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

DEPARTMENT OF HEALTH

MEDICAID CLINIC AND EMERGENCY ROOM CLAIMS PAID DURING A RECIPIENT'S HOSPITAL STAY

REPORT 98-S-10

H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit and State Financial Services

Report 98-S-10

Barbara A. DeBuono, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. DeBuono:

The following is our report on Medicaid payments for clinic and emergency room claims for services provided to recipients during their hospital stay.

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 2, 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

November 18, 1998

Executive Summary

Department Of Health
Medicaid Clinic And Emergency Room Claims Paid During A Recipient's Hospital Stay

Scope of Audit

The New York State Department of Health (Health) administers the State's Medical Assistance Plan (Medicaid). 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. The Department of Social Services (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 establishes one all-inclusive prospective rate for inpatient hospital care, to reflect the cost of medical services that a recipient receives during a hospital stay. Health also establishes all-inclusive rates for emergency room services, clinic services and for other services as deemed appropriate. According to Health's policies, if a Medicaid recipient receives medical services in a hospital emergency room or outpatient clinic and is subsequently admitted to the affiliated hospital on the same day, Medicaid reimbursement is limited to the hospital's inpatient rate. It is generally inappropriate for Medicaid to pay claims for clinic or emergency room services which were rendered to a recipient either on the day the recipient was admitted into a hospital or during the rest of the recipient's hospital stay.

Our audit addressed the following question concerning controls over Medicaid payments for clinic and emergency room services for recipients admitted into a hospital for the period April 1, 1993 through September 1, 1998:

- Does Health have adequate controls to prevent or detect inappropriate Medicaid payments to clinics and emergency rooms for recipients during their hospital stay?

Audit Observations and Conclusions

Health has not established adequate controls to prevent or detect most inappropriate payments to clinics or emergency rooms for Medicaid recipients during their hospital stay. As a result, we found that Medicaid inappropriately paid as much as $16.9 million for clinic and emergency room claims during the 57 month period ended December 31, 1997.

Due to system design constraints, the MMIS cannot prevent clinics and emergency rooms from receiving Medicaid payments for recipients who

are in a hospital. Therefore, Health must rely on computer software used by its auditors to detect and recover such inappropriate payments on a post payment basis. In a 1994 audit, we reported that the computer software used at the time did not adequately detect such inappropriate payments. Subsequent to our previous audit, the computer software was modified by the Department of Social Services, and for the period April 1, 1993 through June 30, 1996, Social Services' auditors identified about $5.8 million in potential inappropriate clinic and emergency room payments. However, as of April 15, 1998, Health had requested providers to repay only $2.3 million of these payments. We recommend that Health improve the timeliness of recovery activities relating to these payments. (See pp. 4-5)

In addition, due to incorrect specifications, the audit software no longer considered the recipient's admission date to the hospital, but considered only the remainder of the recipient's hospital stay. We developed our own computer programs to review clinic and emergency room payments for the period April 1, 1993 through December 31, 1997, which Medicaid made for recipients who were admitted to an affiliated hospital. When we compared our results with the results achieved by Health's audit software, we found an additional $11.3 million in inappropriate clinic and emergency room claims. These claims were for the date that the recipient was admitted into a hospital. We recommend that Health investigate these claims and recover any overpayments, as well as strengthen controls to prevent future overpayments. (See pp. 4-5)

We also found that Health has not established adequate controls to prevent or detect inappropriate payments when the clinic and hospital providers are not affiliated with each other. For the period April 1, 1993 through December 31, 1997, we reviewed clinic claims for recipients who were in a nonaffiliated hospital, according to information on the claims submitted. We found more than $5.6 million in such claims, which MMIS paid for dates of service occurring after the recipient's hospital admission date, but before the hospital discharge date. We provided Health officials with computerized files of the potential inappropriate claims we identified. Health should investigate these claims and recover any overpayments, as well as enhance post payment audit software to include payments to clinics not affiliated with the hospital. (See pp. 5-6)

Comments of Officials

Health Department officials generally agree with our recommendations. They indicated that staff are working on modifying the computer programs to address the issues raised in this report and that appropriate recoveries will be made once the computer program changes are completed. Also, Health officials indicated that enhancements to the post payment software to include payments to clinics not affiliated with hospitals are dependent on a pending policy decision.

Contents

Introduction

Background

The New York State Department of Health (Health) administers the State's Medical Assistance Plan (Medicaid), which was established under 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 (Social Services) administered the State's Medicaid program and operated MMIS through the fiscal agent until October 1, 1996, when Health assumed these responsibilities.

