**New York State Office of the State Comptroller**
Thomas P. DiNapoli

Division of State Government Accountability

# Payments for Inmate Health Care Services

# Department of Corrections and Community Supervision

Report 2010-S-41 December 2012

# Executive Summary

## Purpose

To determine if the Department paid health care providers the correct rate for only appropriate and authorized medical services that were actually provided to inmates for the two years ended March 31, 2010.

## Background

The Department is responsible for providing inmates with health care that is consistent with a level of care that would be received in the community. The Department contracts with outside health care providers for certain emergency, inpatient, and outpatient services. Such services are initiated by a referral from facility medical staff. The Department paid approximately $230 million to outside medical providers for the two years ended March 31, 2010.

## Key Findings

- Medical services to inmates were authorized and, with few exceptions, were provided to inmates.
- Medical care providers were not always paid correctly and overpayments resulted. For example, five providers were overpaid $84,053 in connection with 141 sampled claims where hours billed exceeded hours worked.
- The State could save an estimated $20 million annually if the Department billed Medicaid for eligible inmates inpatient care.

## Key Recommendations

- Review the providers identified by this audit as overcharging the Department for hourly clinical services, medical procedures, and mileage. Collect overpayments made to those providers.
- Seek reimbursement from Medicaid or other third party insurance for medical services from outside providers when appropriate.

## Other Related Audits/Reports of Interest

Department of Health: Medicaid Claims Processing Activity April 1, 2010 through September 30, 2010 (2010-S-15)

# State of New York
# Office of the State Comptroller

## Division of State Government Accountability

December 5, 2012

Mr. Brian Fischer
Commissioner
Department of Corrections and Community Supervision
State Campus Building 2
1220 Washington Avenue
Albany, New York 12226-2050

Dear Mr. Fischer:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of *Payments for Inmate Health Care Services.* This audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

*Office of the State Comptroller*
*Division of State Government Accountability*

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**State Government Accountability Contact Information:**
**Audit Director:** Carmen Maldonado
**Phone:** (212) 417-5200
**Email:** StateGovernmentAccountability@osc.state.ny.us
**Address:**
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236


This report is also available on our website at: www.osc.state.ny.us

# Background

The Department of Corrections and Community Supervision (Department) is responsible for providing inmates with health care that is consistent with a level of care that would be received in the community. The Department's Health Services Program (Health Services) oversees the delivery of health services. Department officials indicated that inmates often have significant health care needs when they enter Department facilities. Medical staff at each facility is the primary service providers. The Department also contracts with outside health care providers for specialist services and certain testing and treatments such as remote electrocardiogram readings and clinical laboratory services. The Department has agreements with over 1,300 providers. The providers treat inmates in correctional facilities or at external locations such as hospitals or other medical facilities.

The payments that the Department makes to providers are based on negotiated rates which are typically based on an agreed upon percentage above the Medicaid or Medicare rates. Most providers have a written agreement with the department to stipulate payment rates. When there is no provider agreement, the Department pays based on the Medicaid rate.

Facility medical staff initiates all medical services with outside providers with a referral. The Department uses an automated information system (FHS-1) to track inmate healthcare services. FHS-1 allows Department workers to track inmate medical referrals, treatment scheduling, treatment disposition, and the payment of providers' medical bills.

The Department contracts with a vendor, APS Healthcare Bethesda, Inc. (APS), to review referrals for appropriateness, conformance with Department Practice Guidelines, the community standard of care, and medical necessity. APS does not review certain routine services, such as for work release inmates and children of inmates born during the mothers' incarceration. Referrals for these services are submitted to Health Services for review and approval.

Since peaking at nearly 71,600 in 1999, the State's inmate population has declined by 20 percent to about 57,000 inmates as of March 2011. Despite this decrease in population total medical costs for inmates have nearly doubled from $185 million in fiscal 1999-00 to a projected $360 million in 2010-11. Contractual payments for health services have increased from about $67 million to about $134 million during the same period. According to the State Accounting System, the Department paid a total of approximately $230 million to outside medical vendors from April 1, 2008 to March 31, 2010. Department officials replied to our draft report that the increased costs from 1999-2000 to 2010-2011 are significant changes in union negotiated salaries; consumer price index for medical services and the Department opened two new Regional Medical Units.

