

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF PHYSICIAN SUPPLEMENTAL  
PAYMENTS MADE TO THE UNIVERSITY  
OF NORTH TEXAS**

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Texas, the Health and Human Services Commission (State agency) administers the program.

Texas State plan amendment 04-010 (SPA) provided for quarterly physician supplemental payments (supplemental payments) for services provided by physicians who were employed by group practices owned or operated by one of the three State academic health systems. The State agency provides supplemental payments to encourage physicians to provide health care to more Medicaid patients. The SPA was codified in the Texas Administrative Code. This is the first in a series of reports on the Texas physician supplemental payment program.

The State agency contracted with Public Consulting Group (PCG) to develop the supplemental payment program. PCG drafted the SPA; determined which physician group practices qualified for supplemental payments; and calculated the supplemental payments for the State agency until 2007, when the State agency began performing the calculations with assistance from PCG.

The University of North Texas Health Science Center (UNT), 1 of the 3 State academic health systems, provides health care services in more than 35 locations in Tarrant County, Texas. The State agency made \$8,332,388 (\$5,058,004 Federal share) in supplemental payments to UNT for Medicaid services provided between May 1, 2004, and September 30, 2007.

The SPA required the State agency to calculate an average commercial ratio (ratio) based on fees that commercial carriers would have paid for Medicaid physician services (commercial fees) and fees that Medicare would have paid for the same services (Medicare equivalent fees). Commercial fees and Medicare equivalent fees are typically higher than Medicaid fees. To calculate each quarterly supplemental payment made during Federal fiscal years 2004 through 2007, the ratio was multiplied by the total of all Medicare equivalent fees for Medicaid services provided during the quarter. This amount, less Medicaid payments already made for those services, was the supplemental payment.

### **OBJECTIVE**

Our objective was to determine whether the State agency calculated supplemental payments made to UNT in accordance with Federal and State requirements.

### **SUMMARY OF FINDINGS**

The State agency did not always calculate supplemental payments made to UNT in accordance

with Federal and State requirements. Specifically, the supplemental payment calculations included:

- overstated Medicare equivalent fees for claims that included diagnostic tests and Current Procedural Terminology code payment modifiers,
- Medicaid services that were performed by ineligible providers, and
- Medicaid services that did not have Medicare equivalent fees.

As a result, UNT received \$1,229,407 (\$746,461 Federal share) in unallowable supplemental payments.

The overpayments occurred because the State agency did not have any formal written policies and procedures to ensure that the methodology used to calculate supplemental payments was consistent with the terms of the SPA and complied with Federal and State requirements. According to a State agency official, PCG provided 6 months of hands-on training to a State agency rate analyst before the State agency assumed responsibility for calculating the supplemental payments. The official said that the rate analyst, who initially calculated the supplemental payments for the State agency, created a one-page document based on the training that PCG provided. That document contained only limited procedures for the calculation.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund to the Federal Government the \$746,461 Federal share of improper supplemental payments made to UNT and
- develop formal written policies and procedures to ensure that the supplemental payment calculations include only eligible services performed by eligible physicians and are performed in a manner that reduces the potential for errors.

## **STATE AGENCY COMMENTS AND OUR RESPONSE**

In written comments on our draft report, the State agency disagreed with two of our four findings, described the actions that it planned to take for three of those findings, and described the actions that it had already implemented for the other finding. Additionally, the State agency commented that it calculated supplemental payments with the methodology approved by CMS. However, the methodology the State agency used to calculate supplemental payments for our audit period was not in compliance with the SPA in effect during our audit period. Nothing in the State agency's comments caused us to change our findings or recommendations.

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# INTRODUCTION

## BACKGROUND

### Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Texas, the Health and Human Services Commission (State agency) administers the program.

### Supplemental Payments

CMS approved Texas State plan amendment 04-010 (SPA) on October 19, 2006, with an effective retroactive date of May 1, 2004. The SPA provided for quarterly physician supplemental payments (supplemental payments) for services provided by physicians who were employed by group practices owned or operated by one of the three State academic health systems.<sup>1</sup> The State agency provides supplemental payments to encourage physicians to provide health care to more Medicaid patients. This is the first in a series of reports on the Texas physician supplemental payment program.

### Public Consulting Group

The State agency contracted with Public Consulting Group (PCG) to develop the supplemental payment program. PCG drafted the SPA; determined which physician group practices qualified for supplemental payments; and calculated the supplemental payments for the State agency until 2007, when the State agency began performing the calculations with assistance from PCG.<sup>2</sup>

### University of North Texas Health Science Center

The University of North Texas Health Science Center (UNT), 1 of the 3 State academic health systems, provides health care services in more than 35 locations in Tarrant County, Texas. The State agency made \$8,332,388 (\$5,058,004 Federal share) in supplemental payments to UNT for Medicaid services provided from May 1, 2004, through September 30, 2007.

