

# STATE OF NEVADA

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## Performance Audit

Department of Health and Human Services  
Division of Health Care Financing and Policy

2015



Legislative Auditor  
Carson City, Nevada

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# Audit Highlights



Highlights of Legislative Auditor report on the Division of Health Care Financing and Policy issued on May 4, 2015. Report # LA16-02.

## Background

The Division of Health Care Financing and Policy administers two major federal health coverage programs, Medicaid and the Children's Health Insurance Program (CHIP). The largest program is Medicaid, which provides health care to low-income families, and the aged, blind, and disabled. The CHIP provides health care to low-income, uninsured children who are not eligible for Medicaid.

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. The Act includes expanding Medicaid to individuals and families with incomes up to 133% of the federal poverty level, including adults without disabilities and without dependent children. Medicaid expansion has resulted in a significant increase in Nevada enrollment. Nevada enrollment has increased from 314,166 in July 2013, to 573,119 in July 2014, an 82% increase.

Funding for Medicaid programs comes from several sources including federal funds, state appropriations, and local governments. In fiscal year 2014, Medicaid expenditures totaled \$2.3 billion. The Division had 278 authorized positions with offices located in Carson City, Elko, Las Vegas, and Reno.

## Purpose of Audit

The purpose of this audit was to determine if sufficient controls were in place to detect and prevent fraud, abuse, and billing errors that result in Medicaid overpayments. Our audit focused on paid claims for behavioral health services during fiscal years 2013 and 2014, and dental services during fiscal years 2012 and 2013.

## Audit Recommendations

This audit report contains six recommendations to strengthen processes for detecting and preventing fraud, abuse, and billing errors that result in Medicaid overpayments.

The Division of Health Care Financing and Policy accepted the six recommendations.

## Recommendation Status

The Division's 60-day plan for corrective action is due on July 29, 2015. In addition, the six-month report on the status of audit recommendations is due on January 29, 2016.

# Division of Health Care Financing and Policy

## Department of Health and Human Services

### Summary

Although the Division has strengthened its oversight of Medicaid payments since our last audit in 2008, we identified certain areas where improvements are needed. Our testing identified about \$780,000 in overpayments from behavioral health claims. We also identified improper billings and overpayments totaling more than \$285,000 with dental claims. Improper billings and overpayments occurred primarily because the Division's computer system lacked sufficient edit checks to stop the payment of improper claims. Computer edit checks are an important system control to help ensure claims are paid according to Medicaid policies.

### Key Findings

Based on our analysis of claims data, we identified overpayments of about \$780,000 in behavioral health claims during fiscal years 2013 and 2014. Behavioral health services we reviewed included: basic skills training, crisis intervention, day treatment, and psychosocial rehabilitation services. These services are provided in a community-based or inpatient setting, and are designed to reduce a physical or mental disability and restore an individual to the best possible functioning level. Of these overpayments, about \$680,000 was for basic skills training and \$100,000 was for other behavioral health services. For these services, daily limits are established in Medicaid policy. According to management, these overpayments occurred because the Division's computer system, the Medicaid Management Information System (MMIS), did not process claims according to policy. (page 6)

The Division's computer system also lacked sufficient edits to prevent overpayments to dental providers submitting incorrect or excessive claims. One dental provider overbilled Medicaid by submitting multiple claims for procedures that should be billed on a per visit basis. For other procedures, the number of claims submitted per patient per day were excessive when compared with other dentists' claims. We estimate more than \$285,000 was overpaid to this provider during fiscal years 2012 and 2013. To identify overpayments, we performed sorts and queries of paid dental claims data. This analysis identified unusual billing practices by one provider. Because edits were not in place, other providers also submitted incorrect claims. However, the number of incorrect claims by other providers was minimal in comparison to excessive billing practices by one provider. (page 10)

Examples of overbilling by one provider include:

- One dentist submitted 4,177 claims or 48% of all claims submitted statewide for the "emergency treatment of dental pain – minor procedure," during fiscal years 2012 and 2013. Billing guidance indicates this procedure should be billed on a per visit basis. Unlike other providers, this dentist submitted multiple claims for the same patient on the same day. For example, 24 claims for the treatment of dental pain were submitted on one patient for the same day. We estimate the Division overpaid this dentist nearly \$124,000 for the emergency treatment of dental pain during fiscal years 2012 and 2013. (page 11)
- During fiscal years 2012 and 2013, the same dentist submitted 4,442 or 21% of all claims for oral/facial photographs submitted statewide. The Division pays \$20.36 for each traditional photographic image taken of the face or inside the mouth with a camera. We found this dentist typically submitted many claims for photographs of the same patient on the same day. For example, during fiscal year 2013, 32 patients received 20 or more photographs on the same day. The vast majority of other dentists submitted claims for one photograph per patient per day. We estimate the Division overpaid this dentist more than \$67,000 for photographs during fiscal years 2012 and 2013. (page 13)
- This dentist also submitted 6,690 or 80% of all claims for pulp vitality tests in fiscal years 2012 and 2013. A pulp vitality test is conducted to examine the integrity of a tooth's nerve. Billing guidance indicates this procedure includes checking multiple teeth. However, this dentist submitted many claims for the same patient on the same day. For example, this dentist submitted 10 or more claims for pulp vitality tests on the same patient and same day 85 times in fiscal year 2013. In one case, 28 claims were submitted for one patient on the same day. We estimate this dentist was overpaid nearly \$52,000 during fiscal years 2012 and 2013 for pulp vitality tests. (page 13)

We notified Division management of the dentist with multiple billing issues. In addition, claims information was provided to the Division for further investigation. According to the Division, an investigation of the billing issues has been initiated regarding this provider. (page 14)

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This report contains the findings, conclusions, and recommendations from our performance audit of the Division of Health Care Financing and Policy. This audit was conducted pursuant to the ongoing program of the Legislative Auditor as authorized by the Legislative Commission. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions.

