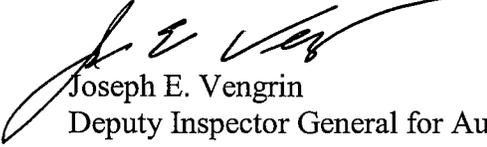




NOV 10 2008

**TO:** Kerry Weems  
Acting Administrator  
Centers for Medicare & Medicaid Services

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

**SUBJECT:** Review of Clinic and Practitioner Claims Billed as Family Planning Services  
Under the New York State Medicaid Program (A-02-07-01037)

Attached is an advance copy of our final report on our review of clinic and practitioner claims billed as family planning services under the New York State (the State) Medicaid program. We will issue this report to New York State within 5 business days.

Our objective was to determine whether the State properly claimed enhanced 90-percent Federal reimbursement for family planning claims submitted by clinics and practitioners.

The State improperly received enhanced 90-percent Federal reimbursement for family planning claims submitted by clinics and practitioners. Of the 119 claims in our sample, 17 qualified as family planning services. However, the remaining 102 did not. Of those 102 claims, 96 were for services unrelated to family planning, 2 did not include a properly completed sterilization consent form, 3 lacked documentation, and 1 was for a service that was not provided. Based on our sample results, we estimated that the State improperly received \$17,151,156 in Federal Medicaid reimbursement.

This overpayment occurred because providers incorrectly claimed services as family planning, and the State's Medicaid Management Information System (MMIS) edit routines did not adequately identify claims unrelated to family planning.

We recommend that the State:

- refund \$17,151,156 to the Federal Government,
- reemphasize to providers that only services directly related to family planning should be billed as family planning,

- ensure that MMIS edit routines use all appropriate claim information to identify claims that are ineligible for enhanced 90-percent Federal reimbursement, and
- determine the amount of Federal Medicaid funds improperly reimbursed for claims unrelated to family planning subsequent to our audit period and refund that amount to the Federal Government.

In its comments on our draft report, the State generally concurred with our recommendations. Regarding our first recommendation to refund \$17,151,156 to the Federal Government, the State requested copies of our related working papers and indicated that, following a review of the working papers, it will refund any excess Federal reimbursement associated with claims inappropriately classified as family planning.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at [George.Reeb@oig.hhs.gov](mailto:George.Reeb@oig.hhs.gov) or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through e-mail at [James.Edert@oig.hhs.gov](mailto:James.Edert@oig.hhs.gov). Please refer to report number A-02-07-01037 in all correspondence.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General  
Office Of Audit Services

Region II  
Jacob K. Javits Federal Building  
26 Federal Plaza  
New York, NY 10278

NOV 13 2008

Report Number: A-02-07-01037

Richard F. Daines, M.D.  
Commissioner  
New York State Department of Health  
14<sup>th</sup> Floor, Corning Tower  
Empire State Plaza  
Albany, New York 12237

Dear Dr. Daines:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Clinic and Practitioner Claims Billed as Family Planning Services Under the New York State Medicaid Program." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, the final report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact John Berbach, Audit Manager, at (518) 437-9390, extension 228, or through e-mail at [John.Berbach@oig.hhs.gov](mailto:John.Berbach@oig.hhs.gov). Please refer to report number A-02-07-01037 in all correspondence.

Sincerely,

A handwritten signature in black ink that reads "James P. Edert".

James P. Edert  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Jackie Garner, Consortium Administrator  
Consortium for Medicaid and Children's Health Operations  
Centers for Medicare & Medicaid Services  
233 North Michigan Avenue, Suite 600  
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF CLINIC AND  
PRACTITIONER CLAIMS  
BILLED AS FAMILY PLANNING  
SERVICES UNDER THE  
NEW YORK STATE  
MEDICAID PROGRAM**



Daniel R. Levinson  
Inspector General

November 2008  
A-02-07-01037

# ***Office of Inspector General***

<http://oig.hhs.gov>

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The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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# *Notices*

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Pursuant to Title XIX of the Social Security Act (the 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 Medicaid 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.

