APR - 6 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

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

SUBJECT: Review of Inpatient Hospital Claims Billed as Family Planning Services Under the New York State Medicaid Program (A-02-06-01007)

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

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

The State improperly claimed enhanced 90-percent Federal reimbursement for inpatient family planning claims submitted by hospitals. Of the 173 claims in our sample, 3 qualified as family planning services and could be claimed at the enhanced 90-percent Federal reimbursement rate. However, the remaining 170 could not be claimed as family planning services or could be claimed only in part as family planning services. Of those 170 claims, 117 were for services unrelated to family planning, 42 were for services partially related to family planning, and 11 did not include a properly completed sterilization consent form. Based on our sample results, we estimate that the State received $2,603,128 in unallowable Federal Medicaid reimbursement.

This overpayment occurred because: (1) providers incorrectly claimed services as family planning, (2) the State's Medicaid Management Information System (MMIS) edit routines did not adequately identify claims unrelated to family planning, (3) the State did not have procedures to allocate the costs of inpatient hospital claims partially related to family planning, and (4) providers did not properly complete sterilization consent forms.

We recommend that the State:

- refund $2,603,128 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,

- develop procedures to properly allocate the cost of inpatient hospital stays partially related to family planning,

- reinforce guidance to hospitals that a properly completed sterilization consent form must be prepared and maintained for all Medicaid sterilizations and ensure that hospitals comply with this guidance, 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 first recommendation and fully concurred with our remaining recommendations. Regarding our first recommendation to refund $2,603,128 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 all Federal Medicaid funds improperly reimbursed for claims unrelated to family planning services.

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 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. Please refer to report number A-02-06-01007 in all correspondence.

Attachment

Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

APR - 9 2009

Report Number: A-02-06-01007

Richard F. Daines, M.D.
Commissioner
New York State Department of Health
14th 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 Inpatient Hospital 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 Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this 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. Please refer to report number A-02-06-01007 in all correspondence.

Sincerely,

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 INPATIENT HOSPITAL CLAIMS BILLED AS FAMILY PLANNING SERVICES UNDER THE NEW YORK STATE MEDICAID PROGRAM

Daniel R. Levinson
Inspector General

April 2009
A-02-06-01007

Office of Inspector General

http://oig.hhs.gov

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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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

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 (January 1, 2000, through June 30, 2005), 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 inpatient family planning claims submitted by hospitals.

SUMMARY OF FINDINGS

The State improperly claimed enhanced 90-percent Federal reimbursement for inpatient family planning claims submitted by hospitals. Of the 173 claims in our sample, 3 qualified as family planning services and could be claimed at the enhanced 90-percent Federal reimbursement rate. However, the remaining 170 could not be claimed as family planning services or could be claimed only in part as family planning services. Of those 170 claims, 117 were for services unrelated to family planning, 42 were for services partially related to family planning, and 11 did not include a properly completed sterilization consent form. Based on our sample results, we estimate that the State received $2,603,128 in unallowable Federal Medicaid reimbursement.

This overpayment occurred because: (1) providers incorrectly claimed services as family planning, (2) the State's Medicaid Management Information System (MMIS) edit routines did not adequately identify claims unrelated to family planning, (3) the State did not have procedures to allocate the costs of inpatient hospital claims partially related to family planning, and (4) providers did not properly complete sterilization consent forms.

RECOMMENDATIONS

We recommend that the State:

- refund $2,603,128 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,
- develop procedures to properly allocate the cost of inpatient hospital stays partially related to family planning,
- reinforce guidance to hospitals that a properly completed sterilization consent form must be prepared and maintained for all Medicaid sterilizations and ensure that hospitals comply with this guidance, 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 agreed with our recommendations and described actions that it will take in response. Regarding our first recommendation to refund $2,603,128 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 all Federal Medicaid funds improperly reimbursed for claims unrelated to family planning services. 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's 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 (January 1, 2000, through June 30, 2005), the FMAP in New York State was 50 percent from January 1, 2000, through March 31, 2003, 52.95 percent from April 1, 2003, through June 30, 2004, and 50 percent from July 1, 2004, through June 30, 2005.

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 or an "F" through "K" in the sterilization/abortion field[1] to be related to family planning.

[1]Codes for this field are "F" (Sterilization),"G" (Sterilization and Induced Abortion–Danger to Woman's Life),"H" (Sterilization and Induced Abortion–Physical Health Damage to the Woman), "I" (Sterilization and Induced Abortion–Victim of Rape or Incest), "J" (Abortion–Medically Necessary), and "K" (Abortion–Elective).

