided in a non-emergency room setting. For other claims, physicians did not provide the names of the hospitals where services were provided. Since UHC officials did not have accurate information, they paid these charges erroneously.

Recommendations

1. *Review the population of questionable claims from which we estimate that $889,240 was overpaid. Recover costs for improperly paid claims from the appropriate parties and remit the recoveries to the Plan.*

2. *Analyze the cause(s) of the errors made in processing claims affected by the global reimbursement policy and take appropriate corrective actions.*

3. *Instruct Plan providers on the proper way to complete claims forms including accurate reporting of service locations, and the need to include hospital names.*

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,

David R. Hancox
Director
State Audit Bureau

cc: Daniel E. Wall, Department of Civil Service
Robert Barnes, Division of the Budget
Carl Mattson, United HealthCare