New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

UnitedHealthcare: Out-of-Network Providers Upcoding Selected Evaluation and Management Services

New York State Health Insurance Program

Report 2017-S-34 December 2018

Executive Summary

Purpose

To determine whether UnitedHealthcare sufficiently monitors out-of-network providers who routinely bill for higher-level Evaluation and Management services and to determine if out-of-network providers billed UnitedHealthcare for higher-paying Evaluation and Management services than what were actually performed. The audit covered the period January 1, 2016 through December 31, 2016.

Background

The New York State Health Insurance Program (NYSHIP) provides health insurance coverage to over 1.2 million active and retired State, participating local government and school district employees, and their dependents. The Empire Plan is the primary health benefits plan for NYSHIP, covering a comprehensive range of services for about 1.1 million of these members. The State Department of Civil Service (Civil Service) administers NYSHIP. In carrying out its responsibilities, Civil Service contracts with UnitedHealthcare (United) to administer the Empire Plan's medical/surgical program. Medical/surgical benefits cover a range of services such as office visits, outpatient surgery, diagnostic testing, physical therapy, and chiropractic services.

Evaluation and Management (E/M) billing codes are used by most physicians to report a significant portion of their services. The E/M codes are divided into broad categories such as office visits, hospital visits, and consultations. Within each category, there are either three or five levels of care that providers bill. The amount of United's reimbursement depends on the level of care billed – the higher the level billed, the greater the reimbursement. Billing for a higher level of care, which is higher paying, than the service actually provided is a practice known as upcoding.

During the period January 1, 2016 to December 31, 2016, United paid out-of-network providers over $65.6 million for E/M services, of which 57 percent, or $37.4 million, represented high-level E/M services.

Key Findings

- Improvements are needed in United's method for monitoring out-of-network providers who bill for higher-level E/M services. The system that United uses can miss providers who routinely improperly bill the majority of their claims at higher-level E/M codes.
- Based on a test of 90 claims from nine providers, which paid $72,245 for high-level E/M services, 42 claims (47 percent) totaling $28,731 were upcoded or unsupported for the higher level of care billed.

Key Recommendations

- Improve the monitoring of claims submitted for E/M services by assessing out-of-network providers who routinely bill the majority of their claims at high-level E/M codes.
- Review the $28,731 and make recoveries, as warranted. Expand the review of the at-risk providers we identified and recover other improper payments.

Other Related Audits/Reports of Interest

UnitedHealthcare: Upcoding of Selected Evaluation and Managements Services (2006-S-11)
UnitedHealthcare: Upcoding of Selected Evaluation and Managements Services (Follow-Up) (2007-F-41)
UnitedHealthcare: Upcoding of Selected Evaluation and Managements Services (Follow-Up) (2013-F-13)

State of New York
Office of the State Comptroller

Division of State Government Accountability

December 31, 2018

Mr. Carl A. Mattson
Vice President, Empire Plan
UnitedHealthcare National Accounts
13 Cornell Road
Latham, NY 12110

Dear Mr. Mattson:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the New York State Health Insurance Program entitled *Out-of-Network Providers Upcoding Selected Evaluation and Management Services.* The audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

The New York State Health Insurance Program (NYSHIP) provides health insurance coverage to over 1.2 million active and retired State, participating local government and school district employees, and their dependents. The Empire Plan is the primary health benefits plan for NYSHIP, covering about 1.1 million of these members. The Empire Plan covers a comprehensive range of services including, but not limited to, hospital services, office visits, outpatient surgery, home care services, medical equipment and supplies, mental health and substance abuse services, and prescription drugs.

The New York State Department of Civil Service (Civil Service) administers NYSHIP. In carrying out its responsibilities, Civil Service contracts with UnitedHealthcare (United) to provide coverage for services provided to Empire Plan members under the Empire Plan's medical/surgical program. Medical/surgical benefits cover a range of services including, but not limited to: office visits, surgery, diagnostic testing, physical therapy, chiropractic services, home care services, and durable medical equipment. United is responsible for establishing a network of participating providers, establishing reimbursement rates, processing and paying claims from participating and non-participating providers, and ensuring compliance with the requirements of the Empire Plan.

Medical providers bill United for their services using Current Procedural Terminology (CPT) codes established by the American Medical Association (AMA). The CPT manual is a listing of descriptive terms and identifying codes for billing medical services and procedures performed by providers. The AMA developed the CPT to provide a uniform language to accurately describe medical services.

Evaluation and management (E/M) CPT codes are used by most physicians to report a significant portion of their services. The E/M CPT codes are divided into broad categories such as office visits, hospital visits, and consultations. Within each category, there are either three or five levels of unique CPT codes that providers use to represent the level of care provided. To illustrate, for established patient office visits, five E/M CPT codes, 99211 through 99215, are used for billing purposes. Code 99211 represents a level 1 visit – the lowest level of care (typically 5 minutes) and 99215 represents a level 5 visit – the highest level of care (typically 40 minutes).

