Office of Multnomah County Auditor

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Date: April 10, 2015

To: Chair Kafoury; Commissioners Bailey, Smith, Shiprack, and McKeel; Sheriff Staton; District Attorney Underhill; Director Wendt; Division Director Hidalgo

From: Steve March – Multnomah County Auditor

RE: Report to Management: MHASD Claims Processing

This report covers claims processing by the Mental Health and Addiction Services Division which handled about 350,000 claims payments in each of the two years we reviewed. Because of the volume both in number and dollars, as well as the susceptibility of improper billing with medical-related claims, it qualified as an area of "significant risk." We found instances of likely overbilling along with errors and inconsistencies in the data. The takeaways for management are that it can be more efficient internally and with their vendors by:

- Performing data monitoring and analysis on a timely basis.
- Using modern analytical tools that allow for analysis of the entire set of relevant claims as opposed to just sampling.
- Updating the process to keep pace with the changes in payment models, codes, and best medical practices. For example, had MHASD required differentiating between billing codes for group sessions versus individual sessions in their coding scheme it would have been easier for both the claims processing vendor and MHASD staff to review claims and compile accurate service usage rates.

We would like to thank the Department of County Human Services and the Division of Mental Health and Addiction Services for their cooperation and we believe this report will assist them to more efficiently and effectively operate their claims processing and usage data. Mark Ulanowicz and Nicole Dewees performed the audit work for this report.

Results Summary

Government Auditing Standards require us to assess systems for inconsistencies, errors, and fraud when these issues pose a significant risk. The MHASD claims payment system meets this "significant risk" threshold, due to the dollar volume of claims involved and the susceptibility of medical claims billing systems to improper billing.

We reviewed more than 700,000 MHASD mental health insurance service claims across two fiscal years. We found instances where overbilling likely occurred as well as errors and inconsistencies in the data that prevented more complete data analysis. MHASD has already taken some steps to address these issues. Accurate and complete data are not only essential for analysis to guard against fraud and errors, they are also important to ensure that clients are receiving appropriate care.

We recommend that the Division build sufficient capacity within its compliance support function to conduct routine monitoring of claims and to improve the accuracy and completeness of data submitted by contracted service providers.

Background

Government Auditing Standards (Standards) require performance audits to include an assessment of the "audited entity's systems and processes to detect inconsistencies, significant errors, or fraud…" The depth of the assessment depends on the level of risk associated with these systems and controls. During our review of the County's mental health care insurance plan, we identified the claims payment system and controls over improper billing (erroneous and fraudulent) as being a significant risk. We assessed the risk as high because:

- The claims payment system processes a very large amount of money – almost $61 million combined for fiscal years 2012 and 2013;
- Medical billing systems are highly susceptible to improper billing due to their complexity, the volume of money in the systems, and the difficulty of monitoring them;
- Controls over the payment system are critical to ensuring compliance with federal and state laws, and administrative rules; and
- The level of service the County can provide to some of its most vulnerable residents depends in part on the extent to which only appropriate claims are paid.

To comply with the Standards, we used data analysis techniques to identify indicators of erroneous billing. This type of analysis is an efficient way to test a system for errors and/or fraud because it allows auditors to test all of the claims, rather than a sample. In this case, we reviewed more than 700,000 individual claims. Data analysis of this sort is now seen as being an

important tool in combating fraud. In 2013, the federal government began allowing states to be reimbursed for costs associated with data analysis of Medicaid claims. While data analysis is an efficient tool, it also has drawbacks in that the analysis can only highlight *probable* errors and *indicators* of erroneous billing – follow up is still necessary for definitive results. And, the effectiveness of the analysis depends on quality and accuracy of the data in the system.

Claims Analysis Details

In any health insurance business, there are a number of areas where erroneous claims and data entry errors can occur within a claims payment process. We focused our review of claims data on an area that is common in medical claims analysis: claims for services that were not actually provided. To do this using only claims data, we created algorithms to identify instances where 1) a provider billed for services for an individual client for more than 8 hours in a single day or 2) an individual clinician billed for services totaling more than 8 hours in a single calendar day. Since both of these scenarios are unlikely to actually occur, finding instances that met either of these criteria would be a good indicator of erroneous claims and/or errors.

Using these criteria, we were able to identify 61 instances involving 103 individual claims in FY 2013 where MHASD was billed for more than 8 hours of service for an individual client in a single day. We reviewed these claims with MHASD staff and they agreed that the analysis methodology was sound and that the identified claims required follow-up with providers. We made a significant effort to eliminate false positives. In doing so, we may have eliminated some claims that are associated with more than 8 hours of service for a client in a single day.

Our test of the second criteria was less conclusive. We identified numerous claims that could potentially be associated with more than 8 hours of service by a clinician in a single day. However, omissions and errors in the data submitted by providers made it impossible to substantiate our results. For example, MHASD paid many claims that did not have a clinician's name attached to it – more than 39,000 claims for $5.4 million in FY13. MHASD management told us that they will no longer pay claims without an individual clinician being identified. In other cases, errors and omissions made it very difficult to create an algorithm that resulted in a sufficiently low number of false positives, without the potential of also eliminating too many actual erroneous claims.

Even with the difficulties related to the data, we did identify claims that warranted investigation. For example, a clinician billed for more than 17 hours of various services in a single day and received $1,945 in payment for these services.

