An Audit Report on the Analysis of Potential Overpayments through the Medicaid Program

Table of Contents

Table of Contents, concluded

Key Points Of Report

An Audit Report on the Analysis of Potential Overpayments Through the Medicaid Program

September 1995

Key Facts And Findings

- Estimated annual Medicaid savings of $736,000 could be realized by improving controls designed to detect specific types of Medicaid overpayments.

- The Texas Department of Health (Department) could save approximately $369,000 if the Department could recover laboratory payments made in error during 1994. Controls have been added by the contractor which should reduce these overpayments in future years if implemented properly. The omission of certain procedure codes from the contractor's payment system appears to be the prevalent reason for these overpayments.

- The Department could save approximately $824,000 annually by extending the Department's policy of denying related outpatient claims paid 24 hours prior to the admission as an inpatient to three days. Although the Department's current Medicaid policy is within federal requirements, *Medicare* regulations require a three-day payment policy.

- The appropriate use of one payment code by providers may provide for additional savings. We identified an apparent misuse of this code relating to the unreasonable quantity of chemistry tests performed when the payment code is used. Our estimates indicated that approximately $997,000 was paid to providers in 1994 when the characteristics of this misuse existed.

- The Department's Statistics and Analysis Division identified and referred approximately $15.9 million in potential overpayments to the contractor for recoupment for the 12 months ended July 1994.

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This audit was conducted in accordance with Government Code, §§321.0131, 321.0132, and 321.0135. The audit was performed as part of a joint effort with the U.S. Department of Health and Human Services-Office of Inspector General, Office of Audit Services.

Executive Summary

Our review of the Texas Department of Health's Medicaid program found that the Department could save approximately $1.9 million annually for three distinct payment issues. These savings can be realized by correcting ineffective post-payment and pre-payment automated controls, refining other controls, and broadening a payment policy. This audit was a limited purpose audit in that we examined three payment issues which represented approximately $5.6 million in Medicaid payments during June and July 1994 and an estimated $32 million annually. The audit was requested by the U.S. Department of Health and Human Services and was performed in partnership with this federal agency.

All savings are based on two-month statistical projections relating to the payment issues. The annualized savings estimates are based on other methods determined to be reasonable by the State Auditor's Office. Figure 1 illustrates the estimated annualized savings which could be realized by successfully implementing our audit recommendations.

In addition, our computer applications indicated that a payment code (Modifier 76) is apparently being misapplied by Medicaid providers. We estimate that $997,000 was paid to providers in fiscal year 1994 when the characteristics of the payment indicated the misapplication of the Modifier 76 code. This problem should be easily corrected because 70 percent of the dollars paid were paid to only five of more than 170 providers using the code.

> We estimate that an additional $997,000 was paid to providers when the characteristics of the payment indicated the misapplication of the Modifier 76 code.

Estimated Annual Medicaid Savings of $736,000 Could Be Realized by Improving Controls Designed to Detect Specific Types of Medicaid Overpayments

Controls over information do not ensure that information provided to the Department is accurate. There are significant problems with two reports provided to the Department by the Texas Department of Human Services

Figure 1

Payment Issues Where <u>Overpayments</u> Existed	**Estimated Annualized Savings**
Patient Transfers	$290,000
Related Non-Physician Outpatient Claims Paid *During* An Inpatient Stay	$227,000
Related Non-Physician Outpatient Claims Paid *One Day Prior* To An Inpatient Stay	$219,000
Laboratory Claims Submitted For Payment With Improper Coding	$369,000
Payment Issues Where <u>Savings</u> Existed:	
Extension Of Outpatient Payment Window To *Three Days Prior*	$824,000
Estimated Annual Impact Of Audit Recommendations	**$1,929,000**

(TDHS) which are used to monitor potential overpayments. One report is used to detect overpayments for patient transfers between hospitals. The other report is used to detect unallowed non-physician related outpatient claims paid during an inpatient stay. We estimate that there is approximately $129,000 in unrecovered overpayments which should have been identified in these two reports during June and July 1994. We estimate that $736,000 could be saved annually by successfully implementing recommendations relating to these overpayments.

In addition, a computer control in the National Heritage Insurance Company's payment system does not consistently reduce payment rates for patient transfer claims. The system is not consistently identifying a disallowed payment when a hospital properly records a patient transfer as a transfer to another hospital.

The Department's Statistics and Analysis Division does not have formal policies and procedures designed to assist in the determination of overpayments. The Department has information in several memos which relate to ineligible patient transfer payments. However, there is not an overall documented methodology available for analysts.

Expansion of the Preadmission Outpatient Payment Window to Three Days Could Save Approximately $824,000 Annually

We estimate that the Department could save approximately $416,000 annually by extending to two days the Department's policy of denying related outpatient claims paid 24 hours prior to the admission as an inpatient. Extending the policy to three days prior, the Department could save an additional $408,000 annually for a total annual savings of approximately $824,000. The three-day payment window is a requirement for *Medicare*, but is not a current federal requirement for *Medicaid*.

In our tests of outpatient claims occurring up to three days prior to admission as an inpatient, 76 percent of the outpatient claims were related to the inpatient claim, indicating that many outpatient claims could be disallowed. Our review indicated that 1,623 outpatient claims in a two-month period in 1994 would have contained a potential overpayment had the Department disallowed related outpatient claims three days prior to admission.

Potential Savings of Approximately $369,000 Exist for Laboratory Payments Made in Fiscal Year 1994, and the Appropriate Use of One Payment Code by Providers May Provide for Additional Savings

Our annualized estimates indicate a total potential annual savings of approximately $369,000 if the Department could recover payments made in error during 1994. Controls have been added by the Contractor which should reduce these overpayments in future years if implemented properly. The omission of certain procedure codes from the National Heritage Insurance Company's automated payment system appears to be the prevalent reason for these overpayments.

The abuse or inappropriate use of one payment code (Modifier 76) by providers could result in additional overpayments within laboratory claims. The code is available for provider use when a procedure is performed more than once on the same day. We identified an apparent misuse of this code relating to the unreasonable quantity of chemistry tests performed when the payment code is used. Our estimates indicated that approximately $997,000 was paid in fiscal year 1994 to providers when the characteristics of this misuse existed.

The Department's Statistics and Analysis Division Referred Over $15.9 Million in Medicaid Overpayments to the Contractor for Recovery During the 12-Month Period Ended July 1994

In state fiscal year 1994, there were approximately $3.7 billion in Medicaid payments processed through the contractor's automated payment system. Although this report identifies instances of unidentified potential overpayments, the Department's Statistics and Analysis Division did identify and refer $15.9 million in potential overpayments to the contractor for recoupment for the 12 months ended July 1994. Of this amount, approximately $4.6 million (29 percent) of the dollars were referred for patient transfers and non-physician related outpatient services. During the same period, the Department and its contractor recovered approximately $14.6 million for overpayments and paid out approximately $8.8 million for underpaid claims.

At the end of June 1994, the Department's Statistics and Analysis Division was comprised of 17 staff with about 218 years of cumulative Medicaid experience. As of March 1995, the Division had lost only one staff member and a new section, the Actuarial Analysis Section, had been added.

Summary of Audit Objective and Scope

In partnership with the U.S. Department of Health and Human Services-Office of Inspector General, the objective of this audit was to determine if adequate processes and controls exist within the *Medicaid* program to prevent or detect potential overpayments made to providers and to initiate a statewide recovery action for identified and potential overpayments as appropriate.

The scope of this audit included consideration of the program's primary controls to prevent or detect potential overpayments relating to the following:

- inappropriately paid patient transfer claims
- related non-physician outpatient services paid during and prior to the patient's inpatient stay
- laboratory claims submitted for payment with improper coding

The Department's responses to the audit report, along with Auditor Follow-Up Comments, are included following the Detailed Issues and Recommendations section of this report. The Department disagrees with certain methodologies used in the audit and the audit recommendations concerning the expansion of a payment policy. The Texas State Auditor's Office has re-examined these issues and is committed to the audit methodologies and recommendations detailed in the report.

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Section 1:

Estimated Annual Medicaid Savings of $736,000 Could Be Realized by Improving Controls Designed to Detect Specific Types of Medicaid Overpayments

There are significant problems with two reports provided by the Texas Department of Human Services (TDHS) which are used by the Texas Department of Health (Department) to monitor potential overpayments in two of the three payment issues examined by our audit team. One report is used to detect overpayments for patient transfers between hospitals. The other report is used to detect unallowed non-physician related outpatient claims paid during an inpatient stay. Figure 2 illustrates the estimated overpayments within June and July 1994 and the annual potential savings which could be realized by the Department by implementing our recommendations.

Figure 2

Payment Issues Where Overpayments Existed	Two-Month Statistical Projection	Estimated Annualized Savings[1]
Patient Transfers	$48,000	$290,000
Related Non-Physician Outpatient Claims Paid *During* An Inpatient Stay	$41,000	$227,000
Related Non-Physician Outpatient Claims Paid *One Day Prior* To An Inpatient Stay	$40,000	$219,000
Total Estimated Two-Month And Estimated Annual Impact Of Audit Recommendations	**$129,000**	**$736,000**

In addition, a computer prepayment control in the contractor's[2] payment system does not consistently reduce payment rates for patient transfer claims. The system is not identifying a disallowed payment when a hospital properly records a patient transfer as a transfer to another hospital.

The Department's Statistics and Analysis Division does not have formal policies and procedures designed to assist in the determination of overpayments. The Department has information in several memos which relate to ineligible patient transfer payments. However, there is not an overall documented methodology available for analysts.

1 All Estimated Annualized Savings are based on non-statistical methods which are detailed in Appendix 4.

2 The National Heritage Insurance Company is the contractor which processes Medicaid payments for the Department.

In partnership with the U.S. Department of Health and Human Services-Office of Inspector General, the Texas State Auditor's Office reviewed three types of potential Medicaid overpayments. The types of overpayments included:

- inappropriately paid patient transfer claims
- related non-physician outpatient services paid during and prior to the patient's inpatient stay
- laboratory claims submitted for payment with improper coding (discussed in Section 3)

This audit was a limited purpose audit in that we examined three payment issues as requested by the U.S. Department of Health and Human Services and which represented about $5.6 million in Medicaid payments during June and July 1994 and an estimated $32 million annually.

The Department's responses to the audit report, along with Auditor Follow-Up Comments, are included following the Detailed Issues and Recommendations section of this report.

Section 1-A:

Reports Provided by the Texas Department of Human Services for Payment Monitoring Do Not Identify All Potential Overpayments

In our sample of potential overpayments[3] for non-physician related outpatient claims, 76 percent (38 of 50) were not included on the report provided to the Department by the Texas Department of Human Services (TDHS). In another sample of potential patient transfer overpayments, 40 percent (20 of 50) were not included on the report provided by TDHS. Combined, these two reports did not include 58 percent (58 of 100) of the items examined. For the two-month period of June and July 1994, we estimate that at least $89,000 in potential overpayments exists for these two types of overpayments. Based upon this amount, we estimate that the potential annual savings to the Department are approximately $517,000.[4]

Post-Payment Controls Need to Be Evaluated

Two Hospital Utilization Monitoring System reports provided by the Texas Department of Human Services need extensive modifications.

The Department pays TDHS to provide computer processing of Medicaid data on a monthly basis. The Hospital Utilization Monitoring (MX) system is owned by the

3 A potential overpayment is defined as a payment to a provider when characteristics on the claim indicate that an overpayment could likely occur. These characteristics which could generally result in an overpayment were determined by the audit team. The specifics of these characteristics are described in Appendix 4.

4 This amount includes $290,000 for inappropriately paid patient transfers and $227,000 for related non-physician outpatient claims paid during an inpatient stay.

Department and maintained by TDHS as part of this arrangement. The system produces two reports which are used by the Department's Statistics and Analysis Division as the primary controls for analyzing and recovering potential overpayments relating to patient transfers and outpatient services paid during an inpatient stay.

Medicaid payments for related outpatient services to providers are currently disallowed if they occur during or 24 hours[5] prior to an inpatient stay. This policy is based on the premise that reimbursement for these services are included in the payment to the hospital for the inpatient stay.

When a patient transfer occurs, the transferring hospital generally receives a per diem amount based on the number of days of care provided to the patient at the hospital. The receiving hospital will generally receive the full payment. An overpayment for a hospital transfer generally exists when the transferring hospital erroneously receives the full payment amount.

For claims relating to outpatient services provided during an inpatient stay, it appears that the Hospital Utilization Monitoring System has the following characteristics:

- The system is not identifying claims processed for independent labs. The system only detects potential overpayments to hospital laboratories. We identified ten overpayments due to this omission.

- The system is not including outpatient claims to Federally Qualified Health Centers. These centers include community health centers, migrant health centers, and health care for the homeless. The reimbursement amount for an inpatient stay includes all facility services provided to the client while registered as an inpatient, even if the service is provided by a different facility. In our testing of claims, four payments to these providers were related to an inpatient stay at another provider and resulted in an overpayment.

- Two overpayments were not detected by the system and an explanation for their exclusion could not be reasonably determined by the Department or our Office. These claims appear to be identical to claims typically detected by the system.

