



JUL 19 2007

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: 
Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Abortion-Related Laboratory Claims Billed as Family Planning Under the New York State Medicaid Program (A-02-05-01009)

Attached is an advance copy of our final report on Medicaid abortion-related laboratory claims billed as family planning services by New York State. We will issue this report to the State within 5 business days. This audit is the second of a series on Medicaid family planning claims made by the State.

Our objective was to determine whether claims for abortion-related laboratory services for which New York State received Federal reimbursement at the enhanced 90-percent rate of Federal financial participation (FFP) qualified as family planning services.

The State improperly received the enhanced 90-percent FFP rate for abortion-related laboratory services that did not qualify as family planning services. In our opinion, 98 of the 100 claims in our sample did not qualify as family planning services. Forty-two of the ninety-eight claims involved abortion-related laboratory services for which no Federal funding is available. In addition, 56 claims involved abortion-related laboratory tests that are allowable at the applicable Federal medical assistance percentage rate but not eligible for the enhanced 90-percent rate of FFP. The remaining two claims were allowable. As a result, we estimate that the State improperly received \$3,235,640 in Federal Medicaid funds. However, we have set aside this amount for consideration by the Centers for Medicare & Medicaid Services (CMS) and the State because no medical review was performed of the 100 sample claims by qualified practitioners.

This overpayment occurred because (1) providers improperly coded the family planning indicator box on the Medicaid claim form and (2) the State's Medicaid Management Information System (MMIS) edit routines were inadequate to identify improperly coded laboratory claims that were not related to family planning.

We recommend that the State:

- work with CMS to resolve \$3,235,640 in set-aside claims;
- reemphasize to all providers, and specifically the laboratory provider who submitted 95 of the 98 improper sample claims, that abortion-related services are not considered family planning and the abortion/sterilization field on the Medicaid claim form must be properly coded when an abortion-related service is provided;
- strengthen MMIS edit routines to make use of all appropriate claim information to properly identify abortion-related laboratory claims that are ineligible for Federal funding; and
- determine the amount of Federal Medicaid funds improperly reimbursed at the 90-percent rate for ineligible abortion-related laboratory services, both prior and subsequent to our January 1, 2000, through December 31, 2003, audit period, and work with CMS to determine the amount to be refunded to the Federal Government.

In its comments on our draft report, the State concurred with our findings and recommendations.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620. Please refer to report number A-02-05-01009 in all correspondence.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region II
Jacob K. Javits Federal Building
New York, New York 10278
(212) 264-4620

JUL 24 2007

Report Number: A-02-05-01009

Richard F. Daines, M.D.
Commissioner
State of New York Department of Health
Empire State Plaza, Room 1408
Albany, New York 12237

Dear Dr. Daines:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Abortion-Related Laboratory Claims Billed as Family Planning Under the New York State Medicaid Program." A copy of this report will be forwarded to the action official noted on the next page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action 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 reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-02-05-01009 in all correspondence.

Sincerely,

James P. Edert
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Ms. Sue Kelly
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services, Region II
Department of Health and Human Services
26 Federal Plaza, Room 3811
New York, New York 10278

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF ABORTION-RELATED
LABORATORY CLAIMS BILLED AS
FAMILY PLANNING UNDER THE
NEW YORK STATE MEDICAID
PROGRAM**



**Daniel R. Levinson
Inspector General**

**July 2007
A-02-05-01009**

Office of Inspector General

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

The Federal Government and the States share the costs of the Medicaid program. The Federal share of the Medicaid program is referred to as Federal financial participation (FFP). The Federal share of a State's Medicaid program is determined by the Federal medical assistance percentage (FMAP). Pursuant to Title XIX of the Social Security Act, Federal funds are paid to States at the regular FMAP rate for costs incurred for covered medical services. During our audit period (January 1, 2000, through December 31, 2003), the FMAP in New York State was 50 or 52.95 percent. The FMAP was 50 percent from January 1, 2000, through March 31, 2003, and 52.95 percent from April 1 through December 31, 2003.