This report includes six recommendations to improve controls for detecting and preventing fraud, abuse, and billing errors that result in Medicaid overpayments. We are available to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other state officials.

Respectfully submitted,

Paul V. Townsend, CPA  
Legislative Auditor

April 16, 2015  
Carson City, Nevada

# Division of Health Care Financing and Policy

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# Introduction

## Background

In 1965, Congress established the Medicaid program under Title XIX, of the Social Security Act. Medicaid was established in response to the widely perceived inadequacy of welfare medical care under public assistance. Nevada adopted the Medicaid program in 1967 with the passage of legislation placing the program in the Welfare Division (currently the Division of Welfare and Supportive Services). During the 1997 Legislation Session, the Division of Health Care Financing and Policy (Division) was created.

The Division's mission is to purchase and provide quality health care services to low-income Nevadans in the most efficient manner; promote equal access to health care at an affordable cost to the taxpayers of Nevada; restrain the growth of health care costs; and review Medicaid and other state health care programs to maximize potential federal revenue.

The Division administers two major federal health coverage programs, Medicaid and the Children's Health Insurance Program (CHIP). The largest program is Medicaid, which provides health care to low-income families, and the aged, blind, and disabled. The CHIP in Nevada is known as Nevada Check Up and provides health care coverage to low-income, uninsured children who are not eligible for Medicaid. The Division of Welfare and Supportive Services is responsible for determining eligibility.

States have broad discretion in determining eligibility and the amount, duration, and scope of services offered under Medicaid. States may place appropriate limits on services based on criteria such as medical necessity and utilization control. For example, states may limit the number of covered physician visits or may require prior authorization. In general, Nevada made program services available to low-income persons who are aged, blind or disabled, and pregnant women and children.

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. The Act includes expanding Medicaid to individuals and families with incomes up to 133% of the federal poverty level, including adults without disabilities and without dependent children. Medicaid expansion has resulted in a significant increase in Nevada enrollment. According to statistics provided by Division staff, Nevada enrollment has increased from 314,166 in July 2013, to 573,119 in July 2014, an 82% increase.

Funding for Medicaid comes from several sources including federal funds, state appropriations, and local governments. Exhibit 1 shows revenues and expenditures from 2010 to 2014.

**Medicaid Revenues and Expenditures  
Fiscal Years 2010 – 2014**

**Exhibit 1**

|                                 | 2010                   | 2011                   | 2012                   | 2013                   | 2014                   |
|---------------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|
| <b>Revenues</b>                 |                        |                        |                        |                        |                        |
| Appropriations                  | \$ 431,258,049         | \$ 464,477,843         | \$ 535,331,735         | \$ 545,663,765         | \$ 550,163,050         |
| Federal Funds                   | 1,021,163,827          | 1,054,164,574          | 1,008,868,779          | 1,157,801,090          | 1,492,028,340          |
| Local Governments               | 128,399,043            | 142,660,620            | 188,105,816            | 185,683,588            | 156,292,593            |
| Transfers <sup>(1)</sup>        | 87,475,772             | 114,441,110            | 178,721,091            | 153,986,371            | 131,555,282            |
| Miscellaneous                   | 4,046,253              | 3,991,718              | 4,751,514              | 4,238,410              | 4,345,226              |
| Beginning Funds                 | 3,945,909              | 22,095,384             | 25,680,545             | 3,098,975              | 6,975,860              |
| <b>Total Revenues</b>           | <b>\$1,676,288,853</b> | <b>\$1,801,831,249</b> | <b>\$1,941,459,480</b> | <b>\$2,050,472,199</b> | <b>\$2,341,360,351</b> |
| <b>Expenditures</b>             |                        |                        |                        |                        |                        |
| Medical Payments <sup>(2)</sup> | \$1,490,499,023        | \$1,579,524,854        | \$1,675,046,834        | \$1,775,362,642        | \$2,064,447,794        |
| Transfers <sup>(3)</sup>        | 105,585,384            | 132,704,709            | 197,344,083            | 180,435,819            | 158,421,571            |
| Personnel                       | 18,208,469             | 18,161,737             | 17,680,022             | 18,224,582             | 17,937,649             |
| Operating                       | 6,812,059              | 4,379,934              | 3,890,848              | 4,058,609              | 4,970,888              |
| Fiscal Agent <sup>(4)</sup>     | 22,229,925             | 22,690,054             | 23,408,270             | 30,047,226             | 33,286,207             |
| Miscellaneous <sup>(5)</sup>    | 10,777,843             | 15,525,630             | 18,351,382             | 33,127,296             | 27,699,604             |
| <b>Total Expenditures</b>       | <b>\$1,654,112,703</b> | <b>\$1,772,986,918</b> | <b>\$1,935,721,439</b> | <b>\$2,041,256,174</b> | <b>\$2,306,763,713</b> |
| Difference                      | 22,176,150             | 28,844,331             | 5,738,041              | 9,216,025              | 34,596,638             |
| Less Reversions                 | (80,766)               | (3,163,786)            | (2,639,066)            | (2,240,165)            | <sup>(6)</sup> 0       |
| <b>Ending Funds</b>             | <b>\$ 22,095,384</b>   | <b>\$ 25,680,545</b>   | <b>\$ 3,098,975</b>    | <b>\$ 6,975,860</b>    | <b>\$ 34,596,638</b>   |