# Audit Findings and Recommendations

## Accuracy of Inmate Health Care Service Payments

Health care service providers should only be paid for authorized services provided to inmates. We found that the Department generally ensures that inmates are seen by the medical provider, that the visit was authorized, and that the appropriate rate is paid. The Department's Medical Bill Payment Unit receives and reviews the claim forms to determine if they are complete and mathematically accurate, if the patient is a Department inmate at the time of service, and if the correct rate is charged. Despite these controls we found that certain providers overcharged the Department $88,187 for hourly clinics and medical procedures. Subsequent to our review, the Department and APS reviewed additional claims and identified about $173,300 more in overcharges. We also found weaknesses in the FHS-1 system that limits its usefulness to monitor payments for potential inappropriate billings.

### *Hourly Clinics*

Hourly clinic service providers should be paid for the number of hours worked, unless the contract specifies a minimum charge. The Medical Bill Payment Unit (Unit) authorizes payment for clinic claims when the number of hours claimed by the provider agrees with the scheduled hours in the FHS-1 system. However, the Unit does not verify if the hours billed by the providers are accurate.

We sampled 430 clinical claims and compared the hours the providers were at the facilities to the hours billed. We found that five providers were overpaid $84,053 because they billed for more hours than they were actually present at 141 of the 430 clinics. The resulting overpayments to the five providers ranged from $624 to $73,347. Subsequent to our review, the Department reviewed additional provider claims and identified more overcharges. The Department reports that it has recovered $78,966 and is in the process of recovering $46,133 over the next year. Also, Department officials told us they have taken steps to determine if all new claims reflect the appropriate hours. We believe that the Department ought to further sample and review paid provider claims to determine if additional overpayments should be recovered.

### *Double Billing*

We reviewed a sample of 45 claims totaling $711,829 for nine of the highest paid health care service providers. We found that the Department paid two claims from two providers totaling $4,134 for procedures billed for twice. We referred these cases to the Department for review and recoupment.

In addition, our analysis of FHS-1 data identified procedure codes that were incorrectly billed twice. In some cases, it is appropriate for two claims to be submitted for a procedure: one claim for the technical component of the procedure, and a second claim for the professional component. In such cases, a special billing code called a "modifier" is used for the professional component of the procedure. However, in other instances, the technical and professional components are both paid

in one fee, so the components should not be billed separately. For example, we identified 424 instances where the Department overpaid $32,708 in separate fees that were already included in the payments for the primary procedures. The Department needs to further examine the FHS-1 data to determine whether there are other similar situations where overpayments could occur.

One reason why such double payments are not detected is that the Department does not have a system to compare services claimed on Health Insurance Claim Forms (HICF) with Uniform Billing (UB). UBs are claim forms used for inpatient or outpatient services provided in a hospital. HICFs are claim forms used by physicians for outpatient services generally done at the provider's office. When services are billed on a UB and a HICF for the same date for the same inmate, there is a risk of double billing. The Medical Bill Payment Unit assumes that all such cases are correct and does not check the appropriateness based on the procedure codes.

We also found all potential cases of double billing cannot be identified using the FHS-1 data. One reason is that the FHS-1 does not contain all procedure codes that the Department pays for. The UB form holds up to 22 procedure codes, but FHS-1 only has space to enter four procedure codes per claim form. Another reason is there are no guidelines on which procedure codes to enter in FHS-1 and the Medical Bill Payment Unit staff are not trained in which codes are the most important to enter when there are more than four. For example, one UB claim reviewed had 22 procedure codes for $19,591. FHS-1 contained only three lab service procedure codes for about $63 and omitted 19 procedure codes including a heart catheterization procedure for $17,613.

