

CLAIMS AUDIT 101

electronic claims audit made easy

By John D. Cowan, CIA, CFSA

According to an Associated Press news service report, the first ever comprehensive audit of 1996 payments to hospitals, physicians, nursing homes, home health care agencies, medical laboratories, and other health care providers under the U.S. Medicare program found overpayments nationwide of at least \$23.2 billion. These expenditures were largely made by contractor intermediaries. And, no meaningful distinction between Medicare program health care provider legitimate errors and outright fraud could be made.

A sobering situation indeed! And one that presents numerous unprecedented changes and opportunities for the audit community.

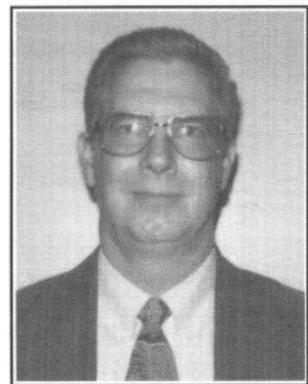
ComCare is one of the largest behavioral health organizations in the United States, combining Medicaid, state and locally funded services in a managed care environment providing services to over 5 1,000 individuals each year. To accomplish this, ComCare contracts with approximately 110 individuals and agencies that provide direct services. These providers do their billing electronically and are paid through a claims processing system provided by Electronic Data Systems (EDS). The billing data is then subsequently passed to ComCare's AS/400 system for review. The number of claims paid to a provider range from 4,000 to 130,000 per year depending on their size and type of service provided. We, at the Provider Audit department of ComCare increasingly employ Computer Assisted Audit Techniques (CAATs) in our quest to ensure that our funds are utilized accurately and effectively to deliver services to our members.

We reviewed and tested several sampling and computerized auditing tool software packages. Due to its speed and ease of use, ACL for Windows became our CAAT of choice. Our typical claims audit includes performing the following processes and tests:

Sampling Techniques

We first started using ACL to generate attribute samples for the claims validation test work for the provider financial reviews. Our test was to determine if there was adequate documentation to authenticate the performance of the service for which a claim was paid. The population we were testing was the provider's paid claims processed during the audit period. This sampling technique was used for the purpose of drawing conclusions about the effectiveness of control procedures present at the provider to ensure only claims for services actually performed were submitted. If we found

the errors located during the review were in excess of the tolerable error rate or there appeared to be reasons to doubt the integrity of the process, we performed additional test work using substantive test work -Monetary Unit Sampling (MUS)- in order to evaluate the effects of the provider's weak controls.



Using substantive test work (MUS) and stating a conclusion based on the amount of dollar errors in the population has made a greater impact on ComCare and provider management than the attribute testing. We found, through our test work, that some providers were billing from the service authorization and not from documentation that the service was actually performed. Since we were finding a higher than expected rate of providers requiring additional test work, thereby increasing our time at the provider and affecting the scheduling of other reviews, we decided to switch all of our sampling to MUS. MUS sampling can also be used internally to better utilize audit resources in order to sample and test the higher risk claim, both dollar and type of service.

Evaluating the sample

The generation and evaluation of the results of a statistically sound sample were very important to the integrity of our program. Once the test work was completed and errors were noted within the sample, an evaluation needed to be completed in order to express a conclusion. In order to evaluate we needed to compute:

The **projected error**. This is the auditor's best estimate of dollar error in the population based upon the sample results and

The **upper error limit (UEL)**. This is the maximum error estimated to exist in the population at a specified confidence level. Calculations using the projected error, basic precision and allowance for sampling risk (a value table) will give us the UEL.

ACL Audit Software can perform all necessary calculations and report the outcome through the EVALUATE COMMAND. The result is expressed in error amount and the UEL for the speci-

fied confidence. The EVALUATE command uses the sampling parameters and error(s) and calculates their effect on the UEL. This process is fairly simple and helps alleviate the possibility of human error in the calculation of the most likely error and UEL. Choose the SAMPLE menu, EVALUATE command:

- In the Evaluate dialog box, click on the Monetary radio button.
- In the Confidence text box, type the confidence level you used in generating the sample.
- In the Interval text box, type the interval ACL used in generating the sample.
- In the Errors text box, type each item (book amount) and the error amount (difference between the book amount and the audited amount).
- Click [OK]. The result appears in the Last Result window (can be saved in clipboard to include in the audit report).