Source: State accounting system.

<sup>(1)</sup> Transfers include funding from intergovernmental transfers and the nursing facility provider tax.

<sup>(2)</sup> Includes Nevada Check Up expenditures. In fiscal year 2014, Nevada Check Up expenditures totaled \$38 million.

<sup>(3)</sup> Includes accounting entries to transfer intergovernmental funds to pay Medicaid expenditures and healthcare related activities provided by other Department of Health and Human Services agencies.

<sup>(4)</sup> Vendor that performs several functions including the payment of claims, provider enrollment, and distribution of medical cards.

<sup>(5)</sup> Miscellaneous includes items such as grant expenditures, travel, equipment, information technology, training, fees, and reimbursements.

<sup>(6)</sup> Chapter 446, Statutes of Nevada, 2013 (A.B. 507) authorized the transfer of appropriations from one fiscal year to another with the approval of the Interim Finance Committee (IFC) upon the recommendation of the Governor. The IFC approved this action on August 27, 2014. Therefore, the Division did not revert money to the General Fund in 2014.

Exhibit 1 shows Medicaid expenditures have increased from about \$1.65 billion in fiscal year 2010 to \$2.3 billion in fiscal year 2014, or 39%. Most of the increase that occurred between fiscal years 2013 and 2014 resulted from ACA Medicaid expansion.

In fiscal year 2014, Medicaid managed care expenditures were about \$543 million, or about 26% of total medical expenditures. Managed care is provided through contracts with two Managed Care Organizations (MCO) that function similar to Health Maintenance Organizations. The program objectives are to improve access to care and coordination of care, while managing costs. Currently, services are available to recipients living in the urban areas of Clark and Washoe counties. About 65% of the Medicaid recipients are enrolled in MCOs.

In 2014, the Division had 278 authorized positions with offices in Carson City, Elko, Las Vegas, and Reno.

## **State and Federal Oversight of Medicaid Payments**

The State and Federal Government have made progress in recent years with preventing and detecting improper Medicaid payments. Since our last audit in 2008, the Legislature provided the Division with several new positions to help identify improper payments from fraud, abuse, and non-compliance with billing procedures. In addition, the Division made organizational changes including creating the Fiscal Integrity Unit and centralizing overpayment collections. The Federal Government also provided for independent contractors to assist the Division with identifying overpayments. In fiscal year 2014, the Division and various contractors reported recovering nearly \$6.4 million in overpayments.

The State has made several improvements in recent years to help address improper payments. These efforts include:

- Surveillance and Utilization Review (SUR) – SUR conducts random and focused reviews of claims and handles complaints against providers. It also reviews providers through self-audits, reviewing records, and on-site visits to identify improper payments. In addition, SUR coordinates audit activities between the Division and the Medicaid

Integrity Contractor and the Recovery Audit Contractor. SUR staffing has increased from 3 to 14 staff since 2007.

- Fiscal Integrity Unit – This Unit was created in February 2010 with 7 positions and has increased to a current level of 15 staff. Fiscal Integrity audits various contractors including managed care organizations, the fiscal agent, and providers participating in the federal Electronic Health Records program. In addition, the Unit oversees Payment Error Rate Measurement (PERM) audits to help ensure the accuracy of medical records, claims, and eligibility information.
- Recoupment and Recovery – The Division centralized overpayment recovery efforts, previously handled by SUR and Accounting, into Recoupment and Recovery. Recovery efforts are performed by three staff located in the Fiscal Integrity Unit.

The Federal Government created additional oversight functions including the Medicaid Integrity Program Contractor (MIC) and Recovery Audit Contractor (RAC).

- Medicaid Integrity Program – the federal Deficit Reduction Act of 2005 created the Medicaid Integrity Program. The Program's purpose is to reduce provider fraud, waste, and abuse. The federal Centers for Medicare and Medicaid Services (CMS) hires and pays contractors to audit claims, identify overpayments, and educate providers. In addition, CMS provides support and assistance to the states in their efforts to combat provider fraud and abuse.
- Recovery Audit Contractor – The RAC program originally began as a demonstration program in Medicare. In 2010, with the passage of the Affordable Care Act, states were required to establish Medicaid RAC programs. Contractors are hired to identify improper payments and their work is approved by the Division. The RAC is paid through a percentage of overpayments recovered.



