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COMPTROLLER

OFFICE OF THE
NEW YORK STATE COMPTROLLER

DIVISION OF STATE
GOVERNMENT ACCOUNTABILITY

DEPARTMENT OF HEALTH

MEDICAID OVERPAYMENTS FOR MENTAL HEALTH SERVICES

Report 2006-S-53

AUDIT OBJECTIVE

Our audit objective was to identify Medicaid overpayments for certain mental health services and the causes for such overpayments.

AUDIT RESULTS - SUMMARY

For the period August 30, 1999 to October 26, 2006, our audit identified more than $1.3 million in Medicaid overpayments for mental health services. Many of these overpayments were the result of providers double-billing Medicaid, as follows:

- Nearly $662,000 was paid to providers who inappropriately billed for pharmacologic management, even though this service was billed as part of other procedures. [Pages 3-4]

- More than $380,000 was paid to practitioners at outpatient clinics that also billed Medicaid for the same services. [Pages 4-5]

- Approximately $303,000 was paid to clinics that double billed for mental health services using inappropriate reimbursement rates. [Pages 5-6]

- More than $436,000 was paid to a psychiatrist who admitted not seeing certain patients, used his clinical social worker to see patients and then billed at a higher Medicaid rate using his Medicaid provider number, billed for more than 24 hours of treatment in a day, and did not have documentation to support many of his billings. We are referring this matter separately to the Office of the New York State Attorney General for determination as to whether further investigation and criminal prosecution is appropriate.

Our report contains eight recommendations. Department of Health officials generally agreed with our recommendations and either have taken steps to implement them or are investigating the feasibility of implementing the recommendations. Department officials are also working with the Office of Medicaid Inspector General to investigate the overpayments identified in this report.

This report, dated December 17, 2007, is available on our website at http://www.osc.state.ny.us.
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Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
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BACKGROUND

The Medicaid program was established under Title XIX of the Federal Social Security Act to provide medical assistance to needy individuals. The Department of Health (Department) administers the Medicaid program in New York State. One area of care provided under the Department's Medicaid program is mental health services. These services include individual, group and family psychotherapy, pharmacologic management, and electroconvulsive therapy, among other procedures.

To manage and process Medicaid claims, the Department utilizes the State's eMedNY system, which the Department implemented on March 24, 2005. Since its implementation, the Department has programmed numerous computer checks (edits) into the eMedNY system to help prevent incorrect payments to providers. As new risks of incorrect payment processing are identified, including those identified by the Comptroller's Medicaid audits, the Department adds edits to address those risks.

During the period January 1, 2003 to May 31, 2006, Medicaid paid approximately $1.5 billion for nearly 16 million mental health procedures performed by over 5,000 providers. This includes 1,343 clinics and 4,191 practitioners. In 2005, Medicaid payments for mental health services more than doubled the amount in 2004, increasing from $363 million to $808 million.

AUDIT FINDINGS AND RECOMMENDATIONS

Double Billing of Pharmacologic Management

Pharmacologic management involves the review and prescribing of medication with no more than minimal psychotherapy and is one of the most frequently billed mental health procedures. According to the Department's Medicaid billing rules for mental health services, psychiatrists cannot bill for pharmacologic management services in conjunction with other mental health procedures or certain evaluation and management procedures since it is already included in the reimbursement rates for these procedures.

For the five-year period ended October 6, 2006, we identified 389 providers that billed nearly $662,000 for pharmacologic management while also billing separately for a mental health procedure or an evaluation and management procedure on the same day for the same patient. Of these 389 providers, 387 were individual practitioners that were overpaid for 27,459 claims totaling approximately $657,000. The remaining two providers were mental health clinics that were overpaid for 21 claims totaling over $5,000.

We met with nine providers that were among those who double billed the most to assess the cause for their inappropriate billings. Eight of the providers were confused about the differences between Medicare and Medicaid billing rules and, thus, misinterpreted the Department's policy. One provider was unaware such a policy existed.

In addition, we determined the Department could have programmed its Medicaid claims processing system to prevent such overpayments, yet had not done so. We recommend the Department develop and implement an edit in its Medicaid claims processing system to deny separate payment for pharmacologic management when it is billed in conjunction with other mental health procedures or certain evaluation and management procedures. In addition, the Department should recover all overpayments

made to providers who double billed for pharmacologic management. We also recommend the Department clarify and re-communicate its policy on this matter to all providers.

Recommendations

1. Develop and implement an edit in the Medicaid claims processing system that will prevent double payments to providers for pharmacologic management services when providers are paid for other mental health procedures or certain evaluation and management procedures that already included the pharmacologic management services.

2. Investigate and recover all overpayments made to providers who double billed for pharmacologic management.

3. Clarify and re-communicate to all providers the Department's policy on properly billing for pharmacologic management with other procedures.

Practitioners' Billing for Mental Health Services Provided at an Outpatient Clinic

Since the Department administers the Medicaid program, it is responsible for ensuring medical providers are made aware of all applicable Medicaid billing rules. As part of the Medicaid program, the Office of Mental Health (OMH) licenses mental health outpatient clinics and is responsible for setting the Medicaid reimbursement rates for these clinics. OMH bases these rates on reports submitted by clinics, which identify each clinic's costs for providing mental health services.