The Federal share of the Medicaid program is determined by the Federal medical assistance percentage (FMAP). During our audit period (April 1, 2003, through March 31, 2007), the FMAP in New York State (the State) was 50 or 52.95 percent. Section 1903(a)(5) of the Act and 42 CFR §§ 433.10 and 433.15 provide enhanced 90-percent Federal reimbursement for family planning services. Pursuant to section 4270 of the CMS "State Medicaid Manual," family planning services prevent or delay pregnancy or otherwise control family size.

### **OBJECTIVE**

Our objective was to determine whether the State properly claimed enhanced 90-percent Federal reimbursement for family planning claims submitted by clinics and practitioners.

### **SUMMARY OF FINDINGS**

The State improperly received enhanced 90-percent Federal reimbursement for family planning claims submitted by clinics and practitioners. Of the 119 claims in our sample, 17 qualified as family planning services. However, the remaining 102 did not. Of those 102 claims, 96 were for services unrelated to family planning, 2 did not include a properly completed sterilization consent form, 3 lacked documentation, and 1 was for a service that was not provided. Based on our sample results, we estimated that the State improperly received \$17,151,156 in Federal Medicaid reimbursement. This overpayment occurred because providers incorrectly claimed services as family planning, and the State's Medicaid Management Information System (MMIS) edit routines did not adequately identify claims unrelated to family planning.

### **RECOMMENDATIONS**

We recommend that the State:

- refund \$17,151,156 to the Federal Government,
- reemphasize to providers that only services directly related to family planning should be billed as family planning,

- ensure that MMIS edit routines use all appropriate claim information to identify claims that are ineligible for enhanced 90-percent Federal reimbursement, and
- determine the amount of Federal Medicaid funds improperly reimbursed for claims unrelated to family planning subsequent to our audit period and refund that amount to the Federal Government.

## **NEW YORK STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In its comments on our draft report, the State generally concurred with our first recommendation and fully concurred with our remaining recommendations. Regarding our first recommendation to refund \$17,151,156 to the Federal Government, the State requested copies of our related working papers and indicated that, following a review of the working papers, it will refund any excess Federal reimbursement associated with claims inappropriately classified as family planning. We will provide the State with copies of working papers related to claims questioned by our audit. The State's comments are included in their entirety as Appendix C.

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## INTRODUCTION

### BACKGROUND

#### Medicaid Program

Pursuant to Title XIX of the Social Security Act (the 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.

#### New York State Medicaid Program

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

The Federal share of the Medicaid program is determined by the Federal medical assistance percentage (FMAP). During our audit period (April 1, 2003, through March 31, 2007), the FMAP in the State was 52.95 percent from April 1, 2003, through June 30, 2004, and 50 percent from July 1, 2004, through March 31, 2007.

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

The MMIS uses a variety of indicators on the Medicaid claim form to identify family planning services eligible for enhanced 90-percent Federal reimbursement. These indicators include the family planning indicator code, special program code, and sterilization/abortion code. The State agency considers all claims with either a "Yes" or "1" in the family planning indicator field or special program code to be related to family planning. If the service is related to an induced abortion or sterilization, the provider must enter a proper code in the abortion/sterilization field.<sup>1</sup>

All claims marked "Yes" in the family planning indicator field and "0" (Not Applicable) or "F" (Sterilization) in the abortion/sterilization field are processed for enhanced 90-percent Federal reimbursement. However, for claims marked "Yes" in the family planning indicator field with a

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<sup>1</sup>Codes for this field are "0" (Not Applicable), "A" (Induced Abortion–Danger to the Woman's Life), "B" (Induced Abortion–Physical Health Damage to the Woman), "C" (Induced Abortion–Victim of Rape or Incest), "D" (Induced Abortion–Medically Necessary), "E" (Induced Abortion–Elective), and "F" (Sterilization).

code other than “0” or “F” in the abortion/sterilization field, the MMIS denies the claim and returns it to the provider for clarification because an abortion procedure does not qualify as a family planning service.

### **Medicaid Coverage of Family Planning Services**

Section 1905(a)(4)(C) of the Act requires States to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and who desire such services and supplies. Section 1903(a)(5) of the Act and 42 CFR §§ 433.10(c)(1) and 433.15(b)(2) authorize enhanced 90-percent Federal reimbursement for family planning services.