- Three overpayments were not detected when the outpatient claim occurred on the date of discharge, but prior to the hour of discharge of the patient while registered as an inpatient.
- Another 19 potential overpayments were not detected; however, no overpayment existed. This occurred when an outpatient payment was made to a different provider on the date of admission at the inpatient hospital. An

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5 It is important to note that the contractor has defined 24 hours as one day prior to an inpatient stay. To be consistent with the current monitoring procedures and to facilitate analyses, our audit also defined 24 hours as being one day prior to an inpatient stay. This distinction is necessary because it is possible to have an outpatient claim occur one day prior to a related inpatient claim yet more than 24 hours from the admission hour on the inpatient claim.

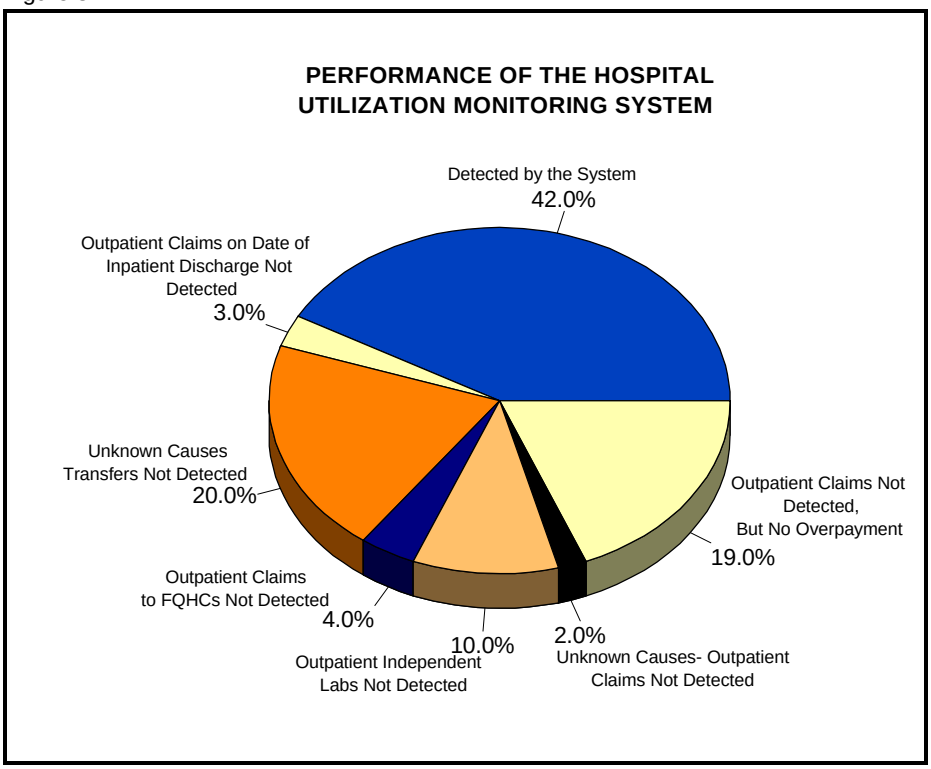
overpayment exists when the outpatient service is provided subsequent to the inpatient admission hour. By having the report identify these claims, the Department can determine which outpatient claims occurred subsequent to the inpatient stay. This analysis can be done by examining the hour of service and the hour of admission on the outpatient and inpatient claims, respectively.

In addition, the report which detects claims for related outpatient services paid during an inpatient stay is not designed to identify the claims paid one day prior to the date of an inpatient stay. We found that 74 percent (23 of 31) of the outpatient claims we examined were related to the inpatient stay and 65 percent (20 of 31) of the claims resulted in overpayments. For the two-month period of June and July 1994, we estimate that at least an additional $40,000 in overpayments exist for this type of claim. We estimate that approximately $219,000 in potential annual savings exist relating to this type of claim.

Reports Do Not Capture All Potential Overpayments

Reports are not designed to identify potential overpayments for related outpatient services paid prior to a patient's inpatient stay.

Figure 3



Without performing an in-depth review of the Hospital Utilization Monitoring System, we could not reasonably determine the cause for the omission of the patient transfer claims on the other monitoring report. Both the Department and the State Auditor's Office reviewed these claims and determined that the claims in question were claims which should appear on the report. (See Figure 3 for a summary of the Hospital Utilization Monitoring System's performance.)

Of the 42 remaining potential overpayments correctly identified on the Hospital Utilization Monitoring System reports, five had not been recovered. All five were for patient transfer claims. All items identified by the Hospital Utilization Monitoring system's report for non-physician related outpatient services during an inpatient stay were recouped from the provider.

Recommendations:

The Department should:

1. Evaluate the cost of updating the Hospital Utilization Monitoring System to determine whether it can adequately serve the needs of the Department. The evaluation should examine the causes for the omission of patient transfer claims from the report provided by the Texas Department of Human Services. The review should examine adding controls to detect outpatient claims paid one day prior to an inpatient stay by the same provider.

   For outpatient claims paid during an inpatient stay, the Department should add the following items to the monitoring report:

   - outpatient services billed by independent laboratories
   - hospital outpatient services rendered one day prior to admission as an inpatient
   - outpatient services at any provider on the date of admission as an inpatient which are after the hour of admission as an inpatient
   - outpatient services at any provider on the date of discharge as an inpatient which are before the hour of discharge
   - outpatient services billed by Federally Qualified Health Centers during an inpatient stay
   - the hour of admission/discharge from the inpatient claim
   - the hour of service from the outpatient claim

2. Have Department staff work closely with the Texas Department of Human Services in the development and implementation of the changes, provided updates to the Hospital Utilization Monitoring System are cost beneficial. If updates are not cost beneficial, the Department should develop its own controls for monitoring these payment issues.

   Note: The Texas State Auditor's Office has offered to provide the computer programs used in this audit to the Department.

3. Develop test data consisting of the types of claims normally identified for recoupment by the Statistics and Analysis Division to periodically test the accuracy of the post payment review system, regardless of the system used.

4. Take steps toward the recovery of overpayments identified in our audit relating to the following:

   - inappropriately paid patient transfer claims
   - non-physician related outpatient claims during and one day prior to an inpatient stay

Section 1-B:

A Prepayment Control at the Contractor for Preventing Patient Transfer Overpayments Needs Improvement

A computer edit in the contractor's payment system is not consistently reducing payment rates for patient transfers to the appropriate reimbursement rate when the provider has correctly coded the patient discharge as a transfer to another short-term general hospital. Our tests showed that in 50 percent (6 of 12) of the claims where the provider had coded the transfer appropriately, the contractor's payment system did not automatically reduce the transferring hospital's payment to a per diem rate. According to the Department, the contractor did not know the exact cause for this systemic problem as of the end of our fieldwork and is currently investigating the problem.

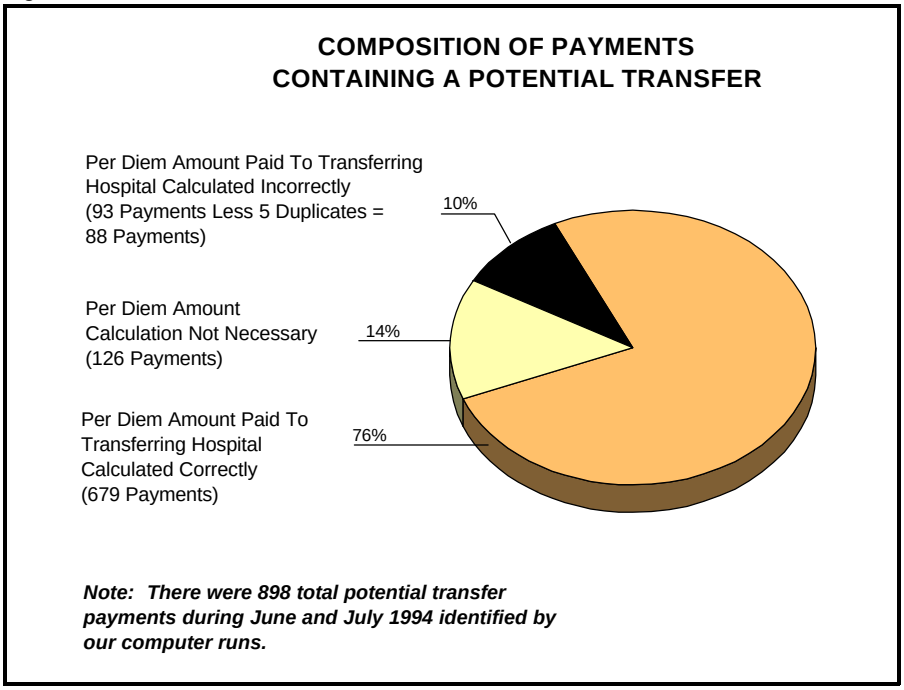
Departmental Monitoring of Prepayment Controls Is Needed

The Statistics and Analysis Division does not actively monitor of test the effectiveness of the prepayment controls maintained by the contractor. Given the extensive number of Medicaid payment guidelines, this oversight is crucial.

The Medicaid State Plan states that when a patient has been transferred to another hospital, the payment to the receiving hospital is the full amount entitled to the hospital for that specific service. In most cases, the transferring hospital receives a per diem amount (a lesser amount) based on the length of stay of the patient.

The overall occurrence of inappropriately paid patient transfers is around 10 percent of all claims processed relating to a patient transfer. Figure 4 illustrates the number of times a per diem calculation was not necessary, the number of times the per diem amount was determined correctly, and the number of times the per diem amount was determined incorrectly. All figures are a result of our tests for the two-month period between June and July 1994.

Figure 4



Recommendations:

The Department should:

1. Ensure that the contractor corrects the system's edit which should consistently reduce properly reported patient transfer claims to a per diem amount.

2. Implement a process to monitor the effectiveness of the contractor's

automated controls. Specifically, the Department should:

- Dedicate sufficient employee time in the Department's Policy and Data Analysis Section of the Statistics and Analysis Division to reviewing and testing these controls.

- Develop and test data files. This approach will only identify problems; it will not identify individual claims for recovery. Once payment issues are identified using this test data approach, the Department should pursue actual overpayments on a claim by claim basis.

Section 1-C:

The Department's Statistics and Analysis Division Does Not Have Formal Policies and Procedures Designed to Assist in the Determination of Overpayments

The criteria used to determine whether or not a patient transfer has occurred is not documented in a clear and complete manner. The Department has information in several memos which relate to patient transfers, but there is not an overall documented methodology available for analysts to use in performing their duties.

The lack of formal policies appeared to be a contributing factor when the Statistics and Analysis Division did not refer all ineligible patient transfer claims for recovery. For example, a memo stated criteria to be used in determining how to recover patient transfer overpayments. In this memo, staff were directed to use Major Diagnostic Categories in determining if the claim from the transferring hospital was related to the claim from the receiving hospital. However, the staff were not given copies of the Major Diagnostic Category manual and appeared to be using more restrictive criteria.

In addition, the Department does not have formal documentation of its policy for not recovering outpatient claims which are equal to or under $50. The policy is important for clarifying the Department's position on claims recovery and should be documented in a formal manner. Our analysis of this policy showed that the policy was reasonable because approximately 43 percent of the total claims, but only 7 percent of the total dollars paid fell within this category. The lack of formal documentation of this policy caused a delay in the discovery of the policy by our audit team and resulted in additional work for both the Department and the State Auditor's Office.

Policies and procedures are integral to the planning process and are essential tools for managerial direction and control of the operating environment. Because approximately $3.7 billion passed through the contractor's automated payment system to Medicaid providers in 1994, the development of these tools should be of the highest priority for the Medicaid payment monitoring function.

Recommendations:

The Department should:

1. Identify management decisions and recurring tasks related to the identification and recovery of Medicaid overpayments.

2. For these management decisions and tasks, develop formal policies for standard management decision areas and procedures for recurring tasks based on input from affected parties. The formal policies and procedures should be:

   - communicated in writing to all affected parties
   - implemented, monitored, and reviewed periodically for appropriateness, compliance, and alignment with the Department's goals and objectives
   - adjusted as needed

Section 2:

Expansion of the Preadmission Outpatient Payment Window to Three Days Could Save Approximately $824,000 Annually

The Department could save approximately $416,000 annually by extending the policy of denying related outpatient claims paid 24 hours prior to the admission as an inpatient to two days prior. Extending the policy to three days prior, the Department could save an additional $408,000 annually for a total annual savings of approximately $824,000. These annualized, non-statistical audit estimates are based on our statistical two-month projections of $75,000 and $74,000, respectively. Currently, the Department's contractor disallows payments for related outpatient claims if they occur within one day preceding the admission date of the patient to the same hospital. These services are included in the inpatient reimbursement and should not be paid separately on an outpatient claim.

Although there are no federal requirements for a three-day payment exclusion for related non-physician outpatient claims for Medicaid, the requirement exists for Medicare. The current Medicaid policy in place at the Department is acceptable. The Medicare payment policy was implemented as a result of the Omnibus Budget Reconciliation Act of 1990. Per Section 4003 of Title IV, Subtitle A of the Act, the payment for inpatient services includes the costs of related outpatient services during the three days immediately preceding the date of inpatient admission.

