



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

July 23, 2002

Common Identification Number: A-05-02-00027

Ms. Jackie Garner
Director
Illinois Department of Public Aid
201 South Grand Avenue East
Springfield, Illinois 62763

Dear Ms. Garner:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled, "Partnership Review of Medical Claims Submitted by an Alternate Payee Under the Illinois Medicaid Program." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, OIG OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR part 5.) As such, within 10 business days after the final report is issued, it will be posted on the world wide web at <http://oig.hhs.gov>.

To facilitate identification, please refer to Common Identification Number A-05-02-00027 in all correspondence relating to this report.

Sincerely,

Paul Swanson
Regional Inspector General
for Audit Services

Robb Miller
Inspector General
Illinois Department of Public Aid

Enclosures – as stated

Direct Reply to HHS Action Official:

Cheryl Harris, Associate Regional Administrator
Centers for Medicare & Medicaid Services – Division of Medicaid, Region V
233 North Michigan Avenue
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PARTNERSHIP REVIEW OF
MEDICAL CLAIMS SUBMITTED
BY AN ALTERNATE PAYEE UNDER THE
ILLINOIS MEDICAID PROGRAM**

**ILLINOIS DEPARTMENT OF
PUBLIC AID
SPRINGFIELD, ILLINOIS**



JANET REHNQUIST
Inspector General

JULY 2002
A-05-02-00027



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Ms. Jackie Garner, Director
Illinois Department of Public Aid
201 South Grand Avenue East
Springfield, Illinois 62763

Dear Ms. Garner:

This final report provides you with the results of the partnership review of medical claims submitted under the Medicaid program by an entity referred to in this report as Payee A. Although this review raised questions about certain billing practices, the Federal Medicaid program was not charged for inappropriate services.

Under its Partnership Plan, the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services (OAS), entered into this joint project with the Illinois Department of Public Aid's (IDPA) Office of Inspector General. The IDPA administers the Illinois Medicaid Program and submits quarterly claims to the Centers for Medicare and Medicaid Services (CMS), previously referred to as the Health Care Financing Administration.

The objective of our joint review was to develop and validate a time dependent billing routine that would identify practitioners who submitted claims for more time than is feasible in a day. To identify these practitioners, IDPA OIG performed an analysis of claims for specific procedure codes billed to the Medicaid program based on minimum established time guidelines. The time dependent billing routine identified practitioners who billed for one or more 12-hour days for dates of service from July 1, 1998 to June 30, 2000, inclusive. Under the Partnership Plan, Payee A was identified as the alternate payee for Physician A and several other physicians in the time dependent billing project. These physicians had charged for more time than is feasible in a day.

Payee A submitted claims for physician services and received payments on behalf of the physicians. Based on our review of the medical records for services provided by Physician A, we concluded that the physician did see the patients on the dates in question. However, the physician claims for services provided at one particular nursing facility were submitted using procedure codes that were higher than the level of care actually performed (a condition commonly referred to as upcoding).

Although billing for a more complex level of care than that which was provided results in increased Medicaid reimbursement, the majority of the physician services were provided to patients residing in a nursing facility categorized as an Institution for Mental Diseases (IMD). Federal matching is not available for any medical assistance to patients in IMDs unless the

individual is over 65 years of age or under age 22. Although the physician services provided to patients residing in the IMD were not claimed for Federal matching, Payee A did submit claims for Medicaid services provided in other nursing facilities. As a result, we recommend that IDPA instruct Payee A and the physicians to submit properly coded claims based on the level of care and time spent by the physician with each patient. In a letter dated June 11, 2002, the IDPA concurred with our findings and recommendations.

INTRODUCTION

BACKGROUND

In order to provide broader audit coverage of State Medicaid programs in Region V states, the U.S. Department of Health and Human Services, Office of Inspector General, proposed to jointly review Medicaid payments with the Illinois Department of Public Aid, Office of Inspector General and Division of Medical Programs. As our model, we referred to previously successful approaches presented in the existing publication, *Partnerships Work and Deliver Results, A Summary of Federal/State Joint Audit Initiatives*. That document suggests that State and Federal oversight groups working together are the most effective and efficient use of scarce Federal and State resources. In implementing the partnership approach, the following offices with their compatible missions participated in this joint project.