Another limitation of FHS-1 is that modifiers designating second claims for the same service cannot be entered. When FHS-1 shows a HICF and a UB claim for the same procedure code, on the same date for the same inmate, it is not clear if a second claim was appropriate. Therefore, the actual claims must be obtained to see if a modifier was on the claim form for a procedure code for which billing two separate claims is appropriate.

In addition, APS uses the data within FHS-1 to determine which codes they are going to audit. Because FHS-1 does not contain all procedures, APS may not be selecting some procedures and claims for audit that it would have selected with complete information.

The limitations of FHS-1 severely reduce its usefulness as a tool to analyze medical claim payments, to identify double billing, and other inappropriate billing practices such as double billing, upcoding, and unbundling. Upcoding is a practice of billing for a service that pays more than the service that was necessary or actually provided. Unbundling is a practice of billing parts of a procedure under multiple codes that should be billed under one all-inclusive procedure code.

## Recommendations

1. Collect overpayments made to providers cited in this audit.

2. Test samples of future payments to service providers to determine if recovery for overcharges is necessary.

3. Review claims to determine if procedure codes are being inappropriately separated resulting in overcharges.

4. Verify that the actual hours worked in connection with clinic services agree with the hours billed and paid for.

5. Research alternatives to electronically capture all procedure codes and modifiers on paid claims for analysis of billing accuracy and appropriateness.

## Health Service Payment Standards

Healthcare payers generally set up billing standards for various procedures. For example, Medicaid and Medicare each have group rates for multiple procedures that are typically performed at the same time. The group rates are lower than paying for each test separately. Medicaid, Medicare, and other insurers also have thresholds to ensure paid services are appropriate and do not exceed a reasonable standard of care. For example, arthroscopic knee surgery is normally limited to four procedures in a lifetime by Medicaid.

We found that the Department has not established such a system of standards to monitor the services billed for each inmate over time by outside service providers. This reduces the Department's ability to identify inaccurate bills, incompatible services, or unnecessary services.

The Department stresses that the medical necessity of all referrals is verified when the referral is approved which negates the need for a system of standards. We agree that the approval process for each referral is a good control. However, applying a system of standards would better permit the department to detect patterns of improper billing that result in overpayments.

### *Incompatible Codes and Services*

Our analysis of the highest paid health care providers identified potential overpayments of $16,078 on combinations of procedures that typically would not be paid for together. For example, on six occasions the Department paid for multiple balloon angioplasties or stenting procedures on the same patient in the same vein on the same day. Also, the Department paid for both basic and comprehensive blood tests for the same inmate on the same day on 30 occasions. In these instances, Medicaid standards dictate that one procedure be charged.

Subsequent to our test results, APS performed a limited review of procedure codes billed for the period April 1, 2010 to October 31, 2010. APS found 109 inappropriate claims for combinations of procedures that should not be billed together. APS had not previously conducted such reviews. The Department overpaid approximately $107,000 for the 109 claims even though they were approved by the Department and APS.

### *High Frequency Services*

We analyzed the FHS-1 data for a sample of 23 procedures for which Medicaid has set frequency standards (we used Medicaid in the absence of Department standards), to determine if providers billed for the same service for an inmate a high number of times during a given period of time. The services may have been provided by one or more providers. Our analysis identified 64 inmates that received at least one service in excess of the thresholds set by Medicaid. Some examples include:

- Blood tests for 23 different inmates between nine and 40 times over a two year period compared to the Medicaid standard of four times per year.
- Six knee surgeries for one inmate over a two year period; Medicaid allows up to four such surgeries in a lifetime.
- An eye procedure nine times for one inmate over a two year period; the Medicaid standard is up to four times in a lifetime.
- Multiple follow-up exams for inmates receiving inpatient care when these exams are limited to one per day by Medicaid. We were unable to quantify the full extent this billing occurred because the Department staff did not record the specific date of service for each procedure during an inpatient stay at the hospital. Instead, they recorded the first or last date of the hospital stay as the date of service for each procedure performed.

The cases we identified could represent potential problems such as billing errors, duplication of services, or lack of coordination of services by different providers that should be reviewed by the Department or APS for accuracy and reasonableness. Therefore, the use of standards for services billed for an inmate during a period of time could enable the Department to identify outlier cases for further review to assess whether the claims are accurate and services were appropriate.