Pursuant to section 4270 of the CMS “State Medicaid Manual” (the manual), family planning services prevent or delay pregnancy or otherwise control family size. In addition, this section generally permits an enhanced 90-percent rate of Federal reimbursement for counseling services and patient education; examination and treatment by medical professionals pursuant to State requirements; devices to prevent conception; and infertility services, including sterilization reversals. The manual further says that abortions may not be claimed as a family planning service. Only items and procedures clearly furnished or provided for family planning purposes may be claimed at the enhanced 90-percent rate of reimbursement.

On January 30, 1991, CMS issued Financial Management Review Guide Number 20 (the guide), entitled “Family Planning Services,” to the State via Medicaid State Operations Letter 91-9. The guide states that any procedure provided to a woman known to be pregnant may not be considered a family planning service reimbursable at the enhanced 90-percent Federal rate of reimbursement. Likewise, tests and procedures performed during pregnancy, regardless of their purpose or intent, are not considered family planning services eligible for the enhanced 90-percent Federal rate of reimbursement. Updates to the CMS guide in 1993, 1997, and 2002 contained the same provisions.

The State’s Medicaid State plan says that family planning services and supplies for individuals of childbearing age are covered without limitations. State regulations define family planning services as the offering, arranging, and furnishing of those health services that enable individuals, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies.<sup>2</sup> The regulations state that such services include professional medical counseling services; prescription drugs; nonprescription drugs and medical supplies prescribed by a qualified physician, nurse practitioner, or physician’s assistant; and sterilizations.

### **Medicaid Coverage of Abortions**

Since 1977, Congress has passed Appropriations Acts restricting Federal funding of abortions. Pursuant to the Supplemental Appropriations and Rescission Act of 1981, P.L. No. 97-12, Federal funds are available for abortions performed only when the life of the mother would be endangered if the fetus were carried to term. Pursuant to 42 CFR, part 441, subpart E, Federal

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<sup>2</sup>Official Compilation of Codes, Rules and Regulations of the State of New York, Title 18, § 505.13.

reimbursement at the standard FMAP rate is available for abortions only when a physician has certified in writing to the Medicaid agency that the life of the mother would be endangered if the fetus were carried to term.

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

### **Objective**

Our objective was to determine whether the State properly claimed enhanced 90-percent Federal reimbursement for family planning claims submitted by clinics and practitioners.

### **Scope**

Our audit period covered April 1, 2003, through March 31, 2007. We did not review the overall internal control structure of the State or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at DOH's offices in Albany, New York; the State MMIS fiscal agent in Rensselaer, New York; and at numerous providers' offices throughout the State from September 2007 through February 2008.

### **Methodology**

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance and the State plan;
- held discussions with CMS officials and acquired an understanding of CMS guidance furnished to State officials concerning Medicaid family planning claims;
- held discussions with State officials to ascertain State policies, procedures, and guidance for claiming Medicaid reimbursement for family planning services;
- ran computer programming applications at the MMIS fiscal agent, which identified 1,241,764 paid clinic and practitioner claims for services billed at the enhanced 90-percent rate of Federal reimbursement by the State totaling \$133,914,606 (\$120,398,791 Federal share) for the period April 1, 2003, through March 31, 2007;
- eliminated from the 1,241,764 claims:
  - 363,667 claims containing a primary or secondary diagnosis code in the V25 series (encounter for contraceptive management);<sup>3</sup>

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<sup>3</sup>According to CMS's Financial Management Review Guide Number 20, primary or secondary diagnosis codes in the V25 series indicate the procedure/service was generally performed for a family planning purpose.

- 71,531 claims having Federal paid amounts that were not equal to 90 percent of their Medicaid paid amounts; and
- 332,083 claims reviewed by other Office of Inspector General audits;<sup>4</sup>
- identified a sampling frame of 474,483 clinic and practitioner claims billed at the enhanced 90-percent rate of Federal reimbursement totaling \$51,704,945 (\$46,532,392 Federal share);
- used stratified random sampling techniques to select a sample of 119 claims for review from the population of 474,483 claims;
- obtained and reviewed medical records from 46 providers (25 clinics and 21 practitioners) who submitted the 119 sample claims to make an initial determination as to whether the claimed services were related to family planning and eligible for enhanced 90-percent Federal reimbursement;
- submitted the medical records and our sample results to our medical reviewer, a CMS physician and policy expert on family planning; and
- estimated the dollar impact of the improper Federal reimbursement claimed in the total population of 474,483 claims.