Section 1903(a)(5) of the Social Security Act and 42 CFR §§ 433.10 and 433.15 provide enhanced 90-percent FFP for family planning services under Medicaid. According to section 4270 of the Centers for Medicare & Medicaid Services (CMS) "State Medicaid Manual," family planning services are those furnished to prevent or delay pregnancy or to otherwise control family size. In general, Federal funding at the enhanced 90-percent matching rate is available for the costs of laboratory examinations and tests; medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception; and infertility services, including sterilization reversals. The CMS "State Medicaid Manual" indicates that States are free to determine the specific services and supplies which will be covered as Medicaid family planning services as long as those services are sufficient in amount, duration, and scope to reasonably achieve their purpose. However, only items and procedures clearly furnished or rendered for family planning purposes may be claimed at the 90-percent rate of FFP. Section 4270 also provides that an abortion may not be claimed as a family planning service.

Since 1977, Congress has passed Appropriations Acts that restrict Federal funding of abortions. Pursuant to the Supplemental Appropriations and Recession Act of 1981, Public Law Number 97-12, Federal funds are available for abortions performed only when the life of the mother would be endangered if the fetus were carried to term.

Section 4432 of the CMS "State Medicaid Manual" defines the types of abortion-related services eligible and ineligible for Federal funding. Laboratory services directly related to the performance of an abortion for which no Federal funding is available include both tests performed on the extracted fetus or abortion contents and tests performed before the abortion to assess the anesthetic/surgical risk to the patient. However, Federal funding is available at the applicable FMAP for the costs of certain services associated with a non-Federally funded abortion, if those same services would have been rendered to a pregnant woman regardless of whether she was seeking an abortion. These services include laboratory tests such as pap smears, urinalysis, and those for pregnancy and sexually transmitted diseases, as well as charges for all services, tests, and procedures performed for complications of a non-Federally funded abortion. Additionally, FFP is available at the standard FMAP for covered medical services performed during a single hospital stay that also involved an abortion.

New York's Medicaid State plan states that family planning services and supplies for individuals of childbearing age are covered without limitation. State regulations (New York Compilation of Codes, Rules and Regulations, Title 18, section 505.13) define family planning services as the offering, arranging, and furnishing of those health services that enable individuals, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies. The regulations state that such services include professional medical counseling services; prescription drugs; nonprescription drugs and medical supplies prescribed by a qualified physician, nurse practitioner, or physician's assistant; and sterilizations.

OBJECTIVE

Our objective was to determine whether claims for abortion-related laboratory services for which New York State received Federal reimbursement at the enhanced 90-percent rate of FFP qualified as family planning services.

SUMMARY OF FINDINGS

The State improperly received the enhanced 90-percent FFP rate for abortion-related laboratory services that did not qualify as family planning services. In our opinion, 98 of the 100 claims in our sample did not qualify as family planning services. Forty-two of the ninety-eight claims involved abortion-related laboratory services for which no Federal funding is available. In addition, 56 claims involved abortion-related laboratory tests that are allowable at the applicable FMAP rate but not eligible for the enhanced 90-percent rate of FFP. The remaining two claims were allowable. As a result, we estimate that the State improperly received \$3,235,640 in Federal Medicaid funds. However, we have set aside this amount for consideration by CMS and the State because no medical review was performed of the 100 sample claims by qualified practitioners.

This overpayment occurred because (1) providers improperly coded the family planning indicator box on the Medicaid claim form and (2) the State's Medicaid Management Information System (MMIS) edit routines were inadequate to identify improperly coded laboratory claims that were not related to family planning.

RECOMMENDATIONS

We recommend that the State:

- work with CMS to resolve \$3,235,640 in set-aside claims;
- reemphasize to all providers, and specifically the laboratory provider who submitted 95 of the 98 improper sample claims, that abortion-related services are not considered family planning and the abortion/sterilization field on the Medicaid claim form must be properly coded when an abortion-related service is provided;

- strengthen MMIS edit routines to make use of all appropriate claim information to properly identify abortion-related laboratory claims that are ineligible for Federal funding; and
- determine the amount of Federal Medicaid funds improperly reimbursed at the 90-percent rate for ineligible abortion-related laboratory services, both prior and subsequent to our January 1, 2000, through December 31, 2003, audit period, and work with CMS to determine the amount to be refunded to the Federal Government.