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.

According to section 4270 of the CMS "State Medicaid Manual" (the manual), family planning services prevent or delay pregnancy or otherwise control family size. The manual also states that enhanced 90-percent rate of 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. In addition, the manual states that 90-percent Federal reimbursement is not available for costs related to other procedures performed for medical reasons, such as the removal of an intrauterine device due to infection.

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 refers to a 1980 policy memorandum regarding CMS policy in allocating inpatient costs where multiple procedures are performed. That CMS policy states that when multiple procedures are performed during a single hospital stay and submitted as a single inpatient claim, a State claim for Federal reimbursement must distinguish between those costs attributable to family planning (eligible for 90-percent Federal reimbursement) and those costs attributable to other covered services (reimbursed at the regular FMAP rate). 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.[2]

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our audit period covered January 1, 2000, through June 30, 2005. 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 did not review the claims in our sample for compliance with Medicaid requirements other than those related to whether the claims qualified for enhanced 90-percent Federal reimbursement as family planning services.

[2]Official Compilation of Codes, Rules and Regulations of the State of New York, Title 18, § 505.13.

We performed fieldwork at DOH's offices in Albany, New York; the State MMIS fiscal agent in Rensselaer, New York; and at 38 hospitals throughout the State.

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 2,724 paid inpatient hospital services billed at the enhanced 90-percent rate of Federal reimbursement by the State totaling $8,813,959 ($7,929,434 Federal share) for the period January 1, 2000, through June 30, 2005;
- eliminated from the 2,724 claims 67 claims with Federal paid amounts that were not equal to 90 percent of their Medicaid paid amounts and 1 claim for a beneficiary in client aid category 56;[3]
- identified a sampling frame of 2,656 inpatient hospital claims billed at the enhanced 90-percent rate of Federal reimbursement by the State, totaling $8,597,705 ($7,737,923 Federal share);
- selected a stratified random sample of 173 claims from the population of 2,656 claims;
- obtained and reviewed medical records from the 38 inpatient hospitals that submitted the 173 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 unallowable Federal reimbursement claimed in the total population of 2,656 claims.

Appendix A contains the details of our sample design and methodology, and Appendix B contains our sample results and estimates.

[3]Beneficiaries in client aid category 56 were included in a family planning waiver program that we reviewed under a separate audit (A-02-07-01001, May 22, 2008).

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 claimed enhanced 90-percent Federal reimbursement for inpatient family planning claims submitted by hospitals. Of the 173 claims in our sample, 3 qualified as family planning services and could be claimed at the enhanced 90-percent Federal reimbursement rate. However, the remaining 170 could not be claimed as family planning services or could be claimed only in part as family planning services. Of those 170 claims, 117 were for services unrelated to family planning, 42 were for services partially related to family planning, and 11 did not include a properly completed sterilization consent form. Based on our sample results, we estimate that the State received $2,603,128 in unallowable Federal Medicaid reimbursement.

This overpayment occurred because: (1) providers incorrectly claimed services as family planning, (2) the State's MMIS edit routines did not adequately identify claims unrelated to family planning, (3) the State did not have procedures to allocate the costs of inpatient hospital claims partially related to family planning, and (4) providers did not properly complete sterilization consent forms.

SERVICES UNRELATED TO FAMILY PLANNING

According 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 117 of the 173 claims in our sample, we determined that the billed services were unrelated to family planning. The 117 claims included 73 inpatient psychiatric claims, 17 claims for graduate medical education (GME) services, 13 claims for the removal of an intrauterine device due to infection,[4] and 14 other claims unrelated to family planning. All 117 claims were for services eligible for reimbursement at the applicable FMAP rate of 50 or 52.95 percent.

Inpatient Psychiatric Claims

One provider submitted 68 of the 73 inpatient psychiatric claims. For these 68 claims, the provider improperly entered a "1" (for yes) in the family planning indicator field, even though none of the services were related to family planning. Provider officials stated that this miscoding occurred as a result of a January 2003 software upgrade. The officials stated that the problem was discovered in February 2003 and corrected for subsequent claims.

[4]There were actually 15 claims involving the removal of an intrauterine device, but 1 claim was allowable and 1 claim also involved an inpatient psychiatric stay and is included in the 73 inpatient psychiatric claims.