The errors recorded are processed and reported in detail. The report includes the effects of each error and shows the most likely amount of total error and the UEL expressed as a dollar amount. This is the amount that we are confident that the total errors do not exceed.

Writing reports that quantified the probable range of error in a population (Most Likely Error and Upper Error Limit) achieved the impact (and possible payback) we wanted!

Duplicate claims tests

We use ACL as part of our normal testing at each provider for duplicate billings. There are three separate duplicate billing tests we perform. These duplicate billing tests can be used internally using the organization's own automated billing records as part of an ongoing compliance program. However, these test are not appropriate for manual claims which have not been entered into a database or spreadsheet. Specialized manual tests should be developed in order to determine if duplicate manual claims have been processed.

First Test

In the first test we match member ID, service code and dates of service. We test this way primarily due to providers processing the same claim through different site numbers, bypassing edits within the claims system. To perform this test the input file containing the population of paid claims processed by the provider should be in the default view. Then follow these steps:

- Click either the SORT icon or go to the DATA menu, SORT command.
- SORT the population file on <MEMBER ID field>, then <SERVICE START DATE field>, then on <SERVICE CODE field>, by holding down the control key and choosing the desired fields from the list. This opens a new input file.
- Click on the DUPLICATES icon or go to ANALYZE menu, DUPLICATES command.
- Check DUPLICATES on <MEMBER ID field>, <SERVICE

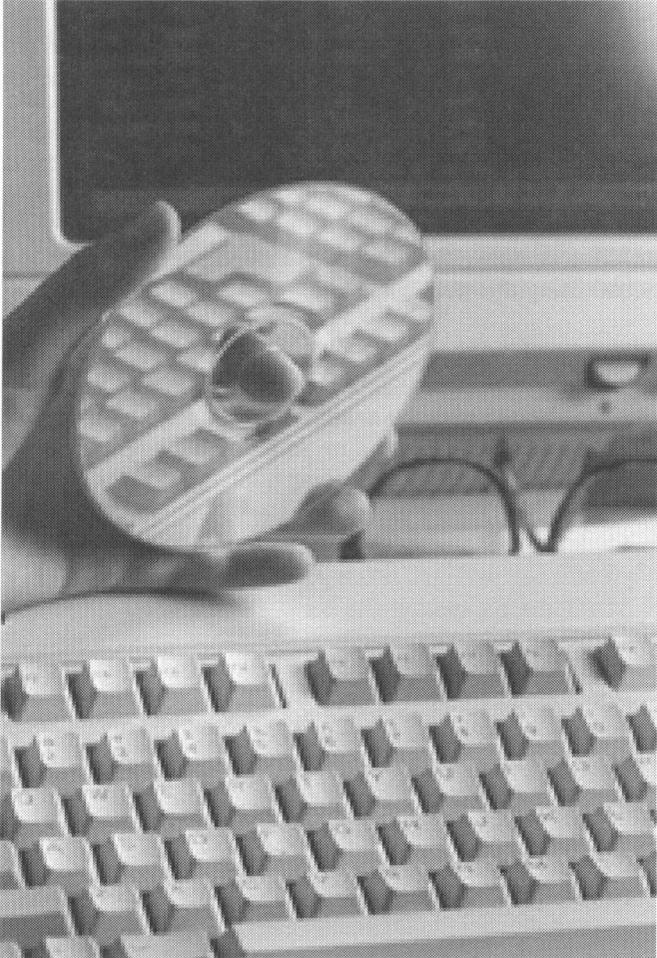
START DATE field>, <SERVICE CODE field> by holding down the control key and choosing these fields from the list:

- In the same dialog box, choose the following LIST FIELDS: <MEMBER NAME field>, <SERVICE END DATE field>, <NET PAID field>, <UNITS field>, <PROVIDER SITE field>.