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<sup>1</sup> The State agency selected these three State academic health systems for supplemental payments because the doctors they employ serve a disproportionate share of Medicaid patients.

<sup>2</sup> Although PCG performed most of the supplemental payment calculations during our audit period, we use the term “State agency” when discussing supplemental payment calculations. The State agency is ultimately responsible for ensuring that supplemental payments are calculated correctly.

## Calculating Supplemental Payments

To calculate quarterly supplemental payments made for services provided by physicians performed from May 1, 2004, through September 30, 2007, the State agency was to:

- calculate an average commercial ratio (ratio) based on fees that commercial carriers would have paid for Medicaid physician services (commercial fees) and fees that Medicare would have paid for the same services (Medicare equivalent fees)<sup>3</sup> for Medicaid services provided during the base period (2005),
- calculate the aggregate of all of the Medicare equivalent payments for the Medicaid physician services performed during the quarterly payment period by multiplying Medicare fees by the number of times the services were performed,
- multiply the ratio by the aggregate of all of the Medicare equivalent payments, and
- subtract from that amount what Medicaid already had paid for the Medicaid physician services during the quarterly payment period to eligible physician group practices.<sup>4</sup>

## Current Procedural Terminology Codes

The SPA required the State agency to use the American Medical Association's Current Procedural Terminology (CPT) codes when determining fees for physician services across commercial, Medicare, and Medicaid fee schedules. CPT is a uniform coding system that identifies medical services performed by physicians and other health care professionals.<sup>5</sup>

## Current Procedural Terminology Code Modifiers

A CPT code modifier is a two-character (alpha and/or numeric) code that gives Medicare, Medicaid, and commercial payers additional information needed to process a claim. Physicians use claim modifiers to indicate that a special circumstance has altered a service or procedure without changing the code for that service or procedure. Some modifiers are informational only and do not affect reimbursement. Other modifiers will increase or decrease a physician's payment (payment modifiers).

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<sup>3</sup> See Appendix A for a detailed description of how the State agency calculated the ratio.

<sup>4</sup> See Appendix B for a detailed description of how the State agency calculated supplemental payments.

<sup>5</sup> The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2004-2007 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.

UNT used payment modifiers 22 (increased procedural services), 50 (bilateral surgery), 51 (multiple procedures),<sup>6</sup> 52 (reduced services),<sup>7</sup> 62 (cosurgeons), 80 and 82 (assistant at surgery services), AQ (physician service provided in an unlisted health professional shortage area), and QU (physician service provided in an urban health professional shortage area).<sup>8</sup>

## **Diagnostic Test Modifiers**

A diagnostic CPT code without any modifier indicates that the fee is for the “global” service, which includes both the professional and technical components of a diagnostic test. Providers add the modifier 26 or the modifier TC to diagnostic CPT codes on Medicare and Medicaid claims when only one component is claimed. Modifier 26 indicates that the fee is for the professional component of a diagnostic test, i.e., the physician’s interpretation of a test. Modifier TC indicates that the fee is for the technical component of a diagnostic test, i.e., the cost of the physician’s equipment, supplies, and personnel.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the State agency calculated supplemental payments made to UNT in accordance with Federal and State requirements.

### **Scope**

We reviewed \$8,332,388 (\$5,058,004 Federal share) in supplemental payments made to UNT for Medicaid CPT codes, or claim lines (services), provided from May 1, 2004, through September 30, 2007. For Texas Health Steps services, we could not verify whether the physicians who performed the services were eligible providers, so we selected a random sample for further review.<sup>9</sup> We did not review the overall internal control structure of the State agency. We limited our review to internal controls directly related to our objective.

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<sup>6</sup> Modifier 51 signals that the highest valued procedure is paid at 100 percent of the fee schedule and the second through fifth highest valued procedures are paid at 50 percent of the fee schedule. Because we could not determine the order of procedures, we recalculated payments with modifier 51 at 100 percent of the fee schedule.

<sup>7</sup> When providers use modifier 22 or 52, they must submit additional documentation to receive a payment adjustment. In determining the Medicare equivalent, we would have had no way to determine whether any incentive payment would have been made for these services. We used 100 percent of the Medicare fee schedule for claims with these modifiers.

<sup>8</sup> When providers amend services with modifier AQ or QU, they must submit additional documentation to receive a 10-percent incentive payment. In determining the Medicare equivalent, we would have had no way to determine whether any incentive payment would have been made for these services. We used 100 percent of the Medicare fee schedule for claims with these modifiers.