Exhibit 2 shows recoveries reported by Division staff and contractors over the last 3 fiscal years.

| <b>Medicaid Recoveries<br/>Fiscal Years 2012 – 2014</b> |                    |                    |                    | <b>Exhibit 2</b>    |
|---|--------------------|--------------------|--------------------|---------------------|
|   | <b>2012</b>        | <b>2013</b>        | <b>2014</b>        | <b>Totals</b>       |
| <b><u>Division Recoveries</u></b>                       |                    |                    |                    |                     |
| SUR Recoveries  | \$4,601,906        | \$2,481,847        | \$1,405,260        | \$ 8,489,013        |
| Fiscal Integrity Recoveries                             |                    | 42,014             | 173,359            | 215,373             |
| <b><u>Contractor Recoveries</u></b>                     |                    |                    |                    |                     |
| RAC Recoveries  |                    | 1,188,967          | 4,797,692          | 5,986,659           |
| MIC Recoveries  |                    | 14,512             | 0                  | 14,512              |
| <b>Total Recoveries</b>                                 | <b>\$4,601,906</b> | <b>\$3,727,340</b> | <b>\$6,376,311</b> | <b>\$14,705,557</b> |

Source: Division records.

Exhibit 2 shows the Division's Medicaid recoveries for fiscal years 2012 to 2014 totaled \$14.7 million, including \$8.7 million recovered by Division staff and \$6 million by contractors. The amounts in Exhibit 2 do not include recoveries by the Medicaid Fraud Control Unit in the Office of Attorney General.

## Scope and Objective

The scope of our audit included a review of the Division's paid claims data for behavioral health services during fiscal years 2013 and 2014, and dental services during fiscal years 2012 and 2013. Behavioral health and dental services represent about 9.2% of the Division's health care expenditures. Our audit objective was to:

- Determine if the Division has sufficient controls in place to detect and prevent fraud, abuse, and billing errors that result in Medicaid overpayments.

This audit is part of the ongoing program of the Legislative Auditor as authorized by the Legislative Commission, and was made pursuant to the provisions of NRS 218G.010 to 218G.350. The Legislative Auditor conducts audits as part of the Legislature's oversight responsibility for public programs. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions.

# Improvements Can Be Made to Identify Medicaid Overpayments

Although the Division has strengthened its oversight of Medicaid payments since our last audit in 2008, we identified certain areas where improvements are needed. Our testing identified about \$780,000 in overpayments from behavioral health claims. We also identified improper billings and overpayments totaling more than \$285,000 with dental claims. Improper billings and overpayments occurred primarily because the Division's computer system lacked sufficient edit checks to stop the payment of improper claims. Computer edit checks are an important system control to help ensure claims are paid according to Medicaid policies.

## **Behavioral Health Providers Paid More Than Allowed**

Based on our analysis of claims data, we identified overpayments of about \$780,000 in behavioral health claims during fiscal years 2013 and 2014. Behavioral health services we reviewed included: basic skills training, crisis intervention, day treatment, and psychosocial rehabilitation services. These services are provided in a community-based or inpatient setting, and are designed to reduce a physical or mental disability and restore an individual to the best possible functioning level.<sup>1</sup> Of these overpayments, about \$680,000 was for basic skills training and \$100,000 was for other behavioral health services. For each of these services, daily service limits are established by Medicaid policy. According to management, the Division's computer system, the Medicaid Management Information System (MMIS), lacked sufficient edits

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<sup>1</sup> Behavioral health services are available to both children and adults in either a community-based or inpatient setting. Services must be recommended by a physician or other licensed practitioner to reduce a physical or mental disability and to restore the individual to the best possible functioning level. All services must be documented as medically necessary and appropriate, and prescribed in an Individualized Treatment Plan. Services assist individuals to develop and retain psychiatric stability, social integration skills, and independent living in order to experience success and to function as independently as possible. See Appendix A for a description of services.

to identify billings exceeding the daily limits. Therefore, overpayments occurred because MMIS did not process certain claims according to policy.

To identify overpayments, we analyzed claims data by performing computer sorts and queries of all behavioral health claims paid during fiscal years 2013 and 2014. During this period, about 2.4 million behavioral health claims were paid totaling approximately \$293 million. Overall, behavioral health services represent about 7.5% of the Division's health care expenditures.

Most of the overpayments we identified were for basic skills training (BST). The Division overpaid about \$680,000 for these services during fiscal years 2013 and 2014. Division policy allowed up to 4 hours of BST services per day based on the recipient's needs. We found providers billed and were paid for more than 4 hours of BST per recipient on the same day. Exhibit 3 shows examples of six claims where the Division paid for more than 4 hours of BST on 1 day.