### *Unsuccessful Procedures*

We reviewed the provider billing for two procedure codes for stenting and two procedure codes for angioplasty. Our analysis showed the Department paid at least $32,312 for those procedures. Department officials stated they must pay for unsuccessful procedures because the provider agreements require the Department to pay for all procedures performed. However, other major healthcare payers do not pay for unsuccessful procedures. We believe the Department should amend its agreements to require payment only for successful procedures, and not pay for unsuccessful procedures from providers without agreements. Further, not all providers have agreements with the Department so it should not have to pay for unsuccessful procedures by these providers.

## Recommendations

6. Establish and use billing standards for periodic analysis of historical paid claims data to identify indications of inaccurate bills, incompatible services and unusually high levels of a service for an inmate. Follow-up on such instances to assess their appropriateness.

7. Amend the current provider agreements to require the Department to pay only for successful procedures.

## Potential Third Party Insurance Coverage

The Department does not have a system to identify and track whether inmates have other potential sources of health insurance coverage for services received from outside providers. We reviewed the medical billing process at five work release facilities. Four of the facilities told us inmate healthcare costs may be paid by insurance through a spouse, a work release employer, or by workers compensation for injuries on the job. However, the facilities vary in whether they attempt to identify other health insurance sources. Two facilities actively sought out, and identified, alternative sources of inmate healthcare coverage. The remaining three facilities did not track opportunities for third party coverage. Consequently, the Department is not always checking for additional healthcare coverage unless an inmate volunteers such information.

Department officials told us there is no statute specifically allowing them to seek payments from outside insurances. They also indicate that the number of inmates with other insurance is unlikely to be significant because 75 percent of inmates are not married, and only one percent of inmates are in work release and are employed. They also raised other concerns including the potential cost to identify and track other insurance, and the additional security and transportation expense that may arise if inmates with insurance opt to see their own doctors covered under their insurance policies. Therefore, the Department's policy is to pay for the health care for all inmates.

Department officials also told us that they are in the midst of seeking Medicaid coverage for inpatient care. Federal Medicaid rules allow states to bill Medicaid for inpatient services received by Medicaid eligible inmates. Five states including Louisiana, Mississippi, Nebraska, Oklahoma, and Washington charge eligible inmate inpatient health care to Medicaid according to a report by North Carolina's State Auditor. During our audit period over $89 million paid to outside health care providers was for inpatient services. Billing Medicaid for eligible inmate health care costs could potentially reduce the Department's costs for such care. We estimate the State could save about $20 million annually if the Department billed Medicaid for eligible inmate inpatient care. Therefore, we encourage the Department to continue to explore obtaining Medicaid coverage. In response, the Department indicates that in cooperation with the Division of the Budget and Department of Health reimbursement of over $4.5 million has already been received from the federal government.

## Recommendation

8. Seek reimbursement from Medicaid or other third party insurance for medical services from outside providers when appropriate.

# Audit Scope and Methodology

The objective of our audit was to determine if the Department pays health care providers the correct rate for only appropriate and authorized medical services that were actually provided to inmates. Our audit scope period was from April 1, 2008 through March 31, 2010.

To achieve our objective we interviewed Department staff, reviewed Department policies and procedures related to inmate healthcare, examined Department provider agreements, and reviewed selected provider claims for payment. We obtained a download of FHS-1 system data for all services provided by outside vendors from April 1, 2008 through March 31, 2010. We used computerized audit tools and specialized queries to analyze the data for indications of inaccurate bills, incompatible services, or unnecessary services. We also obtained information on Medicaid and Medicare guidelines and standards related to allowable service billings and service frequencies.

We judgmentally selected nine outside providers and reviewed five claims for each provider to determine if paid claims were appropriate and accurately calculated. Our selection included providers that received high total payments and a mix of different types of medical service providers. Our review identified billings for certain procedure codes that are generally considered incompatible in the medical insurance industry. We subsequently expanded our analysis of the FHS-1 data to identify whether providers billed for these incompatible codes. We also analyzed FHS-1 data to determine the quantity and types of services received by individual inmates and whether the services exceeded the quantity and types of services that would be covered by Medicaid.

