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.

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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)