### Examples of Basic Skills Training Claims Paid Claims Exceeding 4-Hour Daily Limit

### Exhibit 3

| Date of Service   | Hours Paid for 1 Day | Maximum Daily Hours Allowed <sup>(1)</sup> | Hours Overpaid | Hourly Rate | Amount Overpaid |
|-------------------|----------------------|--|----------------|-------------|-----------------|
| September 1, 2012 | 18                   | 4  | 14             | \$36.36     | \$ 509.04       |
| December 1, 2012  | 44                   | 4  | 40             | \$36.36     | \$1,454.40      |
| January 3, 2013   | 38                   | 4  | 34             | \$36.36     | \$1,236.24      |
| May 11, 2013      | 42                   | 4  | 38             | \$36.36     | \$1,381.68      |
| November 6, 2013  | 28                   | 4  | 24             | \$36.36     | \$ 872.64       |
| December 1, 2013  | 58                   | 4  | 54             | \$36.36     | \$1,963.44      |

Source: Medicaid behavioral health claims data for fiscal years 2013 and 2014.

<sup>(1)</sup> Maximum daily hours limited to 2 hours effective January 10, 2014.

According to policy, the maximum daily payment allowed for each claim in Exhibit 3 is \$145.44, or no more than 4 hours a day at \$36.36 per hour.

During our audit, the Division recognized there were problems with overutilization of BST services. Among policy revisions made in January 2014, BST was reduced to a maximum of 2 hours per

day for each recipient. In addition, prior authorization was required before BST services were provided. However, we found providers continued to be paid for more than 2 hours of BST per recipient on the same day.

Exhibit 4 shows six claims with service dates in April, May, and June 2014, where the Division paid for more than 2 hours of BST.

**Examples of Basic Skills Training Claims  
Paid Claims Exceeding 2-Hour Daily Limit**

**Exhibit 4**

| <b>Date of Service</b> | <b>Hours Paid for 1 Day</b> | <b>Maximum Daily Hours Allowed</b> | <b>Hours Overpaid</b> | <b>Hourly Rate</b> | <b>Amount Overpaid</b> |
|------------------------|-----------------------------|------------------------------------|-----------------------|--------------------|------------------------|
| April 2, 2014          | 16                          | 2                                  | 14                    | \$36.36            | \$509.04               |
| April 5, 2014          | 28                          | 2                                  | 26                    | \$36.36            | \$945.36               |
| May 17, 2014           | 7                           | 2                                  | 5                     | \$36.36            | \$181.80               |
| May 27, 2014           | 8                           | 2                                  | 6                     | \$36.36            | \$218.16               |
| June 2, 2014           | 8                           | 2                                  | 6                     | \$36.36            | \$218.16               |
| June 8, 2014           | 8                           | 2                                  | 6                     | \$36.36            | \$218.16               |

Source: Medicaid behavioral health claims data for fiscal year 2014.

According to policy, the maximum daily payment allowed for each claim in Exhibit 4 is \$72.72, or 2 hours a day at \$36.36 per hour. In total, we identified \$680,000 in BST overpayments during fiscal years 2013 and 2014. Of this amount \$547,000 occurred from January to June 2014.

In addition, we identified about \$100,000 in overpayments during fiscal years 2013 and 2014 from other behavioral health services. These include crisis intervention, behavioral day treatment, and psychosocial rehabilitation services. These overpayments were also the result of claims paid in excess of daily limits.

Overpayments occurred because the Division's computer system, MMIS, lacked sufficient edits to identify billings exceeding daily limits. Edits are designed to help ensure that claims are processed within proper parameters and in compliance with Medicaid policy. For example, the Division has restricted daily service limits for BST to 2 hours per day. A computer edit would stop any claim that billed for more than 2 hours of BST per recipient on the same day. The provider would then be notified

that the claim was not properly billed and provided with the opportunity to resubmit it correctly.

We identified overpayments by performing queries and calculations of paid claims data to test whether daily services limits were exceeded. Although a policy change reduced daily service limits for BST from 4 to 2 hours per day in January 2014, the Division had not established a process to ensure compliance with daily hour limits or identified the need to develop edits for daily hour limits. Recipients are typically authorized to receive a total number units or hours of treatment during a 90-day period. According to the Division, MMIS has edits to ensure the total hours authorized during a 90-day period are not exceeded. However, MMIS does not always have edits in place to ensure daily hour limits are not exceeded.

The Division was very responsive in assisting us with the audit and plans to implement edits or alternative controls to help ensure payments do not exceed daily limits. According to staff, alternative controls may be necessary because MMIS technology is old and cannot always be updated in a cost effective manner. The Division is currently seeking to replace MMIS. In addition, staff indicated that computer edits may have failed or were not feasible in all instances. In these cases, the Division should periodically review claims data and the number of service hours paid per day to ensure payments are correct. To assist the Division, we provided detailed information regarding the overpayments we identified.

### **Recommendations**

1. Develop computer edits or alternative controls to identify behavioral health claims requesting payment for services that exceed daily allowed hours (units).
2. Develop procedures to review behavioral health claims data to identify potential problems, ensure edits are working as intended, and identify overpayments where the development of computer edits are not feasible.

## **Dental Claims Not Billed Properly**

The Division's computer system also lacked sufficient edits to prevent overpayments to dental providers submitting incorrect or excessive claims. One dental provider overbilled Medicaid by submitting multiple claims for procedures typically billed on a per visit basis. For other procedures, the number of claims submitted per patient per day were excessive when compared with other dentists' claims. In addition, some x-rays were taken more frequently than allowed by policy. We estimate more than \$285,000 was overpaid to this provider during fiscal years 2012 and 2013. To identify overpayments, we performed sorts and queries of paid dental claims data. This analysis identified unusual billing practices by one provider. Because edits were not in place, other providers also submitted incorrect claims. However, the number of incorrect claims by other providers was minimal in comparison to excessive billing practices by one provider.