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

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 objective.

## **FINDINGS AND RECOMMENDATIONS**

The State improperly received enhanced 90-percent Federal reimbursement for family planning claims submitted by clinics and practitioners. Of the 119 claims in our sample, 17 qualified as family planning services. However, the remaining 102 did not. Of the 102 claims, 96 were for services unrelated to family planning, 2 did not include a properly completed sterilization consent

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<sup>4</sup>Of the 332,083 claims, 325,126 claims contained Recipient Aid Category 56 and Recipient Medicaid Coverage Code 18. These claims were reviewed under our audit of the New York Family Planning Benefit Program (A-02-07-01001, May 22, 2008). The remaining 6,957 claims contained specialty code 159. These claims were reviewed under our audit of the Medicaid Obstetrical Maternal Services Program (A-02-05-01001, July 20, 2005).

form, 3 lacked documentation, and 1 was for a service that was not provided.<sup>5</sup> Based on our sample results, we estimate that the State improperly received \$17,151,156 in Federal Medicaid reimbursement. This overpayment occurred because providers incorrectly claimed services as family planning, and the State's MMIS edits did not adequately identify claims unrelated to family planning.

## **SERVICES UNRELATED TO FAMILY PLANNING**

Pursuant to section 4270 of the manual, family planning services prevent or delay pregnancy or otherwise control family size. The manual states that only items and procedures clearly furnished or provided for family planning purposes may be claimed at the enhanced 90-percent rate of Federal reimbursement. However, for 96 of the 119 claims in our sample, we determined that the billed services were unrelated to family planning. Of the 96 claims, 33 were for services for which no Federal Medicaid reimbursement was available and 63 were for services eligible for reimbursement at the applicable FMAP rate of 50 or 52.95 percent.

Of the 33 services for which no Federal Medicaid reimbursement was available, 27 were abortion procedures, 4 were services performed in conjunction with an abortion, 1 was considered medically unnecessary, and 1 was a duplicate bill. Pursuant to Federal regulations (42 CFR, part 441, subpart E), Federal reimbursement at the standard FMAP rate is available for abortions only when a physician has certified in writing to the Medicaid agency that the life of the mother would be endangered if the fetus were carried to term. This certification was not present in any of the 27 cases.<sup>6</sup>

Sixty-three claimed services were eligible for reimbursement at the applicable FMAP rate of 50 or 52.95 percent, including chemotherapy treatments, colposcopy examinations, hysterectomy surgeries, services to pregnant women, and deliveries of children.

## **IMPROPERLY COMPLETED STERILIZATION CONSENT FORMS**

Section 4270 of the manual states that enhanced 90-percent Federal reimbursement is available for the cost of a sterilization if a properly completed sterilization consent form is submitted in accordance with the requirements of 42 CFR part 441, subpart F. Regulations at 42 CFR § 441.256(a) state that Federal Medicaid reimbursement “. . . is not available in expenditures for any sterilization or hysterectomy unless the Medicaid agency, before making payment, obtained documentation showing that the requirements of this subpart were met.” In accordance with 42 CFR § 441.258(b)(4), the sterilization consent form must be signed and dated by the physician

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<sup>5</sup>Of the 102 claims, 39 were for services not eligible for Federal reimbursement, and 63 were eligible for Federal reimbursement at the applicable FMAP rate. One claim, for a sterilization and hernia surgery, fell under both categories. The sterilization portion of the claim was not eligible for Federal Medicaid reimbursement because a sterilization consent form was not properly completed. The hernia surgery was eligible at the applicable FMAP rate. We included this claim among the 39 for which no Federal reimbursement is available.

