115781

REPORT BY THE U.S.

General Accounting Office

District Needs To Improve The Process For Identifying Misuse Of Its Medicaid Program

The District of Columbia's Department of Human Services has not established and implemented effective methods and procedures to identify and safeguard against recipient abuse and misuse of medical services. As a result, the extent of the misuse cannot be determined.

The Department is in the process of installing a Medicaid Management Information System which, along with other planned operations, should help improve management of the Medicaid program.

GGD-81-78
JULY 13, 1981

017572

Request for copies of GAO reports should be sent to:

U.S. General Accounting Office
Document Handling and Information
Services Facility
P.O. Box 6015
Gaithersburg, Md. 20760

Telephone (202) 275-6241

The first five copies of individual reports are free of charge. Additional copies of bound audit reports are $3.25 each. Additional copies of unbound report (i.e., letter reports) and most other publications are $1.00 each. There will be a 25% discount on all orders for 100 or more copies mailed to a single address. Sales orders must be prepaid on a cash, check, or money order basis. Check should be made out to the "Superintendent of Documents".

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

GENERAL GOVERNMENT
DIVISION

B-203719

Mr. James A. Buford
Director, Department of
Human Services
801 N. Capitol Street, N.E.
Washington, D.C. 20002

Dear Mr. Buford:

We have reviewed the effectiveness of the Department of Human Services' (DHS) surveillance and utilization review procedures in identifying and controlling misuse/abuse of medical services. This report summarizes the results of our work.

The Department of Human Service's Surveillance and Utilization Review (SUR) program--a program designed to identify and safeguard against Medicaid fraud, misuse, and abuse--could be improved. DHS has not established and implemented effective methods and procedures to identify and safeguard against recipient misuse and abuse of medical services. As a result, the department could not determine the extent of recipient misuse or abuse. Also, since audits are not made of all providers' records, some overpayments could exist that are not identified. Our review showed that there was a need for:

--A better system to identify potential misuse/abuse cases for review.

--More effective procedures for counselling, monitoring, and controlling persons misusing/abusing medical services.

--More effective controls for processing cases and an improved reporting system to facilitate management reviews.

--Improved procedures for recovering improperly billed Medicaid payments.

A new Medicaid Management Information System, expected to be operational in mid-1981, will correct some of the deficiencies noted in our review. However, to realize full benefits of the system, other operational improvements should be made. For

example, an adequate followup and enforcement mechanism also should be established to assure that misuse and abuse of the Medicaid program are minimized.

We discussed our findings with the Office of Health Care Financing Chief and top SUR officials. They generally agreed with the recommendations and indicated corrective action would be taken. Their comments are included in the appendix to this letter.

Copies of this report are being sent to the Mayor; Chairman, Council of the District of Columbia; the District of Columbia Auditor; the Inspector General; and interested congressional committees.

We appreciate the cooperation received from DHS officials and employees. Please let us know of the final actions taken on the matters discussed in this report.

Sincerely yours,

Daniel F. Stanton

For William J. Anderson
Director

IMPROVEMENTS NEEDED IN THE DISTRICT'S DEPARTMENT OF HUMAN SERVICES' SURVEILLANCE AND UTILIZATION REVIEW PROGRAM

BACKGROUND

Medicaid, established by the Social Security Amendments of 1965, is a Federal-State program in which the Federal Government participates in the cost incurred by the State in providing medical assistance to the poor. Medicaid is administered by the Department of Health and Human Services' Health Care Financing Administration.

The Federal Government pays 50 percent of the District's allowable costs in providing medical service under Medicaid. Federal reimbursement for fiscal year 1980 was estimated at about $75 million. The District has about 123,000 persons receiving medical care under the Medicaid program, which is administered by the District's Department of Human Services (DHS).

The Social Security Amendments of 1967, which became effective in April 1968, require that State Medicaid plans:

> "* * * provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."

Department of Health and Human Services' regulations require that each State agency implement a statewide surveillance and utilization review program to control inappropriate and overutilized Medicaid services. Regulations also require that where overutilization of medical services has been determined, the State agency may take action to restrict the use of medical services.