STATE'S COMMENTS

In its April 9, 2007, comments on our draft report, New York State concurred with our findings and recommendations.

The State's comments are included in their entirety as Appendix C.

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INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act (the Act), established the Medicaid program, which pays the health care costs of persons who qualify by virtue of medical conditions, economic conditions, or other factors. The Federal Government and States share Medicaid costs. The Federal share of the Medicaid program is referred to as Federal financial participation (FFP). The Federal share of a State's Medicaid program is determined by the Federal medical assistance percentage (FMAP). Within the Federal Government, the Centers for Medicare & Medicaid Services (CMS) administers Medicaid.

To participate in Medicaid, a State must submit and receive CMS's approval of a State plan. The State plan is a comprehensive document detailing the nature and scope of the State's Medicaid program and the State's obligations to the Federal Government. Medicaid pays for medically necessary services that are specified in Medicaid law provided they are included in the State plan and rendered to individuals eligible under the State plan.

Medicaid Coverage of Family Planning Services

Section 1905(a)(4)(C) of the Act requires States to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and who desire such services and supplies. Section 1902(a)(10)(A) of the Act specifies that family planning services be available to "categorically needy" Medicaid beneficiaries, while section 1902(a)(10)(C) specifies that the services may be rendered to "medically needy" Medicaid beneficiaries at the State's option. Section 1903(a)(5) of the Act and 42 CFR §§ 433.10(c)(1) and 433.15(b)(2) authorize an enhanced rate of FFP for family planning services.

According to section 4270 of the CMS "State Medicaid Manual," family planning services prevent or delay pregnancy or otherwise control family size. In addition, this section generally permits an enhanced 90-percent rate of FFP for counseling services and patient education; examination and treatment by medical professionals pursuant to State requirements; laboratory examinations and tests; medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception; and infertility services, including sterilization reversals. The CMS "State Medicaid Manual" indicates that States are free to determine the specific services and supplies that will be covered as Medicaid family planning services as long as those services are sufficient in amount, duration, and scope to reasonably achieve their purpose. However, only items and procedures clearly furnished or rendered for family planning purposes may be claimed at the 90-percent rate of FFP. Finally, according to the "State Medicaid Manual," an abortion may not be claimed as a family planning service.

New York's Medicaid State plan states that family planning services and supplies for individuals of childbearing age are covered without limitation. State regulations (New York Compilation of Codes, Rules and Regulations, Title 18, section 505.13) define family planning services as the offering, arranging, and furnishing of those health services that enable individuals, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies. The regulations state that such services include professional medical counseling services; prescription drugs; nonprescription drugs and medical supplies prescribed by a qualified physician, nurse practitioner, or physician's assistant; and sterilizations.

Medicaid Coverage of Abortions and Abortion-Related Services

Since 1977, Congress has passed Appropriations Acts that restrict Federal funding of abortions. Pursuant to the Supplemental Appropriations and Recession Act of 1981, Public Law Number 97-12, Federal funds are available for abortions performed only when the life of the mother would be endangered if the fetus were carried to term. Pursuant to Federal regulations 42 CFR, part 441, subpart E, Federal funding at the standard FMAP rate is available for abortions only when a physician has found and certified in writing to the Medicaid agency that in his or her professional judgment, the life of the mother would be endangered if the fetus were carried to term.

Section 4432 of the CMS "State Medicaid Manual" defines the types of abortion-related services eligible and ineligible for Federal funding. Laboratory services directly related to the performance of an abortion for which no Federal funding is available include both tests performed on the extracted fetus or abortion contents and tests performed before the abortion to assess the anesthetic/surgical risk to the patient. However, Federal funding is available at the standard FMAP rate for the costs of certain services associated with a non-Federally funded abortion, if those same services would have been rendered to a pregnant woman regardless of whether she was seeking an abortion. These services include laboratory tests such as pap smears, urinalysis, and those for pregnancy and sexually transmitted diseases, as well as charges for all services, tests, and procedures performed for complications of a non-Federally funded abortion. Additionally, FFP is available at the standard FMAP for covered medical services performed during a single hospital stay that also involved an abortion.