Errors and omissions in the data generally related to group service codes and/or the number of units of service provided. The federal Centers for Medicare and Medicaid Services procedure

codes for services provided to groups of clients typically include a code modifier that signifies it was a group service. This modifier is important because insurance plans generally reimburse services provided to groups of clients at a lower rate than when the same service is provided to an individual. The MHASD insurance plan does not require that the group code be used for some of these services and it appeared that leaving off the group code was a common practice for some instances. For example, procedure code H0036 is described in the fee schedule as being for "individual and group activities." So, a provider that omitted the group code could have billed correctly and also made it difficult to calculate how many hours of service were performed.

We flagged many claims as potentially erroneous based on what appeared to be unusually large numbers of units of service provided. Some of these issues likely did not result in any loss to the County. For example, one clinician claimed 10 units of service provided at 60 minutes per unit for a total of 10 hours of service in a single day. However, the clinician charged an amount that was consistent with providing only 1 unit of service (60 minutes). While this error likely did not result in over payment, the high unit of service figure has the effect of inflating utilization measures.

Other instances of unusually high units of service are not as easy to explain. One provider submitted a claim for 50 units of "Case management, each 15 minutes". The number of units multiplied by 15 minutes equals 12.5 hours of service in a single day. Multnomah County paid this clinician $1,611 for these services.

Recommendations

Data analysis can be an efficient way for MHASD to fulfill its obligations to protect itself from erroneous insurance claims. For this analysis to be an effective check, it is important that the data in question be accurate. Even when inaccurate data do not result in improper payments, the inaccuracies limit the data's value for evaluation purposes. MHASD can help providers reduce errors in their claims as well as to recover over-payments and correct mistakes by:

- performing data monitoring and analysis in a timely basis;
- including the universe of relevant claims, rather than a sample; and
- continuously updating the process to keep pace with changes in payment models, codes, and best medical practices.

With risk-sharing payment arrangements, like case rate payments, the monitoring focus shifts from over-payment for services to under-service for insurance plan members. Many of the same data analysis techniques used to monitor for overpayments can be used to ensure that plan members are receiving the appropriate care, as long as the data are sufficiently complete.

To do this, MHASD should determine what sorts of tests they intend to perform and work with providers to ensure that the necessary information is available.

Scope and Methodology

We performed our analysis on all MHASD insurance plan claims for fiscal years 2012 and 2013. We worked with MHASD data analysts as well as compliance and utilization review staff to develop the tests we applied to the data. With this assistance, we were able to filter the data to reduce the likelihood of false positive findings. For example, we took care to avoid double counting the time associated with services that occur at the same time, such as respite care combined with individual services. After concluding our analysis, we turned the results over to MHASD.

We conducted this report to management 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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

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April 10, 2015

To: Steve March – Multnomah County Auditor

From: Liesl Wendt, DCHS Director
Joanne Fuller, Health Department Director
David Hidalgo, MHASD Director

Re: Report to Management: MHASD Claims Processing

Thank you for your thoughtful review of the MHASD Claims Processing System.

Your review of 2012 and 2013 claims provides helpful information for our continuous improvement efforts. Monitoring on a regular basis for fraud, waste and abuse is part of our responsibility in administering Multnomah County's Mental Health Medicaid program and a role we take very seriously.

We agree with your recommendations in particular the focus on data analysis techniques to protect from erroneous insurance claims. The Department has undertaken several measures to address the recommendations.

Please see below for examples of current efforts underway:

1) **Perform data monitoring and analysis in a timely basis:**
   - Three staff attended the Health Care Compliance Association Academy and were certified as Health Care Compliance Professionals in 2014.
   - In partnership with Clackamas County and Washington County Mental Health Medicaid plans, we contracted with a national Medicaid compliance expert to evaluate the regional coding guidelines attached to the County Mental Health Plan Medicaid fee schedules.

2) **Include universe of relevant claims rather than a sample:**
   - We will evaluate capacity necessary to perform queries and analysis of the universe of claims on a regular basis. As we determine capacity, we will continue to audit claim submission samples, provider records and review currently available data reports.

3) **Continuously updating the process to keep pace with changes in payment models, codes, and best medical practices:**
    - Also in partnership with Clackamas and Washington counties Mental Health Medicaid plans, all MHASD compliance and quality management staff were educated on the Center for Medicare and Medicaid Service National Correct Coding Initiative (CMC NCCI) edits. The CMS NCCI promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare and Medicaid claims.
    - The MHASD coding guidelines evaluation was completed in late January 2015.
    - Training on CNC NCCI edits for internal compliance staff and for all contracted providers is scheduled for May 2015.
    - To further support and sustain these improvement efforts, PhTech, our third party claims administrator will begin using NCCI edit software after contractors have received training.

Finally, these measures, combined with other currently available regional Medicaid data reports, will help ensure that while we transition from fee-for-service to risk-sharing payment arrangements plan members will continue to receive necessary access and treatment to meet their mental health needs.

Once again, MHASD would like to express our appreciation for the audit and recommendations. We are happy to answer any questions about our updated review of the claims processing analysis conducted by your team. Please let us know if we can provide additional analysis or details as we continue implementing these recommendations.

cc: Deborah Kafoury – Multnomah County Chair
Marissa Madrigal – Chief Operating Officer