The Department of Human Services' Surveillance and Utilization Review (SUR) Branch, part of the Office of Health Care Financing, is responsible for performing utilization reviews in the District.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of our review was to evaluate the effectiveness of the District's Medicaid surveillance and utilization review procedures in identifying and controlling (1) misuse/abuse of medical services received by recipients and (2) inappropriate payments to health care providers.

We reviewed Federal and District legislation, regulations, guidelines, policy, and procedures relating to surveillance and utilization; reviewed and analyzed reports, records, and other data pertaining to the District's Medicaid program; and held discussions with Federal and District officials responsible for administering the Medicaid program. Also, we visited and obtained information from the States of Virginia and Maryland concerning their surveillance and utilization review programs.

We reviewed the results of the Surveillance and Utilization Review program for fiscal year 1979 because it was the most recent complete year for which data was available. Because summary reports were not available showing the results of surveillance and utilization reviews, we examined available files for each case that had been referred for counselling by the review section. From the information in the files we determined the number of recipients counselled and not counselled 1/ and the length of time taken to process cases. For selected cases, we examined if identified recipients continued their aberrant medical service use patterns. We also reviewed data for calendar year 1979 to determine the actions taken to prevent or minimize overpayments to individual medical providers.

METHODS AND PROCEDURES TO DETECT AND CONTROL MEDICAID MISUSE/ABUSE NEED TO BE IMPROVED

DHS has not established and implemented effective methods and procedures to identify and safeguard against recipient misuse and abuse of medical services. As a result, the Department could not determine the extent to which recipients were misusing or abusing the program.

The Office of Health Care Financing (OHCF) Chief and top members of the SUR staff generally agreed with our findings

---

1/The SUR Branch is required to interview recipients who may have misused Medicaid services to verify that the services were received and to counsel them concerning their use of medical services. The term counselling, as used in this report, refers to both the interviewing and counselling process.

and recommendations. According to these officials, the deficiencies we noted have been long-standing problems, but the lack of adequate staff and resources prevented OHCF from correcting them. The OHCF Chief said that with the forthcoming implementation of the new Medicaid Management Information System (MMIS) and a planned reorganization of the SUR Branch, improvements along the lines of our recommendations would be made. According to the Chief, the improvements would include implementation of a restriction policy and written procedures to control identified recipients who were misusing or abusing the Medicaid program and to monitor their future use of medical services. Also, according to the Chief, the policy of sending a notification letter to recipients who may be abusing or misusing medical services would be changed to sending letters only to those recipients who are abusing or misusing the program. The letter will advise such recipients that they have to respond for counselling. He said counselling will be directed only to these recipients and that an "Explanation of Benefits" 1/ notice will be sent to persons on a random basis to verify if billed services were received. He also indicated that, within available resources, action would be taken on the other recommendations.

Identification for review of potential misuse/abuse cases--to be corrected

At the time of our analysis, the Surveillance and Utilization Review Branch did not have an effective method for selecting for review cases with the most potential for misuse/abuse of medical services. Procedures for selecting cases for review did not provide assurance that recipients with the most aberrant patterns of medical service would be reviewed first. Thus, the staff's time was not spent most productively, i.e., reviewing cases with the greatest potential for misuse/abuse.

The SUR Branch established certain parameters or normative standards of usage for 14 selected medical services and procedures. Any recipient exceeding one or more of these parameters, e.g., visits to three or more different internists or more than 15 visits to a physician's office in 1 year, would be subject to review.

The selection of recipients of medical services with a potential for review is done by computer. Stored in the computer

---

1/An "Explanation of Benefits" is a notice sent to the recipient that includes information, such as when a service was provided and type of service provided, about Medicaid claims paid on his/her behalf.

are data on use of medical services by all recipients on a year-to-year basis. The data is arranged according to the recipient's Medicaid identification number. Each month the computer selects, in numerical (identification number) sequence, 350 recipients with one or more medical services or procedures that exceed the established parameters. Recently, 700 cases have been selected bimonthly to reduce computer costs. Once selected for review, cases are not subject to selection again until the case selection cycle is completed. We estimate that it would take about 3 years for the same case to be again selected for review.