HHS, OIG OAS: The mission of the HHS OIG is to improve programs and operations of HHS and to protect against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations, the HHS OIG provides timely, useful, and reliable information and advice to HHS officials, the Administration, the Congress, and the public.

The OAS, one component of the HHS OIG, provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs, in general, and of its grantees and contractors, in regard to carrying out their respective responsibilities. These audits are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency in HHS programs.

IDPA OIG: The IDPA OIG employs 280 staff to fulfill the Illinois General Assembly's mandate to prevent, detect, and eliminate fraud, waste, abuse, mismanagement and misconduct in programs administered by the Department of Public Aid. The IDPA OIG has a multi-disciplinary staff of professionals who initiate enforcement actions and develop prevention strategies to safeguard the Illinois Medical Assistance, Food Stamp, and Temporary Assistance for Needy Families programs.

The IDPA OIG conducts numerous research projects and studies issues affecting the fiscal integrity of the programs it monitors. The IDPA OIG conducted the nation's first statistically valid study of the accuracy of Medicaid payments in Illinois. The project's findings have provided significant guidance to continuing fraud prevention work, and its methodology has served as a blueprint for other states and other payers who are undertaking medical payment

accuracy studies. The IDPA OIG has also produced numerous reports on key program integrity issues.

The IDPA OIG Fraud Science Team (FST) also has an active effort to develop innovative fraud and overpayment detection routines of which this project is a component. FST staff developed and implemented the detection routine used in this review and identified the physicians for field validation. They also contributed to the field validation by providing consultation and detailed claim and payment information for the physicians included in the review.

The IDPA OIG also has a Fraud and Abuse Executive who coordinates actions with State and Federal law enforcement agencies. The Fraud and Abuse Executive also leads and coordinates other State-Federal initiatives for the IDPA OIG, including the HHS OIG Partnership Plan.

OBJECTIVES, SCOPE, AND METHODOLOGY

The OAS conducted this audit in accordance with generally accepted government auditing standards. The primary objectives of this review were:

- ▶ to identify physicians who are billing for more time than is feasible in a day, and
- ▶ to determine whether the physicians properly billed the Medicaid program for services provided.

The OAS conducted its fieldwork at Physician A's office and several locations throughout Chicago where the services were provided by Physician A. Fieldwork was completed in December 2001.

Methodology Used by IDPA OIG to Identify Medical Physicians. The time dependent billing routine was designed to identify practitioners who billed for more time than is feasible in a day. Using practitioner claims data available on IDPA's data warehouse, the routine provides an estimate of the number of hours a practitioner spends on patient care for each day. From that information, IDPA generates a series of reports that can be used to identify providers and payees who warrant follow up action.

To develop this routine, IDPA identified those Current Procedural Terminology (CPT) and local codes that reference time in their description or in American Medical Association's CPT manual. Where a time range is provided, IDPA assigned the lower time value. Since some visit procedures codes did not have a specific time expressed in the CPT, the IDPA assigned three minutes to those non-time dependent codes, with the exception of group codes which were assigned a value of zero minutes in the billing routine. IDPA continues work to refine and enhance this routine currently.

The Partnership examined the results of the IDPA analysis for dates of services between July 1, 1998, and June 30, 2000, inclusive. The routine identified 146 practitioners with at least one day greater than 12 hours. There were 16 practitioners identified in the routine with over 10 days

greater than 24 hours, the most being 371 days. Of the 146 practitioners, 32 are currently the subject of an ongoing investigation or review. Six of the 114 remaining had over 10 days greater than 24 hours.

Selection of Physicians for Validation of Claims. Under the Partnership Plan, it was the general consensus that we would determine the propriety of Physician A's claims submitted under the Medicaid program. For dates of service between July 1, 1998, and June 30, 2000, inclusive, the billing routine identified Physician A as billing 45 days greater than 24 hours and payments of \$167,364. In addition, there were 256 days greater than 12 hours during the two-year period. Payee A submitted claims for services provided by Physician A and was paid \$146,769 or almost 88 percent of the \$167,364.

According to IDPA records, Physician A's specialty was listed as internal medicine. Over 70 percent of the amount paid pertained to procedure codes 99312 and 99313, both relating to subsequent nursing facility care.