<sup>6</sup>One provider was responsible for 25 of the 27 abortion procedure claims. Based on the procedure codes used, it appeared that this provider billed at least 3,900 abortion claims during our audit period. Of those 3,900 claims, we reviewed only the 25 claims in our sample.

who performed the sterilization procedure. Pursuant to 42 CFR § 441.258(c)(2)(iii), except in the case of premature delivery or emergency abdominal surgery, the physician must also certify that at least 30 days have passed between the date of the individual's signature on the consent form and the date upon which the sterilization was performed. Furthermore, 42 CFR § 441.258(a) states that the consent form must be a copy of the form appended to subpart F of § 441 or another form approved by the Secretary of the Department of Health and Human Services.

For 2 of the 119 claims in our sample, a sterilization consent form was not properly completed. For one claim, the beneficiary had a sterilization procedure approximately 2 months after delivering her child. The beneficiary's consent was obtained only 27 days before the sterilization, and the consent form did not indicate any evidence that emergency abdominal surgery had been performed. In addition, this out-of-State provider did not use the required sterilization consent form. For the second claim, the physician did not sign or date the consent form as required. For both claims, no Federal Medicaid reimbursement was available.

### **NO DOCUMENTATION**

Section 1902(a)(27) of the Act and Federal regulations (42 CFR §§ 431.17 and 433.32) require that services claimed for Federal Medicaid reimbursement be documented. For 3 of the 119 claims in our sample, the provider could not provide documentation to support the service billed. Therefore, Federal Medicaid reimbursement was not available for these three claims.

### **NO SERVICE PROVIDED**

Office of Management and Budget Circular A-87, "Cost Principles for State, Local and Indian Tribal Governments," 2 CFR part 225, establishes principles and standards for determining allowable costs applicable to grants with State and local governments. Attachment A, section C.1.c. of Circular A-87 states that to be allowable under a Federal award, costs must be authorized or not prohibited under State or local laws or regulations.

State regulations say that by enrolling in the State's Medicaid program, a provider agrees to submit claims for payment for services furnished.<sup>7</sup> In addition, Title 18, § 540.7(a)(8) states that all bills for medical care, services, and supplies shall contain a dated certification by the provider that the care, services, and supplies itemized have been furnished.

For 1 of the 119 claims in our sample, a provider billed Medicaid for a counseling visit. However, the medical record indicated the counseling service was not provided, as the beneficiary was rushed from the clinic to a hospital for a possible ectopic pregnancy shortly after entering the clinic. Therefore, Federal Medicaid reimbursement was not available for the counseling service claim.

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<sup>7</sup>Official Compilation of Codes, Rules and Regulations of the State of New York, Title 18, § 504.3(e).

## CAUSES OF THE OVERPAYMENTS

We identified two main causes of the overpayment: improperly coded claims and inadequate MMIS edit routines.

### Improperly Coded Claims

For the 96 sampled claims unrelated to family planning, 34 providers incorrectly coded the Medicaid claim form by marking “Yes” in the family planning indicator field, using a procedure code that the MMIS recognized as family planning, or marking the abortion/sterilization field with an “F” (Sterilization) or “0” (Not Applicable). Although the 96 claims were unrelated to family planning, the MMIS categorized them as eligible for enhanced 90-percent Federal reimbursement. Specifically:

- For 90 claims, the provider marked “Yes” in the family planning indicator field.<sup>8</sup> Included in these claims were 27 for abortion procedures for which the provider marked the abortion/sterilization field with a “0” (Not applicable) or left the field blank.<sup>9</sup> The MMIS categorized these claims as family planning and eligible for enhanced 90-percent Federal reimbursement.
- For five claims (three of which were hysterectomies), the MMIS assigned a “1” (Yes) in occurrence “1” (Family Planning) in the special program code.<sup>10</sup>
- For one claim, the provider marked the abortion/sterilization field with an “F” (Sterilization). Although the claim was for treatment of throat pain, the MMIS categorized the claim as family planning and eligible for enhanced 90-percent Federal reimbursement.

### Inadequate Medicaid Management Information System Edit Routines

The MMIS’s edits did not always correctly identify claims for enhanced 90-percent Federal reimbursement. The design of the computer edits in the MMIS was such that the presence of a “Yes” in either the family planning indicator field or occurrence “1” (Family Planning) of the special program code or an “F” in the sterilization/abortion field was the only element needed for the system to classify a claim as family planning. As noted above, 90 claims contained a “Yes” in the family planning indicator field, yet none of the claimed services related to family planning.