We judgmentally selected nine of 39 providers paid a set fee per hour to perform clinics. (A clinic is a block of consecutively scheduled appointments with a provider specializing in a particular field. A clinic can be held in a correctional facility or outside medical facility.) We selected the nine providers based on geographic location, type of service, and the cost of service provided. We reviewed five claims for each provider and based on the test results we reviewed additional claims for two providers. In total, we tested 430 hourly clinic claims totaling approximately $361,868 at eight correctional facilities. We also tested a sample of 25 claims totaling $16,065 from five ambulance providers out of a population of 6,347 claims totaling about $3.6 million. We judgmentally selected the five providers based on the amount of total payments during our audit period. We also reviewed the credentials for all 436 individual providers and 25 of the 874 group providers to determine if they were licensed and registered, and found they were all licensed health care providers.

We conducted our 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.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

# Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

# Reporting Requirements

A draft copy of this report was provided to Department officials for their review and comment. Their comments were considered in preparing this final report and are attached in their entirety to the end of this report. State Comptroller's comments to their response, are also attached at the end of this report.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Corrections and Community Supervision shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

# Contributors to This Report

**Carmen Maldonado,** Audit Director
**Steve Goss,** Audit Manager
**Mark Ren,** Audit Supervisor
**Brandon Ogden,** Examiner-in-Charge
**Gayle Clas,** Staff Examiner
**Stanley Goodman,** Staff Examiner
**Robert Horn,** Staff Examiner

# Division of State Government Accountability

Andrew A. SanFilippo, Executive Deputy Comptroller
518-474-4593, asanfilippo@osc.state.ny.us

Elliot Pagliaccio, Deputy Comptroller
518-473-3596, epagliaccio@osc.state.ny.us

Jerry Barber, Assistant Comptroller
518-473-0334, jbarber@osc.state.ny.us

## Vision

A team of accountability experts respected for providing information that decision makers value.

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To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

# Agency Comments

STATE OF NEW YORK
DEPARTMENT OF CORRECTIONS
AND COMMUNITY SUPERVISION
E HARRIMAN STATE CAMPUS – BUILDING 2
1220 WASHINGTON AVENUE
ALBANY, N.Y. 12226-2050

ANDREW M. CUOMO
GOVERNOR

BRIAN FISCHER
COMMISSIONER

October 25, 2012

Ms. Carmen Maldonado
Office of the State Comptroller
Division of State Government Accountability
123 William Street – 21st Floor
New York, NY 10038

Re: Draft Report 2010-S-41, Department of Corrections and Community Supervision *Payments for Inmate Health Care Services.*

Dear Ms. Maldonado:

In accordance with Section 170 of the Executive Law and in response to your correspondence of July 23, 2010, attached is the Department's reply to the Draft Audit Report 2010-S-41: Department of Corrections and Community Supervision's *Payments for Inmate Health Care Services.*

DOCCS would like to acknowledge the time and effort of all employees that were involved with this audit and their desire to improve the Department's operation.

Sincerely,

Brian Fischer
Commissioner

Attachment

STATE OF NEW YORK
DEPARTMENT OF CORRECTIONS
AND COMMUNITY SUPERVISION
THE HARRIMAN STATE CAMPUS – BUILDING 2
1220 WASHINGTON AVENUE
ALBANY, N.Y. 12226-2050

BRIAN FISCHER
COMMISSIONER

CARL J. KOENIGSMANN, M.D.
DEPUTY COMMISSIONER/
CHIEF MEDICAL OFFICER

October 25, 2012

Ms. Carmen Maldonado
Office of the State Comptroller
Division of State Government Accountability
123 William Street – 21st Floor
New York, NY 10038

Re: Draft Report 2010-S-41, Department of Corrections and Community Supervision
*Payments for Inmate Health Care Services.*

Dear Ms. Maldonado:

The Department of Corrections and Community Supervision (DOCCS) has reviewed Report 2010-S-41 *Payments for Inmate Health Care Services*, and offers the following comments.

