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OFFICE OF THE STATE COMPTROLLER

November 9, 2006

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

Re: Report 2006-F-36

Dear Mr. Bahl:

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 have followed up on the actions taken by United HealthCare to implement the recommendations contained in our audit report, *New York State Health Insurance Program, Outpatient-Related Services* (Report 2004-S-12), an audit of major medical claims processed for the New York State Health Insurance Program's Empire Plan (Plan).

A. Background

The New York State Health Insurance Program provides hospital and surgical services and other medical and drug coverage to more than 1,258,000 active and retired State employees and their dependents; active or retired employees of participating local government units and school districts, and dependents of such employees.

The Department of Civil Service 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.

Our initial audit report, issued on April 5, 2005, examined major medical claims processed for the Plan. The scope of our performance audit included medical claims of Plan members for the four-year period ended December 31, 2003. 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. We concluded that, because of 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 estimated during the audit period, UHC made erroneous payments totaling $889,240. At the time of our initial audit's release, UHC officials said they had recovered about $63,000 of the $889,240 we identified. The objective of our follow-up, which was conducted in accordance with generally accepted government auditing standards, was to assess as of October 30, 2006 the extent of implementation of the three recommendations included in our initial report.

Summary Conclusions and Status of Audit Recommendations

We determined UHC officials implemented the three recommendations included in our initial report.

Follow-up Observations

Recommendation 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.

Status - Implemented

Agency Action - After reviewing the population of questionable claims, UHC identified $783,532 in overpaid claims and has recovered $465,454 from the appropriate parties for the Plan. UHC tracks the overpaid claim population and continues to recover overpaid benefits through reduction of benefits from providers and members as appropriate.

Recommendation 2

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

Status - Implemented

Agency Action - UHC officials analyzed the overpayment file and determined 90 percent of the erroneous payment findings occurred on manually processed claims. UHC officials developed and implemented procedures to reduce manual processing errors. UHC identifies processing errors through a regular quality assurance sample. Errors are reviewed and discussed with the employees who manually process claims. UHC officials also use e-mail to communicate policy issues to employees who manually process claims.

Recommendation 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.

Status - Implemented

Agency Action - Based on recommendations from our audit, UHC reached out to network providers who billed UHC for global claims. UHC officials tracked high volume providers who billed for professional services included in the hospitalization reimbursement. Network Account Managers contacted or visited the providers to educate them on correct billing practices. Network Account Managers continue to address global reimbursement with downstate providers.

Major contributors to this report were Bill Clynes, Don Collins and Anthony Calabrese.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We also thank the management and staff of United Health Care for the courtesies and cooperation extended to our auditors during this process.

Very truly yours,

Sheila A. Emminger
Audit Manager

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