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October 24, 1972

Mr. Neil P. Fallon, Regional Commissioner  
Social and Rehabilitation Service  
John F. Kennedy Federal Building  
Government Center  
Boston, Massachusetts, 02203

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Dear Mr. Fallon:

The Boston Regional Office of the General Accounting Office has made a survey of services provided by dentists, optometrists, podiatrists, private duty nurses, and suppliers of prosthetic appliances under the Medicaid program in Massachusetts. Areas included in our survey were internal controls over authorizing and paying for services provided, eligibility of recipients to receive services, and methods of setting rates of payment for services.

Our work was limited to assistance recipients in the City of Boston and was performed at the Massachusetts Department of Public Welfare (MDPW); the Social and Rehabilitation Service's (SRS) Boston Regional Office, and the Massachusetts Rate Setting Commission.

SELECTION OF VENDORS AND CLAIMS

We randomly selected 136 fiscal year 1971 claims of 27 high dollar volume practitioners. These claims, totaling \$13,262, were for services provided to 127 recipients, as shown below.

<u>Service</u>	<u>Approximate Boston FY 1971 payments</u>	<u>Vendors selected for review</u>		<u>Claims reviewed</u>	
		<u>Number</u>	<u>Payments</u>	<u>Number</u>	<u>Amount</u>
Dentistry	\$5,100,000	7	\$860,000	34	\$2,907
Optometry	1,000,000	5	241,000	27	1,039
Podiatry	435,000	5	116,000	25	335
Private Duty					
Nursing	56,000	5	40,000	25	7,638
Prostheses	178,000	5	85,000	25	1,343
	<u>\$6,769,000</u>	<u>27</u>	<u>\$1,342,000</u>	<u>136</u>	<u>\$13,262</u>

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REDETERMINATIONS NOT BEING PERFORMED

Federal regulations require that when an individual has been determined eligible for public assistance, eligibility factors subject to change be reexamined periodically, but at least every six months on Aid For Dependent Children cases and at least every 12 months in others. The State Public Assistance Policy Manual requires that such redeterminations generally be made more frequently but for the purposes of our survey, we used the Federal criteria.

We reviewed the client case files at Boston welfare offices, and the Boston Records Department to ascertain whether clients were considered eligible at the time they received medical services, and if the cases had been redetermined within the required time period.

We could not locate 23 of the 127 client case files selected, so we referred the names of these clients to the Administrator, Boston Regional Welfare Office. Eleven of these case files had not been located one month after our referral so we suggested to the Administrator that the search be discontinued. The status of the 127 cases and related dollar amounts are shown below.

	<u>Number of cases</u>	<u>Percent</u>	<u>Amount of claims</u>
Redetermined with Federal Criteria	83	65.4	\$8,113
Not Redetermined within Criteria	31	24.4	3,742
Not Located	11 <sup>a/</sup>	8.7	1,114
General Relief Not Eligible For Medicaid	<u>2</u>	<u>1.5</u>	<u>293</u>
Totals	<u>127</u>	<u>100.0</u>	<u>\$13,262</u>

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One of these is a General Relief case. Thus, three recipients were provided medical services totaling \$703 which were paid under Medicaid rather than under the State's General Relief Program.

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The length of time which had lapsed without eligibility redeterminations being made for the 31 cases is shown below:

<u>Aid category</u>	<u>Number of cases not redetermined within the indicated number of months</u>				<u>Totals</u>
	<u>6 to 12</u>	<u>13 to 18</u>	<u>19 to 24</u>	<u>Over 24</u>	
Aid for Dependent Children	12	5	-	-	17
Disability Assistance	-	2	-	1	3
Old Age Assistance	-	2	-	5	7
Medical Assistance	-	1	-	3	4
<u>Totals</u>	<u>12</u>	<u>10</u>	<u>-</u>	<u>9</u>	<u>31</u>

State welfare officials informed us that a lack of staffing prevented redeterminations being made within the specified time limits. Without timely redeterminations being made there is no assurance that recipients continue to be eligible for Medicaid.

We previously reported on redeterminations to you in an August 17, 1970, letter report. On January 6, 1971, you replied that the Department of Public Welfare was engaged in a State-wide pilot study of about 200 cases which would produce findings on the currency of eligibility redeterminations, but the results were not then available. You also stated that the State's new Quality Control Program, initiated in October 1970, as a Federal requirement, provides for review of the frequency of redeterminations.

Apparently these measures have not improved the situation.

WEAKNESSES IN INTERNAL CONTROLS OVER PAYMENTS

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Verifying eligibility before payment

We were advised by an official of the Boston Medical Processing Unit that no verification of client status is made before payment of a claim. Status refers to whether the client is receiving or eligible to receive assistance, or is no longer eligible for assistance. We were informed that such data is available on the bi-weekly "Sorted Recipient Master File Listing" which shows the status of cases and which the Medical Processing Unit has available but does not utilize for this purpose.