In another example, for emergency department visits, five E/M CPT codes, 99281 thru 99285, are used. Unlike office visits, there is no distinction between new and established patients and time is not a factor for code selection. According to the CPT manual, code 99281 represents a level 1 service – the lowest level of care: "usually, presenting problem(s) are self limited or minor." Code 99285 represents a level 5 service – the highest level of care: "usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function."

The amount of United's reimbursement depends on the level of CPT code billed – the higher the level billed, the greater the reimbursement. Billing for a higher-paying service than what was provided is known as upcoding and is a widespread concern in the medical community.

In 2011, the Centers for Medicare & Medicaid Services reported that E/M services were 50 percent more likely to be paid in error than other services, with most improper payments resulting from errors in coding and from insufficient documentation. Also, in 2012, the Department of Health and Human Services Office of the Inspector General (OIG) concluded that, from 2001 to 2010, physicians increased their billing of higher-level codes for E/M services in all visit types. OIG concluded that Medicare inappropriately paid $6.7 billion for E/M service claims in 2010 that were incorrectly coded and/or lacking supporting documentation. In addition, OIG found that claims from high-coding physicians were more likely to be incorrectly coded or insufficiently documented than claims from other physicians.

For calendar year 2016, United paid over $65.6 million for E/M services performed by out-of-network providers. We focused our audit on seven categories of E/M services that accounted for about $55.4 million (84 percent) of United's total payments for E/M services. Of the $55.4 million paid for these seven categories, high-level CPT codes accounted for $37.4 million (67.6 percent). (As previously stated, within each of the seven categories of E/M CPT codes, there are either three or five levels of CPT codes that providers use to represent the level of care provided. For purposes of this audit, we categorized high-level as follows: when there were three levels of care, we classified the last level of care as high-level; when there were five levels of care, we classified the last two levels of care as high-level.)

Audit Findings and Recommendations

Upcoding of Evaluation and Management Services

To identify heath care providers who bill outside of the normal pattern of similar providers rendering similar services (i.e., identifying outliers based on a peer-to-peer analysis), United implemented the Optum prepayment detection system in 2015 to monitor the potential upcoding by both in-network and out-of-network providers. As part of this monitoring, within a peer group, of providers who perform the same services more frequently, high-dollar claims are flagged for further review.

While this analysis can be useful, we found the Optum system does not focus on detecting providers who bill the majority of their overall claims (such as 90 percent of their claims) at a higher-level CPT code. We determined some providers billing the majority of their E/M services at a higher CPT code were not detected by the Optum system.

As shown in Table 1, we analyzed claims from January 1, 2016 through December 31, 2016, and identified 7,725 out-of-network providers, paid about $20.2 million in high-level services, whose billing patterns indicated at least 90 percent of their payments were for high-level E/M codes and/or their percentage of payments from high-level codes was at least twice that of their peers. From this amount, we determined that 332 providers (4 percent) were each paid over $10,000 in high-level E/M codes totaling $12.8 million (over 60 percent of the $20.2 million in total high-level E/M dollars). From the 332 providers, we judgmentally selected nine providers, totaling about $1.4 million in high-level E/M amounts paid, to determine if they met the requirements for the CPT code they billed. We then judgmentally selected a sample of ten patient claims from each of the nine providers and requested the patient records to support these claims. When we selected the nine providers, they were not under review by United; however, during the audit, United initiated a review of one of the nine providers.

Table 1 – Analysis of Out-of-Network Providers With High-Level E/M Services

	Number of Providers	Total High-Level E/M Dollars	Total E/M Dollars	High-Level E/M as a Percent of Total E/M
Providers Paid Over $100,000 for High-Level E/M	18	$3,992,643	$4,466,654	89.4%
Providers Paid Between $50,000–$100,000 for High-Level E/M	48	3,397,466	3,805,403	89.3%
Providers Paid Between $25,000–$50,000 for High-Level E/M	62	2,218,140	3,001,374	73.9%
Providers Paid Between $10,000–$25,000 for High-Level E/M	204	3,159,450	4,662,481	67.8%
Providers Paid Less Than $10,000	7,393	7,407,714	10,317,504	71.8%
Totals	**7,725**	**$20,175,413**	**$26,253,416**	**76.8%**

For each of the nine out-of-network providers we sampled, we found the following percent of high-level E/M codes in six out of the seven E/M categories for the period January 1, 2016 to December 31, 2016 (see Table 2).

Table 2 – Percent of High-Level Coded Claims Among Six E/M Categories

Provider	Office Visits		Hospital Care		Office Consultations	Emergency Department Visits
	New Patient	Established Patient	Initial	Subsequent		
A						95.3%
B						96.6%
C	100%	100%	100%	100%		100%
D	100%	100%				
E	100%	100%			79.7%	
F			100%	91.0%		
G			100%	8.2%		
H		97.2%			100%	
I	100%	98.2%	97.8%	1.8%		

As shown in Table 3, from our judgmental sample of 90 claims for E/M services totaling $72,245, 42 claims (47 percent of the 90 claims) totaling $28,731 (40 percent of the $72,245) were overpaid. The deficiencies were as follows:

- For 20 of the 90 sampled services, the medical records did not support any E/M services.
- For 14 of the 90 sampled services, the medical records supported a lower-level E/M code.
- For 8 of the 90 sampled services, the requested medical records were not provided.