<sup>9</sup> The Texas Health Steps program provides medical and dental checkups to Medicaid beneficiaries from birth through 20 years old. The claim lines did not identify the individuals who performed the services.

We performed our fieldwork at the State agency and the Texas Medicaid and Healthcare Partnership (TMHP)<sup>10</sup> in Austin, Texas.

## Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- reviewed the Medicare fee schedules for our audit period;
- reviewed the *Texas Medicaid Provider Procedures Manuals* in effect during our audit period to understand claim processing requirements for Medicaid providers;
- reviewed the State agency's responses to our questions;
- reviewed written and electronic documents the State agency provided;
- interviewed personnel from CMS, the State agency, and PCG about procedures for calculating supplemental payments;
- obtained a list from UNT of all performing providers<sup>11</sup> whose services were included in the supplemental payment calculations;
- reviewed the list of providers to determine whether the services submitted for supplemental payments were performed by eligible physicians;
- obtained and reviewed the medical records that supported the Texas Health Steps sample claim lines to determine whether eligible providers performed the services;
- recalculated the ratio by:
  - obtaining the Medicaid Management Information System (MMIS) data that the State agency used to calculate the ratio,
  - identifying eligible Medicaid physician services,
  - matching commercial fees to eligible Medicaid services, and
  - matching Medicare fees to eligible Medicaid services;<sup>12</sup>

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<sup>10</sup> TMHP is a contractor that has processed Texas Medicaid claims since January 1, 2004.

<sup>11</sup> Performing providers included physicians, nonphysicians, and facilities.

<sup>12</sup> See Appendix A for more information on our ratio recalculations.

- recalculated the quarterly supplemental payments by:
  - obtaining the MMIS data that the State agency used to calculate quarterly supplemental payments,
  - identifying eligible Medicaid physician services (this step required us to add 1,846 eligible Medicaid services that the State agency had inadvertently omitted from its calculation), and
  - matching Medicare fees to eligible Medicaid services (this step required us to correct Medicare equivalent fees for 769 Medicaid services for which the State agency had used incorrect Medicare equivalent fees);<sup>13</sup> and
- discussed our preliminary findings with the State agency, UNT, and PCG.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## **FINDINGS AND RECOMMENDATIONS**

The State agency did not always calculate supplemental payments made to UNT in accordance with Federal and State requirements. Specifically, the supplemental payment calculations included:

- overstated Medicare equivalent fees for claims that included diagnostic tests and CPT code payment modifiers,
- Medicaid services that were performed by ineligible providers, and
- Medicaid services that did not have Medicare equivalent fees.

As a result, UNT received \$1,229,407 (\$746,461 Federal share) in unallowable supplemental payments.

The overpayments occurred because the State agency did not have any formal written policies and procedures to ensure that the methodology used to calculate the supplemental payments was consistent with the terms of the SPA and complied with Federal and State requirements.

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<sup>13</sup> See Appendix B for more information on our supplemental payment recalculations.

## OVERSTATED MEDICARE EQUIVALENT FEES

### Overstated Medicare Equivalent Fees for Diagnostic Tests

Section 1902(a)(30)(A) of the Social Security Act requires that Medicaid payments be “consistent with efficiency, economy and quality of care ....” Also, Office of Management and Budget Circular A-87 states: “A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost.” Sections e(2)-e(4) of the SPA required the State agency to make supplemental payments that were equal to the difference between the Medicare equivalent fees multiplied by the ratio and the Medicaid payments that already had been made.

The State agency used global service fees to calculate the Medicare equivalent fees for Medicaid physician services related to diagnostic tests even when Medicaid had paid for only the professional or the technical component of the services.<sup>14</sup> In most cases, the global service fee is substantially higher than the professional component fee and moderately higher than the technical component fee. In the following example, the State agency used the global service fee to calculate the Medicare equivalent fee, even though the Medicaid payment was only for the professional component fee.

**Table: Incorrect Use of Global Service Fee**

<b>Atherectomy, X-Ray Exam</b>	<b>Modifier</b>	<b>Medicare Fee 2005</b>	<b>Medicaid Fee 2005</b>
CPT code 75992	No modifier (global fee)	\$657	\$457
CPT code 75992	26 (Professional component)	29	23
CPT code 75992	TC (Technical component)	628	434

The State agency should have used the Medicare fee of \$29 for its supplemental payment calculations. Instead, it used the \$657 global service fee, which overstated the Medicare equivalent fee by \$628 (2,166 percent).