Our analysis of dental claims included downloads of all paid claims during fiscal years 2012 and 2013. During this period, about 980,000 claims were paid totaling about \$61 million. Overall, dental claims represent about 1.7% of the Division's health care expenditures. After we identified one provider with unusual billing practices, we focused our work on five dental procedures and two x-rays where this provider submitted excessive claims.

When performing sorts and queries of paid dental claims data, we identified one dentist that submitted a large number of claims for certain procedures when compared with other providers. Exhibit 5 shows a comparison of five procedures billed by one dentist with the total billed by all dentists during fiscal years 2012 and 2013.

**Comparison of Five Procedures Billed by One Dentist  
With Total Claims Submitted by All Dentists  
Fiscal Years 2012 and 2013**

**Exhibit 5**

| <b>Procedure</b>   | <b>Number of<br/>Claims<br/>Submitted<br/>by One<br/>Dentist</b> | <b>Number of<br/>Claims<br/>Submitted by<br/>All Dentists</b> | <b>Percent of<br/>Total Claims<br/>Submitted by<br/>One Dentist</b> |
|--|--|---|---|
| Treatment of Complications (post-surgical) – unusual circumstances | 382  | 415   | 92%   |
| Office Visit for Observation – no other services performed         | 1,606  | 1,926   | 83%   |
| Pulp Vitality Test – investigate the integrity of the nerve        | 6,690  | 8,336   | 80%   |
| Treatment of Dental Pain (emergency) – minor procedure             | 4,177  | 8,651   | 48%   |
| Oral/Facial Photographic Images                                    | 4,442  | 21,171  | 21%   |

Source: Medicaid dental claims data for fiscal years 2012 and 2013.

Exhibit 5 shows one dentist submitted 80% or more of all claims statewide for the treatment of dental complications, office visits for observation, and pulp vitality tests. This dentist also submitted the most claims for the treatment of dental pain and photographic images (not x-rays). Based on our review of claims data, this dentist incorrectly submitted multiple claims for procedures that should be billed on a per visit basis. In other cases, the number of claims submitted per patient on the same day of service were excessive when compared to other dentists' claims.

**Multiple Claims Incorrectly Submitted for Procedures That Should Be Billed Per Visit**

Multiple claims were submitted for the same procedure, patient, and day where dental billing guidance indicates procedures should be billed on a per visit basis. These procedures include: (1) emergency treatment of dental pain – minor procedure, (2) office visit for observation – no other services performed, and (3) treatment of complications (post-surgical) – unusual circumstances. As a result, we estimate one dentist was overpaid about \$164,000 for these types of procedures during fiscal years 2012 and 2013.

Treatment of Dental Pain – One dentist submitted 4,177 claims or 48% of all claims submitted statewide for the emergency treatment of dental pain – minor procedure, during fiscal years 2012 and 2013. Billing guidance indicates this procedure should

be billed on a per visit basis. Unlike most providers, this dentist submitted multiple claims on the same patient and same day. For example, 24 claims for the treatment of dental pain were submitted on one patient for the same day. We found other dentists typically submitted one claim per patient per day for the emergency treatment of dental pain. Based on our review of claims data, we estimate the Division overpaid this dentist nearly \$124,000 for the emergency treatment of dental pain during fiscal years 2012 and 2013.

Office Visit for Observation – The same dentist submitted 1,606, or 83% of all claims submitted statewide for office visits for observation – no other services performed, during fiscal years 2012 and 2013. We found 1,227 of the 1,606 claims (76%) improperly included both the observation and additional procedures performed on the same patient on the same day. According to dental billing guidance, this procedure should be billed on a per visit basis, only when no other services are performed. As a result, we estimate this dentist was overpaid more than \$30,000 for this procedure during fiscal years 2012 and 2013.

Treatment of Complications – This dentist also submitted 382, or 92% of all claims submitted statewide for the treatment of complications (post-surgical) – unusual circumstances, during fiscal years 2012 and 2013. We found 286 of the 382 claims (75%) included more than one claim for the same patient on the same day. Billing guidance indicates this procedure should be billed on a per visit basis. As a result, we estimate this dentist was overpaid about \$10,000 for this procedure during fiscal years 2012 and 2013.

### **Excessive Number of Claims Submitted Per Patient**

The number of claims submitted by this dentist for certain procedures per patient on the same day were excessive. These include oral/facial photographic images (not x-rays) and pulp vitality tests to investigate the integrity of the tooth's nerve. As a result, we estimate this dentist was overpaid about \$119,000 for these types of claims during fiscal years 2012 and 2013.