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<sup>8</sup>Officials at Planned Parenthood providers stated that they believed that nearly all the services they provide are related to family planning. However, the medical review determined that the providers improperly claimed, for example, services to pregnant women, treatment for sexually transmitted diseases, and counseling visits unrelated to family planning services.

<sup>9</sup>For claims marked “A,” “B,” “C,” or “D” in the abortion/sterilization field, the MMIS denied the claims and sent them back to the provider for clarification because abortion procedures are not considered a family planning service.

<sup>10</sup>For four of the five claims, the provider used a procedure code that caused the MMIS to code the claim as family planning. We could not determine why the MMIS coded the remaining claim as family planning.

Even when providers correctly marked “No” in the family planning indicator field for certain services (e.g., hysterectomies), the MMIS categorized the corresponding claims as family planning services because of the procedure code used. Finally, for claims coded with an “F” (Sterilization) in the sterilization/abortion field, the MMIS considered the corresponding service as related to family planning even if the family planning indicator field and the special program code were marked “No.”

## **ESTIMATION OF THE UNALLOWABLE AMOUNT**

Of the 119 claims in our statistical sample, 17 qualified as family planning services eligible for Federal Medicaid reimbursement at the 90-percent rate. However, the remaining 102 sample claims were improperly paid at the 90-percent rate. Of the 102 claims, 39 were not eligible for any Federal Medicaid reimbursement and 63 were eligible for reimbursement at the applicable FMAP rate of 50 or 52.95 percent. Based on the results of our sample, we estimated that the State improperly received \$17,151,156 in Federal Medicaid reimbursement. The details of our sample results and estimates are shown in Appendix B.

## **RECOMMENDATIONS**

We recommend that the State:

- refund \$17,151,156 to the Federal Government,
- reemphasize to providers that services only directly related to family planning should be billed as family planning,
- ensure that MMIS edits use all appropriate claim information to identify claims that are ineligible for enhanced 90-percent Federal reimbursement, and
- determine the amount of Federal Medicaid funds improperly reimbursed for claims unrelated to family planning subsequent to our audit period and refund that amount to the Federal Government.

## **NEW YORK STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In its comments on our draft report, the State generally concurred with our first recommendation and fully concurred with our remaining recommendations. Regarding our first recommendation to refund \$17,151,156 to the Federal Government, the State requested copies of our related working papers and indicated that, following a review of the working papers, it will refund any excess Federal reimbursement associated with claims inappropriately classified as family planning. We will provide the State with copies of working papers related to claims questioned by our audit. The State’s comments are included in their entirety as Appendix C.

# **APPENDIXES**

## **SAMPLE DESIGN AND METHODOLOGY**

### **POPULATION**

The population was Medicaid claims billed by New York State at 90-percent Federal reimbursement for clinic and practitioner services during our April 1, 2003, through March 31, 2007, audit period.

### **SAMPLING FRAME**

The sampling frame was a Microsoft Access computer file containing 474,483 Medicaid claims for clinic and practitioner services billed as family planning at 90-percent Federal funding during our review period. The total Medicaid reimbursement for the 474,483 claims was \$51,704,945 (\$46,532,392 Federal share). The Medicaid claims were extracted from the paid claims' files maintained at the Medicaid Management Information System fiscal agent.

### **SAMPLE UNIT**

The sample unit was an individual Medicaid claim for a clinic and practitioner service billed as family planning at the enhanced Federal reimbursement rate of 90 percent.

### **SAMPLE DESIGN**

We used stratified random sampling to evaluate the population of Medicaid clinic and practitioner claims. To accomplish this, we separated the sampling frame into three strata as follows:

- Stratum 1: Claims with a Federal share payment amount from \$0.01 to \$250.00—466,980 claims.
- Stratum 2: Claims with a Federal share payment amount from \$250.01 to \$1,000.00—7,484 claims.
- Stratum 3: Claims with a Federal share payment amount greater than \$1,000.00—19 claims.

## **SAMPLE SIZE**

We selected a sample of 119 claims as follows:

- 50 claims from the first stratum,
- 50 claims from the second stratum, and
- 19 claims from the third stratum.