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<sup>14</sup> The State agency used diagnostic test modifier 26 for 2008 reconciliation payments that it made to UNT for services that UNT physicians performed in 2006. We factored the reconciliation payments into our supplemental payment recalculations.

## **Overstated Medicare Equivalent Fees for Current Procedural Code Payment Modifiers**

Chapter 12, section 20.4, of the *Medicare Claims Processing Manual* states that adjustments should be made to fees for services when there are multiple surgeries, bilateral surgeries, assistants at surgeries, or two surgeons or a surgical team. These situations require payment modifiers that adjust the fees for the services.

The State agency calculated Medicare equivalent fees for Medicaid physician services at 100 percent of the Medicare fee schedule even when the CPT codes were appended with payment modifiers.<sup>15</sup> For example:

- The State agency used 100 percent of the Medicare fee of \$1,326 for CPT code 35666, which had been appended with modifier 82. The State agency should have multiplied the Medicare fee by 16 percent, which would have yielded a \$212 Medicare equivalent payment. This error resulted in a Medicare equivalent overstatement of \$1,114.
- The State agency used 100 percent of the Medicare fee of \$468 for CPT code 49505, which had been appended with modifier 50. The State agency should have multiplied the Medicare fee by 150 percent, which would have yielded a \$702 Medicare equivalent payment. This error resulted in a Medicare equivalent understatement of \$234.

Additionally, the State agency should have adjusted fees for CPT codes appended with modifiers 62 and 80. For these modifiers, the State agency should have multiplied the Medicare fee by 62.5 percent and 16 percent, respectively.

The State agency overstated Medicare equivalent fees for diagnostic tests and claims that included CPT code payment modifiers because it did not have any formal written policies and procedures to ensure that the supplemental payments were calculated in accordance with the terms of the SPA. As a result, the State agency overstated supplemental payments by \$828,497 (\$503,034 Federal share).<sup>16</sup> See Appendix B for more information on the error's effect on supplemental payment calculations.

## **MEDICAID SERVICES PERFORMED BY INELIGIBLE PROVIDERS**

Sections e(1) and (2) of the SPA required that to be eligible for supplemental payments, services be rendered by physicians who were employed by group practices owned or operated by one of

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<sup>15</sup> The State agency used CPT code modifiers for 2008 reconciliation payments that it made to UNT for services that UNT physicians performed in 2006. We factored the reconciliation payments into our supplemental payment recalculations.

<sup>16</sup> This amount reflects the overstated supplemental payments for both the Medicare equivalent fees for diagnostic tests and Medicare equivalent fees for CPT code modifiers.

the three State academic health systems (eligible physicians).<sup>17</sup> Those sections of the SPA also specifically excluded services that contractors performed.

In calculating supplemental payments, the State agency included services performed by nonphysicians and contractors. The State agency made these errors because it did not have any formal written policies and procedures to ensure that it included in its supplemental payment calculations only services that eligible physicians provided.<sup>18</sup> As a result, the State agency overstated supplemental payments by \$431,082 (\$261,738 Federal share). See Appendix A for the error's effect on the ratio and Appendix B<sup>19</sup> for more information on the error's effect on supplemental payment calculations.

### **MEDICAID SERVICES THAT DID NOT HAVE MEDICARE EQUIVALENT FEES**

Section e(3)III of the SPA directed the State agency to calculate the ratio for each Medicaid physician service using a Medicare equivalent fee. Section e(4)(i) of the SPA directed the State agency to calculate supplemental payments for only those Medicaid physician services that had Medicare equivalent fees listed in the Medicare fee schedule.

The State agency included Medicaid physician services that did not have Medicare equivalent fees listed in the Medicare fee schedule. The State agency included these services because it did not have any formal written policies and procedures to ensure, in its supplemental payment calculations, that it included only physician services that had Medicare equivalent fees. As a result, the State agency understated supplemental payments by \$30,172 (\$18,311 Federal share). The State agency's inclusion of these services accounted for most of the overstatement of the ratio it computed (Appendix A). See Appendix B for more information on the error's effect on supplemental payment calculations.

### **THE STATE AGENCY LACKED FORMAL WRITTEN POLICIES AND PROCEDURES**

The overpayments occurred because the State agency did not have any formal written policies and procedures to ensure that the methodology used to calculate the supplemental payments was consistent with the terms of the SPA and complied with Federal and State requirements. According to a State agency official, PCG provided 6 months of hands-on training to a State agency rate analyst before the State agency assumed responsibility for calculating the supplemental payments. The official said that the rate analyst, who initially calculated the

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<sup>17</sup> Section e(1) of the SPA says that "... supplemental payments are available ... to physicians who are recognized as essential to the Texas State Medicaid program. To be identified as an essential physician and qualify for a supplemental payment, the physician must be ... [a] Texas licensed physician ... and ... [e]mployed by an eligible physician group practice that is state-owned or operated."