In our tests of outpatient claims occurring two and three days prior to admission as an inpatient, 76 percent (47 of 62) of the outpatient claims were related to the inpatient claim. A significant number of existing outpatient claims would be subject to the expansion of the outpatient payment window. Our computer applications revealed that the number of outpatient claims in Figure 5 would have contained a potential overpayment had the Department disallowed non-physician related outpatient services two and three days prior to admission.

Figure 5

Description of Proposed Expansion Period	Number of Claims for June-July 1994
Outpatient service date was two days prior to a related inpatient stay	906 claims
Outpatient service date was three days prior to a related inpatient stay	717 claims
Total	**1,623 claims**

Recommendations:

The Department should:

1. Be consistent with Medicare and extend the policy for denying related outpatient payments from 24 hours to three days prior to the admission of the patient as an inpatient.

2. Develop appropriate controls to detect and initiate recovery for these outpatient claims after the implementation of the policy. These controls should be considered along with the evaluation of the revisions to the Hospital Utilization Monitoring System detailed in our first recommendation under Section 1-A.

Section 3:

Potential Savings of Approximately $369,000 Exist for Laboratory Payments Made in Fiscal Year 1994, and the Appropriate Use of One Payment Code by Providers May Provide for Additional Savings

Our non-statistical estimates indicate a total potential annual savings of approximately $369,000 if the Department could recover payments made in error during 1994. From our review of laboratory payments, we statistically estimated at least $67,000 in potential overpayments for June and July 1994. The omission of certain procedure codes from the National Heritage Insurance Company's automated payment system appears to be the prevalent reason for these overpayments. Controls have been added by the contractor which should reduce these overpayments in future years if implemented properly.

In our review of 138 claims from laboratory payments for June and July 1994, we estimated potential overpayments of $67,000 for laboratory tests in these two months. The specific reasons for potential overpayments in each category differ substantially, but all are the result of prepayment controls not operating effectively. Figure 6 illustrates the estimated overpayments in June and July 1994 and our non-statistical estimate of annual potential savings which could be realized by the Department.

Figure 6

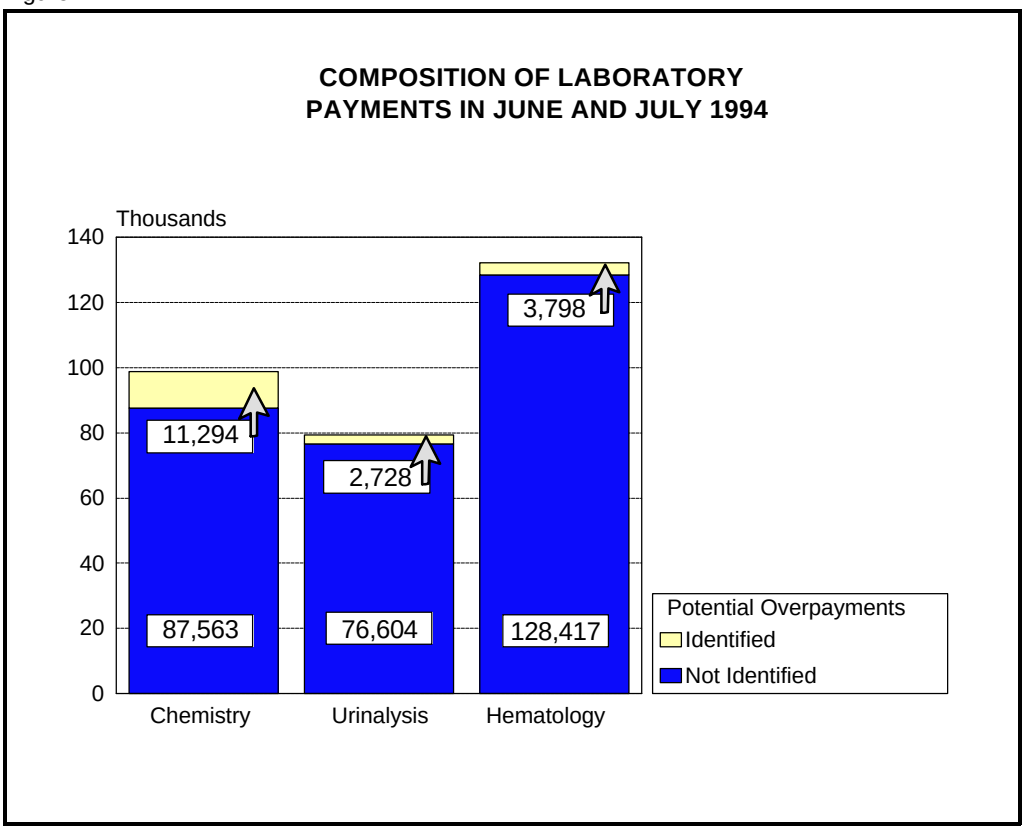
Payment Issues Where Overpayments Existed Associated With Prepayment Controls	Two-Month Statistical Projection	Estimated Annualized Savings
Grouping of Chemistry Tests into panels	$44,000	$242,000
Grouping of Urinalysis Tests into panels	$9,000	$52,000
Grouping of Hematology Tests into panels	$14,000	$75,000
Total Estimated Two-Month And Annual Impact Of Audit Recommendations	**$67,000**	**$369,000**

The abuse or inappropriate use of one payment code by providers could result in additional overpayments within laboratory claims. The code is available for provider use when a procedure is performed more than once on the same day. For June and July 1994, we identified an apparent misuse of this code relating to the quantity of tests performed when the payment code is used.

We recognized that some overlap could occur between overpayments identified within our laboratory overpayment testing and those identified in our testing of related outpatient services provided during or prior to an inpatient stay. We performed computer matches of claims identified in each category and found that less than one percent were actually captured in both payment categories. Therefore, the overlap was minimal, and we did not adjust our projections.

Overall, the majority of laboratory payments processed by our computer applications were identified as correct payments. Less than six percent of the laboratory claims paid in June and July 1994 which included a chemistry, urinalysis, or hematology laboratory code subject to certain payment rules were identified as containing a potential overpayment. This percentage represents 17,800 laboratory payments out of approximately 310,400 payments processed by our audit team. Figure 7 illustrates the number of payments processed containing a potential overpayment and those which did not appear to have an overpayment. The audit populations from which our audit team's samples were obtained are the number of payments determined to be processed incorrectly by our computer applications.

Figure 7



Section 3-A:

Estimated Savings of $242,000 Could Be Realized by Correcting Ineffective Controls and Initiating a Recovery Action on Chemistry Claims Processed in Error

Our non-statistical estimates indicate that the Department could save approximately $242,000 annually by identifying and recovering chemistry laboratory claims paid in error during 1994. This estimate is based on a two-month statistical projection for June and July 1994. We estimate that ineffective controls resulted in approximately $44,000 in overpayments for chemistry laboratory payments relating to procedures known as panel tests. The Department should also realize savings in future years by implementing the recommendations contained within this section of our report.

The process of grouping multiple chemistry tests performed for a patient on the same day into one procedure code for billing purposes is called "paneling." If the tests are each billed separately, a higher payment amount would be received by the provider than would occur if they were billed and paid as a panel. During 1994, there were 27 chemistry tests which were required to be grouped into a panel code for billing purposes.

The last two digits of a chemistry test panel code represent the number of tests performed for a specific patient on a specific date. The panel codes range from 80002 to 80019. The 800**19** panel code is used to group **19** or more individual tests together

for payment. The following three examples demonstrate how a chemistry panel code should and should not be used:

Example 1: Patient A has **2** chemistry tests performed on the same day at Hospital B. Each of the two tests has a specific procedure code, and each procedure code is one of the 27 codes required to be paneled for billing purposes. Hospital B should submit the claim using only the panel code of 8000**2,** and the specific code for each test should not appear on the claim.

Example 2: Patient B has **8** of the 27 chemistry tests subject to paneling performed on the same day at Hospital B. Hospital B erroneously submits the claim using panel codes 8000**5** and 8000**3**. The claim should be submitted using only the 8000**8** panel code.

Example 3: Patient C has **3** of the 27 chemistry tests subject to paneling performed on the same day at Hospital B. Hospital B erroneously submits the claim using 8000**2** for two of the tests and the specific procedure code for the other test performed. The claim should have been submitted using only the 8000**3** panel code.

Our tests showed that combined, two specific overpayment conditions occurred in 58 percent (22 of 38) of the potential chemistry overpayments examined. These two different types of overpayments are detailed in Figure 8.

Figure 8

Type of Overpayment		Reason for Overpayment
1.	Multiple chemistry panel codes were inappropriately paid on the same day for the same patient.	Only one panel code should appear on a specific claim.
2.	Specific tests subject to paneling were paid on the same claim and not paneled.	When certain specific chemistry tests are performed they should be grouped together and submitted for payment using a panel code.

We identified approximately 11,000 claims where a potential overpayment existed. There were approximately 99,000 claims processed in June and July 1994 which included chemistry procedure panel codes or an individual code subject to paneling.

The contractor had two automated controls in place during the period of our testing and implemented two additional automated controls subsequent to our test months. Combined, these control enhancements should help prevent overpayments from occurring in the future; however, control issues still exist which should be addressed by the Department. The controls can be separated into two categories:

- controls existing prior to our sample months of June and July 1994 where revisions occurred subsequently to June and July 1994

- controls which have been recently implemented

We reviewed the current functional descriptions of the new controls and the revisions to the existing controls to determine whether the controls appeared to be appropriate. Our test period was prior to these enhancements and, therefore, we were unable to test these modifications. The contractor refers to each of these prepayment controls as an "Audit" and numbers are assigned to each "Audit." Figure 9 identifies the controls in each of these categories and our assessment of each.

Figure 9

Controls Existed and Revisions Have Occurred		Effectiveness
1)	Lab procedures billed more than once per day, by the same provider, on the same claim are suspended and reviewed - (Audit #728)	This control should assist in preventing duplicate payments.
2)	Two or more specific lab tests that should be billed as a panel are denied if submitted on the same day - (Audit #605)	This control should assist in ensuring panel codes are used when appropriate.
New Controls Recently Implemented		**Effectiveness**
3)	A specific lab test that should be billed as a panel is denied if it is on the same claim as only one specific panel code, procedure code 80019 - (Audit #735)	The description of this control only identifies one panel code. Panel codes 80002 - 80018 are not included.
4)	Multiple (two or more) panels are denied when billed on the same day by the same provider. These panels should be combined and billed as one panel code - (Audit #747)	This control should assist in preventing more than one panel code from being billed on the same claim.

The proper implementation of controls 3 and 4 above should prevent 73 percent of the overpayments identified in our tests. The expansion of control 3 to include the other panel codes should capture the remaining 27 percent of overpayments.

Recommendations:

The Department should:

1. Take steps toward the recovery of potential overpayments identified in our audit related to chemistry laboratory potential overpayments.

2. Have the contractor expand Audit #735 to include all chemistry panel codes in addition to the one code already included. This step involves adding procedure codes 80002 through 80018 to the Audit.

Section 3-B:

Estimated Savings of $52,000 Could Be Realized by Correcting Isolated Ineffective Controls and Initiating a Recovery Action on Urinalysis Claims Processed in Error

Overall, 72 percent (36 of 50) of potential overpayments examined were determined to be actual overpayments. Eighty-nine percent (32 of 36) of these overpayments were the direct result of a delay in the addition of one procedure code to the contractor's computerized control. One overpayment was a result of a manual override, and three overpayments should have been prevented by the automated control.

Our non-statistical estimates indicate that the Department could save approximately $52,000 annually by identifying and recovering urinalysis laboratory claims paid in error during 1994. We estimate that ineffective controls resulted in approximately $9,000 in overpayments for urinalysis laboratory payments for June and July 1994. The Department should also realize savings in future years by implementing the recommendations contained within this section of our report.

Urinalysis tests are paneled similarly to chemistry tests. However, there is only one panel code. If more than one specific urinalysis test is billed on the same day, it should be paneled using this one code.

A significant amount of overpayments for urinalysis laboratory payments identified in our tests were the direct result of the omission of one procedure code from the contractor's computerized control. We found that 89 percent (32 of 36) of actual overpayments resulted from this omission. The code is a procedure code for a glucose sugar test (code 82947). The glucose sugar test was changed from code 82954 to 82947 in the 1993 Physician's Current Procedural Terminology manual. The change should have been updated in the contractor's control system at that time. The contractor did not add the update until April 1, 1995.

Recommendations:

The Department should:

1. Monitor the timely addition of laboratory procedure codes to the contractor's automated payment system.

2. Take steps toward the recovery of potential overpayments identified in our audit related to urinalysis laboratory potential overpayments.

Section 3-C:

Estimated Savings of $75,000 Could Be Realized by Correcting Isolated Ineffective Controls and Initiating a Recovery Action on Hematology Claims Processed in Error

Monitoring of Current Procedural Codes Is Critical

The Department should monitor procedure code changes in the Physician's Current Procedural Terminology Manual to ensure procedural coding updates are in place in a timely manner.