Table 3 – Results of Sample (Ten Claims Per Provider) Alongside the 2016 E/M Payments

Provider	Number of Claims That Did Not Support High-Level E/M	Amount Paid That Did Not Support High-Level E/M	Total E/M Paid in 2016	Total High-Level E/M Paid in 2016	High-Level E/M as a Percent of Total E/M Paid in 2016
A	0	$0	$644,371	$614,404	95%
B	0	0	241,499	233,396	97%
C	10	4,395	173,062	173,062	100%
D	10	1,554	78,425	78,425	100%
E	10	2,911	66,036	65,342	99%
F	0	0	60,887	57,340	94%
G	6	16,818	80,285	54,798	68%
H	0	0	52,140	50,626	97%
I	6	3,053	71,172	50,095	70%
Totals	**42***	**$28,731***	**$1,467,877**	**$1,377,488**	

*Using the assistance of a registered nurse, our review found $42,299 of the $72,245 (59 percent) was upcoded. We shared those results with United, which, with the assistance of certified coders, found $28,731 was upcoded (for instance, we found all ten of Provider A's claims were upcoded, although United disagreed). This report reflects United's determinations.

Three key components in selecting a level of E/M service are medical history, medical examination, and medical decision making. Providers must maintain documentation identifying these components to support the level of service billed.

In one case, Provider E billed the high-level E/M codes for office visits for new and established patients 100 percent of the time (see Table 2). We reviewed the medical documentation for the ten sampled claims and found that the documentation did not support the high-level E/M services billed for all ten claims (see Table 3). Therefore, we determined the ten claims were upcoded and the provider should have billed a lower-level E/M code for the office visits.

Two other providers, C and D, provided documentation that did not support their high-level E/M services for office visits for established patients. In these two cases, both providers supplied documentation that did not support an E/M service was provided. These providers consistently billed high-level E/M codes for office visits for new and established patients 100 percent of the time (see Table 2). In addition, our sample review showed Provider C billed two high-level emergency department visits that were not supported by documentation. Throughout 2016, Provider C submitted emergency room visit claims using the high-level codes 100 percent of the

time (see Table 2). During our audit fieldwork, United put this provider under review by its Special Investigation Unit, with a potential risk assessment of $8 million.

In addition, Providers G and I, who billed a high-level E/M code 100 percent and 98 percent of the time, respectively, for initial hospital care (see Table 2), did not provide documentation as requested to support all of their initial hospital care E/M claims. Our sample review showed not only the upcoding of 4 hospital care claims, but also that Provider G did not submit documentation for 5 claims and Provider I for 3 claims, accounting for 8 of their 20 sampled claims.

While the sample we examined represents a small subset of the total amount billed for E/M services, it validated the method we used to isolate providers potentially upcoding and improperly billing E/M services. Although United's Optum monitoring system is based on provider peer comparisons, United could do more to monitor and identify out-of-network providers potentially upcoding E/M services.

Recommendations

1. Improve the monitoring of claims submitted for out-of-network E/M services by supplementing the current peer-to-peer review with an assessment of out-of-network providers who routinely bill the majority of their claims at a higher-level E/M CPT code (such as above 90 percent in an individual E/M category). Conduct reviews of these out-of-network providers to ensure payments reflect the services actually performed and recover any overpayments identified.

2. Assess the results of our review of the nine out-of-network providers and, where warranted, expand the review of each provider to identify and recover other overpayments, in addition to the $28,731 identified by our audit.

Audit Scope, Objectives, and Methodology

The objectives of our audit were to determine whether United is sufficiently monitoring out-of-network providers who routinely bill for higher-level Evaluation and Management (E/M) services and if out-of-network providers billed United for higher-paying E/M services than what were actually performed. The audit covered the period January 1, 2016 through December 31, 2016.

To accomplish our objectives and assess internal controls related to our objectives, we interviewed United officials to gain an understanding of their internal controls and reviewed the CPT codes established by the AMA. We judgmentally selected nine providers whose billing patterns indicated at least 90 percent of their payments were for high-level codes and/or their percentage of payments from high-level codes was at least twice that of their peers. We judgmentally selected ten claims from each of the nine providers and requested patient records to support these claims. We reviewed the patient medical records to determine if the claims were billed at the appropriate CPT service code.

We conducted our 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 addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided preliminary copies of the matters contained in this report to United officials for their review and comment. Their comments were considered in preparing this final report.

Within 90 days of the final release of this report, we request that United officials report to the State Comptroller, advising what steps were taken to implement the recommendations included in this report.

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