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Oral/Facial Photographic Images (not x-rays) - During fiscal years 2012 and 2013, this dentist submitted 4,442 or 21% of all claims for oral/facial photographs submitted statewide. The Division pays \$20.36 for each traditional photographic image taken of the face or inside the mouth with a camera. We found this dentist typically submitted many claims for photographs of the same patient on the same day. For example, during fiscal year 2013, 32 patients received 20 or more photographs on the same day. One patient was photographed 32 times on the same day. The vast majority of other dentists submitted claims for one photograph per patient per day. We estimate the Division overpaid this dentist more than \$67,000 for photographs during fiscal years 2012 and 2013.

Pulp Vitality Tests - This dentist also submitted 6,690 or 80% of all claims for pulp vitality tests in fiscal years 2012 and 2013. A pulp vitality test is conducted to examine the integrity of a tooth's nerve. Dental billing guidance indicates this procedure includes checking multiple teeth. This dentist submitted many claims for the same patient on the same day. For example, this dentist submitted 10 or more claims for pulp vitality tests on the same patient and same day 85 times during fiscal year 2013. In one case, 28 claims were submitted for one patient on the same day. Based on claims data and dental billing guidance, we estimate this dentist was overpaid nearly \$52,000 during fiscal years 2012 and 2013 for pulp vitality tests.

### **X-Rays Billed More Frequently Than Allowed by Policy**

The same dentist billed for both a panoramic x-ray of all teeth and then separately for a complete series of x-rays of the whole mouth for the same patient and day. Medicaid policy allows for either a panoramic or a complete series of x-rays (usually consisting of 14 to 22 bitewing x-rays) not more often than once every 3 years. During fiscal year 2013, this dentist submitted claims for both a panoramic and a complete series x-rays 99 times for the same patient and same day. As a result, we estimate the Division overpaid more than \$4,000.

In addition, we found a discrepancy between policy and billing guidelines. Medicaid policy allows either a panoramic or complete series of x-rays once every 3 years. However, the Division's

Dental Billing Guide allows a complete series of x-rays every 12 months. The Division should resolve this discrepancy to avoid potential billing errors.

### **Investigation of Provider**

We notified Division management of the dentist with multiple billing issues and overpayments and discussed insufficient computer edits for certain dental procedures with staff. In addition, claims information was provided to the Division for further investigation. The Division has staffing and processes in place to investigate overpayments and improper practices. According to the Division, an investigation of the billing issues has been initiated regarding this provider.

### **Recommendations**

3. Develop computer edits or alternative controls to identify duplicate billings of dental procedures that should be billed on a per visit basis.
4. Develop computer edits or alternative controls to limit the number of claims paid for specific dental procedures per patient per day.
5. Develop procedures to analyze dental claims data to identify billing anomalies such as providers with excessive claims and recipients with excessive services.
6. Resolve the discrepancy between Medicaid policy and the Dental Billing Guide on how frequently a complete series of x-rays is allowed.

# Appendix A

## Definitions of Selected Behavioral Health Services

### Basic Skills Training (BST)

BST services are designed to reduce cognitive and behavioral impairments and restore recipients to their highest functioning level. BST services teach recipients a variety of life skills such as learning how to manage their daily lives, social and communication skills, organization and time management, and independent living.

### Crisis Intervention

Crisis Intervention services target situations where recipients are experiencing acute psychiatric and/or personal distress. The goal of Crisis Intervention is to assess and stabilize situations (through brief and intense intervention) and provide appropriate mental and behavioral health service referrals. Crisis Intervention should reduce psychiatric and personal distress, restore recipients to their highest level of functioning and help prevent acute hospital admissions.

### Day Treatment

Day Treatment services are performed in a therapeutic environment designed to reduce emotional, cognitive, and behavioral problems. Day Treatment services provide recipients the opportunity to implement and expand upon what they previously learned/gained from other mental and/or behavioral health therapies and interventions in a safe setting. The goal of Day Treatment services is to restore recipients to their highest level of functioning while preparing them for reintegration back into home or community based settings.

### Psychosocial Rehabilitation

Psychosocial Rehabilitation services are designed to reduce psychosocial dysfunction and restore recipients to their highest level of functioning. These services target psychological functioning within a variety of social settings. Psychosocial Rehabilitation may include behavior management, interpersonal-social skills, problem identification and resolution, effective communications, moral reasoning, identity and emotional intimacy, self-sufficiency, and life goals.

## Appendix B

### Audit Methodology

To gain an understanding of the Division of Health Care Financing and Policy, we interviewed staff and reviewed statutes, regulations, policies, procedures, and guidelines significant to the Division's operations. We reviewed financial information, budgets, legislative committee minutes, and other information describing Division activities. We examined various reviews or audits performed by SUR, the Fiscal Integrity Unit, the Medicaid Integrity Contractor, and the Recovery Audit Contractor. Finally, we reviewed and assessed internal controls in place to identify and recover overpayments.

To determine if the Division has sufficient controls in place to detect and prevent fraud, abuse, and billing errors over behavioral health claims, we obtained a download of claims paid during fiscal years 2013 and 2014. We sorted these claims by procedure, whether treatment was approved for 1 day or multiple days, and if treatment was on an individual or group basis. For each claim, we divided the amount paid by the hourly rate to determine the number of hours paid. From information in the claims data, behavioral health billing guides, and Division policy, we identified the number of treatment hours allowed. We subtracted the number of hours paid from the hours allowed to determine whether each claim was overpaid. The number of hours overpaid was multiplied by the hourly rate to determine the amount overpaid. Overpaid claims were totaled by procedure; individual, group, or multi-day setting; and time period. We then provided examples to the Division and discussed these with staff to verify overpayments had occurred. Finally, we performed additional data sorts and calculations to verify the accuracy of overpayment numbers.