The Report states that the State could save an estimated $20 million annually if DOCCS billed Medicaid for eligible offender inpatient care. While DOCCS has been doing this, we want to note that estimated savings is speculative, since we do not know the percentage of offenders who are eligible for Medicaid. It was also noted that medical costs for offenders has increased at DOCCS from April 1, 2008 to March 31, 2010 while the offender population has decreased. While medical costs have gone up, so have other Agency expenses. It should be noted that the total cost of health expenditures as a percentage of total DOCCS expenditures has decreased from 14.84% during fiscal year 2008-09 to 13.09% during fiscal year 2009-10 to 12.01% during fiscal year 2010-11. DOCCS notes that the 62% increase in health spending between FY 1999-2000 and FY 2010-2011 which OSC cites can be attributed to three significant changes: the NYS employee union negotiated salaries increases by 34.75% during this time period, the BLS Consumer Price Index for Medical Services increased by 54.70% during this time period and most DOCCS health care contracts allot CPI increases year to year to keep up with inflation, and DOCCS opened up two new Regional Medical Units, two new maximum security facilities with high levels of medical care, and a 30 bed Unit for the Cognitively Impaired (UCI) all with the intent of reducing medical costs in the long term.

* Comment 1

* See State Comptroller's Comments, on page 19.

Additionally, new AIDS and Hepatitis C treatments came into existence during this time period which resulted in an increase in drug and lab expenditures as more offenders were put onto these multi-drug therapies. DOCCS continues to explore avenues to reduce medical costs while maintaining or improving health care quality.

Another concern for DOCCS were changes in the data and overcharges presented in the draft report from the four preliminary findings presented to DOCCS in November and December of 2010. The more specific discrepancies are indicated below:

* Comment 1

- Hourly Clinics: Final draft report indicates five providers were overpaid $84,483.00. The Preliminary Finding indicated five providers were overpaid $83,635.22. However, DOCCS discovered additional overpayments and to date DOCCS has collected $78,966.27 in overcharges and is in the process of collecting $46,132.85 over the next year.

* Comment 2

- Double Billing: The two claims overcharged in the amount of $4,134.99 cannot be identified. Please provide the detail on these two claims.

* Comment 3

- The final draft report indicates OSC identified 424 instances where the Department overpaid $32,708.00 in separate fees that were already included in the payments for the primary procedures. DOCCS had discussed this with OSC at the time of this audit and the issue concerning modifiers for professional and technical components and the claims that we reviewed did not result in overpayments.

Since OSC's recommendation and DOCCS' interest are to recover these overcharges, DOCCS requests that OSC provide the supporting documentation to these discrepancies.

DOCCS' responses to the eight OSC recommendations are as follows:

**Recommendation #1:** Collect overpayments made to providers cited in this audit.

* Comments 1 & 2

**DOCCS Response:** DOCCS agrees in part. DOCCS has recovered and is still seeking reimbursement for the overcharges cited in OSC's preliminary findings. Currently, DOCCS has collected $78,966.27 in overcharges and is in the process of receiving $46,132.85 over the next year. DOCCS is requesting the supporting documentation from OSC for the overcharges cited in this report, but not disclosed in the preliminary findings.

**Recommendation #2:** Test samples of future payments to service providers to determine if recovery for overcharges is necessary.

* Comment 4

**DOCCS Response:** DOCCS disagrees. DOCCS has developed a *Clinic Hours Tracking Form* in triplicate to be used by the health care provider and verified by the facility medical staff to document the hours that the health care provider was at the facility. It is signed by a facility medical supervisor with a copy issued to the health care provider and the DOCCS Medical Bill Payment Unit where it is reconciled with

* See State Comptroller's Comments, on page 19.

the medical bill from the provider. This recommendation is not necessary due to this new process which was developed after the OSC audit.

**Recommendation #3:** Review claims to determine if procedure codes are being inappropriately separated resulting in overcharges.