New York's Medicaid Program

In New York State, the Department of Health is the State agency responsible for operating the Medicaid program. Within the Department of Health, the Office of Medicaid Management administers the Medicaid program. The Department of Health uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

The State's FMAP was 50 percent for claims paid from January 1, 2000, through March 31, 2003, and 52.95 percent for claims paid from April 1 through December 31, 2003.

Laboratory providers enrolled in the Medicaid program submit claims to the State's MMIS for payment. The State furnishes an MMIS provider manual to laboratories that contains instructions for the proper completion and submission of claims. On the claim form are certain fields the provider is required to complete to indicate the type of service provided.

If the service is related to family planning, providers are instructed to check "Yes" in the family planning indicator box contained in field 22I. If the service is related to an induced abortion or sterilization, one of the following codes must be entered in field 22E of the claim form:

- "0" - Not applicable
- "A"- Induced Abortion – Danger to the woman's life
- "B"- Induced Abortion – Physical health damage to the woman
- "C"- Induced Abortion – Victim of rape or incest
- "D"- Induced Abortion – Medically necessary
- "E"- Induced Abortion – Elective

All claims coded by the providers as "Yes" in the family planning box and "0" in the sterilization/abortion field will be considered related to family planning and processed for payment. However, when claims are coded as "Yes" in the family planning box with any of the other above codes in the abortion/sterilization field, the claim will be denied by the MMIS and sent back to the provider for clarification because an abortion procedure cannot be a family planning service.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether claims for abortion-related laboratory services for which New York State received Federal reimbursement at the enhanced 90-percent rate of FFP qualified as family planning services.

Scope

Our audit period covered January 1, 2000, through December 31, 2003. During our audit, we did not review the overall internal control structure of the State or the Medicaid program. Rather, we reviewed internal controls that pertained directly to the objective of our audit.

We conducted fieldwork at the State Department of Health in Albany, New York; the State MMIS fiscal agent in Menands and Rensselaer, New York; and at various provider offices in and around New York, New York.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance;
- held discussions with CMS officials and acquired an understanding of CMS guidance furnished to State officials concerning Medicaid family planning, abortion, and abortion-related claims;
- held discussions with State officials to ascertain State policies, procedures, and guidance for claiming Medicaid reimbursement for family planning, abortion, and abortion-related services;
- held discussions with officials at one laboratory that submitted 96 percent of the claims in our revised universe described below to review their policies and procedures (this provider specialized in examining abortion-related specimens);
- ran computer programming applications at the MMIS fiscal agent, which identified 983,381 paid laboratory services claimed at 90 percent by the State and totaling \$11,227,943 (\$10,101,279 Federal share) for the period January 1, 2000, through December 31, 2003;
- extracted 633,968 claims with diagnosis codes 635 (legally induced abortion), 636 (illegally induced abortion), 637 (unspecified abortion), and 638 (failed attempted abortion), from the universe of 983,381 claims;
- eliminated from the 633,968 claims, 1,216 claims for beneficiaries in client aid category 56;¹
- identified a revised universe of 632,752 potentially improper abortion-related laboratory claims totaling \$6,669,586 (\$5,999,939 Federal share) as follows:
 - 624,808 claims with diagnosis code 635,
 - 38 claims with diagnosis code 636,
 - 7,868 claims with diagnosis code 637, and
 - 38 claims with diagnosis code 638;

¹Beneficiaries in client aid category 56 are included in a family planning waiver program that we intend to review under a separate audit.

- used simple random sampling techniques to select a sample of 100² claims for review from the revised universe of 632,752 claims;
- contacted both the laboratory that performed the test and the provider who ordered the test to review medical records for our 100 sample claims;
- developed a worksheet used for the review of the medical records, including notation of any indication the abortion was performed because the life of the mother was in danger if the pregnancy was carried to term and if so, was there a certification from a physician attesting to this; and
- used a variables appraisals program to estimate the dollar impact of the improper Federal funding claimed in the total population of 632,752 laboratory claims.