Overall, 84 percent (42 of 50) of potential overpayments examined were determined to be actual overpayments. Potential overpayments, however, made up approximately three percent of the total claims processed by our audit which included hematology tests subject to paneling.

The paneling procedures for hematology tests are similar to chemistry and urinalysis tests, but are extremely complex.[6] Figure 10 illustrates the various causes for the 42 overpayments identified in our tests.

Figure 10

Number of Occurrences	Overpayment Descriptions
29	A panel code and an individual procedure code subject to paneling were billed separately. Only the panel code should have been billed.
6	Individual procedure codes which should have been combined and billed as a panel code were not combined.
6	Two procedure codes subject to paneling were billed on the same day. These codes should be combined and billed as a panel code.
1	One panel code was billed twice on the same day for the same patient, and the appropriate code allowing this situation was not used.

Our non-statistical estimates indicate that the Department could save approximately $75,000 annually by identifying and recovering hematology laboratory claims paid in error during 1994. We estimate that ineffective controls resulted in approximately $14,000 in overpayments for hematology laboratory payments for June and July 1994. The Department should also realize savings in future years by implementing the recommendations contained within this section of our report.

The contractor has three automated controls which should prevent overpayments from occurring. We reviewed the functional descriptions of the controls to determine whether the control appeared appropriate. Figure 11 identifies the controls and our assessment of each.

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6 In general, when any three or more of specified individual tests of a complete blood count are processed on the same day, they must be billed as one of two codes. If only two of the same specified individual tests are billed on the same day, another code should be used. However, the code used when only two individual tests are performed is not allowed on the same claim as the codes used when three or more individual tests were performed. For example, if one of the panel codes available is used when three tests were performed, the panel code used when two tests were performed cannot appear on the same claim.

To further complicate payments, if two or more of the same specified individual codes are performed with a platelet count on the same day, the use of one of five codes is required. In addition, there are specialized blood counts which are allowed to be billed on the same day as a complete blood count.

Figure 11

Existing Controls	Effectiveness
1) Individual procedures considered part of a panel are denied when billed on the same day by the same provider - (Audit #504)	It appears that the control does not eliminate all combinations of codes which could cause an overpayment. All individual procedure codes are not included for every panel code, resulting in overpayments on some claims and a prevention of overpayments on other claims.
2) Two or more procedures considered part of a panel are denied when billed separately on the same day - (Audit #618)	It appears that the control does not include all procedure codes. However, the logic of the control appears correct, and the control should help ensure that panel codes are used when two or more specific procedures are performed.
3) A specific type of procedure code is denied when billed with two or more related procedures - (Audit #581)	The control should appropriately deny a certain type of procedure when billed along with two or more other related procedures. This control appeared to work effectively in our testing.

Recommendations:

The Department should:

1. Take steps toward the recovery of potential overpayments identified in our audit related to hematology laboratory potential overpayments.

2. Insist that the contractor expand its computerized controls to include all hematology procedure codes subject to paneling. Specifically, Audit #618 should be revised to ensure that all appropriate codes are included. Codes 85008, 85024, 85027, and 85022 should be added to Audit #618.

3. Revise Audit #504 to prevent any combination of component codes and platelet count codes from occurring on the same claim.

4. Monitor the changes in laboratory procedure codes as they are updated in the *Physician's Current Procedural Terminology Manual*. The timely addition of these codes should be monitored.

Section 3-D:

The Appropriate Use of One Payment Code by Providers May Provide for Additional Savings

The Modifier 76 Code Is Used Extensively by Providers

Audit estimates show that approximately $2.3 million in Medicaid payments were made in fiscal year 1994 using the Modifier 76 payment code in conjunction with chemistry, urinalysis, and hematology laboratory tests.

The abuse or inappropriate use of the "Modifier 76" payment code could result in overpayments within laboratory claims. For June and July 1994, we identified $416,000 in claims for chemistry, urinalysis, and hematology laboratory tests in which this code was used and more than one service was billed. An examination of computer generated summary

information for chemistry laboratory tests identified an apparent inappropriate use of the code by providers. The code is available for provider use when a procedure is performed more than once on the same day. The code is used in conjunction with an amount indicating the number of times the procedure is performed. The Physician's Current Procedural Terminology Manual identifies the Modifier 76 code as the code used for this purpose. The Manual establishes procedural coding requirements for laboratory tests. We estimate that $997,000 was paid to providers when the characteristics of chemistry laboratory payments indicated the misapplication of the Modifier 76 code. The use of the Modifier 76 code is illustrated in the following example:

Example: A laboratory test is performed by Hospital A. The technician performing the test inadvertently contaminates or destroys the sample. The test is performed a second time for the same patient. Hospital A uses the Modifier 76 code to indicate the procedure was performed more than once for a valid reason. The claim is submitted with an amount indicating that the procedure was performed twice. As long as the Modifier 76 code is used, the claim should be paid.

As discussed in Section 3-A, the chemistry panel codes are structured to identify the number of individual chemistry tests performed. These numerical codes range from 80002 to 80019, with the last two digits of the code indicating the number of individual tests performed and grouped together for payment under the panel code.

The following three hypothetical examples illustrate the potential overpayment issue relating to chemistry panel codes and the use of the Modifier 76 payment code:

Example 1: **Nineteen** individual chemistry tests subject to being paid as a panel code are performed by Hospital A. Hospital A correctly groups all of these codes under the panel code 800**19**. However, for a legitimate reason all the tests need to be redone. Hospital A uses the Modifier 76 code, but indicates that the procedure code 800**19** was performed **19** times instead of only twice. This example would result in code 80019 being correctly used, but being paid 19 times instead of only twice.

Example 2: Hospital B performs **19** chemistry tests and correctly groups them under the panel code 800**19**. Hospital B always uses the Modifier 76 code because the purpose of the code is not fully understood. The claim is submitted in error indicating that the procedure was performed 19 times. The procedure code 80019 is paid 19 times instead of only once.

Example 3: Hospital C performs the same tests as Hospital A and B. The panel code 80019 is used appropriately. Hospital C, however, realizes that the use of the Modifier 76 code will allow them to be paid multiple times for a procedure when it is actually

only performed once. This situation represents a fraudulent intent and indicates that a hospital understands that the contractor's payment system will not detect this overpayment.

Five Providers Received the Majority of the Expected Potential Overpayments

When the Modifier 76 code was used, 70 percent of the dollars paid were paid to only five of the approximately 170 providers. This indicates that the inappropriate use of the code might be easily corrected.

During our review, our computer applications strongly suggested that an improper use of the Modifier 76 code in conjunction with chemistry panel codes exists. This is apparent because the number of times a chemistry panel code is performed when the code is used appears unreasonable. We did not test chemistry laboratory payments to verify that they were not recovered subsequent to our computer runs. The Department indicated that this was a payment issue that they had not reviewed. In addition, the Department does not have a control to prevent or detect this type of overpayment, and we believe it is likely that the expected potential overpayments have not been recovered. Overall, 67 percent of the dollars paid for chemistry claims when the Modifier 76 was used appeared to be coded similar to one of the three preceding examples. Over the June and July 1994 period, approximately $179,000 was paid when the number of times a procedure was claimed to have been performed was greater than one and the number equaled the last two digits of the chemistry panel code.

To further illustrate this potential overpayment issue, we identified that when the Modifier 76 code was used and the number of procedures performed was **19**, code 800**19** was the procedure code used in 98 percent (149 of 152) of the occurrences. There was $41,000 in Medicaid claims paid for this one combination during June and July 1994. Likewise, when the Modifier 76 code was used and the number of services performed was equal to **18**, procedure code 800**18** was the code used 99 percent (146 out of 148) of the time. There was $36,000 in Medicaid claims paid during June and July 1994 for this unique combination. This relationship was prevalent for all chemistry panel codes when the Modifier 76 code was used.

Recommendations:

The Department should:

1. Monitor the use of the "Modifier 76" code for laboratory payments on a quarterly basis.

2. Evaluate the use of the code by providers which seem to significantly use the code. This can initially be done by using the documents provided to the Department by our audit team, but subsequent methodologies will need to be developed.

3. Send correspondence on the proper use of the code and the apparent misuse of the code to providers identified as having significant use of the code.

4. Require the contractor to establish a prepayment edit which will suspend payments for review or autodeny payments when the number of times a procedure is performed for a chemistry panel test is equal to the corresponding number of individual tests contained within the panel test.

5. Establish reasonable limits on the number of times a laboratory code can be billed when the Modifier 76 code is used before it is questioned by the Department. A prepayment edit should be implemented to detect or prevent use in excess of this limit.

Section 4:

The Department Has Not Referred Unresolved Claims to the Texas Department of Human Services for Medical Records Review since May 1994

The Department has not referred unresolved potential overpayments to the Texas Department of Human Services (TDHS) for medical records review since May 1994. Periodically, a claim is identified by the Department as a potential overpayment, yet the existence of an actual overpayment cannot be determined by the Department's analysts. When this situation occurs, the Department relies on TDHS' Utilization and Assessment Review Section to provide medical reviews of the claims. The staff within this Section have medical backgrounds and are trained to perform medical records reviews.

The Department pays TDHS to perform assessment and review of hospitals based upon an agreement between the two agencies. The agreement states that TDHS will perform medical record reviews of patient admissions to Medicaid certified hospitals. A sample of approximately 40,000 admissions are to be reviewed annually. These samples are reviewed on a quarterly basis. The agreement also states that TDHS will provide other reports to the Department upon request.

TDHS indicated that unresolved claims referred by the Department would already be included in the TDHS quarterly sample because the claims' characteristics would result in the claims being selected for review. In the past, the Department referred claims on a quarterly basis to TDHS and requested that the claims be added to TDHS' quarterly sampling of claims. In two separate instances, the Department referred claims to TDHS and did not receive notification on the status of the claims. Our tests of the Department's February and May 1994 referred claims indicated that 13 percent (4 of 31) of the claims had not been reviewed and adjusted by TDHS.

In recognition that the TDHS sampling process would already capture some of the claims previously referred from the Department, the Department revised its procedure to postpone the referral of claims until the claims are one-year old. This new procedure is appropriate because the Department now allows enough time for claims to be captured by TDHS' quarterly claims review process. The procedure states that at the one-year anniversary of the claim's paid date, the unadjusted claim will be referred to TDHS for review. Although the revised procedure is appropriate, it is limited in that

it does not specifically include all types of claims. For example, the procedure does not include claims relating to patient transfers.

Recommendations:

The Department should:

1. Continue to refer unresolved claims to the Texas Department of Human Services on a quarterly basis, but only for unadjusted claims that are at least one-year old. Referrals should include all unadjusted claims, including potential patient transfer claims. The Department should also explicitly identify this function in the fiscal year 1996 agreement with the Texas Department of Human Services.

2. Request that the Texas Department of Human Services inform the Department in writing of the anticipated resolution date on these claims. This correspondence should occur shortly after TDHS has received the quarterly referrals from the Department.

3. Continue to monitor the actual resolution of claims referred to the Texas Department of Human Services after a reasonable time has been allowed for the Utilization and Assessment Review section's review.

4. Revise the Department's current procedure to refer all claims which are identified by the Department that require a medical records review.

Section 5:

The Department's Statistics and Analysis Division Referred over $15.9 Million in Medicaid Overpayments to the Contractor for Recovery During the 12-Month Period Ended July 1994

Although this report identifies instances of unidentified potential overpayments, the Department's Statistics and Analysis Division has identified and referred $15.9 million in potential overpayments to the contractor for recoupment for the 12 months ended July 1994. Of this amount, approximately 29 percent ($4.6 million) of the dollars related to patient transfers and non-physician related outpatient services. During the same period, the Department and its contractor recovered approximately $14.6 million for overpayments and paid out approximately $8.8 million for underpaid claims. In state fiscal year 1994, there was approximately $3.7 billion in Medicaid payments processed by the contractor's automated system on behalf of recipients.

The Department's Statistics and Analysis Division Staff Have Extensive Medicaid Experience

At the end of June 1994, the Department's Statistics and Analysis Division was comprised of 17 staff with about 218 years of cumulative Medicaid experience. As of March 1995, the Division had lost only one staff member and a new section, the Actuarial Analysis Section, had been added.

There are over 36 categories of potential payment issues analyzed by the Division on an ongoing basis. In addition, other categories are analyzed as a specific need arises. Our review was focused on only three specific types of potential overpayments as determined by our arrangement with the U.S. Department of Health and Human Services-Office of Inspector General. We did not examine underpayments to providers, although we recognize that the Division also examines these payments.

The Department's claims processing assessment system[7] has been certified by the U.S. Health Care Financing Administration and is submitted every year for approval. This system has identified approximately $184.2 million in erroneously paid and denied claims since its inception in 1983. The claims processing system in Texas is currently referred to as the Computerized Medicaid Claims Processing Assessment System (COMPAS). The Texas State Auditor's Office conducted an overall review of this system in the Spring of 1994 and found that overall, the system was making payments to eligible providers at allowable rates.

7 A claims processing assessment system reviews claims payments, evaluates the appropriateness of individual payments, and makes referrals for corrective action. The operation of a claims processing assessment system is federally mandated.