<sup>18</sup> In our sample of 100 Texas Health Steps services, we did not have a sufficient number of errors to estimate an overpayment. As a result, all Texas Health Steps services will remain in the supplemental payment calculation.

<sup>19</sup> Tables 3 and 5 in Appendix B represent separate steps we took to identify Medicaid services performed by ineligible providers and are combined in the report under the heading "Medicaid Services Performed by Ineligible Providers."

supplemental payments for the State agency, created a one-page document based on the training that PCG provided. That document contained only limited procedures for the calculation.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund to the Federal Government the \$746,461 Federal share of improper supplemental payments made to UNT and
- develop formal written policies and procedures to ensure that the supplemental payment calculations include only eligible services performed by eligible physicians and are performed in a manner that reduces the potential for errors.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the State agency disagreed with two of our four findings, described the actions that it planned to take for three of those findings, and described the actions that it had already implemented for the other finding. Additionally, the State agency commented that it calculated supplemental payments with the methodology approved by CMS. However, the methodology the State agency used to calculate supplemental payments for our audit period was not in compliance with the SPA in effect during our audit period. The State agency's comments are included in their entirety as Appendix C. Nothing in the State agency's comments caused us to change our findings or recommendations.

### **Overstated Medicare Equivalent Fees for Diagnostic Tests and Current Procedural Code Payment Modifiers**

#### *State Agency Comments*

The State agency disagreed with this finding, stating that it had calculated supplemental payments to physician groups affiliated with the University of North Texas in accordance with the methodology approved by CMS. The State agency added that it would work with CMS to develop how to best resolve this issue.

#### *Office of Inspector General Response*

The State agency did not present any facts or analysis to show that calculating Medicare equivalent fees for diagnostic tests using global fees when those diagnostic tests were billed to and paid by Medicaid using Modifier 26 or TC was in accordance with SPA 04-010. Moreover, the State agency did not present any facts or analysis to show that calculating Medicare equivalent fees for certain services without modifiers when those procedures were billed to and paid by Medicaid using modifiers was in accordance with SPA 04-010. The State agency did not show how a global fee was "equivalent" to either the professional component *or* technical component, or how an unmodified fee was "equivalent" to a modified fee. In addition, the State agency did not present any facts to show how or when CMS approved (a) calculating Medicare

equivalent fees for diagnostic tests using global fees when those diagnostic tests were billed to and paid by Medicaid using Modifier 26 or TC or (b) calculating Medicare equivalent fees for certain services without modifiers when those services were billed to and paid by Medicaid using modifiers. Finally, the State agency did not present any facts or analysis to show that our calculations were not in accordance with SPA 04-010.

Sections e(4)(i) and (ii) of SPA 04-010 required that the State agency make supplemental payments that were equal to the difference between the Medicare equivalent fees multiplied by the ratio and the Medicaid payments that had already been made. When a Medicaid payment was for either the professional or the technical component of a diagnostic test, the Medicare equivalent fee also should have been for either the professional or the technical component of the diagnostic test, not both. The State agency's use of global service fees to determine Medicare equivalent fees for diagnostic tests did not comply with sections e(4)(i) and (ii) of SPA 04-010 because providers received supplemental payments for services that were not included in the Medicaid payments that had already been made. Additionally, the State agency deleted all current procedural code payment modifiers from its supplemental payment calculations. Therefore, the Medicare equivalent payments the State agency calculated for Medicaid services appended with payment modifiers were not correct.

### **Medicaid Services Performed by Ineligible Providers**

#### *State Agency Comments*

The State agency agreed that services performed by ineligible providers should not be included in supplemental payment calculations. The State agency said that it would work with UNT to determine whether any ineligible providers were included in the physician supplemental payment calculations and would refund the Federal share of any physician supplemental payments that did not meet applicable requirements.

### **Medicaid Services That Did Not Have Medicare Equivalent Fees**

#### *State Agency Comments*

The State agency disagreed with this finding, stating that there are Medicaid and commercial insurance program physician services involving, but not limited to, children and newborns, which are not services specifically outlined in the Medicare fee schedule. The State agency said that it is appropriate to include these services in the calculation of average commercial rates and physician supplemental payments. The State agency added that it would work with CMS to develop how to best resolve this issue.