Appendix A contains the details of our sample design and methodology.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The State improperly received the enhanced 90-percent rate of FFP for abortion-related laboratory services that did not qualify as family planning services. In our opinion, 98 of the 100 claims in our sample did not qualify as family planning services.³ Forty-two of the ninety-eight claims involved abortion-related laboratory services for which no Federal funding is available. In addition, 56 claims involved abortion-related laboratory tests that are allowable at the applicable FMAP rate but are not eligible for 90-percent reimbursement. The remaining two claims were allowable. As a result, we estimate that the State improperly received \$3,235,640 in Federal Medicaid funds. However, we have set aside this amount for consideration by CMS and the State because no medical review of the 100 sample claims was performed by qualified practitioners.

This overpayment occurred because: (1) providers improperly coded the family planning indicator box on the Medicaid claim form and (2) the State's MMIS edit routines were inadequate to identify improperly coded laboratory claims that were not related to family planning.

SERVICES UNRELATED TO FAMILY PLANNING

In 98 of the 100 sampled claims, medical records plus discussions with laboratory staff and ordering providers showed that the laboratory test was performed in connection with an abortion procedure when the life of the mother would not have been endangered if the fetus was carried to term. Since the 98 sampled claims were unrelated to the provision of

²Of the sample claims, 99 contained diagnosis code 635 and 1 contained diagnosis code 637.

³One laboratory provider submitted 95 of the 98 improper sample claims.

a family planning service, they were not eligible for Federal reimbursement at the enhanced 90-percent rate.

Section 4432 of the CMS “State Medicaid Manual” defines the types of abortion-related services eligible and ineligible for Federal funding. Laboratory services for which no Federal funding is available include both tests performed on the extracted fetus or abortion contents and tests performed before the abortion to assess the anesthetic/surgical risk to the patient. However, Federal funding is available at the applicable FMAP for the costs of certain services associated with a non-Federally funded abortion, if those same services would have been rendered to a pregnant woman regardless of whether she was seeking an abortion. These services include laboratory tests such as pap smears, urinalysis, and those for pregnancy and sexually transmitted diseases, as well as charges for all services, tests, and procedures performed for complications of a non-Federally funded abortion. Additionally, FFP is available at the standard FMAP for covered multiple medical procedures involving an abortion.

Forty-two of the ninety-eight claims involved abortion-related laboratory services for which no Federal funding is available. These 42 claims included tests performed on the extracted fetus or abortion contents and tests performed before the abortion to assess the anesthetic/surgical risk to the patient, such as complete blood counts, electrolytes, and blood typing.

In addition, 56 claims involved abortion-related laboratory tests that are eligible at the applicable FMAP of 50 or 52.95 percent but that are not eligible for 90-percent reimbursement. The 56 claims included laboratory tests such as pap smears, urinalysis, and those for pregnancy and sexually transmitted diseases.

The remaining two sampled claims were allowable.

CAUSES OF THE OVERPAYMENT

As discussed below, we identified two main causes of the overpayment.

Improperly Coded Claims

The State furnishes an MMIS provider manual to laboratories that contains instructions for the proper completion and submission of claims. The MMIS provider manual includes specific instructions on the completion of the family planning indicator field and the abortion/sterilization field on the Medicaid claim form.

For all 98 sampled claims in error, providers incorrectly checked the “Yes” box in the family planning indicator field on the Medicaid claim forms, even though the services provided had nothing to do with family planning. The presence of a “Yes” in that field prompted the State’s MMIS to place these claims with those eligible for the enhanced 90-percent matching rate for family planning, rather than the applicable FMAP rate (of

50 or 52.95 percent) or 0 percent (in those cases where no FFP should have been claimed).

Providers were also incorrectly filling out the sterilization/abortion code on the Medicaid claim form. This code indicates whether the service is for an induced abortion or sterilization. When billing for laboratory tests directly related to an induced abortion, providers are instructed to use codes A, B, C, D, or E. The presence of this alpha code identifies the claim as abortion-related and that no Federal funding will be claimed by the State. However, we found that all 632,752 laboratory claims incorrectly contained code “0,” or not applicable. As a result, all 632,752 laboratory services were claimed at the enhanced 90-percent matching rate.