Management's Responses to Report

Texas Department of Health

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Mr. Lawrence Alwin
State Auditor
P. O. Box 12067
Austin, Texas 78711-2067

Dear Mr. Alwin:

Texas Department of Health staff have recently reviewed a draft version of a report titled "Analysis of Potential Overpayments Through The Medicaid Program". We appreciate the opportunity to review the draft report and, more importantly, the opportunity to improve the performance of the Texas Medicaid Program. Attached is the Department response in detail.

We are always receptive to suggestions about how we review claims in the program, and will diligently pursue many of the recommendations made. However, we must call attention to one major area of concern: the inferences drawn from sample findings. Very simply, the samples drawn by auditor staff was for a two month period. However, the figures shown in the draft report are inferred for a twelve month period. We believe that the report should be rewritten to describe the findings for the two month period. Our enclosed comments give our recommendations in this area. In summary, we believe it unfair to measure our work for two months, yet give us a grade for a twelve month period.

Thank you for providing the opportunity to comment. Any questions covering our detailed response may be directed to Mr. Gary Bego at 338-6523 or Mr. Steve Scarborough at 338-6526.

David R. Smith, M.D.
Commissioner of Health

Attachment

cc: Frank Ditmore

bcc: Scarborough
Svadlenak
Washington
Bego

RESPONSE TO THE OFFICE OF THE STATE AUDITOR **8/31/95**
Statistics and Analysis Division, Texas Department of Health

I. General Overview

Recently, staff in the Texas Department of Health (TDH) have been given draft copies of an audit effort by State Auditor staff titled "Analysis of Potential Overpayments Through The Medicaid Program". This draft report is a result of the work of an estimated 1,000 hours of State Auditor staff time, plus about 1,500 hours of Department time. To put the scope of the audit into perspective, samples were drawn from two months of claim payments to providers made by the Department contractor, NHIC (National Heritage Insurance Company). The two months of claim payments, June 1994 and July 1994, represented nearly $540 million of state and federal dollars paid to providers such as hospitals and physicians.

An evaluation of auditor work indicates that for a sample of 269 claims, $47,992.25 was deemed to be overpayments to providers by NHIC. This outcome is the net result of Department staff working closely with Auditor staff to ensure accuracy of the findings. From the sample results, Auditor staff, with consultation with a statistical expert, estimated the lower bound of a confidence interval --- thereby yielding an estimate of the universe overpayments. This estimate, calculated by Auditor staff to be $194,929.00, is portrayed by Auditor staff as follows: "We are 95 percent confident that the overpayments within the two month period are at least the amount of our projections." Furthermore, the draft report states in the Executive Summary: "Our review of the Texas Department of Health's Medicaid program found that the Department could save approximately $1.9 million annually for three distinct payment issues."

II. Summary of TDH Comments

Staff in TDH have carefully evaluated the findings cited in the draft report. TDH staff will ensure that future efforts to review claims paid by NHIC will incorporate many aspects of the Auditor recommendations. Staff will maximize their efforts to pursue improvements in the current system based on the Auditor findings.

However, there are significant areas of disagreement that TDH staff have with the report. For example, the first sentence of the Executive Summary states "Our review ... found that the Department could save approximately $1.9 million annually...". This statement is based on premises which we do not agree with and should be replaced. TDH staff recommend that the new sentence read "Our review of the Texas Department of Health's Medicaid Program found, from a sample of two months of claims, overpayments of $47,992.25. Our projections indicate that $170,000 could have been saved for June and July of 1994."

If the first sentence of the draft report is not corrected, the Auditor report will have a discrepancy of over $1.7 million ($1.9 million versus $170,000). This sentence and many others in the report should be rewritten to fairly reflect the real outcome of the audit.

More specific TDH findings are as follows:

1. Auditor staff sampled two months of NHIC paid claims. The main body of the draft report does not mention the size of the sample, the size of the universe, nor does it mention other important statistics from the sample. The report should have stated that the universe size was 20,260 claims and the sample size was 269 (or about 1.3% of the universe) from claims paid 6/94 and 7/94.

2. The Auditor findings for the sample of 269 claims showed $47,992.25 in overpayments to providers of services. The draft copy of the report is deficient in that this important fact is ignored. TDH staff recommend the following table be included in the report:

Item	Universe Size	Sample Size	Auditor Sample Exceptions	TDH Sample Exceptions	Auditor 2 Mo. Est.*	TDH 2 Mo. Est.**
Transfers	88	50	$ 41,798.43	$ 41,798.43	$ 47,992.00	$ 42,920.22
Outp. During	1,821	50	2,213.41	2,213.41	40,954.00	33,090.22
Outpat. 1 day	531	31	3,351.57	3,167.55	39,535.00	32,182.75
Chem. lab	11,294	38	216.82	216.82	43,660.00	39,547.22
Urinal. lab	2,728	50	201.90	201.90	9,286.00	8,943.47
Hematol. lab	3,798	50	210.12	210.12	13,502.00	13,014.26
Total	20,260	269	$ 47,992.25	$ 47,808.23	$ 194,929.00	$ 169,698.14

* Computed by Auditor staff from the sample result of the dollar exceptions. Estimate is from the lower bound of a 90% confidence interval, i.e., a one-tail 95% bound.

** Computed by TDH staff from the correct sample result of the dollar exceptions. Estimate is from the lower bound of a 95% confidence interval, i.e., a one-tail 97.5% bound.

3. TDH discovered a discrepancy in the Auditor sample findings. The correct result is that the exceptions total $47,808.23 instead of the $47,992.25.

4. Because of the very small sample sizes used (about 1.3% of the universe), the lower bound of a confidence interval was used to project the universe dollar amounts of exception. While

TDH statistical staff agree with this methodology, they disagree with the confidence bound used by Auditor staff. Auditor staff used a confidence bound that is not generally accepted in the statistical community --- a result that overstates the magnitude of the dollar exception amounts. Auditor staff employed a 90% two-tail confidence band (which results in a one-tail bound of 95%), while TDH recommends the more generally accepted 95% figure (which results in a one-tail bound of 97.5%). Also TDH staff recommend that, after employing the more generally accepted confidence band, the wording from Appendix 4, page 7 be changed. The sentences as written: "We are 95 percent confident that the overpayments within the two month period are at least the amount of our two month projections. Conversely, there is a five percent risk that our projections are too high." We recommend that the revised wording be as follows: "We are 97.5% confident that the sampling method produced an estimate of the overpayments within the two month period that is at least the amount of our projections."

5. Correcting for the discrepancy cited above in the findings and for the non-standard confidence band, the TDH computed estimate of the overpayments for June and July 1994 is $169,698.14.

6. The report stated on the first page of the Executive Summary that "the Department could save approximately $1.9 million annually....". The report does not clearly demonstrate just how the $1.9 million was calculated. A TDH staff review of the report indicates that the $1.9 million is derived by converting the following: a) the sample results to b) the universe of two months to c) a 12 month period. Auditor staff only sampled the two months of claim payments, June and July 1994; other months were not sampled. Page 7 of a draft of supplemental information titled "Matching and Statistical Methodologies" states: "Because we only sampled two months of data, we cannot use statistical methods to project to an annual figure."

   Auditor staff have chosen to use a non-scientific, non-statistical method to generate annualized figures. TDH staff vigorously disagree with such an approach. Because the universe did not embrace a 12 month period, the Auditor report should only address the time period from which the sample was drawn --- June and July of 1994. TDH staff believe that inclusion of annual figures in the Audit report is a significant error. Had the Auditor staff wanted to project annual figures, they should have sampled from 12 months of paid claims, not two months. Auditor staff did not sample from a universe of 12 months and, in our opinion, annual figures should not be inferred from the two month sample as they are impossible to generate from the data.

   TDH staff object to all figures in the report that allude to non-statistical annualized numbers.

7. The report states on Page 2 that "Expansion Of The Preadmission Outpatient Payment Window To Three Days Could Save Approximately $824,000 Annually". TDH staff are adamantly opposed to the report findings in this area. TDH staff understood that the original scope of the audit was to focus on current TDH rules and policies. The current policy is that

the window is for one day. As noted in the report, Medicare uses three days. However, the two programs are vastly different in coverage and scope. An analyst could find other policy differences --- where Medicaid is either more restrictive or less restrictive than other programs such as Medicare --- an example of which is that Texas Medicaid uses a 95 day claim filing deadline, while Medicare uses 24 months. Yet the report uses language crafted to make the reader believe that Auditor staff found $1.9 million in annual savings, $824,000 of which was from a suggested change in policy. The main body of the report does not describe how the $824,000 figure is computed. TDH statistical staff further point out that the $824,000 figure is an annual estimate based on the same non-statistical methods cited for the other audit items.

TDH staff will note that it has been suggested that the current policy of one day could be changed to three days. However, TDH staff do not recommend doing so at this time and request the Auditor report be amended to remove the references to changing this policy.

8. Page 1 of the draft report states "We estimate that an additional $997,000 was paid to providers when the characteristics of the payment indicated the misapplication of the Modifier 76 code." The report does not state how the $997,000 is computed, nor have TDH statistical staff been given back-up documentation for the statement. Without a complete and thorough statistical review of this figure, it is difficult to determine if the findings are accurate. TDH staff recommend that a detailed table be added to the report showing the true and correct findings for this item. In addition, if information was only sampled for two months, TDH does not believe estimates of annualized figures should be included. Thus, if the $997,000 figure is an annual number, it should be removed from the report.

III. Other Detailed TDH Comments

A. Section 1-A REPORTS PROVIDED BY THE TEXAS DEPARTMENT OF HUMAN SERVICES FOR PAYMENT MONITORING DO NOT IDENTIFY ALL POTENTIAL OVERPAYMENTS

Response:

1. The Department will evaluate the cost effectiveness of updating and correcting the existing TDHS Hospital Utilization Reporting System versus developing a new reporting system that will meet the needs of the Department in identifying claims paid during an inpatient stay and one day prior to an inpatient stay by the same provider and patient transfers.

   Implementing an automated system to monitor outpatient hospital claims paid one day prior to an inpatient hospital stay is difficult since the provider can bill multiple dates-of-service encounters. Outpatient claims have one field for the hour of admission and one field for the hour of discharge. Therefore, using the current claims filing procedures, if there is only one date-of-service on the outpatient hospital claim, the hour of admission

and discharge could be used. However, if there are multiple dates-of-service on the outpatient hospital claim it would be impossible to determine to which date-of service the hour of admission and hour of discharge applies. This is a problem we've encountered before and have been unable to resolve. The Department will continue to review possible solutions. Independent labs, Federally Qualified Health Centers, and outpatient services (including outpatient hospital services) rendered one day prior to inpatient admission, or during an inpatient hospital stay will be identified and processed appropriately.

2. The Department will evaluate the cost effectiveness of updating and correcting the existing TDHS Hospital Utilization Reporting System versus developing a new reporting system by either TDHS or the Department that will identify claims paid one day prior to an inpatient stay by the same provider and claims paid during an inpatient stay by any provider and patient transfers.

   The Department may use the computer programs offered by the State Auditor's Office in evaluating and testing of any programs developed by the Department or TDHS.

3. Additional staff is needed to test data and evaluate the accuracy of the post payment review system whether being done by the Texas Department of Human Services or within the Department.

4. The Department will use the findings from the State Auditor's sample of inappropriately paid patient transfer claims or outpatient claims paid during and within one day prior to an inpatient stay to refer overpayments to the Contractor for recoupment.

B. Section 1-B A PREPAYMENT CONTROL AT THE CONTRACTOR FOR PREVENTING PATIENT TRANSFER OVERPAYMENTS NEEDS IMPROVEMENT

Response:

1. The State Auditor's sample for June and July 1994 identified an inconsistency of reducing patient transfer claims to a per diem amount. The Contractor implemented a policy change to their automated system effective December 1994. This resulted in a partial correction. Statistics and Analysis staff identified there was still an inconsistency in handling of patient transfers. The Department was informed in June 1995 that the Contractor will review their guidelines and procedures to consistently reduce patient transfer claims to a per diem amount. The Department will continue to monitor the Contractor's handling of patient transfers.

2. The Department agrees that sufficient employee time is needed to develop, review and test the Contractor's automated controls. The number of Medicaid eligible clients from COMPAS year 1988/89 (OBRA 1989/90) to COMPAS year 1994/95 increased from

868,131 to 1,955,248 (an increase factor 2.25). Contractor Medicaid claims during that same timeframe increased from 1,713,172 claims/month to 5,585,632 claims/month (an increase factor of 3.26). These numbers are statistically significant especially considering that the staff monitoring those claims has decreased. The Department will evaluate staffing functions and existing workloads to determine how to best distribute the resources available.

C. Section 1-C THE DEPARTMENT'S STATISTICS AND ANALYSIS DIVISION DOES NOT HAVE FORMAL POLICIES AND PROCEDURES DESIGNED TO ASSIST IN THE DETERMINATION OF OVERPAYMENTS

Response:

The Department currently has policies in place for the analysts to use in the recovery of Medicaid overpayments. Each claims review analyst has a written job description regarding their work. However, TDH staff will develop additional written policies and procedures for the recovery of Medicaid overpayments. These policies and procedures will be shared with staff, updated and revised as needed for appropriateness, compliance and alignment with the Department's goals and objectives.