Department officials agreed with an internal legal opinion provided to us by OMH that forbids practitioners from individually billing for mental health services provided at clinics. Therefore, only the clinics are eligible to receive reimbursement from Medicaid for mental health services rendered by practitioners at a clinic. Individual practitioners cannot bill Medicaid directly for the services they provide at mental health outpatient clinics since their fees should be included in those billed by the clinics.

We identified 106 different practitioners who were inappropriately paid for services they provided at 17 outpatient mental health clinics. The payments to these practitioners were in addition to payments made to the clinics for the same services (same patients, same procedures, and same dates of service). In total, we found 21,132 inappropriate payments to these providers totaling $381,356 from June 27, 2002 to December 31, 2005.

We determined that the Department failed to develop an edit in its Medicaid claims processing system to prevent these inappropriate payments. Department officials informed us such an edit may not have been feasible. However, if a preventive edit was not possible, then the Department should have had compensating controls in place to detect these inappropriate payments. We found the Department did not have such controls in place.

We also identified a lack of communication between the Department, OMH, and providers regarding this billing practice. Department officials initially stated they were not sure whether practitioners were allowed to bill Medicaid for mental health services provided at clinics. The Department told us to contact OMH and OMH officials agreed they are responsible for calculating the clinics' rates but stated they do not send directives to providers explaining how to properly bill Medicaid for mental health services.

We found additional evidence of the lack of communication during our visits to three outpatient clinics. Each clinic claimed they were never provided with a directive from the Department or OMH forbidding their practitioners from billing for mental health services provided at the clinic. The clinics believed their practitioners could bill separately for their services since the practitioners' salary expenses were not included in the clinics' annual mental health rate calculation. However, when we interviewed OMH staff responsible for calculating clinics' reimbursement rates, they informed us it does not matter if practitioners' salaries are included in the rate calculations. It is clear that better communication is needed among these agencies.

Recommendations

4. Develop and implement appropriate edit(s) in the Department's Medicaid claims processing system to prevent practitioners from being paid for mental health services provided at an outpatient clinic. If such edits are not feasible, develop procedures for monitoring these claims to detect inappropriate payments and take appropriate enforcement action when such payments are identified.

5. Recover all payments to the 106 practitioners we identified that incorrectly billed for mental health services provided at an outpatient clinic.

6. Improve communication with OMH and providers to ensure providers are aware of all mental health billing policies.

Double Billing by Clinics Using Incorrect Rates

Many clinics enrolled in Medicaid provide both medical and mental health services. In these cases, both the Department and OMH are responsible for annually calculating clinics' Medicaid reimbursement rates for medical services (Department) and mental health services (OMH). According to a Department policy issued to providers in August 2005, these clinics are required to bill Medicaid for mental health services using the rates established by OMH. For medical services, clinics must bill Medicaid using the rates established by the Department.

We identified 27 clinics that inappropriately billed Medicaid for 1,898 mental health service claims using a Department rate code. In each case, the clinics were paid by Medicaid twice for mental health services provided to the same patient on the same date of service (once under an OMH rate and once under a Department rate). Overpayments for these 1,898 claims totaled $302,568 for dates of service ranging from June 15, 2001 to October 16, 2006.

We determined that the Department had no edit in its Medicaid claims processing system to prevent these inappropriate payments. In addition, while the Department communicated to providers the applicable Medicaid billing policy forbidding this billing practice in August 2005, they have not adequately monitored compliance with the policy, since 369 (19 percent) of the 1,898 overpaid claims we identified were for services provided after August 2005. If the Department does not implement an edit or improve its monitoring procedures, these clinics will continue to be overpaid.

Recommendations

7. Implement an edit in the Department's Medicaid claims processing system to prevent payment for mental health service claims using a Department rate. If this is not feasible, develop a process

for monitoring these claims to detect over billings.

8. Recover all payments from the 27 clinics we identified who inappropriately billed for mental health services using a Department rate.

Attorney General Referral

We examined all Medicaid claims for mental health services during our audit scope with a time derivative and recorded the minimum time the provider was required to spend with their patients in order to warrant the payment. From this analysis we identified one psychiatrist who received more than $436,000 in Medicaid payments during our audit scope, and who engaged in improper billing practices. Upon visiting this provider, he admitted to not seeing certain patients, used his clinical social worker to see some patients while the social worker then billed at the higher paying psychiatrist's rate, billed on several occasions for more than 24 hours of treatment in a day, and did not have documentation to support many of his billings. The myriad of concerns raised regarding improper and possibly illegal conduct on the parts of this Medicaid provider and his social worker, have been referred separately to the Office of the New York State Attorney General for determination as to whether further investigation and criminal prosecution is appropriate.

AUDIT SCOPE AND METHODOLOGY

We conducted our audit in accordance with generally accepted government auditing standards. Our audit primarily focused on identifying Medicaid overpayments for mental health services during the period January 1, 2003 to May 31, 2006. However, for some of our analyses in certain areas, we expanded our scope to include from August 30, 1999 to October 26, 2006, and examined additional medical procedures, including evaluation and management services.