Officials from the laboratory that submitted 96 percent of the claims in our revised universe did not properly follow the billing instructions contained in the MMIS provider manual. Rather, they relied on information contained in general Medicaid brochures that did not specifically relate to the proper billing of claims.

Inadequate Computer System Edits

The design of the computer edit routines in the MMIS was such that the presence of a “Yes” in the family planning indicator box was the only element needed for the system to classify a claim as family planning. Other appropriate elements, such as procedure code and diagnosis code, were not included in these edit routines. When the family planning indicator was checked “Yes” and the abortion/sterilization field was coded with “0,” the State incorrectly included these claims with those eligible for 90-percent Federal reimbursement, even if the diagnosis codes indicated that an abortion had occurred.

ESTIMATION OF THE UNALLOWABLE AMOUNT

Based on our sample results, we estimate that the State improperly received \$3,235,640 in Federal Medicaid funds. This included the entire 90-percent Federal funding amount of the 42 claims for which no funding is available and the difference between 90 percent and the State’s FMAP rates (either 50 or 52.95 percent) for the 56 claims that contained abortion-related laboratory tests that are eligible at the FMAP rate. We have set aside the \$3,235,640 for consideration by CMS and the State because no medical review was performed of the 100 sample claims by qualified practitioners. The details of our sample appraisal are shown in Appendix B.

RECOMMENDATIONS

We recommend that the State:

- work with CMS to resolve \$3,235,640 in set-aside claims;
- reemphasize to all providers, and specifically the laboratory provider who submitted 95 of the 98 improper sample claims, that abortion-related services are

not considered family planning and the abortion/sterilization field on the Medicaid claim form must be properly coded when an abortion-related service is provided;

- strengthen MMIS edit routines to make use of all appropriate claim information to properly identify abortion-related laboratory claims that are ineligible for Federal funding; and
- determine the amount of Federal Medicaid funds improperly reimbursed at the 90-percent rate for ineligible abortion-related laboratory services, both prior and subsequent to our January 1, 2000, through December 31, 2003, audit period, and work with CMS to determine the amount to be refunded to the Federal Government.

STATE'S COMMENTS

In its April 9, 2007, comments on our draft report, New York State concurred with our findings and recommendations.

The State's comments are included in their entirety as Appendix C.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine whether claims for abortion-related laboratory services for which New York State received Federal reimbursement at the enhanced 90-percent rate qualified as family planning services.

POPULATION

The population was abortion-related laboratory claims billed as family planning services by the State at 90-percent Federal funding, during our January 1, 2000, through December 31, 2003, audit period.

SAMPLING FRAME

The sampling frame was a computer file containing 632,752 Medicaid claims for abortion-related laboratory services billed as family planning at 90-percent Federal funding, during our review period. The total Medicaid reimbursement for the 632,752 claims was \$6,669,586, of which the Federal share was \$5,999,939. We extracted the Medicaid claims from the paid claims' files maintained at the Medicaid Management Information System fiscal agent.

SAMPLE UNIT

The sampling unit was an individual Medicaid claim for abortion-related laboratory services billed as family planning at the enhanced Federal funding rate of 90 percent.

SAMPLE DESIGN

We used simple random sampling techniques to evaluate the population of Medicaid laboratory claims for abortion-related services billed as family planning under the State's Medicaid program.

SAMPLE SIZE

We selected 100 sample claims for review.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Audit Services statistical sampling software dated September 2003. We used the random number generator for our sample selection.

METHOD OF SELECTING SAMPLE ITEMS

We sequentially numbered the claims in our sampling frame and selected the random numbers that correlated to the sequential numbers assigned to the claims in the sampling frame. We then created a list of the 100 sample items.

CHARACTERISTICS TO BE MEASURED

We based our determination as to whether a claim was improper on applicable Federal laws and regulations, Federal guidance, a review of all information contained on the claim form, and a review of documentation from the laboratory that submitted the claim and from the provider who ordered the laboratory test. Specifically, if the following characteristics were met, the claim under review was considered improper:

- The claim was for an abortion-related service or procedure and the life of the mother was not endangered if the fetus was carried to term and the claim did not qualify for Federal funding; in this case, we set aside the entire 90-percent Federal funding amount.
- The claim was for an abortion-related service or procedure and the life of the mother was not endangered if the fetus was carried to term and the claim qualified for Federal funding at the applicable Federal medical assistance percentage; in this case, we set aside the portion of the claim between 90 percent and the State's regular Federal funding rates (50 and 52.95 percent during our audit period).