To determine if the Division has sufficient controls in place over dental claims to prevent overpayments we obtained a download of claims paid during fiscal years 2012 and 2013. We sorted claims by procedure, patient, and provider and identified billing patterns that seemed unusual. We reviewed billing requirements and guidance provided by the American Dental Association, a dental coding and payment guide service, and the Division's dental billing guide and policy. To determine potential overpayments for procedures that should be billed on a per visit basis we sorted claims by provider, patient, service date, and procedure. In cases where more than one claim was submitted on the same patient and day, we considered these claims to be overpayments. To determine overpayments from claims that were excessive, we analyzed the number of claims submitted by other dentists on a per patient per day basis. We considered the number of claims submitted by other dentists for these procedures to be a reasonable standard. The number of claims submitted per patient per day, above what other dentists submitted, were considered overpayments. We then provided examples and discussed dental overpayments with the Division. Finally, we performed additional data sorts and calculations of certain dental procedures to verify the accuracy of overpayment numbers.

To ensure the reliability of paid claims data and our analysis of overpayments, we compared the paid claims downloads to the Division's financial information to verify completeness. To verify the accuracy of the information received, we obtained and compared data on 85 paid claims to our downloads. In addition, we verified that claims were processed according to approved rates for the provider types included in the scope of our testing. We also requested Division management to review selected claims to confirm our understanding of potential overpayments. Further, we verified the accuracy of our sorts and queries by having another auditor recalculate the overpayments and claim counts.

Our testing included sorts and queries of paid claims data for all behavioral health claims (2.4 million) and all dental claims (980,000) paid during the fiscal years reviewed. Behavioral health

and dental services represent about 9.2% of the Division's health care expenditures. Because of the uniqueness of services and billing requirements among provider types, we do not believe a projection of the overpayments we identified to the other provider types or total health care expenditures would be appropriate.

Our audit work was conducted from September 2013 to December 2014. 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 objectives.

In accordance with NRS 218G.230, we furnished a copy of our preliminary report to the Administrator of the Division of Health Care Financing and Policy. On March 31, 2015, we met with agency officials to discuss the results of the audit and requested a written response to the preliminary report. That response is contained in Appendix C which begins on page 19.

Contributors to this report included:

Lee Pierson  
Deputy Legislative Auditor

Rocky Cooper, CPA  
Audit Supervisor

# Appendix C

## Response From the Division of Health Care Financing and Policy



BRIAN SANDOVAL  
*Governor*

STATE OF NEVADA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
**DIVISION OF HEALTH CARE FINANCING AND POLICY**  
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RICHARD WHITLEY  
*Interim Director*

LAURIE SQUARTSOFF  
*Administrator*

April 13, 2015

Paul V. Townsend, CPA  
Legislative Counsel Bureau  
401 South Carson Street  
Carson City, NV 89701

Re: Legislative Counsel Bureau Audit Findings March 2015

Dear Mr. Townsend:

The Division of Health Care Financing and Policy (DHCFP) has reviewed the audit recommendations from the audit of the Division which were formally reviewed with your staff on March 31, 2015. The Division is in agreement with all recommendations.

I would like to thank the Legislative Counsel Bureau audit staff for their professionalism and dedication in assisting the Division with valuable information to help improve our operations.

Sincerely,

A handwritten signature in black ink that reads "Laurie Squartsoff".

Laurie Squartsoff  
Administrator

Cc: Richard Whitley, Interim Director, Department of Health and Human Services  
Leah Lamborn, ASO IV, DHCFP

## Division of Health Care Financing and Policy's Response to Audit Recommendations

| <u>Recommendations</u>  | <u>Accepted</u> | <u>Rejected</u>   |
|---|-----------------|-------------------|
| 1. Develop computer edits or alternative controls to identify behavioral health claims requesting payment for services that exceed daily allowed hours (units).....   | <u>X</u>        | <u>          </u> |
| 2. Develop procedures to review behavioral health claims data to identify potential problems, ensure edits are working as intended, and identify overpayments where the development of computer edits are not feasible..... | <u>X</u>        | <u>          </u> |
| 3. Develop computer edits or alternative controls to identify duplicate billings of dental procedures that should be billed on a per visit basis. ....  | <u>X</u>        | <u>          </u> |
| 4. Develop computer edits or alternative controls to limit the number of claims paid for specific dental procedures per patient per day. ....   | <u>X</u>        | <u>          </u> |
| 5. Develop procedures to analyze dental claims data to identify billing anomalies such as providers with excessive claims and recipients with excessive services. ....  | <u>X</u>        | <u>          </u> |
| 6. Resolve the discrepancy between Medicaid policy and the Dental Billing Guide on how frequently a complete series of x-rays is allowed. ....  | <u>X</u>        | <u>          </u> |
| TOTALS  | <u>6</u>        | <u>          </u> |