#### *Office of Inspector General Response*

Including Medicaid services that did not have Medicare fees listed in the Medicare fee schedule was not appropriate, and the State agency did not present any facts or analysis to show that doing so was appropriate and in accordance with SPA 04-010. Section e(4)(ii) of SPA 04-010 states: "Medicaid volume [i.e., the number of times a service is performed] and payments shall include all available payments and adjustments." However, sections e(3)III and e(4)(i) of SPA

04-010 directed the State agency to calculate the ratio using Medicare equivalent fees and to calculate supplemental payments for only those Medicaid physician services that had Medicare fees listed in the Medicare fee schedule. The State agency could not calculate Medicare equivalent fees for physician Medicaid services that did not have fees listed in the Medicare fee schedule. Thus, the State agency should not have included those services in the ratio or the quarterly supplemental payment calculations.

### **The State Agency Lacked Formal Written Policies and Procedures**

#### *State Agency Comments*

The State agency stated that after CMS approved the revised methodology included in SPA 04-029 on April 21, 2008, it implemented detailed procedures for ensuring that only services performed by eligible providers were included in physician supplemental payment calculations. In addition, the State agency said that it had implemented a second-level review of all physician supplemental payment calculations, Medicare fee schedules, and other calculations to ensure that calculations were correct and consistent with Federal and State rules and regulations.

#### *Office of Inspector General Response*

We did not base our findings on SPA 04-029. The State may have implemented new detailed policies and procedures for ensuring that only services provided by eligible providers were included in 2008 physician supplemental payment calculations and a second-level review to ensure that calculations were correct and consistent with Federal and State rules and regulations. However, these actions are outside the scope of our review, which was based on policies set forth in SPA 04-010.

# **APPENDIXES**

## APPENDIX A: ORIGINAL AND RECALCULATED RATIOS<sup>1</sup>

The State agency calculated an average commercial ratio (ratio) using fiscal year 2005 data from the Medicaid Management Information System using the following methodology. For each Current Procedural Terminology (CPT) code:

- Number of times the Medicaid service was provided × average commercial fee<sup>2</sup>  
(these amounts were aggregated to determine the numerator in the formula below).
- Number of times the Medicaid service was provided × Medicare equivalent fee<sup>3</sup>  
(these amounts were aggregated to determine the denominator in the formula below).

$$\frac{\text{Aggregated average commercial payments}}{\text{Aggregated average Medicare equivalent payments}} = \text{ratio} \quad \text{or} \quad \frac{\$1,698,249}{\$1,453,121} = 116.8691\%$$

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To recalculate the ratio, we made the following adjustments:

1. We removed Medicaid services performed by an ineligible provider (Ph.D.), who we identified by reviewing the University of North Texas's (UNT) personnel listing.

$$\frac{\$1,697,840}{\$1,452,770} = 116.8692\%$$

2. We removed Medicaid services that did not have Medicare equivalent fees.<sup>4</sup>

$$\frac{\$1,689,983}{\$1,452,770} = 116.3283\%$$

3. We removed Medicaid services that had CPT code modifiers SA or U7, which indicate that ineligible providers (nonphysicians) performed the services.

$$\frac{\$1,607,943}{\$1,382,598} = 116.2987\%$$

We used 116.2987 percent as the ratio in our recalculation of the supplemental payments made to UNT.

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<sup>1</sup> For presentation purposes, we rounded dollar amounts to the nearest dollar and ratios to four decimal places.

<sup>2</sup> According to a State agency official, the average commercial fees are proprietary. Therefore, we could not independently verify their accuracy.

<sup>3</sup> We verified the Medicare equivalent fees that the State agency provided us. We did not consider any modifiers for these fees because the State agency did not provide us with the effect of the modifiers on the commercial fees.

<sup>4</sup> Removing services that had no Medicare equivalent fees left the denominator unchanged.

## APPENDIX B: ORIGINAL AND RECALCULATED SUPPLEMENTAL PAYMENTS<sup>1</sup>

**Table 1: State-Agency-Calculated Supplemental Payment**

Medicare Equivalent Fees	Ratio	Medicare Equivalent Fees × Ratio	Less What Medicaid Already Paid	= Supplemental Payment
\$14,505,869	116.87% <sup>2</sup>	\$16,952,881	\$8,620,493	\$8,332,388

To recalculate the supplemental payment as shown below, we corrected the errors. In addition, we used the corrected ratio shown in Appendix A.<sup>3</sup>

**Table 2: Overstated Medicare Equivalent Fees**

We used the Medicare equivalent fees that corresponded with the modifiers used for diagnostic services rather than the global fees that the State agency had incorrectly used, and we used the payment modifiers that the State agency had incorrectly omitted.