Graduate Medical Education Claims

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. GME Medicaid payments cover GME training expenses related to inpatient hospital stays for Medicaid beneficiaries enrolled in a managed care plan. In these instances, an inpatient hospital stay is billed to the managed care plan; however, a separate GME claim is also billed to and paid by the State's MMIS as a 1-day inpatient claim. Because each of the 17 GME claims included a family planning procedure (sterilization or Depo-Provera injection), hospital providers coded the GME claims with either a "Y" or "1" in the family planning indicator field or an "F" or "J" in the abortion/sterilization field. When we discussed these claims with CMS headquarters officials, they stated that GME Medicaid payments relate only to training costs. Therefore, according to these officials, no portion of the 17 separately billed Medicaid GME claims was eligible for 90-percent Federal reimbursement.

Removal of Intrauterine Device Due to Infection

Section 4270 of the CMS "State Medicaid Manual" states that 90-percent Federal reimbursement is not available for costs related to procedures performed for medical reasons, such as the removal of an intrauterine device due to infection. However, when hospital providers used procedure code 9771 (related to the removal of an intrauterine contraceptive device), the State's MMIS categorized the service as family planning and assigned a "1" (for yes) in occurrence 1 (Family Planning) of the special program code.[5] As a result, 13 claims were submitted for enhanced 90-percent Federal reimbursement despite having been correctly coded with a "0" or "N" in the family planning indicator field.

Other Claims Unrelated to Family Planning

We also identified 14 claims that contained procedure and diagnosis codes unrelated to family planning but contained either a "Y" or "1" in the family planning indicator field or an "F" or "K" in the abortion/sterilization field. As a result, these 14 claims were not eligible for enhanced 90-percent Federal reimbursement. Some of these 14 claims related to circulatory system diseases, renal failure, and acute lymphoid leukemia.

SERVICES PARTIALLY RELATED TO FAMILY PLANNING

On January 30, 1991, CMS issued the guide to the State via Medicaid State Operations Letter 91-9. The "Policy Memorandums" section of the guide states that when multiple procedures are performed during a single hospital stay and submitted as a single inpatient claim, the State claim must distinguish between those costs attributable to family planning and those costs attributable to services covered at the regular FMAP. The guide also states that medical complications caused by or following a family planning procedure should only be reimbursed at the regular FMAP, not the enhanced 90-percent reimbursement rate. We determined that 42 of the 173 claims in our sample were partially related to family planning.

[5]According to the guide, code 9771 is among codes that are for "diagnostic and nonsurgical procedures." The guide states that these codes "would rarely, if ever, be coded on an inpatient hospital claim."

For 35 sampled claims, the beneficiary was hospitalized for a nonfamily planning procedure, but a portion of the beneficiary's inpatient stay included a family planning procedure. For each of these claims, the State claimed the entire cost of the inpatient stay at the enhanced 90-percent Federal reimbursement rate rather than allocating the costs between 90 percent and the regular FMAP. Of the 35 sampled claims, 33 involved services related to the delivery of a baby or postpartum care followed by a sterilization, 1 involved a bladder augmentation with a vasectomy, and 1 involved the delivery of a baby followed by a Depo-Provera injection before the beneficiary was discharged.

In addition, for seven other sampled claims, the beneficiary was hospitalized as a result of medical complications following a sterilization procedure. The State claimed the entire cost of the inpatient stay at the enhanced 90-percent Federal reimbursement rate rather than allocating the costs between 90 percent and the regular FMAP.

The 42 claims were not allocated between the enhanced 90-percent Federal reimbursement rate and the regular FMAP because the State did not have controls to allocate inpatient hospital claims between nonfamily planning and family planning procedures.[6]

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 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 part 441 or another form approved by the Secretary of the Department of Health and Human Services.

For 11 of the 173 claims in our sample, a sterilization consent form was not properly completed. For 10 claims, the physician did not sign or date the consent form. In 4 of these 10 cases, the beneficiary signed the consent form fewer than 30 days before the sterilization.[7] For one claim,

[6]After consulting with CMS headquarters officials, we calculated the amount of the claims that would have been payable at the enhanced 90-percent Federal reimbursement rate for the 41 claims that included a sterilization or vasectomy if the sterilization or vasectomy had been performed as an outpatient service in the hospital and the amount of the remainder, which would have been payable at the regular FMAP. For the claim involving the Depo-Provera injection, we calculated the amount of the claim that would have been payable at the enhanced 90-percent Federal reimbursement rate if the injection had been given in the hospital's clinic and the amount of the remainder, which would have been payable at the regular FMAP.