**DOCCS Response:** DOCCS agrees. DOCCS uses an outside vendor, APS Healthcare Bethesda Inc (APS), to review health care referrals to determine if the health care referral is medically necessary. APS also reviews a percentage of inpatient and outpatient billings for appropriateness and receives a commission for any overpayments they discover. Since APS began their review of outpatient billing in December 2010 to present, APS has recovered $48,221.00 in overpayments for DOCCS. During this same timeframe, APS has recovered $1,059,325.00 for DOCCS in overpayments from inpatient claims.

**Recommendation #4:** Verify that the actual hours worked in connection with clinic services agree with the hours billed and paid for.

**DOCCS Response:** DOCCS agrees. As cited in recommendation #2, DOCCS uses the *Clinic Hours Tracking Form* to be used by the health care provider and verified by the facility medical staff and forwarded to the DOCCS Medical Bill Payment Unit to document the hours that the health care provider was at the facility.

**Recommendation #5:** Research alternatives to electronically capture all procedure codes and modifiers on paid claims for analysis of billing accuracy and appropriateness.

**DOCCS Response:** DOCCS agrees. DOCCS agrees to investigate the need and possibility of expanding the parameters currently used by APS for review. Currently APS utilizes several triggers to target claims for audit such as dollar amount thresholds, evaluation codes combined with procedure codes and inpatient versus outpatient evaluation codes. DOCCS is currently in the process of purchasing Ambulatory Patient Groups (APG) software from 3M Corporation to be used by the Medical Bill Payment Unit to calculate Medicaid rate based outpatient payments, and All Patient Refined Diagnosis Related Groups (APR DRG) software also from 3M Corporation to Calculate Medicaid rate based inpatient payments. While this will not aid in capturing procedure codes and modifiers on the FHS-1 system, we believe that the use of this software, that is the same used by Medicaid as well as hospitals to calculate Medicaid payments, will increase the accuracy of payments over the current process in which payment amounts are manually calculated. It should be noted that the FSH-1 system was developed for the purpose of scheduling offender medical visits and not for auditing bills. DOCCS' Management Information Services (MIS) unit indicated that to program such edits into the current FSH-1 system would be costly and time consuming.

**Recommendation #6:** Establish and use billing standards for periodic analysis of historical paid claims data to identify indications of inaccurate bills, incompatible services and unusually high levels of a service for an inmate. Follow-up on such instances to access their appropriateness.

**DOCCS Response:** DOCCS agrees in part. DOCCS uses APS to identify inaccurate bills. APS is focusing on unbundling of procedures. DOCCS does not agree with OSC's assumption that we model our healthcare program after Medicaid's program. These are two distinct and separate programs. Medicaid establishes frequency limitations on medical procedures but does not require patients to demonstrate medical necessity of the procedure until the frequency limitation is exceeded. DOCCS, however, will not refer an offender for any medical procedure until DOCCS' primary care medical doctors have examined the offender and deemed the medical procedure as being necessary. The medical referral is then reviewed with APS, to see if it is medically appropriate and meets community standards of healthcare based upon Milliman Care Guidelines which is an industry gold standard used by Blue Cross/Blue Shield organizations, traditional health insurers, managed care organizations, and third party administrators. DOCCS asserts our process provides better healthcare outcomes, is more cost effective and more efficient than the Medicaid model. DOCCS Medical Bill Payment Unit would not benefit from a review of unusually high levels of service for an offender as an internal control procedure since DOCCS Health Service staff and APS have deemed the procedure necessary. The DOCCS Medical Bill Payment Unit needs to only verify if the procedure was done, not if it was necessary.

* Comment 5

**Recommendation #7:** Amend the current provider agreements to require the Department to pay for successful procedures.

**DOCCS Response:** DOCCS agrees in part. The industry standard for paying for unsuccessful procedures includes the use of modifiers to CPT codes. Currently, providers bill for services and use modifier codes when appropriate to bill for unsuccessful procedure attempts. DOCCS agrees that appropriate future provider agreements will include a requirement to use a modifier code to the CPT code for billing for unsuccessful procedure attempts. Likewise, existing provider agreements will include this same language if the provider agreement is updated. This is commensurate with current industry standards. DOCCS asserts that to change over 1,000 provider agreements is prohibitive. Further, DOCCS asserts the current billing practice of using modifier codes is acceptable industry standard and will continue. This is how this information is captured.