Medicare Equivalent Fees	Recalculated Ratio	Medicare Equivalent Fees × Ratio	Less What Medicaid Already Paid	= Supplemental Payment	Supplemental Payment (Decrease) or Increase
\$13,864,632	116.30%	\$16,124,384	\$8,620,493	\$7,503,891	(\$828,497)

**Table 3: Medicaid Services Performed by Ineligible Providers**

We identified ineligible providers by reviewing UNT's personnel directory. We determined whether the providers were physicians or nonphysicians and whether they were employees or contractors. We removed the ineligible providers.

Medicare Equivalent Fees	Recalculated Ratio	Medicare Equivalent Fees × Ratio	Less What Medicaid Already Paid	= Supplemental Payment	Supplemental Payment (Decrease) or Increase
\$13,555,829	116.30%	\$15,765,250	\$8,471,417	\$7,293,833	(\$210,058)

<sup>1</sup> For presentation purposes, we rounded dollar amounts to the nearest dollar and ratios to two decimal places.

<sup>2</sup> The actual ratio used by the State agency in the original payment calculations was 116.86912 percent.

<sup>3</sup> The actual ratio used in the payment recalculations was 116.29868 percent.

**Table 4: Medicaid Services That Did Not Have Medicare Equivalent Fees**

When we removed Medicaid physician services that did not have Medicare equivalent fees, supplemental payments increased because what Medicaid already had paid was reduced.<sup>4</sup>

<b>Medicare Equivalent Fees</b>	<b>Recalculated Ratio</b>	<b>Medicare Equivalent Fees × Ratio</b>	<b>Less What Medicaid Already Paid</b>	<b>= Supplemental Payment</b>	<b>Supplemental Payment (Decrease) or Increase</b>
\$13,555,829	116.30%	\$15,765,250	\$8,441,245	\$7,324,005	\$30,172

**Table 5: Medicaid Services Performed by Ineligible Providers**

After reviewing UNT’s personnel directory to identify services performed by nonphysicians and contractors, we identified and removed additional services performed by nonphysicians by reviewing data from the Medicaid Management Information System and identifying services that had modifiers SA and U7. These modifiers indicate that nonphysicians had provided the services. On the basis of UNT’s directory alone, we could not determine whether these providers were nonphysicians because nonphysicians in Texas are sometimes allowed to use physician provider numbers for billing purposes.

<b>Medicare Equivalent Fees</b>	<b>Recalculated Ratio</b>	<b>Medicare Equivalent Fees × Ratio</b>	<b>Less What Medicaid Already Paid</b>	<b>= Supplemental Payment</b>	<b>Supplemental Payment (Decrease) or Increase</b>
\$13,207,332	116.30%	\$15,359,953	\$8,256,972	\$7,102,981	(\$221,024)

Total questioned costs: \$1,229,407 (\$746,461 Federal share).

<sup>4</sup> The underpayment was offset by the error’s effect on the ratio. Removing these services accounted for most of the 0.5704-percent ratio reduction.

APPENDIX C: STATE AGENCY COMMENTS



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANCK, M.D.  
EXECUTIVE COMMISSIONER

May 30, 2014

Ms. Patricia Wheeler  
Regional Inspector General for Audit Services  
Office of Inspector General, Office of Audit Services  
1100 Commerce, Room 632  
Dallas, Texas 75242

Reference Report Number A-06-10-00082

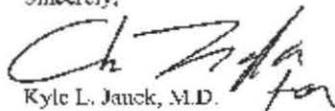
Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Review of Physician Supplemental Payments Made to the University of North Texas" from the Department of Health and Human Services Office of Inspector General. The cover letter, dated March 31, 2014, requested that HHSC provide written comments, including the status of actions taken or planned in response to report recommendations.

I appreciate the opportunity to respond. Please find the attached HHSC management response which (a) includes comments related to the content of the findings and recommendations, and (b) details actions HHSC has completed or planned.

If you have any questions or require additional information, please contact David Griffith, Director of IHS Risk and Compliance Management. Mr. Griffith may be reached by telephone at (512) 424-6998 or by e-mail at [David.Griffith@hhsc.state.tx.us](mailto:David.Griffith@hhsc.state.tx.us).

Sincerely,

  
Kyle L. Janck, M.D.

Texas Health and Human Services Commission  
Management Response to the  
U.S. Department of Health and Human Services Office of Inspector General Report:

**Review of Physician Supplemental Payments  
Made to the University of North Texas**

**Summary of Management Response**

HHSC disagrees with Department of Health and Human Services (DHHS) Office of Inspector General (OIG) findings that suggest supplemental payments related to (a) Medicare equivalent fees for diagnostic tests payment modifiers and (b) no corresponding published Medicare fee or code, were not calculated in accordance with state and federal requirements in effect during the period examined during this audit. In addition, HHSC disagrees with the DHHS OIG finding that Medicaid services without Medicare equivalent fees should have been excluded from the calculation of the University of North Texas average commercial rate.