D. Section 2 EXPANSION OF THE PREADMISSION OUTPATIENT PAYMENT WINDOW TO THREE DAYS COULD SAVE APPROXIMATELY $824,000 ANNUALLY

Response:

As stated in an earlier section above, TDH staff do not agree with the report findings in this area. (See #7. of section II. above.) The main body of the report does not describe how the $824,000 figure is computed. TDH statistical staff further point out that the $824,000 figure is an annual estimate based on the same non-statistical methods cited for the other audit items.

TDH staff note that it has been suggested that the current policy of one day could be changed to three days. However, TDH staff do not recommend doing so at this time. TDH staff recommend that the Auditor report be amended to remove the references to changing this policy. Besides the considerable havoc we believe this would create for Medicaid participating hospitals and physicians, the administrative difficulties of suspending approximately 500,000 inpatient hospital claims and millions of outpatient hospital claims to correctly and fairly determine payments is both enormous and costly in its own right. For example, a routine outpatient procedure performed two days before an inpatient admission for auto accident injuries is obviously allowable. To discover such occurrences requires TDH to suspend (or pay and recoup) all inpatient and outpatient claims and compare them to specific criteria. Medicare, which has a three day policy, is a program for aged and disabled, whereas Medicaid largely covers women and children. There is no state or federal requirement for a three day Medicaid policy. TDH does not agree with this policy recommendation.

E. Section 3 POTENTIAL SAVINGS OF APPROXIMATELY $ 369,000 EXIST FOR LABORATORY PAYMENTS MADE IN FISCAL YEAR 1994 AND THE APPROPRIATE USE OF ONE PAYMENT CODE BY PROVIDERS MAY PROVIDE FOR ADDITIONAL SAVINGS

Response:

No recommendations by auditors. TDH staff are opposed to incorporation of non-statistically valid annualized figures in the report, as stated earlier in this document.

F. Section 3-A ESTIMATED SAVINGS OF $242,000 COULD BE REALIZED BY CORRECTING INEFFECTIVE CONTROLS AND INITIATING A RECOVERY ACTION ON CHEMISTRY CLAIMS PROCESSED IN ERROR

Response:

The Department has met with the Contractor and is taking steps toward identifying and recouping all overpayments identified by the State Auditor's sample. Automated system controls are being reviewed and changes made as needed to identify inappropriately paid laboratory panels/procedures as identified by the Auditor's report.

G. Section 3-B ESTIMATED SAVINGS OF $52,000 COULD BE REALIZED BY CORRECTING ISOLATED INEFFECTIVE CONTROLS AND INITIATING A RECOVERY ACTION ON URINALYSIS CLAIMS PROCESSED IN ERROR

Response:

The Department agrees the Contractor's automated payment system should be monitored for the timely addition of procedures. However, due to staff shortages and existing workloads we are unable to dedicate sufficient staff time to do a thorough job of this task. The Department will work with the Contractor in identifying and recovering any overpayments identified by the State Auditor's sample on urinalysis. Review of existing automated system controls will be done and necessary changes made to prevent future overpayments.

H. Section 3-C ESTIMATED SAVINGS OF $75,000 COULD BE REALIZED BY CORRECTING ISOLATED INEFFECTIVE CONTROLS AND INITIATING A RECOVERY ACTION ON HEMATOLOGY CLAIMS PROCESSED IN ERROR

Response:

The Department is already working with the Contractor in identifying and recovering the

overpayments identified by the State Auditor's sample related to hematology laboratory procedures. Existing automated controls and procedure codes are being reviewed and appropriate adjustments made to the system to ensure that laboratory procedures are processing correctly. Laboratory audits are being reviewed for appropriateness.

Additional Department staffing would be needed to monitor the additions, deletions, and changes as updated in the Physician's Procedural Terminology Manual to ensure that they are added, deleted or changed in a timely manner.

I. Section 3-D THE APPROPRIATE USE OF ONE PAYMENT CODE BY PROVIDER MAY PROVIDE FOR ADDITIONAL SAVINGS

Response:

The Department is working with the Contractor in developing policies and procedures to set reasonable limits to the number of times a laboratory code can be paid. Providers will be notified on the proper use of multiple laboratory procedure codes and the Department will monitor payments on an ongoing basis.

J. Section 4 THE DEPARTMENT HAS NOT REFERRED UNRESOLVED CLAIMS TO THE TEXAS DEPARTMENT OF HUMAN SERVICES FOR MEDICAL RECORDS REVIEW SINCE MAY 1994

Response:

The Department management will develop new guidelines and procedures for referring all unresolved or questionable inpatient hospital claims to TDHS for additional research and/or medical records review. The Department will be explicit in defining the functional reviews with TDHS in the FY 1996 agreement (ex. TDHS anticipated resolution date and status of referrals). The Statistics and Analysis staff will continue to monitor and review referrals for appropriate resolution in a timely manner.

K. Section 5 THE DEPARTMENT'S STATISTICS AND ANALYSIS DIVISION REFERRED OVER $15.9 MILLION IN MEDICAID OVERPAYMENTS TO THE CONTRACTOR FOR RECOVERY DURING THE 12 MONTH PERIOD ENDING JULY 1994

Response:

No recommendations

Auditor Follow-Up Comments

The Department indicates concerns about the methodologies used, the scope of the audit, and the conclusions made in the report.

We are firmly committed to the audit conclusions based on the 95 percent one-sided confidence limit. All of our statistical methodologies have been reviewed and deemed acceptable by our statistical expert, as detailed in Appendix 4 of the report. The projections presented in the report are conservative because they are actually the *minimum* dollar amount expected to be recovered or saved. The procedure employed by the State Auditor's Office has a five percent risk that the total recovery will be less than our projections. Although our audit is not intended to be scientific research, this level of risk is consistent with generally accepted scientific standards for social science research.

The same projection methodology used by the State Auditor's Office is commonly used by other entities. For example, the Internal Revenue Service uses this methodology in its statistical audits of taxpayer (business) returns. The taxpayer must pay the statistically projected deficiency. The stakes for the Department in this audit are much less because full recoveries are not required. Our audit focused on the correction and monitoring of controls and the consideration of Departmental policy opportunities.

The Department has also expressed concern with the non-scientific judgmental annual estimates presented in the report. Audit conclusions are based on a reasonable rather than absolute basis and are not intended to always be scientific or statistical. If this objection were taken seriously in the auditing profession, then auditors would have to renounce much of their work, for much of auditing work is based on professional judgment. As stated by our statistical consultant, "One feels on surer ground if estimates can be based on science. But it is not the case that we know nothing in the absence of scientific studies."

The non-statistical methodology was derived based on input from our statistical consultant. In addition, the estimation approach was discussed with staff members of the American Institute of Certified Public Accountants (AICPA). The AICPA confirmed that AICPA standards do not preclude annual estimates of this nature. We believe that we are very explicit throughout the report that these estimates are non-statistical. We also discuss this methodology in detail in Section 3 of Appendix 4. Annualized estimates are used because they provide the reader with a reasonable estimate as to the impact of conditions identified by the audit.

Follow-up Management's Response to Section 2 (Page 33 of Responses):

The Department's position to not expand the payment window from one day to three days indicates that many inpatient and outpatient claims will need to be suspended. This reason was a significant factor in the State Auditor's Office's decision to examine only payments to the *same* provider for pre-admission outpatient services rendered.

We identified 1,623 claims during June and July 1994 which were paid under these conditions involving approximately $333,000 in Medicaid payments. Although not all of the 1,623 claims would be related to the inpatient stay, these numbers represent a potential recovery of about $205 per claim.

Modifications to the existing control within the Hospital Utilization Monitoring System could identify these claims for post-payment review as already done for related outpatient services during an inpatient stay, eliminating the need for claim suspension. We have identified that the expansion of this payment policy represents a significant opportunity for the Department. The U.S. Department of Health and Human Services, Office of Inspector General also believes there is an opportunity for significant savings.

Appendix 1:

Objectives, Scope, and Methodology

Objectives

In partnership with the U.S. Department of Health and Human Services-Office of Inspector General, Office of Audit Services (OIG), our audit objectives were to:

- Determine if adequate processes and controls exist within the Medicaid program maintained by the Texas Department of Health (Department) to prevent or detect potential overpayments made to Medicaid providers.

- Initiate a statewide recovery action for identified and potential overpayments as appropriate.

The OIG had identified potential overpayment issues in the *Medicare* program and had reason to believe that these issues also existed in the *Medicaid* program on a nationwide basis. The OIG requested that the State Auditor's Office examine these potential overpayment issues within the Texas Medicaid program.

Scope

The scope of this audit included consideration of the program's primary controls to prevent or detect potential overpayments relating to:

- inappropriately paid patient transfer claims
- related non-physician outpatient services paid during and up to three days prior to the patient's inpatient stay
- laboratory claims submitted for payment with improper coding

The review of the program's primary controls designed to *prevent* potential overpayments included consideration of:

- claims processed by the contractor's automated payment system
- functional descriptions of computerized edits within the contractor's automated payment system
- processes used in identifying, reviewing, and recovering overpayments
- required provider billing procedures

The review of the program's primary controls designed to *detect* potential overpayments included consideration of:

- claims processed by the contractor's automated payment system
- functional descriptions of computerized edits within the contractor's automated payment system
- functional descriptions of computer programs used to generate reports provided by the Texas Department of Human Services

- reports generated and provided by the Texas Department of Human Services
- processes used in identifying, reviewing, and recovering overpayments
- required provider billing procedures

In addition, audit staff identified a related overpayment issue associated with laboratory payments and developed the issue for inclusion in the report. This issue is detailed in Section 3-D.

We reviewed payment history files prepared by the National Heritage Insurance Company. Additionally, we reviewed supplemental information, including financial information presented in reports and documents prepared by the Department. The accuracy of this information was not verified.

Methodology

The methodology used on this audit consisted of collecting information, performing audit tests and procedures, and analyzing the information against pre-established criteria. Individual payments were examined to determine whether overpayments actually existed. Detailed descriptions of the sample selection process, statistical methodologies, and non-statistical methodologies used during the audit are presented in Appendix 4.

Information collected to accomplish our objectives included the following:

- Interviews with staff and management of the Texas Department of Health, the Texas Department of Human Services, and the National Heritage Insurance Company
- Documentary evidence such as:
  - Federal statutes
  - National Heritage Insurance Company's contract with the Texas Department of Health
  - Medicaid audit guide prepared by the U.S. Department of Health-Office of Inspector General
  - Automated claim payment records
  - Hospital Utilization Monitoring System reports generated by the Texas Department of Human Services
  - COMPAS Annual Report, July 1993 - June 1994
  - National Heritage Insurance Company's 1994 and 1995 Provider Manuals
  - *Physician's Current Procedural Terminology Manual*
  - Medicaid policies and procedures
  - Descriptions of automated payment edits

Procedures and tests conducted:

- Reviewed overpayment identification, referral, and recovery procedures

- Identified potential overpayment populations for all payment categories using Computer Assisted Audit Techniques (CAATs)
- Sampled and tested Medicaid claims from June and July 1994
- Determined whether overpayments were subsequently corrected as of the time of our fieldwork
- Statistically projected results of our tests to the two-month period being tested using statistical projection computer software
- Contracted with a statistician to assist in the development of primary and secondary statistical methodologies
- Produced non-statistical annual audit estimates of Program savings

Criteria used:

- OBRA 1990 requirements
- Guidelines established by the U.S. Department of Health and Human Services-Office of Inspector General
- Required provider procedures as detailed in the 1994 *National Heritage Insurance Company Provider Manual*
- Medicaid policies and procedures
- Federally Approved Medicaid State Plan
- State Auditor's Office payment testing criteria
- *Physician's Current Procedures Terminology Handbook*
- Policies and procedures developed by the Department's Statistics and Analysis Division

Fieldwork was conducted from April 1, 1995, through June 9, 1995. The audit was conducted in accordance with applicable professional standards, including:

- Generally Accepted Auditing Standards
- Generally Accepted Government Auditing Standards

There were no significant instances of non-compliance with these standards.

The audit work was conducted by the following members of the State Auditor's staff:

- Bob Launius, MBA (Project Manager)
- DeAnn Kiser, CPA
- Dorvin Handrick, CISA
- Kay Kotowski, CPA (Audit Manager)
- Deborah L. Kerr, Ph.D. (Audit Director)

Appendix 2.1:

Profile of Texas Medicaid

Title XIX of the Social Security Amendments Act of 1965 established the Medicaid program. The program was created to provide quality health care to low income persons and persons over the age of 65. Texas began its Medicaid program in 1967. As a result of HB 7, 72nd Legislature, R.S., major portions of the Medicaid program were moved to the Texas Department of Health from the Texas Department of Human Services in September 1993.

During federal fiscal year 1994, over $6.6 billion in grant benefits were paid on behalf of Texas Medicaid recipients. This amount is estimated to be more than $8 billion by federal fiscal year 1996. Medicaid payments are paid with federal and state funds with the majority of grant benefits being paid from federal funding (approximately 64.4 percent was paid with federal funds during 1994).