Within broad Federal limits, states determine the medical services covered by Medicaid and the rates paid to service providers. Health develops applicable medical standards and sets Medicaid reimbursement rates. Under Part 86 of Title 10 of the New York State Health Code, Rules and Regulations, Section 86-1.18, Health establishes one all-inclusive prospective rate for inpatient hospital care, to reflect the cost of medical services that a recipient receives during a hospital stay. Health also establishes all-inclusive rates for emergency room services, clinic services (either hospital based or freestanding) and for other services as deemed appropriate. According to Health's policies, if a Medicaid recipient receives medical services in a hospital emergency room or outpatient clinic and is subsequently admitted to the affiliated hospital on the same day, Medicaid reimbursement is limited to the hospital's inpatient rate. It is generally inappropriate for Medicaid to pay claims for clinic or emergency room services which were rendered to a recipient either on the day the recipient was admitted into a hospital or during the rest of the recipient's hospital stay.

Audit Scope, Objective and Methodology

We audited the policies and procedures relevant to controlling Medicaid payments for clinic and emergency room services for recipients who were admitted into a hospital for the period April 1, 1993 through September 1, 1998. The objective of our performance audit was to determine whether Health has established adequate control procedures to either prevent or detect clinic and emergency room claims paid while a Medicaid recipient was in a hospital. We did not evaluate other types of ancillary claims that could have been paid during an inpatient stay.

To accomplish our audit objective, we interviewed Health officials, reviewed relevant Health records including claims identified by Health's audits, and reviewed related Medicaid payment policies and procedures. In addition, we used computer-assisted audit techniques to develop computer programs to extract and analyze hospital, clinic and emergency room claims for the period April 1, 1993 through December 31, 1997. The purpose of this computer analysis was to determine whether Health has adequate controls to prevent or detect inappropriate payments to clinics or emergency rooms for Medicaid recipients during their inpatient stay.

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 of 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.

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.

Inappropriate Clinic and Emergency Room Payments Not Detected

Health's management is responsible for establishing and maintaining a system of controls to ensure the accurate payment of all Medicaid claims. While Health has established all-inclusive rates for inpatient hospital care, emergency room and clinic services, we found Health has not established adequate controls to prevent or detect most inappropriate payments to clinics or emergency rooms for Medicaid recipients during their inpatient hospital stay. For example, MMIS does not have computerized controls or edits to prevent or detect Medicaid payments to clinic and emergency rooms for recipients who are subsequently admitted to a hospital on the same day. Consequently, Health relies on its auditors to identify such inappropriate claims on a post payment basis. Health's auditors have developed computer programs to help identify such claims. However, we found that Medicaid inappropriately paid $16.9 million during the period April 1, 1993 through December 31, 1997, because Health's audit software does not detect most instances of clinic and emergency room claims for recipients who were in a hospital.

Admission Date Not Considered by Audit Software

It is inappropriate for Medicaid to pay for clinic or emergency room services rendered on the first day a recipient is admitted into an affiliated hospital as well as during the recipient's inpatient stay. However, due to system design constraints, the MMIS cannot prevent clinics and emergency rooms from receiving payments for recipients who are in a hospital. Therefore, Health must rely on computer software used by its auditors to detect and recover such inappropriate payments on a post payment basis. However, as we first identified in Audit Report 93-S-86, Payment for Outpatient Services for Hospitalized Medicaid Recipients (issued June 10, 1994), the computer software used by the Department of Social Services' auditors did not adequately detect such inappropriate payments. In the audit report, we determined that because the audit software did not review Medicaid claims from all clinics, more than $15 million in inappropriate clinic payments were not detected.

The audit software was modified to correct this oversight. For the period April 1, 1993 through June 30, 1996, Social Services' auditors identified about $5.8 million in potential inappropriate clinic and emergency room payments. However, neither Social Services nor Health recovered these

inappropriate payments in a timely manner, which could lessen the deterrent effect of this activity. As of April 15, 1998, Health had requested providers to repay only $2.3 million of these payments, which covers the period April 1, 1993 through March 31, 1994. Health did not initiate recovery activities for the remaining $3.5 million in payments for the period April 1, 1994 through June 30, 1996.

Moreover, in July 1995, the audit software was modified again, resulting in new errors, which significantly weakened the software's effectiveness. Due to incorrect specifications, the audit software no longer considered the recipient's admission date to the hospital, but considered only the remainder of the recipient's hospital stay. We developed our own computer programs to review clinic and emergency room payments for the period April 1, 1993 through December 31, 1997, which Medicaid made for recipients who were admitted to an affiliated hospital. When we compared our results with the results achieved by Health's audit software, we found an additional $11.3 million in inappropriate clinic and emergency room claims. These claims were for the date that the recipient was admitted into a hospital and were not detected by Health's audit software. After we notified Health officials of the error in their software, they agreed to correct the error and initiate recovery activities. This correction should result in annual savings to the Medicaid program of about $2.5 million.

We determined that the same error was made in the software used to audit and detect inappropriate Medicaid claims received from referred ambulatory and laboratory service providers for recipients during their stay in a hospital. These computer programs also do not consider the recipient's admission date to the hospital when identifying inappropriate claims.