[7]For the four cases in which the beneficiary signed the consent form fewer than 30 days before the sterilization, the premature delivery box or emergency abdominal surgery box was not checked on the form.

the hospital could not locate a sterilization consent form. No Federal Medicaid reimbursement was available for the sterilization procedure; however, we calculated the remainder of each of the 11 claims at the regular FMAP.

CAUSES OF THE OVERPAYMENTS

We identified four main causes of the overpayment. The same control problems were identified in two previous audit reports.[8]

Improperly Coded Claims

For the 117 sampled claims unrelated to family planning, 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," "G," "J," or "K." Specifically:

- For 92 claims, the provider entered a "Y" or "1" (for yes) in the family planning indicator field. Included in these 92 claims were services for cancer, pelvic fracture, renal failure, numerous psychiatric disorders, and a postabortion procedure.

- For 14 claims involving the removal of an intrauterine device due to infection, the MMIS assigned a "1" (Yes) in occurrence "1" (Family Planning) in the special program code.[9]

- For 11 claims, providers marked the abortion/sterilization field with an "F," "G," "J," or "K."[10] As a result, the MMIS identified the service as related to family planning.

Inadequate Medicaid Management Information System Edit Routines

The MMIS contains edits to identify claims that potentially qualify for enhanced 90-percent Federal reimbursement, but these edits did not deny enhanced reimbursement for claims containing evidence that all or some of the services might not have qualified as family planning services. The MMIS screened claims for the presence of specific codes in the family planning indicator field, the special program code field, or the sterilization/abortion field (described above) and required only one of these fields to be coded as related to family planning for the system to classify a claim as eligible for enhanced 90-percent Federal reimbursement, even if

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[8]"Review of Selected Inpatient Claims Billed as Family Planning Services Under the New York State Medicaid Program" (A-02-90-01011, October 1990) and "Review of Inpatient and Ancillary Services Billed as Family Planning Under the New York State Medicaid Program" (A-02-90-01029, August 1991). The State appealed the disallowances in the reports to the Department of Health and Human Services, Departmental Appeals Board (DAB). In New York State Department of Social Services, DAB No. 1284 (1991), and New York State Department of Social Services, DAB No. 1364 (1992), the DAB generally upheld the disallowances in the two reports.

[9]For all 14 claims, providers used procedure code 9771 (removal of intrauterine contraceptive device) that caused the MMIS to code the claims as family planning.

[10]Of the 11 claims, 8 were related to GME, 1 was related to depression, 1 was related to a digestive system operation, and 1 was related to the removal of the fallopian tubes and ovaries of a postmenopausal woman.

other fields indicated that the claims were not related to family planning. As noted above, 92 claims contained a "Yes" in the family planning indicator field, but none of the claimed services related to family planning. Even when providers correctly marked "0" (for no) in the family planning indicator field for certain services (e.g., removal of the intrauterine device due to an infection), the MMIS categorized the corresponding claims as family planning services because of the procedure code used. Finally, for claims coded with an "F," "G," "J," or "K" 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."

Lack of Written Policies for Multiple Procedure Inpatient Stays

The State did not have a written policy to allocate the costs of inpatient stays involving both a nonfamily planning procedure and a family planning procedure (e.g., a delivery of a baby and sterilization during the same inpatient stay). Rather, the State treated these inpatient stays as being entirely eligible for enhanced 90-percent Federal reimbursement. Forty-two of our sampled claims were only partially related to family planning, yet all 42 were claimed at the enhanced 90-percent Federal reimbursement rate.

Incomplete Sterilization Consent Forms

The State issued guidance to inpatient hospitals to assist them in understanding and complying with Medicaid requirements for billing and submitting claims, including an appendix to its billing guidelines that contained step-by-step instructions for completing sterilization consent forms. The instructions noted that the completed and signed form must be kept in the patient's file and if upon audit the consent form is not present or is deficient, all payments associated with the sterilization procedure will be recouped. Nevertheless, 11 of our sampled claims did not include a properly completed sterilization consent form.