Although the Texas Department of Health is the agency responsible for major portions of Medicaid, there are four organizations involved in the management of Medicaid operations transferred to the Texas Department of Health. These organizations are the Texas Health and Human Services Commission (HHSC), the Texas Department of Health (TDH), the Texas Department of Human Services (TDHS), and a primary sub-contractor, the National Heritage Insurance Company (NHIC).

The three agencies which perform significant claims processing are TDH, TDHS, and NHIC. TDH and TDHS process claims from long-term care facilities, pharmacies, primary home care agencies, and other providers. NHIC processes claims from hospitals, physicians, laboratories, home health agencies, optical providers, podiatrists, chiropractors, and other providers.

Federal regulations require all states that receive Medicaid funding to operate a claims processing assessment system (CPAS). A claims processing assessment system historically reviews claims payments, evaluates the appropriateness of the individual payments and makes referrals for corrective action. In Texas, the CPAS is the Computerized Medicaid Claims Processing Assessment System (COMPAS). TDH, TDHS, and NHIC all play a crucial role in the success of COMPAS.

Our review was focused on three different potential overpayment types which all flow through the NHIC payment system. The three types included patient transfers, outpatient claims relating to an inpatient stay, and laboratory claims submitted in error. Elements of COMPAS contain the key controls for the prevention and detection of overpayments relating to these payment issues.

The NHIC payment system has computerized edits within the system which will “autodeny” or suspend payments for review if the characteristics of an erroneous claim are present. These computer controls are known as “prospective” controls because they are designed to prevent overpayments before they are paid.

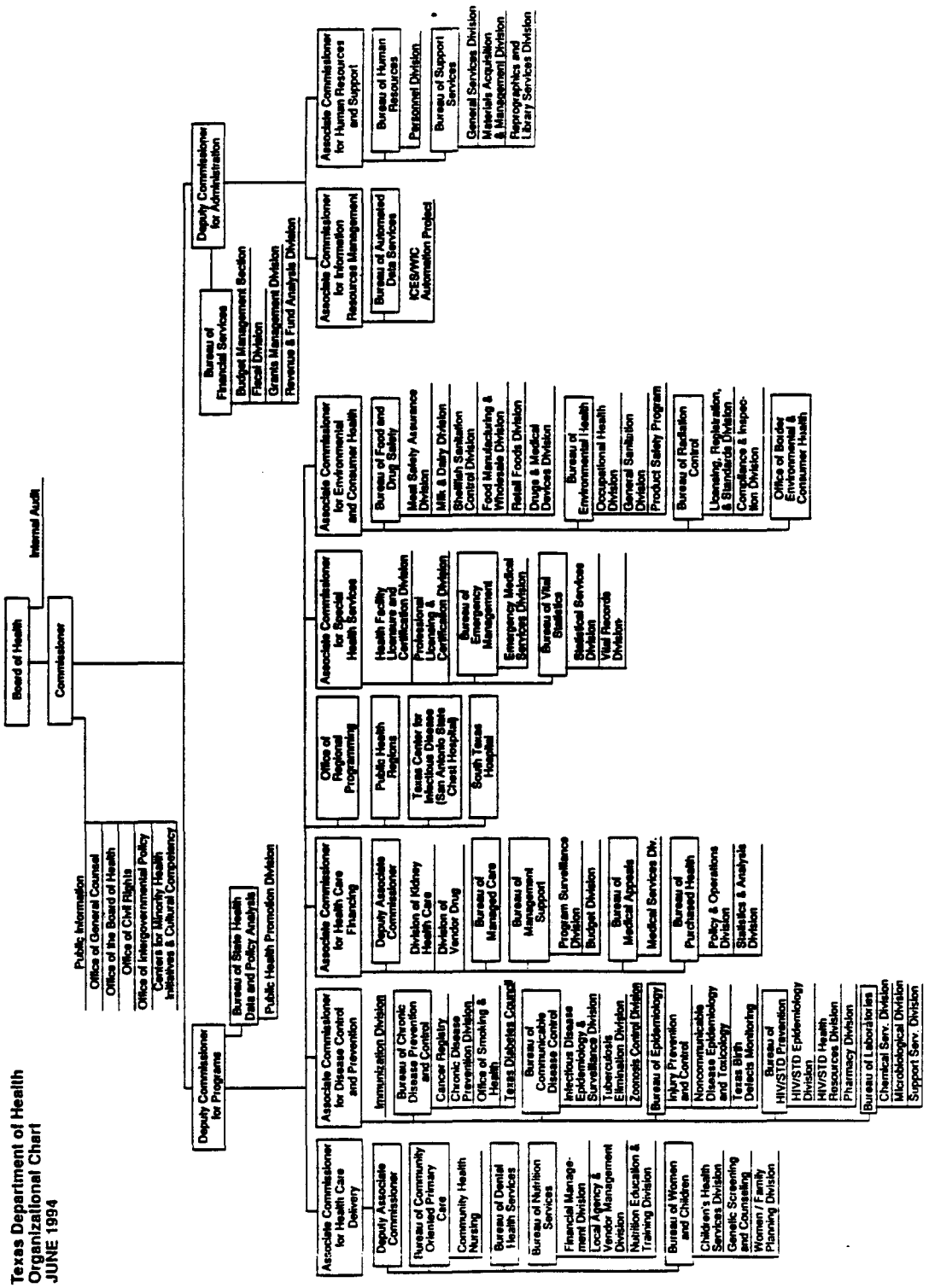
TDHS is paid by TDH to provide information systems services to TDH. These services include the processing of payment history data provided by NHIC to identify

types of payments which were potentially paid in error. These controls are known as "retrospective" controls because they examine claims after payments have been made to providers. The computer system which performs this task is known as the Hospital Utilization Monitoring System, or the "MX" system. This system generates reports which are provided to the Statistics and Analysis Division of TDH for their review on a claim by claim basis.

The primary focus of the Statistics and Analysis Division of TDH is to operate the COMPAS. The division is in a position to receive and generate meaningful reports, documents, action assignments, and special projects.

Appendix 2.2:

Texas Department of Health Organizational Chart



Appendix 3.1:

Reference List

American Medical Association. *Physicians' Current Procedural Terminology*. 1994.

National Heritage Insurance Company (NHIC). *Texas Medicaid Provider Disclosure Report*. July 1993.

_____. *Texas Medicaid Provider Disclosure Report*. September 1994.

Porter, Thomas W., and William E. Perry. *EDP, Controls and Auditing*. Belmont, CA: Kent Publishing Company, 1987.

St. Anthony Publishing, Inc. *St Anthony's ICD-9-CM Code Book for Physician Payment*. Alexandria, Virginia: St. Anthony Publishing, 1994.

State of Texas. Department of Health. *Legislative Appropriations Request*. 1996-1997.

_____. Department of Health. *Medicaid Provider Procedures Manual*. January 1994.

_____. Department of Health. *Medicaid Provider Procedures Manual*. January 1995.

_____. Department of Human Services. *Texas Medicaid Glossary - Commonly Used Terms and Acronyms*. January 1992 (revised May 1993).

_____. Health and Human Services Commission, State Medicaid Office. *Texas Medicaid in Perspective*. May 1994.

_____. Office of the State Auditor. *SAO Project Manual System: The Methodology*. 1993.

3M Health Information Systems. *Diagnosis Related Groups Definitions Manual*, Version 10.0. 3M Health Information Systems, 1992.

U.S. Department of Health and Human Services, Public Health Service - Health Care Financing Administration. *International Classification of Diseases (9th Revision)*, Volume 3. Washington D.C.: U.S. Government Printing Office, 1980.

U.S. Department of Health and Human Services, Office of Inspector General. *Medicare Hospital Patient Transfers Improperly Reported and Paid as Hospital Charges*. March 1991.

_____. *Nationwide Review of Improper Medicare Payments for Non-Physician Outpatient Services Under the Prospective Payment System*. December 1992.

_____. *Partnership Plan - Federal/State Joint Audits of the Medicaid Program*. 1993.

_____. *Medicare Prospective Payment System Edit for Incorrect Hospital Coding of Patient (Discharge) Status*. August 1993.

_____. *Review of Chemistry Tests Performed on Automated Laboratory Equipment*, January 1995.

Appendix 4:
Detailed Methodology

Appendix 4 is divided into three distinct sections:

Section 1) Population Identification for Each Payment Issue

Section 2) Sample Selection and Statistical Methods Used During the Audit

Section 3) Non-statistical Annual Estimation Methodology

Section 1) Population Identification for Each Payment Issue

This section details the procedures used to identify each population before selecting our sample and performing test work. These procedures were performed using Computer Assisted Audit Techniques (CAATs) and were developed by the audit team. Our matches were obtained by using the NHIC STAT files for June and July 1994. These files were obtained from TDHS. Our team verified that only June and July payments were included in the tapes obtained from TDHS.

Issue I - Improperly Paid Patient Transfers

A potential overpayment relating to an improperly paid patient transfer was defined by the audit team as a payment made to a transferring hospital when the amount paid was not the correct amount. The correct amount was calculated based on the approved Medicaid State Plan as follows:

$$\frac{\text{(DRG relative weight x standard dollar amount)}}{\text{DRG Mean Length of Stay}} \times \text{Length of Stay (LOS)}$$

Note: The LOS is the lesser of the DRG mean LOS, the claim LOS, or 30 days.

The above formula was programmed into our computer applications, and claims were selected as a member of the audit population if the amount paid was not calculated correctly.

For this issue, we selected all records where the "TO" field (date of discharge) was the same as the "FROM" field (admission date) for the same recipient at another provider. After this was done, the procedures and characteristics of the population can best be described as follows:

- We excluded TEFRA hospitals (Type of Service = 80) and all crossover claims.
- We included inpatient hospital claims (Claim type = 40) and inpatient adjustment claims (Claim type = 59) in the population.

- We included only the payments which were greater than $0.00 in the population. At this point we had 898 potential transfers.

- We excluded payments where the actual length of stay was greater than the mean length of stay. This process excluded 126 of our 898 potential transfers, leaving us with 772 potential transfers.

- For the remaining 772 potential overpayments, we calculated the per diem amount for the transferring hospital. This process eliminated 679 of the 772 potential overpayments. This left us with a population of 93 potential overpayments. We then combined the records by PCN and the "TO" date (date of discharge) fields. This created our final population of 88 matches.

Issue II - Outpatient Services Paid During an Inpatient Stay or Prior to the Stay

A potential overpayment for this issue was defined by the audit team as an outpatient claim processed during or one day prior to a related inpatient stay for the same patient. Since the two- and three-day categories are not a current policy for the Department, these categories were examined from a "potential savings" position.

There were four distinct populations obtained for this issue. These populations were identified based on the time period for which the outpatient claim occurred in relation to the inpatient stay. The four populations were defined as:

1) Outpatient services provided during an inpatient stay

2) Outpatient services provided one day prior to an inpatient stay

3) Outpatient services provided two days prior to an inpatient stay

4) Outpatient services provided three days prior to an inpatient stay

For the first population (during the inpatient stay), the procedures and characteristics of the populations are as follows:

- We excluded inpatient claims if it included a TEFRA (Tax Equity and Fiscal Responsibility Act) provider or Medicare crossover amounts.

- We matched the "date of service" field from the outpatient claim to the period of stay on the inpatient claim for the same PCN. The period of stay was defined as the time between the "FROM" and "TO" fields.

- Outpatient claims included Claim types 23 (Outpatient Hospital), 20 (Physician Supplier/Genetics), and 39 (Professional Adjustments). For Claim type 20, claims were limited to Service type 05 (Labs) and Provider Specialty code of 69 (Independent Labs).

- We did not exclude TEFRA hospitals from the outpatient claims, as was done on the inpatient claims. Since the outpatient claim was the claim selected as a

potential overpayment, TEFRA hospitals should have been eliminated to provide a more defined population. However, these items were not selected in our sample and were excluded from our population when projections were made.

- Originally, all payments were included in our four populations, regardless of amount. We subsequently determined that it would be unreasonable to refer payments under $50 to NHIC for recovery because of excessive costs. This resulted in the exclusion of these items from both our sample and our populations.

For the remaining populations (one day, two days, and three days prior to an inpatient stay), the procedures and characteristics of the populations are as follows:

- We excluded inpatient claims from the populations if it included a TEFRA provider or Medicare crossover amounts.

- For the outpatient claims, we used only a Claim type 23 because we wanted to limit our population to the same provider. This was not a concern for the "during an inpatient stay" population.

- We matched the PCN, Provider, and Date of Service fields on the outpatient record to the admission date ("from" field) on the inpatient record. A different computer run was performed for each of these populations. If an outpatient Date of Service occurred one day prior to the admission date, it was captured as a potential overpayment occurring one day prior to the inpatient stay at the same provider. The "two days prior" and "three days prior" populations were obtained in the same manner.

- Because we were matching by provider, and we had excluded TEFRA providers from the inpatient records, we also excluded them from our population.