**Recommendation #8:** Evaluate the feasibility and cost benefit to seek reimbursement from Medicaid or other third party insurance for medical services from outside providers when appropriate.

**DOCCS Response:** DOCCS agrees in part. DOCCS, in conjunction with the Division of the Budget (DOB) and the Department of Health (DOH), has been seeking retroactive reimbursement from the Federal Government for inpatient services provide to Medicaid eligible inmates. The Federal Government has provided reimbursements in the amount of $4,589,822.00 to date. DOH is currently receiving the monetary benefit of the Department's effort. DOCCS, DOB, and DOH are also currently working on developing a process in which Inpatient related hospital services provided to Medicaid eligible inmates will be billed directly to Medicaid by the Hospital providing the service. DOCCS Counsel has researched the suggestion on third party insurance coverage payment by offenders and is of the

* Comment 6

* See State Comptroller's Comments, on page 19.

opinion that DOCCS could not unilaterally bill a third party insurance carrier for the medical treatment that we provide to an offender, except for the limited circumstances as provided for in Correction Law §611. DOCCS is legally responsible to provide medical care to offenders, a legal mandate that has been litigated and determined by the highest court in the nation. DOCCS Counsel believes that absent a statute that authorized reimbursement of all medical expenses, DOCCS cannot pursue this option.

Concerning work release offenders, the average cost for a work release offender is from 3% (Rochester Correctional Facility) to 44% (Lincoln Correctional Facility) in comparison to what the average offender's medical cost was in general population during fiscal year 2008 – 2009. Since there are so few work release offenders and their health care costs are already significantly lower, there is little opportunity to reduce costs any further in this area. DOCCS is open to the possibility of reimbursement of health care costs through workers' compensation, however, this rarely occurs to work release offenders. Further, DOCCS would not know if a work release inmate has employer health insurance until the offender is hired. Finally, an offender's spouse can offer to pay for an offender's consultation in accordance with HSPM, Number 7.02, *Inmate Provider of Choice*.

DOCCS would like to acknowledge the time and effort of all employees that were involved with this audit and their desire to improve DOCCS' Health Care Program.

Sincerely,

Carl J. Koenigsmann, M.D.
Deputy Commissioner/Chief Medical Officer

CJK/pb

# State Comptroller's Comments

1. We amended the report based on the information in the report.
2. Information requested in the Department's response was provided.
3. We did not receive any documents from the Department regarding the cases where we determined that the incorrect use of modifiers for professional and technical components did not result in overpayments. According, to industry billing practices, the 424 cases were billings for procedure codes that cannot be billed with the two modifier codes we tested. These 424 cases were provided to the Department on November 2, 2012.
4. The process to verify clinic claims prior to payment was not in place at the time of our audit. We believe this process is a good control. However, we also believe some periodic testing of payments besides clinic claims should also be done.
5. We do not propose that the Department model its health care program after Medicaid as the Department states. Although Department medical staff makes referrals to outside providers and APS approves the referrals, these steps do not mean that the subsequent billing will be accurate. This is shown by the recoveries that the Department has made even though all of the treatments were based on Department referrals and APS approvals. Therefore, we believe it is reasonable to establish standards for the maximum number of procedures on a patient in a given period of time and periodically analyze actual claims against the standards. If the standards are exceeded, the claims should be reviewed to determine if there are errors. Such standards should be based on the Department's patient population. We advocate that the Department create its own standards for certain medical services and we used Medicaid standards as examples due to the lack of Department standards.
6. We are pleased that the Department has collected over $4 million in federal funds for inpatient services to inmates and that the Department of Health will also benefit from the Department's efforts. Thus, it is reasonable for the Department to make some effort to seek payments from third party insurance carriers. If legislation is required then the Department should take appropriate action.