RECOMMENDATIONS

We recommend that the State:

- refund $2,603,128 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,
- develop procedures to properly allocate the cost of inpatient hospital stays partially related to family planning,

- reinforce guidance to hospitals that a properly completed sterilization consent form must be prepared and maintained for all Medicaid sterilizations and ensure that hospitals comply with this guidance, 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 agreed with our recommendations and described actions that it will take in response. Regarding our first recommendation to refund $2,603,128 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 all Federal Medicaid funds improperly reimbursed for claims unrelated to family planning services. 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 inpatient hospital services during our January 1, 2000, through June 30, 2005, audit period.

SAMPLING FRAME

The sampling frame was a computer file containing 2,656 Medicaid claims for inpatient services billed as family planning at 90-percent Federal reimbursement during our review period. The total Medicaid reimbursement for the 2,656 claims was $8,597,705 ($7,737,923 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 an inpatient hospital 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 inpatient hospital 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 $7,499.99—2,513 claims.

- Stratum 2: Claims with a Federal share payment amount equal to or greater than $7,500—70 claims.

- Stratum 3: Claims with an inpatient psychiatric rate code—73 claims.

Note: We put all claims with an inpatient psychiatric rate code, regardless of Federal share payment amount, in stratum 3.

SAMPLE SIZE

We selected a sample size of 173 claims as follows:

- 30 claims from the first stratum,
- 70 claims from the second stratum, and
- 73 claims from the third stratum.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Audit Services' statistical software, RAT-STATS. We used the random number generator for our sample.

METHOD OF SELECTING SAMPLE ITEMS

We sequentially numbered the 2,513 claims in stratum 1. We selected 30 random numbers for stratum one and selected the corresponding frame items. Each of the claims in stratum two and in stratum three were selected. We created a list of the 173 sample items.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We used the lower limit at the 90-percent confidence level to estimate the overpayment associated with the unallowable claims.

APPENDIX B

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	Value of Unallowable Claims (Federal Share)
1. < $7,500	2,513	$6,599,783	30	$84,048	29	$32,968
2. ≥ $7,500	70	717,887	70	717,887	68	300,296
3. Inpatient psychiatric rate code	73	420,253	73	420,253	73	186,288
Totals	**2,656**	**$7,737,923**	**173**	**$1,222,188**	**170**	**$519,552**

Estimates
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$3,248,225
Lower Limit:	$2,603,128
Upper Limit:	$3,893,321

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
Executive Deputy Commissioner

January 27, 2009

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-02-06-01007

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-02-06-01007 on "Review of Inpatient Hospital Claims Billed as Family Planning Services Under the New York State Medicaid Program."

Thank you for the opportunity to comment.

Sincerely,

Wendy E. Saunders
Executive Deputy Commissioner

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-02-06-01007 on "Review of Inpatient Claims Billed as Family Planning Services Under the New York State Medicaid Program"

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-02-06-01007 on "Review of Inpatient Claims Billed as Family Planning Services Under the New York State Medicaid Program."

Recommendation #1:

The State should refund $2,603,128 to the Federal Government.

Response #1:

The Office of the Medicaid Inspector General has requested to be provided with a copy of the OIG workpapers. Following review, the Department will refund all Federal Medicaid funds improperly reimbursed for claims unrelated to family planning services.

Recommendation #2:

The State should reemphasize to providers that only services directly related to family planning should be billed as family planning.

Response #2:

The Department will include an article in its Medicaid Update monthly provider publication defining family planning services and will include instructions on appropriately billing for these services.

Recommendation #3:

The State should ensure that MMIS edit routines use all appropriate claim information to identify claims that are ineligible for enhanced 90-percent Federal reimbursement.

Response #3:

The Department will perform a review of its existing MMIS edit routines to ensure that all appropriate claim information is used to identify claims that are eligible or ineligible for 90-percent Federal financial participation.

Recommendation #4:

The State should develop procedures to properly allocate the cost of inpatient hospital stays partially related to family planning.

Response #4:

The Department will develop procedures to properly allocate Federal shares for inpatient hospital stays during which family planning and non-family planning services are provided.

Recommendation #5:

The State should reinforce guidance to hospitals that a properly completed sterilization consent form must be prepared and maintained for all Medicaid sterilizations and ensure that hospitals comply with this guidance.

Response #5:

The Department will include an article in its Medicaid Update monthly provider publication reinforcing instructions for the proper completion and maintenance of the sterilization consent form.

Recommendation #6:

The State should 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.

Response #6:

The Department will perform a review of inpatient claims subsequent to the audit period and will refund the amount of Federal Medicaid funds it determines was improperly reimbursed for claims unrelated to family planning services.