TREATMENT OF MISSING SAMPLE ITEMS

If supporting information could not be found, the sample item was considered an error.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services variables appraisal program in RAT-STATS to appraise the sample results. We used the lower limit at the 90-percent confidence level to estimate the amount associated with the improper claiming.

SAMPLE RESULTS AND PROJECTION

The results of our review of the 100 laboratory claims were as follows:

Sample Results

Claims in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Improper Claims	Value of Improper Claims (Federal Share)
632,752	\$5,999,939	100	\$961	98	\$599

**Projection of Sample Results
Precision at the 90-Percent Confidence Level**

Midpoint:	\$3,791,197
Lower Limit:	\$3,235,640
Upper Limit:	\$4,346,754
Precision Percent:	14.65 %



STATE OF NEW YORK
DEPARTMENT OF HEALTH

APPENDIX C
Page 1 of 4

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

April 9, 2007

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No. A-02-05-01009

Dear Mr. Edert:

Enclosed are the Department of Health's comments on the DHHS - OIG's Draft Audit (A-02-05-01009) on "Review of Abortion-Related Laboratory Claims Billed as Family Planning."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read 'Brian J. Wing', written over the word 'Sincerely,'. The signature is stylized and includes a long horizontal flourish extending to the right.

Brian J. Wing
Interim Executive Deputy Commissioner

Enclosure

cc: Ms. Bachrach
Mr. Charbonneau
Mr. Hussar
Ms. Kerker
Mr. Howe
Ms. McTague
Ms. Napoli
Mr. Reed
Mr. Seward
Ms. Shaw

**Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-05-01009 on
“Review of Abortion-Related Laboratory Claims
Billed as Family Planning Under
the New York State Medicaid Program”**

The following are the Department of Health’s (DOH) comments in response to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) draft audit report (A-02-05-01009) on “Review of Abortion-Related Laboratory Claims Billed as Family Planning Under the New York State Medicaid Program.”

General Comments:

After a review of the auditor’s workpapers, we found that 95% of the claims identified were submitted by one laboratory provider. Therefore we disagree with the Summary of Findings that states:

“This overpayment occurred because: (1) providers improperly coded the family planning indicator box on the Medicaid claim form, and (2) the State’s Medicaid Management Information System (MMIS) edit routines were inadequate to identify improperly coded laboratory claims that were not related to family planning.”

This statement seems to indicate that there is an inherent problem with the State’s billing instructions for abortion-related lab services and that there are multiple providers who have coded their claims incorrectly, when it was primarily one provider who was coding the abortion/lab claims incorrectly. The Summary of Findings should clearly state this.

Recommendation #1:

We recommend that the State:

- work with CMS to resolve \$3,235,640 in set-aside claims;
- re-emphasize to all providers, and specifically the laboratory provider who submitted 95 of the 98 improper sample claims, that abortion-related services are not considered family planning, and the abortion/sterilization field on the Medicaid claim form must be properly coded when an abortion-related service is provided;

- strengthen MMIS edit routines to make use of all appropriate claim information to properly identify abortion-related laboratory claims that are ineligible for Federal funding; and
- determine the amount of federal Medicaid funds improperly reimbursed at the 90-percent rate for ineligible abortion-related laboratory services, both prior and subsequent to our January 1, 2000 through December 31, 2003 audit period, and work with CMS to determine the amount to be refunded to the Federal Government.

Response #1:

The Department will take the following steps to address the recommendation:

- work with the Centers for Medicare & Medicaid Services (CMS) to resolve the claims.
- issue an article in the Medicaid Update instructing providers to properly code the abortion/sterilization field on the Medicaid claim form when an abortion related service is provided.
- work with systems staff to assure an edit is in place and working properly to identify abortion-related laboratory claims that are ineligible for Federal funding.
- work with CMS to determine the amount to be refunded to the Federal Government.