Audit Software Does Not Consider Payments to Nonaffiliated Providers

We found that Health has not established adequate controls to prevent or detect inappropriate payments when the clinic and hospital providers are not affiliated. For the period April 1, 1993 through December 31, 1997, we reviewed clinic claims for recipients who were in a nonaffiliated hospital, according to claims submitted. We identified more than $5.6 million in such claims, which MMIS paid for dates of service occurring after the recipient's hospital admission date, but before the hospital discharge date. We provided Health officials with computerized files of the potential inappropriate claims we identified.

Most of the inappropriate clinic claims were billed in one of two ways: (1) claims for medical services at a clinic, while the recipients were receiving medical care in hospitals, or (2) claims for mental health clinic services while the recipients were receiving psychiatric inpatient care. For example, MMIS paid over $8,000 to a hospital for a recipient who was receiving medical services for the treatment of pneumonia. The recipient was in the hospital between December 10, 1996 and December 31, 1996. During that period, a nonaffiliated clinic billed Medicaid for services rendered to the recipient. However, the cost of such services are the hospital's and not Medicaid's responsibility. Similarly, Medicaid paid over $18,000 to a psychiatric hospital for mental health services provided to a recipient between December 15, 1996 and December 31, 1996. During that period, a nonaffiliated mental health clinic also billed Medicaid for psychiatric services provided to the recipient. Again, the psychiatric hospital was responsible for paying the clinic. Since Health's audits do not include claims for nonaffiliated providers, the auditors do not identify such potentially inappropriate claims.

Recommendations

1. Improve the timeliness of recovery activities related to inappropriate clinic and emergency room payments.

2. Investigate and recover as necessary clinic and emergency room claims paid on a recipient's hospital admission date as well as claims paid to nonaffiliated clinics during a recipient's hospital stay.

3. Review the logic of the computerized programs used to audit clinic and emergency room claims and determine the corrective action needed to include claims submitted for a recipient's date of admission to a hospital. Perform a similar review for the audit software used to audit claims from referred ambulatory and laboratory service providers and recover payments for any identified inappropriate claims.

4. Develop and follow computer program specification approval procedures to control future modifications to computerized audit software.

5. Enhance post payment audit software to include payments to clinics not affiliated with the hospital.

Major Contributors to This Report

Kevin McClune
Lee Eggleston
William Clynes
Paul Alois
Sharon Whitmore
Nancy Cecot
Paul Bachman

State of New York
Department of Health
Corning Tower, Empire State Plaza
Albany, New York 12237

BARBARA A. DEBUONO, M.D., M.P.H.
Commissioner

Phone: (518) 474-2011
Fax: (518) 474-5450

October 29, 1998

Kevin M. McClune
Audit Director
Office of the State Comptroller
Alfred E. Smith State Office Building
Albany, New York 12236

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 98-S-10 entitled, "Medicaid Clinic and Emergency Room Claims Paid During a Recipient's Hospital Stay."

Thank you for the opportunity to comment.

Very truly yours,

Barbara A. DeBuono, M.D., M.P.H.
Commissioner of Health

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 98-S-10 Entitled
"Medicaid Clinic and Emergency Room
Claims Paid During a Recipient's Hospital Stay"

The following are the Department of Health's (DOH) comments in response to the above cited Office of State Comptroller (OSC) Draft Audit Report entitled "Medicaid Clinic and Emergency Room Claims Paid During a Recipient's Hospital Stay" (98-S-10).

Recommendation #1:

Improve the timeliness of recovery activities related to inappropriate clinic and emergency room payments.

Response #1:

The DOH's Office of Medicaid Management (OMM) routinely processes all collection recovery projects on a first-in first-out basis. As for the situation described in the report, the overpayments were in the process of recovery at the time of the OSC's audit. Based on discussions with the auditors, a decision was made to rerun the overpayment report to take into account software deficiencies discovered during their audit. This resulted in the delayed recovery of the overpayments.

Recommendation #2:

Investigate and recover as necessary clinic and emergency room claims paid on a recipient's hospital admission date as well as claims paid to non-affiliated clinics during a recipient's hospital stay.

Response #2:

OMM staff are in agreement with this recommendation and will investigate and recover the claims as necessary.

Recommendation #3:

Review the logic of the computerized programs used to audit clinic and emergency room claims and determine the corrective action needed to include claims submitted for a recipient's date of admission to a hospital. Perform a similar review for the audit software used to audit claims from referred ambulatory and laboratory service providers and recover payments for any identified inappropriate claims.

Response #3:

OMM staff are currently working on modifying the computer programs to address the issues raised in the report. Appropriate recoveries will be made once the changes are completed.

Recommendation #4:

Develop and follow computer program specification approval procedures to control future modifications to computerized audit software.

Response #4:

OMM staff are in agreement and will take the necessary steps to implement this recommendation.

Recommendation #5:

Enhance post payment audit software to include payments to clinics not affiliated with the hospital.

Response #5:

Because implementation of this recommendation is dependent upon the department's pending policy decision concerning payments made to non-affiliated facilities, who may have provided services in good faith, this recommendation will be addressed once that decision has been made.