Selection of Date of Service for Validation. To determine the propriety of the billings, we obtained the claim detail from IDPA OIG for services performed on February 15, 2000 by Physician A. According to the time dependent billing routine, the time required to perform the services claimed by Physician A on that day would have been 29 hours. The claims were for medical services provided to 99 recipients at 10 different locations in the Chicago area. Our analysis of the claim detail disclosed that 87 of the 99 claims were for subsequent nursing facility care:

Procedure code 99312: Physicians typically spend 25 minutes (63 claims)

Procedure code 99313: Physicians typically spend 35 minutes (24 claims)

Alternate Payee Arrangements. Under certain conditions, IDPA permits individual physicians to designate an alternate payee for payment of claims for services provided by the physician. We found that Payee A was the alternate payee for 88 of the 99 claims, which included all of the 87 claims for subsequent nursing facility care. There were no claims submitted by Payee A for procedure code 99311, relating to subsequent nursing facility care where the physician typically spends 15 minutes at the bedside and on the floor or unit. The inclusion of time in the coding descriptions developed by the American Medical Association (AMA) and published in its *Current Procedural Terminology (CPT)* reference book is intended to assist physicians in selecting the most appropriate procedure code to be billed.

FINDINGS AND RECOMMENDATIONS

PROCEDURE CODES

Although our review of the medical records disclosed that Physician A provided treatment to the patients on the date in question, the claims for services provided at one particular nursing facility were submitted using procedure codes that were higher than the level of care actually performed (a condition commonly referred to as upcoding). Billing for a level of care more complex than

was provided, generally, results in increased Medicaid reimbursement. However, 58 patients seen by Physician A resided in a nursing facility categorized as an Institution for Mental Diseases (IMD). Federal matching under the Medicaid program is not available for any medical assistance to patients in IMDs unless the individual is over 65 years of age or under age 22. Therefore, upcoding at this facility has a financial impact on State funding sources.

Although the physician services provided to patients residing in the IMD were not claimed for Federal matching, Payee A has submitted claims, on behalf of Physician A and other physicians, for Medicaid eligible services provided in other nursing facilities. As a result, we are recommending that IDPA instruct Payee A and the physicians to submit properly coded claims based on the level of care and time spent by the physician with the patient.

Medical Record Review. To determine the propriety of Physician A's claims, we reviewed medical records at the ten locations where services were provided on February 15, 2000. For 58 patients at one nursing facility, the level of care procedure codes assigned for billing IDPA were not substantiated by the medical records. According to the CPT, the physician would typically spend either 25 or 35 minutes at the bedside and on the patient's facility floor or unit to justify the use of the two codes. At this one facility, the procedure codes billed exceed 24 hours.

Physician A, also, saw an additional 41 patients at nine other locations throughout the metropolitan area. Although our medical record review did not support excessive upcoding at all the other locations, 29 of the patients were coded similarly to the IMD patients. Payee A never coded a patient service at the lower 15-minute rate.

Upcoded Services. Based on our discussion with Physician A and review of the medical records, we concluded that the majority of the above 58 claims were upcoded as subsequent nursing facility care performed at a long-term care facility. The patient population of this IMD differs from patients in traditional long term care facilities, in that these IMD patients are relatively young and have psychiatric rather than medical diagnoses. In general, the medical records confirmed that the patients did not have medical conditions requiring ongoing treatment. As a result, Physician A spent minimal time with each patient, usually around three minutes.

Although Physician A admittedly spent minimal time with each patient, all 58 claims submitted by Payee A were billed using "subsequent nursing facility care" procedure codes 99312 (37 claims) and 99313 (21 claims). According to the CPT reference book, these two codes relate to treatment involving complications and significant medical problems, which generally require the provider to spend 25 and 35 minutes, respectively, at the bedside and on the facility floor. We believe that the more appropriate procedure code for the services provided by Physician A would have been 99311 for patients who are stable, recovering or improving, which would require the physician to typically spend up to 15 minutes with the patient. Apparently Payee A entered the improper procedure codes on the claims without getting input from Physician A as to the level of care and actual time spent with each patient.

Arrangement Between Parties. Under a contractual agreement with Payee A, Physician A was to render medical care to patients residing at the IMD and several other facilities. Under the alternate payee agreement, Payee A submitted all claims for these patients on behalf of Physician A and was paid the prevailing Medicaid rate by IDPA. In return, Payee A paid Physician A a fixed amount for each patient treated.