The computer printout of recipients who have exceeded one or more parameters is sent to SUR's Recipient Review Section. The supervisor of the Section numbers the medical profiles of the selected recipients from 1 to 350, or 700 as the case may be, and assigns each reviewer a block of numbered cases. We were advised that because of other assigned work and duties, the staff of six review specialists cannot review all 350 cases in 1 month. Cases not reviewed are not selected for review again until the cycle is complete--approximately 3 years.

The selection of cases in numerical sequence did not assure that the most aberrant cases of potential misuse/abuse would be reviewed first. No comparison was made of all recipients exceeding the parameters so that cases with high aberrant utilization patterns would be selected for review before cases with low aberrant utilization patterns. For example, we reviewed 26 cases and identified 17 recipients who received from 59 to 388 prescriptions valued at $15,135 and were not selected for review in fiscal year 1979 because their identification numbers did not fall within the range of numbers used to select cases. During the year, cases with lower drug use patterns were reviewed.

In October 1980 the Department of Human Services contracted with a systems management firm to develop, install, and operate a new Medicaid Management Information System. Among other things, the MMIS includes subsystems for the processing of claims for payment of medical services and a recipient's medical profile. The Recipient Profile Review System will develop statistical profiles of health care delivery and utilization patterns of Medicaid recipients. New criteria are being developed to provide information which would indicate the highest incidence of potential misuse/abuse of the Medicaid program by individual recipients.

On the basis of our discussions with officials of the Department of Human Services' and officials in the State of Virginia,

where a similar system has been installed, the system will provide a more effective method than currently being used for identifying Medicaid recipients who may be misusing or abusing the program. The new criteria for the selection of cases will, according to these officials, identify those cases with the greatest potential for misuse/abuse.

Because of the pending implementation of the MMIS, we deferred work in this area. However, we plan to evaluate the effectiveness of MMIS at a later date.

Need for more effective procedures and controls to minimize misuse/abuse of medical services

The SUR Branch needs to establish more effective procedures to control persons with aberrant patterns in utilizing medical services. To assist in achieving this objective SUR should (1) improve its method of counselling identified recipients, (2) monitor future medical service use of identified misusers/abusers, (3) establish a control to restrict recipients who have misused or abused the Medicaid program, (4) establish standards for processing cases, and (5) implement a reporting system to provide management with an effective means to evaluate case-processing operations.

Results of SUR case review operations--fiscal year 1979

SUR did not maintain data, nor was data readily available showing the results of SUR recipient review operations for fiscal year 1979. To develop such data we reviewed individual case files and a log listing the cases for which reviews were completed, closed, or incomplete (further action needed). Tables 1 and 2 summarize the results of the case review operations for fiscal year 1979.

TABLE I

	Number of cases
Number of cases determined not to be misuse/abuse	1,301
Number of cases referred to the Health Education Section (HES) for additional action	207
Reviewed and referred to the Investigation Section (IS) for additional action	16
Other	a/30
Total cases referred or closed by Recipient Review Section in fiscal year 1979	b/1,554

a/These consist of 4 cases referred for a determination of the cost of the services involved and 26 cases referred to the medical consultant for additional review before closing the case or forwarding it to the Education or Investigation Section.

b/The statistics do not include cases pending at the end of the year or data concerning cases selected because of cost variances and which were not included in the log.

TABLE 2

Reasons for referral	Number of cases referred	
	HES	IS
Eyeglass abuse	18	10
Utilization of out-patient departments	95	
Overutilization of dental services	14	
Drug overutilization	3	2
Emergency room overutilization	7	
Doctor hopping	5	
Office visits	2	
Misuse of Medicaid card	1	
No record	a/63	a/4
Totals	b/208	16

a/We could not find the files for these cases.
b/While there were a total of 207 cases referred, one was referred for more than one reason.

As shown above, the SUR Branch identified very few potential misuse/abuse cases. Of the cases referred in fiscal year 1979 for which information was available, 95 cases involved recipients who exceeded the established parameters for use of hospital Outpatient Department services (OPD). According to SUR officials, emphasis was placed on reviewing OPD utilization because of the high cost of OPD services. In fiscal year 1979, the cost to the Medicaid program for an OPD visit averaged $60.00, 1/ whereas the cost of an initial office visit to a private physician was $20.00. We reviewed the case files for 17 selected recipients who were counselled by the Health Education Section. The data showed that the Section determined that the visits to the OPD generally were appropriate. A recipient's right to choose an OPD rather than a private physician is allowed under the Medicaid law.