Although our survey did not disclose any instances of claims being paid for clients no longer eligible for assistance, the lack of verification of client status prior to claims payment could permit such payment.

#### Prior approval and individual consideration

Certain medical procedures require prior approval by medical consultants before service is provided. Other services require individual consideration of the fee charged for the service. For example, 42 of the 93 dental procedures listed in the MDEW fee schedule require either prior approval, individual consideration, or both.

Of the 136 randomly selected claims, 17 required prior approval, one required individual fee consideration, and four required both prior approval and individual fee consideration. Prior approval was not obtained for six of the 17 claims. These six claims, paid without prior approval, totaled \$959. In the five other cases, the required action was not obtained prior to payment and claims were paid in the amount of \$101.

An official of the Boston Medical Processing Unit informed us that prior approval forms are not attached to vendor claims but that the prior approval form number is noted on the claim so that processing clerks can refer to the prior approval form to assure that such approval was obtained. The official informed us, however, that processing clerks do not check back to the prior approval form itself. Thus, there is no assurance that the service claimed was given prior approval, or individual fee consideration.

#### Charges not checked to fee schedules

Dental claims were generally checked for correctness of amount. However, optometry and podiatry claims were not generally checked to fee schedules for correctness in claimed amounts although fee schedules were established for these services. There were no fee schedules established for private duty nursing and prosthesis. We noted three instances where amounts higher than allowed by the fee schedule were claimed and paid. Although the amounts only totaled \$5, the paying of fees higher than allowed could be avoided by checking to the fee schedule.

As noted previously, there were several instances where the fee was not individually considered as required. According to an official of the Medical Processing Unit, claims that require individual consideration are pulled for review by medical consultants if the processing clerk recognizes that the claim requires it. However, since the claims are not

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checked to the fee schedules, those that require individual consideration are sometimes missed, as apparently was the case with our selected claims. Some of these claims could have been noted as requiring individual consideration by checking to the fee schedule, while on others the information on the claim was not specific enough to indicate that the service required individual consideration of the fee.

The Medical Processing Unit official agreed that many of the internal controls discussed here should be followed, but a lack of staff prevents this from being done. The official stated that currently, as compared to two years ago, the Medical Processing Unit has one-half the number of personnel and four times as many claims. Officials of the MDPW informed us that a lack of staff in the Boston Medical Processing Unit probably prevented that unit from performing these practices. These officials felt that the planned Financial Management Control System could accomplish many of these internal control checks on an automated basis. The purpose of this system is to provide effective controls over recipient and vendor payments. Recently, a new supervisor was added to the Medical Processing Unit to clear up the backlog of claims, which, once accomplished, should enable processing clerks to devote more effort to the proper processing of claims.

#### OVERUTILIZATION OF SERVICES

GAO will shortly be issuing a report to the Chairman, House Ways and Means Committee on the utilization review system in Massachusetts. In our survey, however we noted apparent overutilization of services by recipients involving two of the selected vendors, and by recipients involving a third vendor as discussed below.

#### Podiatry

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Five randomly selected claims of one podiatrist totaled \$171, while 20 randomly selected claims of the other four podiatrists totaled \$164. The average charge made by this podiatrist was about \$34, while the other four podiatrists averaged slightly over \$8 per claim, and the highest claim they submitted was for \$13.

The State podiatry consultant had reviewed some of the podiatrist's claims which were later paid in March 1972. Claims considered for payment in March totaled \$1,258, of which the consultant disallowed \$634, by reducing some claims in the \$30 to \$40 range to \$5 each. However, included in the March payment to this podiatrist were 13 claims which ranged from \$30 to \$42. An official at the Medical Processing Unit informed us that these 13 claims also should have been reduced to \$5, but

had probably been processed by a different clerk, and thus not submitted to the consultant for review. In addition, the five claims we reviewed had been submitted as far back as August 1970, indicating that the podiatrist had been submitting such claims at least 20 months prior to the March 1972 consultant review.

### Optometry

Our review of five randomly selected claims for one optometrist showed that in four of the five cases two pairs of glasses were prescribed and charges were made for tinting. The number of charges for extra glasses and tinting seemed unusual when compared to claims submitted by the other four optometrists.

We visited this optometrist and obtained the prescriptions for the glasses, and other data such as vision test results. Based on this information the State optometry consultant made the following comments:

- In three of four cases where second pairs of glasses were prescribed and tinting billed for, there was no need for the second pair of glasses or the tint.
- In a case where one pair of glasses was prescribed, the optometry consultant doubted that the individual needed glasses, since the prescription provides practically no correction.
- In three of four cases where tinting was billed, there was one color tint for each of the two pair of glasses, one pair pink tint and one pair green tint. This was shown on the claim as tint, with no specification as to color. Green tint indicates prescription sunglasses which require both prior approval and individual consideration of the fee. The optometry consultant said these claims should have been submitted to him for this purpose.