- The final populations were:

1)	"During the Inpatient Stay" -	1,821 matches
2)	"One day prior to the Inpatient Stay" -	531 matches
3)	"Two days prior to the Inpatient Stay" -	906 matches
4)	"Three days prior to the Inpatient Stay" -	717 matches

Issue III - Potential Laboratory Overpayments

A potential laboratory overpayment was defined by our audit team as an outpatient claim containing a procedure code subject to being grouped into a panel for payment or having at least one of the panel codes on the claim.

We examined Chemistry, Urinalysis, and Hematology laboratory tests. Our identification of the population for each of these categories were very similar. Therefore, individual explanations for each will not be detailed here.

The procedures and characteristics of the populations are as follows:

- We used procedure codes required to be paneled per the 1994 NHIC provider manual. We verified that these claims were Claim types 20 (Physician Supplier/Genetics) and 23 (Outpatient Hospital). We then verified that all claims were coming from Service type 5 (Labs).

- We identified payment records for each of our three categories of laboratory tests (Chemistry, Urinalysis, and Hematology). This process identified 128,201 records for Chemistry tests; 93,495 records for Urinalysis tests; and 161,537 records for Hematology tests.

- We adjusted records which had both positive amounts and corresponding negative amounts. This was done by matching the negative amounts to the positive amounts by PCN, Provider, Date of Service, Original ICN, Procedure Code, and dollar amount.

- The records were then grouped by PCN, Provider, and Date of Service to determine the number of items which were subject to being selected as a member of our audit-defined populations. The number of items for each category of laboratory test consisted of the following:

Figure 12

Laboratory Category	Items Subject to Being Selected Within Our Populations
Chemistry	98,857
Urinalysis	79,332
Hematology	132,215

- We computed the amount that should have been paid based on the criteria in the 1994 NHIC provider manual and the maximum fees in effect for the date of service. The NHIC maximum fees were multiplied by either the 60 percent or 62 percent payment rates for determining what should have been paid.

- We subtracted the correct amount from the amount paid to obtain a potential overpayment for each record.

- If the amount paid was greater than the 60 percent fee for Chemistry tests, it was considered a member of our population. This resulted in 11,294 items in our audit-defined population.

- If the amount paid was greater than the 62 percent fee for Urinalysis and Hematology tests, it was considered a member of the respective population. This resulted in 2,728 claims in our Urinalysis population and 3,798 claims in our Hematology population.

  Note that we used the 60 percent rate in Chemistry and the 62 percent rate in the other two populations. We were given information from the Department which indicated that very few providers are subject to the 62 percent rate. In testing payments for Chemistry tests, we discovered that this information was not accurate and, therefore, we adjusted our approach to the higher rate for our Urinalysis and Hematology populations. Our testing verified the appropriate rate for all sample items, and, therefore, all projections were based on the appropriate rate.

Section 2) Sample Selection and Statistical Methods Used During the Audit

We consulted with Dr. Thomas W. Sager, a Professor of Statistics at The University of Texas, to ascertain the appropriateness of our methodology and to seek his opinion on alternative approaches. The methodologies in this section were discussed with him in depth, and all were acceptable to him. Our process and related issues can best be described as follows:

- Once our population was identified, we used the RANUNI function in SAS to generate random numbers for every item in the population. We then sorted on the number assigned and selected the first 31 to 50 for each sample, depending on the designated sample size.

- In one issue (ISSUE II), we pulled additional sample items to apply management's assertions which were acceptable to the State Auditor's Office and other conditions to our sample and population. In both instances, populations were reduced by the number of related issues identified in the population. Two examples where this occurred are described as follows:

  – After pulling and testing our original sample for the "During the Inpatient Stay" for Issue II, we learned of a policy where TDH does not refer potential overpayments to the contractor (NHIC) for recovery if the amount in question is under $50. Further SAO analysis allowed us to accept the policy as a reasonable one.

  – Subsequent to our original sample, we identified that some of our claims for the "during" category involved outpatient services at a TEFRA provider which was not subject to the payment methodologies in question.

  In handling these situations, we used the Inclusion-Exclusion approach to pull a supplemental sample. The approach was applied as follows:

A supplemental sample was generated by using the seed number generated by SAS. This recreated our exact sample. We printed a larger sample (150) and verified that the 31-50 in our original sample were the same 31-50 in our supplemental sample. We then selected the items which did not fall into one of the two categories mentioned above. For example, if our original sample of 50 had only 30 items which now met our criteria, the other 20 were pulled from items numbered 51-150. Items were selected in sequential order and, hence, we did not need all of our additional 100 sample items.

- We estimated an overpayment at the 90 percent confidence interval. These tests were performed using a statistical package obtained from the U.S. Department of Health and Human Services-Office of Inspector General, Office of Audit Services. This package projects to the population based on the results of audit tests. We decided to present overpayments and savings from the lower limit only, even though this amount may be understated. By using the lower limit only, we had a 95 percent confidence level.

- Dr. Sager recommended a process called the Bootstrap methodology as a secondary analysis tool to verify our projections. This methodology has been applied to our audit results for all issues. The Bootstrap methodology was used as a secondary one; we will only use its results as a comparison to our primary results.

The Bootstrap methodology as applied in our audit worked as follows:

- For each of our eight samples, we generated 9,999 samples using the audited values produced in our original sample; **however, we allowed for an item from our original sample to be selected more than once.** Once completed, we had 10,000 individual samples. A mean was calculated for each sample. The samples were then sorted by mean in ascending order. The 500th mean was selected and multiplied by the corresponding number units in the population for the issue being analyzed. The 500th mean was selected because it represents the lower limit of the samples at the 95 percent confidence level (i.e. 95 percent of the means are above and 5 percent are below).

  The results of this analysis along with our original two-month projections are presented in Figure 13.

Figure 13

Overpayment Issues	Audit Defined Population Size	5th Percentile Bootstrap Means	2-Month Bootstrap Lower Limit Projection	2-Month Original Statistical Projection	Bootstrap % Difference
I-PPS Transfers	88	$443.38000	$39,017.00	$47,992.00	(18.7)%
II-"During"	1,821	$25.59700	$46,612.00	$40,954.00	13.82%
II-"1 Day Prior"	531	$76.39870	$40,568.00	$39,535.00	2.61%

III-Chemistry	11,294	$4.03579	$45,580.00	$43,660.00	4.40%
III-Urinalysis	2728	$3.40240	$9,282.00	$9,286.00	(.04)%
III-Hematology	3798	$3.59540	$13,655.00	$13,502.00	1.14%
Totals for Potential Overpayment Issues			**$194,714.00**	**$194,929.00**	**(.11)%**
Savings Issues					
II-"2 Day Prior"	906	$85.76130	$77,700.00	$75,045.00	3.54%
II-"3 Day Prior"	717	$110.66000	$79,343.00	$73,621.00	7.77%
Totals for Potential Savings Issues			**$157,043.00**	**$148,666.00**	**5.63%**
Grand Totals			**$351,757.00**	**$343,595.00**	**2.38%**

Our Bootstrap methodology results supported our original projections in seven of the eight tests. The PPS Transfer Bootstrap projection yielded a projection lower than our original approach. However, this amount was approximately $2,781 less than the ACTUAL overpayments determined by our testing.

For all other populations, the Bootstrap methodology produced numbers that were very close to our original approach. Therefore, the Bootstrap method supported our original statistical projections.

- Sample sizes were selected based on our assessment of audit risk, our initial judgment, and the costs of sampling. We could not identify elements about the population prior to performing our CAATs work to determine estimated sample sizes needed to obtain desired precision percents and, therefore, our sample sizes were based strictly on these factors.

Section 3) Non-Statistical Annual Estimation Methodology

Because we only sampled two months of data, we could not use statistical methods to project to an annual figure. Statistical calculations were performed for the two-month period only. These statistical calculations were then used to estimate potential savings on an annual basis. No statistical inferences can be made about the annual estimates provided in the report. Statistical methodologies are not required by auditing standards and are often not used. The statistical methodologies were used to assist in determining a reasonable amount to use in obtaining our annual estimates.

Our two month statistical projections were based on the 90 percent confidence interval. We are 95 percent confident that the overpayments within the two-month period are at least the amount of our two month projections. Conversely, there is a five percent risk that our projections are too high. The Bootstrap methodology was used to provide us with some assurance that our projections were not too high.

The annual extrapolation approach used consisted of the following:

- Using two reports (MI-304-01 and the MI-608-01) obtained from the Department of Health, we calculated the Medicaid payment amounts paid for inpatient claims (excluding Medicare crossovers) for June and July 1994. We then performed this same calculation for the total payment amounts for State fiscal year 1994 and determined the percent represented by the June and July 1994 period. This annual extrapolation is used for the **first issue only** since overpayments relate to inpatient claims. The amount is determined by the following formula:

  $$\frac{\text{Two-month Statistical Projection (for each issue)}}{\text{Percent represented by two month period}}$$

  (Our results showed a two month percentage of 16.57 percent.)

- For Issues 2 and 3, the same calculation was used except that we used outpatient payment information (excluding Ambulatory Service Center services, Outpatient Surgery - Ambulatory Service Centers, and Medicare Crossovers). Our results showed a two-month percentage of 18.03 percent.

  Figure 14 illustrates the annual extrapolations based on our two-month projections.

Figure 14

Overpayment Issues	**2-Month Statistical Projection**	**Applicable Percent Of FY94 Medicaid Payments Processed By The Contractor In June & July 1994**	**Annual, Non-Statistical Extrapolations**
I-PPS Transfers	$47,992.00	16.57 Percent	$289,631.86
II-"During"	$40,954.00	18.03 Percent	$227,143.65
II-"1 Day Prior"	$39,535.00	18.03 Percent	$219,273.43
III-Chemistry	$43,660.00	18.03 Percent	$242,151.97

III-Urinalysis	$9,286.00	18.03 Percent	$51,503.05
III-Hematology	$13,502.00	18.03 Percent	$74,886.30
Totals for Potential Overpayment Issues	**$194,929.00**		**$1,104,590.26**
Savings Issues			
II-"2 Day Prior"	$75,045.00	18.03 Percent	$416,222.96
II-"3 Day Prior	$73,621.00	18.03 Percent	$408,325.01
Totals for Potential Savings Issues	**$148,666.00**		**$824,547.97**
Grand Totals	**$343,595.00**		**$1,929,138.23**

Appendix 5:

Glossary of Selected Key Terms

DRG (Diagnosis Related Groups) - A prospective payment system for hospital services based on Medicare taxonomy of diagnoses and/or procedures. Age, sex, complications, and additional illnesses are also considered. Each DRG has a specific relative weight, or measure of service difficulty (intensity). Each hospital has its own separate basic standard dollar amount, which is multiplied by the DRG's relative weight associated with the patient's principal diagnosis and/or procedure code to yield the total reimbursement for the hospital stay.

Inpatient - An person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient-hospital services.

Inpatient Services -Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients.

LOS (Length of Stay) - The number of days in a single inpatient hospital stay. The days may or may not be allowed for payment.

NHIC (National Heritage Insurance Company) - Insurance company responsible for making payment for a number of services, including physician, hospital, and Early Periodic Screening, Diagnosis and Treatment (EPSDT). NHIC also processes claims for MHMR Medicaid services, including targeted case management, mental health rehabilitation, and mental retardation diagnosis and evaluation. The NHIC contract is managed by the Texas Department of Health (TDH).

NHIC STAT FILE - A computer tape file that contains detailed transaction information for paid and denied claims for a given month. The payment month is based upon the accumulation of claims processed in the weekly payment cycles.

Outpatient - An individual who is provided ambulatory services in a hospital, but is not confined for inpatient care.

Outpatient Services - Ambulatory services provided in a hospital, when the individual is not confined for inpatient hospital care. Benefits include those diagnostic, therapeutic, rehabilitative, or palliative items or services deemed medically necessary and furnished by or under the direction of a physician to an outpatient by a Texas Title XIX hospital or an out-of-state hospital. This does not include drugs and biologicals which are taken home by the client. Supplies provided by a hospital supply room for use in physicians' offices in the treatment of patients are not reimbursable as outpatient services.

PCN (Program Case Number) - An NHIC term used to identify the unique client number for an individual eligible for Medicaid.

Provider - A person, group, or agency who provides a covered Medicaid service to a Medicaid client.

RANUNI - A function within the Statistical Analysis System (SAS) software package that generates random numbers.

Recipient - A person who received a Medicaid service while eligible for the Medicaid program. People may be Medicaid eligible without being Medicaid recipients.

SAS - Statistical Analysis System software package used for data analysis.

TEFRA - Tax Equity and Fiscal Responsibility Act - Social Security Administration Medicare and Medicaid amendments of August 1982. TEFRA guidelines are used to determine payments for inpatient stays at children's hospitals and certain DRG outlier payments.

All Medicaid definitions were obtained from the following sources:

Health and Human Services Commission, State Medicaid Office. *Texas Medicaid in Perspective*. May 1994.

Texas Department of Health. *Medicaid Provider Procedures Manual*. January 1994.

Texas Department of Human Services. *Texas Medicaid Glossary - Commonly Used Terms and Acronyms*. January 1992 (revised May 1993).