As shown in table 2, the Recipient Review Section identified 10 cases of drug overutilization and doctor hopping. In June 1978, the Philadelphia Regional Audit Agency of the then Department of Health, Education, and Welfare reported that an effective drug utilization review program had not been implemented and that the SUR Branch could not determine the adequacy of drug services provided or the extent that recipients were abusing the Medicaid program. The Audit Agency identified 959 recipients who received 60,681 prescriptions at a cost of $340,000. Of these, the Audit Agency found that for 446 recipients who received an average of 103 prescriptions each during an 11-month period, 32 percent of the prescriptions they received were for abusable drugs. It found also that 562 recipients obtained drugs from 7 to 18 different pharmacies during the same 11-month period. In a followup review the Audit Agency again reported that the SUR Branch's system to identify and control Medicaid drug abuse needed further improvement. The Audit Agency reported that the system to identify potential drug abusers was ineffective because it could not zero in on the recipients with the most aberrant drug utilization patterns, and procedures had not been established to control recipients who were identified as drug abusers.

Our review showed that, for the same reasons noted by the Audit Agency, the system's effectiveness to detect and control Medicaid misuse/abuse continued to be limited. Areas where improvements are needed are discussed in the following sections.

1/This $60.00 represents the average cost of all services and medication rendered to Medicaid recipients at OPDs.

Need to improve counselling procedures when potential misusers/abusers are identified

SUR's procedures for counselling identified recipients who may have misused or abused the Medicaid program need improvement. Our review of available case files showed that the Health Education Section only counselled the recipients in 44 percent of the cases. As a result, aberrant utilization patterns of medical services could continue.

After a suspected misuse/abuse case is reviewed and the case reviewer determines, on the basis of an analysis of the recipient's medical history, that the recipient may have misused/abused the Medicaid program, the case is referred to either the Health Education or Investigation Section. The Health Education Section is responsible for counselling the recipients concerning their use of medical services. Cases referred to the Investigation Section generally require additional investigative work concerning the recipients' questionable use patterns.

The Investigation Section in SUR is composed of three staff members who investigate cases assigned to them by the SUR Branch Chief. Cases referred by the Recipient Review Section are assigned on the basis of the Branch Chief's judgment that the cases warrant an onsite review rather than a counselling session by HES. In fiscal year 1979, the Recipient Review Section referred 16 cases to the Investigation Section. In addition to referrals from the Recipient Review Section, the Investigation Section also handles cases referred by other sources, such as private citizens, other District agencies, and SUR's Provider Review Section. Because most cases identified by the Recipient Review Section are referred to the Health Education Section, we concentrated our review on cases handled by that section.

The Health Education Section contains only one education specialist. After a case is referred by the Recipient Review Section, the specialist attempts to contact the recipient. According to SUR officials, two letters are to be sent requesting the recipient to arrange an interview to discuss his/her use of medical services.

Data in the files were not complete enough to fully evaluate the actions taken by the Health Education Section. For example, the files did not show whether the required two letters were sent to the recipient. Also, we could not locate the files for 63 cases. SUR officials could not explain why the files were unavailable.

Our review of available information showed that the Health Education Section has been unsuccessful in having recipients visit the section for counselling. Many recipients do not acknowledge receipt of or respond to the Section's notification letters. Consequently, many recipients are not counselled and their questionable use patterns are not discussed.

The Health Education Section notifies, by letter, each recipient that he or she should arrange for an interview to discuss the medical services received in the past year. The notification letter does not mention that the recipient's medical service use pattern is in question, but rather it is designed to solicit a response on whether the recipient is satisfied with the quality of service received and whether the services were received. The notification letters sent to recipients contained the following language.

> "The Department of Human Services need [sic] to insure that Medicaid clients receive quality health services. We must know if you have received the services billed to and paid for by the Medicaid Program."
>
> "We are asking your cooperation in this effort * * *."