These five claims were dated as far back as May 1970. However, it was not until early 1972, at least 20 months since this optometrist began submitting such claims, that the optometry consultant began reviewing his claims on a periodic basis. The optometry consultant stated that he advised the Medical Processing Unit that this optometrist appeared

to be over prescribing on tint, and he now reviews all of this optometrist's claims prior to payment.

The Massachusetts Rate Setting Commission has adopted new regulations requiring that prescriptions be submitted with optometry claims. The optometry consultant felt this would make his reviews easier but would not aid processing clerks who probably would not know what the prescriptions meant.

Because of the findings on this one optometrist's billings, we selected five more high dollar volume optometrists and reviewed their current paid claims for possible overutilization in the areas of extra glasses and tinting.

For one of these optometrists we noted the following.

- For 20 of 42 claims or about 50 percent, tinting was charged. The optometry consultant stated that about 5 to 10 percent of patients might require tinted glasses. He estimated that in a private practice the percentage would be about 35 percent, the difference being patients who desire tints for comfort or cosmetic purposes.
- A review of 64 claims, showed that either two or three pairs of glasses were prescribed for 10 clients. In some cases, a pair of glasses was prescribed on two separate claims for a client, while in other cases two pairs of glasses were prescribed on the same claim and a third pair on a second claim for the same client.
- Two claims submitted for one client were for a service that required individual consideration of the fee but were not submitted to the optometry consultant for this purpose. He said he would have reduced the fee on the two claims by a total of \$30.
- One claim requiring individual consideration had been approved for \$135 by the optometry consultant but the amount paid to the vendor was \$147 and included \$12 for vision examination. The optometry consultant said only \$135 should have been paid because this fee included the vision examination.

The optometry consultant said he could not make a definite statement concerning the need for the two or three pairs of glasses or tint without reviewing the prescriptions, but did agree that the claims appeared questionable. He said he had not performed a review of this optometrist's claims.

MDPW officials stated that the proposed Financial Management Control System either will, or could be structured to provide data necessary for utilization review. However, this system will not be fully operational until late 1973 or early 1974.

LACK OF SPECIFIC REIMBURSEMENT CRITERIA FOR  
PRIVATE DUTY NURSING SERVICES OR PROSTHETIC  
APPLIANCES

The MDPW Medical Care Plan does not specify the amounts to be paid for the services of private duty nurses or for prosthetic appliances such as artificial limbs or hearing aids. The Massachusetts State Plan for Medical Assistance states that private duty nurses are to be paid based on "usual and customary" charges, but is silent on prostheses.

We found that whatever charges were claimed for private duty nurses or for prostheses were paid. Medical Processing Unit personnel informed us that charges for these services were not questioned and whatever amount was billed was paid. This does not seem to be a sound basis for reimbursement.

We were advised by Massachusetts Rate Setting Commission staff of the following

- Regulations providing private duty nursing reimbursement criteria were adopted by the Commission in August 1972, and became effective September 1, 1972.
- New regulations governing rates of payment to pharmacies and medical-surgical supply firms became effective September 1, 1972. These regulations will include criteria for reimbursement on prostheses.
- The Commission staff is interviewing hearing aid dealers for the purpose of establishing a reimbursement criteria for this service. Reimbursement for hearing aids is not presently covered by any regulation.

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These actions should help control payments for these services.

COMMENTS OF SOCIAL AND REHABILITATION SERVICE OFFICIALS

At our exit conference you advised us that your office had long been concerned because MDPW had not made redeterminations within the required time periods. In addition, you advised us that many of the weaknesses in controls that we had mentioned might be corrected by the Financial Management Control System that is being implemented by the MDPW. As suggested we discussed this system with the State Public Welfare Director of Project Management. We were informed that this system either will or should be able to provide the data and controls necessary to correct these problems.

CONCLUSION

Problems similar to those disclosed in our survey regarding recipient eligibility and redeterminations and weaknesses in internal controls have been previously reported on several occasions by GAO, the State Auditor, and the HEW Audit Agency. We do not plan to do any further work in these areas, but feel that we should advise you that these problems still exist.

We noted in an earlier review that SRS recommended that the MDPW hire a management consulting firm to develop an improved payment system and that the State contracted with two firms. One firm issued a report in April 1969, the other in March 1971. SRS officials advised us that neither firm had developed an effective payment system.

Hopefully, the proposed Financial Management Control System will not meet the same fate and an effective and efficient control system for medical care payments will be established.

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We would appreciate receiving your comments on the matters discussed in this report within 30 days from the date of this letter.

A copy of this report is being furnished the Administrator; SRS.

If we can be of any assistance, please let us know.

Sincerely yours,

JOSEPH EDER

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Joseph Eder  
Regional Manager