HHSC calculated supplemental payments to physician groups affiliated with the University of North Texas in accordance with the methodology approved by the Centers for Medicare and Medicaid Services (CMS) after an extensive, thorough, and transparent review process extending for a period of over two years. During this review process, CMS reviewed each component of the proposed supplemental payment methodology, developed by HHSC's contractor the Public Consulting Group (PCG), including methodologies for (a) supplemental payments related to Medicare equivalent fees, (b) global service fees, and (c) calculation of the average commercial rate, and approved the resulting state plan amendment.

DHHS OIG is currently performing similar audits of supplemental payments HHSC made to University of Texas System and Texas Tech System hospitals as part of a series of audits on the Texas physician supplemental payment program. Since payment calculations for each of the university systems still being audited followed the same approved payment methodologies and timeframes as payments to the University of North Texas, HHSC is concerned that audit results for the other systems being audited will have results similar to those presented in this draft report.

HHSC will work with CMS to develop how to best resolve these issues, with the goal of reaching a reasonable resolution shortly after the remaining DHHS OIG audits are completed.

In addition, HHSC will coordinate with the University of North Texas to make a final determination of whether ineligible providers were included in the physician supplemental payment calculation, and refund the federal share of any physician supplemental payments that did not meet applicable requirements.

Detailed responses to each of the recommendations included in the report follow.

HHSC Management Response Review of Physician Supplemental Payments - UNT  
May 30, 2014  
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**DHHS - OIG Recommendation:** *We recommend that the State agency refund to the Federal Government the \$746,461 Federal share of improper supplemental payments made to UNT.*

**HHSC Management Response:**

Overstated Medicare Equivalent Fees for Diagnostic Tests and Current Procedural Code Payment Modifiers

(Audit reported that the federal share of overstated payments was \$503,034)

HHSC disagrees with this finding because it calculated supplemental payments to physician groups affiliated with the University of North Texas in accordance with the methodology approved by CMS. HHSC will work with CMS to develop how to best resolve this issue, with the goal of reaching a reasonable resolution shortly after the remaining DHHS OIG audits are completed.

**Title of Responsible Person:**

Deputy Executive Commissioner for Financial Services

Medicaid Services Performed by Ineligible Providers

(Audit reported that the federal share of overstated payments was \$261,738)

HHSC relies upon the University of North Texas and other physician groups to identify providers eligible for physician supplemental payments. If any ineligible providers were included, HHSC agrees these providers should not be considered in the University of North Texas's supplemental payment calculation.

HHSC has implemented additional safeguards to identify and prevent prospective errors, including requiring hospitals to certify the list of eligible providers for inclusion in the supplemental payment calculation each quarter.

**Actions Planned**

HHSC will work with the University of North Texas to determine whether any ineligible providers were included in the physician supplemental payment calculations. Once a determination is reached, HHSC will refund the federal share of any physician supplemental payments that did not meet applicable requirements.

**Title of Responsible Person**

Deputy Executive Commissioner for Financial Services

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Medicaid Services that Did Not Have Medicare Equivalent Fees

(Audit stated that the federal share of understated payments was \$18,311)

HHSC disagrees with this finding. There are Medicaid and commercial insurance program physician services involving, but not limited to, children and newborns, which are not services specifically outlined in the Medicare fee schedule. In these instances, it is appropriate to include Medicaid services in the calculation of average commercial rates and physician supplemental payments.

HHSC will work with CMS to develop how to best resolve this issue, with the goal of reaching a reasonable resolution shortly after the remaining DHHS OIG audits are completed.

**Title of Responsible Person**

Deputy Executive Commissioner for Financial Services

**DHHS - OIG Recommendation:** *We recommend that the State agency develop formal written policies and procedures to ensure that the supplemental payment calculations include only eligible services performed by eligible physicians and are performed in a manner that reduces the potential for errors.*

**HHSC Management Response:**

After CMS approved the revised methodology included in SPA 04-029 on April 21, 2008, HHSC implemented detailed procedures for ensuring that only services performed by eligible providers were included in physician supplemental payment calculations. In addition, HHSC implemented a second level review of all physician supplemental payment calculations, Medicare fee schedules, and other calculations to ensure calculations are correct and consistent with federal and state rules and regulations.

**Title of Responsible Person**

Director, Rate Analysis Department