Since the notification letter stresses the quality of medical care received, it is likely that recipients could easily misinterpret it as being optional as to whether or not a response is required. The absence of a direct reference to the recipient's aberrant use pattern could have contributed to a low response by recipients. For the cases referred in 1979 for which information was available, in only 53 of 120 cases, or about 44 percent, did recipients respond and receive counselling from the Health Education Section.

The need for more effective recipient notification letters was further indicated in a report to the Medical Assistance Division Chief (now OHCF) on referrals and contacts by the Health Education Section during the period September 1979 to April 1980. The report showed that of 337 recipients contacted by the Section, only 138 recipients, or about 41 percent, responded and were counselled.

We were advised by SUR Branch personnel that instructions or guidelines for counselling recipients do not exist. Currently, counselling is not directed to deterring aberrant utilization of medical services but rather consists of inquiries directed to the verification of services, quality of service, and recipient satisfaction with medical care.

We were advised by the Chief, OHCF, that guidelines will be prepared to change the counselling format and direct it toward correcting aberrant utilization patterns. Failure of a recipient to change would subject the individual to a proposed restriction policy limiting that person's access to physicians and pharmacies. Verifying services received by Medicaid recipients will be accomplished by use of the Explanation of Benefits statement which will be sent on a random basis to various Medicaid recipients, rather than by counselling.

Need to monitor future medical use of identified misusers/abusers

Our review showed that there was no monitoring of future utilization of medical services by identified recipients who have misused or abused the program. As a result, these recipients could continue their aberrant medical service utilization patterns. Procedures should be established to routinely monitor and review future utilization patterns to determine if the recipient has changed or altered his/her medical use patterns.

After a recipient has been counselled by the Health Education Section the case is closed. Cases are also closed for those recipients who did not respond to the section's notification letter. Because there is no monitoring of future medical service use, the SUR Branch would have no way of knowing if the recipient's aberrant utilization patterns continued.

An example is the case of a recipient who was identified by the Recipient Review Section as an abuser of medical services prior to August 1979. The recipient did not respond to correspondence. We found that between April 1979 and April 1980, the recipient visited seven different physicians or hospital outpatient departments and received 258 drug prescriptions, including controlled substances--54 prescriptions of Valium and 49 prescriptions of Percodan. The cost of all treatment received by the above recipient was $8,700 for the year ending April 1980.

In another case, a Medicaid recipient who was overutilizing prescription drugs such as Valium and Percodan was investigated in 1978 and found to be enrolled in the Narcotic Treatment Administration Program for using illicit drugs. An attempt was made to contact the recipient for educational counselling; however, the recipient did not respond and was not monitored thereafter. We found that during the period November 1978 through September 1979, the recipient received 368 prescriptions for drugs by visiting 24 different physicians and 19

different pharmacies. The total cost for prescription drugs was approximately $2,200. In addition to the cost for prescription drugs, the recipient also incurred physician fees for each office visit. For example, during the month of April 1979, the recipient made 18 physician office visits at a cost to the Medicaid program of $241.

In fiscal year 1979, SUR identified five recipients for doctor hopping that were sent to the Health Education Section. Our analysis of the recipients' medical service use subsequent to the time they were referred indicated that in two of the three cases where data was sufficient to make an evaluation, the aberrant medical service use patterns did not change.

Need to establish and implement a restriction policy to prevent continued misuse/abuse of medical services

Although the SUR Branch has identified recipient overutilization of medical services, the lack of a firm policy to restrict recipients' use of medical services could limit its success in preventing continued Medicaid misuse/abuse.

The primary method available to the SUR Branch to control misuse/abuse of medical services is counselling of the recipient. However, if the recipient fails to respond to the notification letter or ignores counselling recommendations and continues to misuse/abuse medical services, nothing further can be done because no controls or restrictions are used to curb use patterns.

Other jurisdictions have enforcement procedures that are used to restrict misusers/abusers of medical services, such as withholding recipients' Medicaid cards until they come in to discuss their overuse patterns and, if after counselling, their patterns continue, restricting them to one preselected physician or one pharmacy and/or clinic of their choosing. This restriction is used when a recipient is seeing several physicians (doctor hopping) for the purpose of obtaining numerous drug prescriptions. Recipients who are doctor hopping can obtain large quantities of controlled substances for personal use because of addiction or for resale to others. Recipients under restriction are permitted to see other physicians only on referral by the primary physicians.