This duplicates test can be output to the screen, to a file or directly to the printer. The result will be all records that have the same member ID, same date of service and same service code. The LIST FIELDS noted above will also be shown to aid in additional research.

Second Test

However, we have discovered providers processing different residential service codes for a member for the same service dates. A residential service day includes various individual and group counseling programs in a supervised setting at a provider's facility. One unit of residential service is allowed per day. This is our second duplicates test. Again, with different residential service



codes, the edits for duplicate claims are bypassed. Since we only want to test the residential service codes, we need to EXTRACT them from the population. To perform this test the input file containing the population of paid claims processed by the provider should be in the default view. Then follow these steps:

- Choose the tools menu and SET GLOBAL FILTER command and create a new filter.
- Use the IF statement to enter the expression <SERVICE CODE field> >= 'S2000' AND <SERVICE CODE field> <= 'S2999' (the residential codes fall between these values). This will create a view filter that will contain only residential service codes.
- Click either the SORT icon or go to the DATA menu, SORT command.
- SORT the population file on <MEMBER ID field>, then <SERVICE START DATE field> by using the control key. This opens a new input file.
- Click on the DUPLICATES icon or go to ANALYZE menu, DUPLICATES command.
- Check DUPLICATES on <MEMBER ID field>, then <SERVICE START DATE field>.
- In the same dialog box, LIST FIELDS on <MEMBER NAME field>, <SERVICE END DATE field>, <SERVICE CODE field>, <NET PAID field>, <UNITS field>, <PROVIDER SITE field>.

This duplicates test can be output to the screen, to a file or directly to the printer. The result of this test will be all residential service code claims that have the same member ID and same date of service. The LIST FIELDS noted above will also be shown to aid in additional research.

During one provider review we located overpayments of over \$19,000 using this duplicates test.

Third Test

We are also using the above “duplicate” test to verify if the provider is billing over the contracted daily maximum per member. To perform this test the original input file containing the population of paid claims processed by the provider should be in the default view. Then follow these steps:

- Click either the SORT icon or go to the DATA menu, SORT command.
- SORT the population file on <MEMBER ID field>, then <SERVICE START DATE field>. This opens a new input file.
- Click on the DUPLICATES icon or go to ANALYZE menu, DUPLICATES command.
- Check DUPLICATES on <MEMBER ID field>, then <SERVICE START DATE field>.
- In the same dialog box, LIST FIELDS on <MEMBER NAME field>, <SERVICE END DATE field>, <SERVICE CODE field>, <NET PAID field>, <UNITS field>, <PROVIDER SITE field>.

The outcome of this test lists all members that had multiple services billed on a per day basis. We use this test to verify that the daily “bundling” of services does not exceed the contract maximum. In cases where we have managed care contracts, we use this test to determine the amount of services being delivered. In addition, by reviewing this file we can determine if the provider is billing for more units of service than is reasonable. We have found in some cases of managed care and block purchases of service, the provider billing in excess of 24 hours of service per day. This could be used to artificially inflate the utilization of the provider services.

Since we use the same tests for each provider, we have these steps saved in a “batch” which we copy for each review and execute without the need to re-enter the various commands.

Billing the date of discharge

During our normal validation of paid claims, we discovered a provider was billing the admittance and discharge date for residential services. The discharge date should not be billed since the member is not utilizing a full day of service (bed day). We used ACL to determine the extent of the improper billing. Since we only wanted to test the residential service codes, we needed to EXTRACT them from the population. To perform this test the input file containing the population of paid claims processed by the provider should be in the default view. Then follow these steps:

- Click on the EXTRACT icon or go to the DATA menu, EXTRACT command.
- Use the IF statement to enter the expression <SERVICE CODE field> >= 'S2000' AND <SERVICE CODE field> <= 'S2999' (the residential codes fall between these values). This will be a new input file containing only residential service codes.
- Choose the EDIT menu, FIELDS/EXPRESSIONS command.
- Click on the ADD A NEW EXPRESSION icon.
- In DATA DEFINITION name the new field <CORRECT BILLING field>, click on DEFAULT VALUE.
- DEFAULT VALUE is where you build the EXPRESSION to calculate the number of days of residential service and the proper billing amount.
- Build the EXPRESSION as (<SERVICE END DATE field> - <SERVICE START DATE field>) X <PER UNIT field>. Click OK and then the green check to have ACL accept the new EXPRESSION. NOTE: The <PER UNIT field> is a standard field we calculate for every review in order to test contract compliance for rate maximums. It is calculated by dividing <NET PAID field> by <UNITS field>.