## **SOURCE OF THE RANDOM NUMBERS**

We used the Office of Audit Services statistical software to generate our sample.

## **METHOD OF SELECTING SAMPLE ITEMS**

We sequentially numbered the 466,980 claims in stratum 1 and the 7,484 claims in stratum 2. After generating 50 random numbers for both stratum 1 and stratum 2, we selected the corresponding frame items. We selected all of the claims in stratum 3. We created a list of the 119 sample items.

## **TREATMENT OF MISSING SAMPLE ITEMS**

The sample item was considered an error if no supporting documentation could be found.

## **ESTIMATION METHODOLOGY**

We used RAT-STATS to calculate our estimates. We used the lower limit of the 90-percent confidence interval to estimate the overpayment associated with the improper claiming.

## SAMPLE RESULTS AND ESTIMATES

## Sample Details and Results

Stratum Number	Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Unallowable Claims	Overpayment Associated With Unallowable Claims (Federal Share)
1 \$0-\$250	466,980	\$42,772,573	50	\$4,683	37	\$1,966
2 >\$250-\$1,000	7,484	3,711,582	50	24,693	46	17,654
3 >\$1,000	19	48,237	19	48,237	19	25,479
<b>Total</b>	<b>474,483</b>	<b>\$46,532,392</b>	<b>119</b>	<b>\$77,613</b>	<b>102</b>	<b>\$45,099</b>

**Estimated Overpayments Associated With Unallowable Claims  
(Limits Calculated for a 90-Percent Confidence Interval)**

<b>Point Estimate:</b>	\$21,027,247
<b>Lower Limit:</b>	\$17,151,156
<b>Upper Limit:</b>	\$24,903,337

**DOH** STATE OF NEW YORK  
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.  
*Commissioner*

Wendy E. Saunders  
*Chief of Staff*

October 14, 2008

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

Ref. No. A-02-07-01037

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the Department of Health and Human Services, Office of Inspector General's draft audit report A-02-07-01037 on "Review of Clinic and Practitioner Claims Billed as Family Planning Services Under the New York State Medicaid Program."

Thank you for the opportunity to comment.

Sincerely,



Wendy E. Saunders  
Chief of Staff

Enclosure

cc: Stephen Abbott  
Deborah Bachrach  
Homer Charbonneau  
Ronald Farrell  
Gail Kerker  
Sandra Pettinato  
Robert W. Reed  
James Sheehan

**New York State Department of Health  
Comments on the  
Department of Health and Human Services  
Office of Inspector General's  
Draft Audit Report A-02-07-01037 on  
"Review of Clinic and Practitioner Claims Billed as Family  
Planning Services Under the New York State Medicaid  
Program"**

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The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General's (OIG) draft audit report A-02-07-01037 on "Review of Clinic and Practitioner Claims Billed as Family Planning Services Under the New York State Medicaid Program" (A-02-07-01037).

**OIG Recommendations:**

OIG recommends that the Department:

- refund \$17,151,156 to the Federal Government,
- reemphasize to providers that services only directly related to family planning should be billed as family planning,
- ensure that MMIS edits use all appropriate claim information to identify claims that are ineligible for enhanced 90-percent Federal reimbursement, and
- determine the amount of Federal Medicaid funds improperly reimbursed for claims unrelated to family planning subsequent to its audit period and refund that amount to the Federal Government.

**Department Response:**

The Department will take the following actions relative to the OIG recommendations:

- The Department requests to be furnished a copy of the OIG workpapers supporting the recommended refund amount, including a listing of the claim reference numbers for the claims in the audit sample. Following review of this data, the Department will refund any excess Federal reimbursement associated with claims determined to have been inappropriately classified as family planning.
- The Department will include an article in an upcoming edition of its monthly Medicaid Update provider publication reminding providers that only services directly related to family planning should be billed as family planning.

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- The Department will review the relevant eMedNY edit logic to verify the system controls in place. It will additionally review the sample of claims to better understand how program integrity can be strengthened. Required changes will be initiated to the extent additional system controls can be designed.
- The Department will refund any excess Federal Medicaid funding it determines was improperly reimbursed subsequent to the audit period, based on its review of the OIG workpapers requested above.