SUR recognizes the need to control overutilization of medical services. According to the functional statement for the operation of the Health Education Section "Mis-utilization or over-utilization results in limiting the client to one basic provider of choice * * * ." The SUR Branch has not, however, developed procedures to implement this provision.

In our opinion, particularly with the pending implementation of MMIS, which will improve SUR's capability to detect recipient misuse/abuse, a policy limiting or restricting such recipients' use of medical services should be implemented to improve the effectiveness of the surveillance and utilization review program.

Need to establish standards for case-processing operations

SUR should strengthen its management controls to assure expeditious case-processing operations. Substantial periods of time often elapsed--ranging from 15 days to 10 months--from the dates the reviews were initially completed to the dates the recipients were counselled. Standards should be established to provide a basis for officials to evaluate the effectiveness of case-processing operations. Improved controls should result in earlier correction of aberrant medical service use patterns.

SUR has not established standards within which cases should be handled, nor did it have effective controls to assure timely case processing. The only record to control and review case processing was a log maintained by the Recipient Review Section. The log did not include information necessary to evaluate the time spent reviewing cases, such as the date the case was assigned for review, the date the review was completed by the reviewer, and the date the case was referred. The Health Education Section did not maintain summary records to control referred cases and summary information showing the time required to handle each case was not available.

To determine the time required to review and process cases it was necessary for us to review the information in the case files. However, an analysis could not be made of all cases referred in fiscal year 1979 because 63 case files were unavailable, and others were incomplete and did not show the dates the reviews were completed or referred.

Our review of available data showed that substantial periods of time elapsed between the dates the reviews were initially completed by the program specialist and the dates the cases were referred, and the dates the recipients were counselled. We found that for the 124 cases for which data was available, the average elapsed time from the dates the reviews were initially completed to the dates the cases were referred was about 98 days--the range was from 15 days to 297 days. Similarly, for the 41 cases for which data was available the average elapsed time from the dates the cases were referred to the dates the recipients were counselled was about 90 days--the range being from 18 days to 320 days.

Although standards are not available to compare and evaluate the time taken to process cases, it seems to us that an average of 98 days to complete supervisory review before a case is referred is too long.

Case-processing standards should be established and records maintained showing the elapsed time to complete work on all cases reviewed. Comparison of the time taken to process cases with established standards would assist management in evaluating case-processing operations and correcting avoidable delays.

Need to improve reporting system to facilitate management reviews

The only report that provided any means for evaluating SUR's operations was a monthly activity report of work performed and staff activities. In our opinion, the monthly reports could be improved to provide management with additional information to evaluate SUR operations. Such information as the type of cases reviewed by the sections, the results of the cases reviewed, the number of recipients that were contacted but did not respond, and the time taken to complete case-processing operations should be helpful to management.

For example, although the current reports show how many cases were referred to the Health Education Section, they do not show how successful the Section has been in contacting the recipients and whether the recipients responded to the letters sent to them. As previously noted, our review showed that 56 percent of the recipients referred to the Health Education Section did not report to the Section for counselling. This information should be provided regularly to management to assist it in evaluating the Section's effectiveness in contacting referred recipients, questioning why recipients do not come in for counselling, and deciding what corrective actions can be taken.

Also, the monthly report of cases completed and on hand does not provide management with information essential for evaluating the case-processing operations primarily because the report does not show the length of time taken to process the case. Because SUR lacks a reporting system whereby the time taken to process cases may be reviewed and evaluated, management officials lack the means for effectively detecting and identifying the causes of processing delays.

The reports should also show the type of cases referred, i.e., the number of identified drug abuse, doctor hopping, etc. This information, which is not regularly accumulated and reported, should assist management in its evaluation of SUR operations.

CONCLUSIONS

Because of ineffective procedures, not all recipients referred to the Health Education Section are counselled nor are their future medical service use patterns monitored. The SUR Branch also lacks an enforcement mechanism to guard against continued misuse/abuse of the Medicaid program. To help increase the effectiveness of the SUR program, the department should take action to assure that all recipients referred to the Health Education Section are counselled and that, where appropriate, their future use of medical services is monitored. To control continued medical misuse/abuse by recipients, the department should implement an enforcement mechanism that would limit the recipient to certain medical service providers.