We used the <CORRECT BILLING field> to calculate the necessary claim adjustment from what was originally paid to the provider. It was determined the provider over billed us in excess of \$100,000 for the entire fiscal year. This calculation is now used on each provider that bills for residential services.

This billing test, combined with a variation of the duplicate

billing tests, could very easily be used to help identify the inpatient/outpatient overlap. It would be able to identify outpatient services within three days of an inpatient admission (PPS facility) or one day before an admission (non-PPS facility). Besides reducing current billing errors, testing previous billing cycles could identify those claims paid incorrectly. These would need to be refunded to the intermediary, and any co-insurance or deductible payments refunded to the patient.

Contract compliance testing

We perform a basic test to quickly determine our contracted providers compliance with contracted service codes and rates using computer data with our audit tool, ACL. To perform this test the input file containing the population of paid claims processed by the provider should be in the default view. Then follow these steps:

- Click on the CLASSIFY icon or go to ANALYZE menu, CLASSIFY command.
- CLASSIFY on <SERVICE CODE field> and ACCUMULATE on <NET PAID field> and <UNITS field>.
- Click on MORE and the output should be to a file.

The results will give you all service codes processed by the provider with the total Net Paid and the total Units for each service code listed. We used this test to determine that only those service codes authorized by the provider contract were processed and paid.

By adding a calculated field, we found we could perform a test to determine the average amount paid per unit did not exceed the authorized contracted rate per unit. With the CLASSIFY file obtained above in the default view, do the following:

- Choose the EDIT menu, FIELDS/EXPRESSIONS command.
- Click on the ADD A NEW EXPRESSION icon.
- In DATA DEFINITION name the new field <PER UNIT field>, click on DEFAULT VALUE.
- DEFAULT VALUE is where you build the EXPRESSION to calculate the average dollar per unit.
- Build the EXPRESSION as <NET PAID field> divided by <UNITS field>. Click OK and then the green check to have ACL accept the new EXPRESSION.
- Add this new field to the default view.

This will result in the average dollar per unit by service code. If the average dollar per unit is higher than the contracted rate, additional research should be done by EXTRACTING all claims over the specific service code contracted rate. We have located over \$20,000 from one provider who continued to bill an old rate after a contract amendment was in force. Conversely, this test could also be performed prior to paying or submitting our own claims. If the average dollar per unit is lower than the contracted rate research should be done by EXTRACTING all claims under the specific service code contracted rate. Any necessary adjustments could be done prior to submission reducing future corrective actions.

Using the same principle, we regularly CLASSIFY the population of paid claims on fund types (category of monies under any funded program). We list individual fund types, the net paid, the net value and the number of units for each. We used this test to validate the fund types as identified by the provider contract and report to management provider utilization of specific fund types.

Conclusion

There is a genuine risk to any health care organization, using federal and state funding to deliver services, from regulatory agencies assessing penalties and fines for paying erroneous and unsubstantiated claims submitted by providers. Unless we can show due diligence in our review process and a settlement of the unsubstantiated claims, health care companies will be held liable for provider errors. With the availability of adequate funding diminishing, the recovery of unsubstantiated claims funds can help replenish those funds and redirect them to needy providers. CAATS is the major part of our review process that is helping us redirect these funds and also playing a substantial role in maintaining and monitoring an effective and comprehensive corporate compliance program. I hope the audit objectives and steps I have highlighted in this article will assist you in developing your own corporate compliance or claims audit program utilizing CAATs. For additional information, a copy of our Provider Financial Review program can be obtained through the AHIA Audit Library*.

John D. Cowan, CIA, CFSA has more than 14 years of managerial experience in audit, operations, and security. He is currently manager of the Provider Audit Department at ComCare Inc. in Phoenix, Arizona. He is a member of AHIA.

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