Other Related Physicians. Our review disclosed three other physicians who also had alternate payee agreements with Payee A. All three physicians were identified in the time dependent billing routine as having more than ten days greater than 24 hours. These physicians also provided services to patients at the above IMD during our audit period. Although we did not review the medical records for these physicians at the IMD, we found their billing practices to be similar to Physician A, i.e., every claim submitted for two of these physicians by Payee A was for either procedure code 99312 or 99313. Based on our review of Physician A's claims submitted by Payee A, and the fact that claims for these three other physicians were submitted under the same circumstances, it appears that many of their claims may have also been upcoded.

Federal Matching and Payment Rates. Physician services provided to patients residing in an IMD are not claimed for Federal matching under the Medicaid program. As a result, the upcoding of claims submitted by Payee A for services provided by the four physicians at the IMD would not affect the Federal reimbursement received by IDPA under the Medicaid program. However, it would affect the State funds paid to Payee A for service provided by the physicians.

During the period July 1, 1998 through June 30, 2000, we estimate that alternate payees were paid \$317,900 for claims relating to procedure codes 99312 and 99313 on behalf of the four physicians. The majority of these payments were made to Payee A. We were unable to segregate the portion of the claims that related to physician services at the IMD and those that related to physician services at other nursing facilities qualifying for Federal matching.

We found that the allowable Medicaid rates paid by IDPA for the period July 1, 1996 through June 30, 2000 did not differ for procedure codes 99311 and 99312 (both \$14.45). However, the rate paid during the period for procedure code 99313 was \$20.15, resulting in a difference of \$5.70 from the 99311 and 99312 codes. Effective July 1, 2000, the following Medicaid rates were paid for the subsequent nursing facility care procedure codes: 99311 - \$15.65; 99312 - \$24.50; and 99313 - \$33.89. If the claims submitted by Payee A continue to be upcoded, the disparity in the current rates paid by IDPA for these codes could result in substantial overpayments.

RECOMMENDATION

We recommend that IDPA instruct Payee A and the physicians to submit properly coded claims based on the level of care and time spent by the physician with each patient.

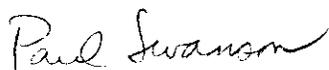
IDPA Comments

In a letter dated June 11, 2002, the IDPA concurred with the findings and recommendation presented in the report. IDPA routinely reminds providers of the requirements of participation in the Medicaid program. Because of the potential problem identified as a result of this study, IDPA will again, and very specifically, remind providers to take due diligence to code claims accurately. The full text of IDPA's response is included as an appendix to this report.

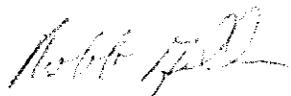
OAS Response

We agree with the actions planned to resolve the audit findings.

To facilitate identification, please refer to Common Identification Number A-05-02-00027 in all correspondence relating to this report.



Paul Swanson
Regional Inspector General
for Audit Services



Robb Miller
Inspector General
Illinois Department of
Public Aid

APPENDIX



George H. Ryan, Governor
Jackie Garner, Director

Illinois Department of Public Aid

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201 South Grand Avenue East
Springfield, Illinois 62763-0001

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June 11 2002

Victor Schmitt
U.S. Department of Health and Human Services
Office of Audit Services
Illinois Business Center
400 West Monroe Street 204B
Springfield, Illinois 62704

Dear Mr. Schmitt:

Thank you for sharing the draft report entitled "Partnership Review of Medical Claims Submitted by Alternate Payee under the Illinois Medicaid Program" (CIN A-05-02-00027). Because of the participation of my department's Office of the Inspector General in the conduct of the study, I am already familiar with the results of the review.

We routinely remind our providers of the requirements of participation in the Medicaid program. Because of the potential problem identified as a result of this study, we will again, and very specifically, remind providers to take due diligence to code claims accurately.

I believe that the partnership approach used in this, and other, studies to be highly beneficial to our relationship with your department and efficient toward meeting our mutual goals with regard to discovering, eliminating, and preventing fraud in the Medicaid program. We look forward to the continuation of this important partnership.

Sincerely,

Jackie Garner
Director

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