Substantial periods of time are taken to process cases. As a result, several months can elapse before recipients are counselled. Also, monthly activity reports do not contain sufficent information to assist management in evaluating SUR operations. In our opinion, reasonable performance standards are necessary and should be established to provide management with a means for effectively evaluating the timeliness of case processing and minimizing avoidable delays. Monthly reports showing the complete results of SUR's operation, including the time taken to process cases, the results of efforts to counsel recipients, and the type of cases identified by the Recipient Review Section, should facilitate management's oversight function.

Many case records on the results of the SUR review were incomplete or unavailable. Complete documentation on all aspects of SUR's review should be maintained.

RECOMMENDATIONS

We recommend that the Department of Human Services Director:

--Establish and implement effective procedures to require that (1) all recipients referred to the Health Education Section are counselled and (2) where appropriate, their future medical service use is monitored.

--Take action to implement a policy to restrict identified misusers/abusers of medical services.

--Prescribe reasonable standards and controls to assure timely processing of cases.

--Establish a system for effective reporting on SUR operations.

--Require that complete and accurate records be maintained on all cases reviewed and processed by SUR.

NEED TO IMPROVE PROCEDURES TO RECOVER IMPROPERLY BILLED MEDICAID PAYMENTS

Because of improper billings for medical services, overpayments were made to individual providers. Although SUR identifies some of these payments, which are to be offset against future billings, audits are not made of all provider records and other overpayments could exist that are not being identified. Improved procedures are to be established to prevent and recover such payments to providers.

At the time of our review, SUR's Provider Review Section annually reviewed the medical records of selected providers to determine, among other things, the appropriateness of billings to and payments received under the Medicaid program. According to SUR procedures, for each provider selected for audit, the medical records of 5 percent of his/her Medicaid patients were to be reviewed.

Audits by SUR's Provider Review Section have shown many improper bills were submitted. For example, during calendar year 1979, the Provider Review Section audited the records of 30 providers. Our analysis of the audit results showed that of 3,630 medical services reviewed, claims for 498, or about 14 percent, were in error. One of the 30 providers had an error rate of 50 percent, and 13 providers had error rates ranging from 11 to 26 percent. The error rate for all 30 providers reviewed ranged from 0 to 50 percent.

Summary data is not available showing the reason for the errors or the dollar amount of the errors. The Chief of the Provider Review Section advised us that generally the errors resulted in an overpayment. Our review of 11 SUR audits showed that of 1,915 services reviewed, 259 services were billed in error, resulting in relatively small overpayments of about $1,446. Some of the reasons for the errors were:

--Billing for services not documented in the medical records.

--Billings based on one code when another code should have been used on the basis of the records (codes are used for various medical services).

--Medical records could not be located.

SUR procedures provide that improperly billed payments identified by the audit will be referred to the appropriate office for recovery. In a typical audit, however, records of only 5 percent of the provider's patients are to be reviewed. Since the selection of records to be reviewed is randomly made, it is likely that errors also exist in the records not audited. SUR does not attempt to identify the total errors.

We noted also that the Provider Review Section generally limits its ongoing reviews of individual providers to physicians. In fiscal year 1979, physicians were reimbursed about $15 million. Regular ongoing reviews are not made of other individual providers, such as dentists, opticians, podiatrists, and laboratories. These other individual providers were reimbursed about $11 million.

In May 1981, the Office of Health Care Financing Chief advised us that the policy of regularly reviewing provider records will be rescinded. He said that under the MMIS a new coding manual for billing for medical services will be developed, a notice of "Explanation of Benefits" will be sent to selected Medicaid recipients, and additional prepayment computer edits will be established in processing bills for payment.

The Office of Health Care Financing Chief also advised us that the new MMIS will identify providers who may be misusing/abusing the program. Onsite audits of their records will be made and appropriate action taken. After MMIS has been operational for a reasonable period of time, we plan to review the implementation of this new system to evaluate its effectiveness.

(427600)

AN EQUAL OPPORTUNITY EMPLOYER

UNITED STATES
GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE,$300

POSTAGE AND FEES PAID
U. S. GENERAL ACCOUNTING OFFICE

THIRD CLASS