To meet our audit objective, we reviewed applicable statutes and Department policies and met with officials from the Department and OMH to clarify our audit criteria. We also contacted several other states to solicit their ideas for auditing mental health services. In addition, we completed numerous analyses of Medicaid claims in our scope, from which we scored providers, giving higher risk providers a higher score. Based on our analyses, we selected a sample of 46 providers who scored the highest, either overall or for a particular analysis, and who received a material amount of payments from Medicaid. We visited each of our sampled providers to review selected medical/billing records to confirm/refute the provider was overpaid. When possible, we used the results from our sampled providers to project/estimate total overpayments for all similar claims for all providers.

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, several of which are performed by the Office of Operations. 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 management functions do not affect our ability to conduct independent audits of program performance.

AUTHORITY

The audit was performed according to the State Comptroller's authority under Article V, Section 1, of the State Constitution; and Article II, Section 8, of the State Finance Law.

REPORTING REQUIREMENTS

We provided a draft copy of this report to Department officials for their review and comment. We considered the Department comments in preparing this report. A complete copy of the Department's response is included as Appendix A. Department officials agreed with our recommendations and indicated the actions planned to implement them.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department 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 therefor.

CONTRIBUTORS TO THE REPORT

Major contributors to this report include Kenneth Shulman, Robert Wolf, Dennis Graves, Jonathan Deeb, Amanda Halabuda, Andrea Inman, Christopher Morris, Joseph Nopper, Resa Ostrander, Daniel Towle, Rebecca Tuczynski and Sue Gold.

APPENDIX A - AUDITEE RESPONSE

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

March 21, 2007

Steven E. Sossei
Audit Director
Office of the State Comptroller
110 State Street
Albany, New York 12236

Dear Mr. Sossei:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report (2006-S-53) on "Medicaid Overpayments for Mental Health Services."

Thank you for the opportunity to comment.

Sincerely,

Brian J. Wing
Interim Executive Deputy Commissioner

Enclosure

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

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
2006-S-53 on
Medicaid Overpayments for Mental Health Services

The following are the Department of Health's (DOH) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2006-S-53 on Medicaid Overpayments for Mental Health Services.

Recommendation #1:

Develop and implement an edit in the Medicaid claims processing system that will prevent double payments to providers for pharmacologic management services when providers are paid for other mental health procedures or certain evaluation and management procedures that already included the pharmacologic management service.

Response #1:

The Department will implement the series of claim edits required to support the instructions in the fee schedule prohibiting these billing combinations.

Recommendation #2:

Investigate and recover all overpayments made to providers who double billed for pharmacologic management.

Response #2:

The Office of Medicaid Inspector General (OMIG) will investigate and determine if any overpayments were made to providers who billed for pharmacologic management in addition to other mental health procedures and, if necessary, recover any overpayments.

Recommendation #3:

Clarify and re-communicate to all providers the Department's policy on properly billing for pharmacologic management with other procedures.

Response #3:

The physician fee schedule clearly instructs providers not to report pharmacological management in addition to evaluation and management services and other psychiatry services. The next update to the fee schedule will include language prohibiting billing of the unusual anesthesia modifier 23 for electroconvulsive therapy (90870-23) in conjunction with pharmacological management.

Recommendation #4:

Develop and implement appropriate edit(s) in the Department's Medicaid claims processing system to prevent practitioners from being paid for mental health services provided at an outpatient clinic. If such edits are not feasible, develop procedures for monitoring these claims to detect inappropriate payments and take appropriate enforcement action when such payments are identified.

Response #4:

It is questionable as to whether an edit can be established to prevent practitioner billing at Office of Mental Health (OMH) licensed mental health outpatient clinics. The Department will explore implementing edits to prevent overpayments. OMIG will further recommend to OMH that they communicate with providers on proper billing rules and policies to prevent future duplicate billings for these services.

Recommendation #5:

Recover all payments to the 106 practitioners we identified that incorrectly billed for mental health services provided at an outpatient clinic.

Response #5:

The OMIG will validate the findings and seek to recover overpayments made to practitioners that incorrectly billed for mental health services provided at outpatient clinics.

Recommendation #6:

Improve communication with OMH and providers to ensure providers are aware of all mental health billing policies.

Response #6:

The Department will work with OMH to insure that OMH effectively communicates to their providers all mental health billing policies.

Recommendation #7:

Implement an edit in the Department's Medicaid claims processing system to prevent payment for mental health service claims using a Department rate. If this is not feasible, develop a process for monitoring these claims to detect over billings.

Response #7:

The Department will explore implementing edits to prevent overpayments, but it is questionable as to whether an edit can be established to prevent payment for a mental health service claim using a Department rate code.

Recommendation #8:

Recover all payments from the 27 clinics we identified who inappropriately billed for mental health services using a Department rate.

Response #8:

The OMIG will verify the findings by investigating a sample of clinic claims to determine whether mental health services were inappropriately billed using a Department rate and recover all identified overpayments.