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

Division of State Government Accountability

UnitedHealthcare: Improper Payments for Medical Services Designated By Modifier Code 59

New York State Health Insurance Program

Report 2013-S-82 January 2015

Executive Summary

Purpose

To determine whether UnitedHealthcare improperly paid for medical services designated with modifier code 59 that were not distinct and independent from other services provided on the same day. The audit covered the period from September 1, 2012 to August 31, 2013.

Background

The New York State Health Insurance Program (NYSHIP) provides health insurance coverage to more than 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. The State Department of Civil Service administers the NYSHIP program and contracts with UnitedHealthcare (United) to process and pay medical and surgical claims for services provided to Empire Plan members.

United's payments to medical providers are based, in part, on procedure codes billed on claims that indicate the medical services performed. United will not pay for certain procedure codes billed in combination with other procedure codes unless the provider includes a modifier code on the claim to further describe the services performed. Modifier 59 is used to indicate that a provider performed a procedure that was distinct or independent from another procedure that was performed on the same day for the same patient. Modifier 59 is used to identify procedures or services that are not normally billed together, but are appropriate under the circumstances. For example, a procedure billed with modifier 59 may involve a different anatomical site or separate injury. From September 1, 2012 to August 31, 2013, United paid over $82.3 million for about 1.3 million services with modifier 59.

Key Findings

- For 13 (5.3 percent) of the 245 claims we tested, a distinct or independent service was not provided despite the service's designation of modifier 59. The overpayments on the 13 claims totaled $39,345. For example, United paid a provider $28,094 for surgical procedures to remove a tumor and to repair blood vessels and a sciatic nerve that resulted from the removal of the tumor. However, the medical records did not support the provider's use of modifier 59 on two of the three procedures - the repair of the blood vessels and nerve - because they were not distinct or independent of the removal of the tumor. Consequently, the provider should not have billed, and United should not have paid, $6,250 for the repair of the blood vessels and nerve.
- Using statistically valid methods, we estimate, with a 90 percent confidence level, that United overpaid between $1.6 million and $5.2 million during the one-year period ending August 31, 2013 because providers improperly applied modifier 59 to their claims.

Key Recommendations

- Formally remind providers on the proper use of modifier 59 for claims preparation and submission.
- Recover the $39,345 in overpayments identified by our audit.

- As priorities and resources permit, review the claims of higher risk providers and recover any overpayments identified.

Other Related Audit/Report of Interest

New York State Health Insurance Program: United HealthCare - Certain Claim Payments for Evaluation and Management Services (2010-S-67)

State of New York
Office of the State Comptroller

Division of State Government Accountability

January 8, 2015

Mr. Carl 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 *UnitedHealthcare: Improper Payments for Medical Services Designated by Modifier Code 59*. This 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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This report is also available on our website at: www.osc.state.ny.us

Background

The New York State Health Insurance Program (NYSHIP) provides health insurance coverage to active and retired State, participating local government and school district employees and their dependents. NYSHIP provides health insurance to more than 1.2 million members. The Empire Plan is the primary health benefits plan for NYSHIP. Nearly 1.1 million of the more than 1.2 million NYSHIP members are in the Empire Plan. The Department of Civil Service (Department) administers the NYSHIP program and contracts with UnitedHealthcare (United) to process and pay medical and surgical claims for services provided to Empire Plan members. United processes over 21 million claims a year for the Empire Plan and in 2013 made claim payments totaling over $2.2 billion.

Medical providers bill United for services provided to Empire Plan members. United's payments are based, in part, on procedure codes billed by providers which indicate the medical services performed. United will not pay for certain procedure codes billed in combination with other procedure codes unless the provider includes a modifier code on the claim. Modifiers are two-digit codes that further describe the services performed. Modifier 59 is used to indicate that a provider performed a procedure that was distinct or independent from another procedure that was performed on the same day for the same patient. Modifier 59 is used to identify procedures or services that are not normally billed together, but are appropriate under the circumstances. For example, a procedure billed with modifier 59 may involve a different anatomical site or separate injury. When modifier 59 is used, a provider's documentation must support and demonstrate that the service was distinct from other services performed.

From September 1, 2012 to August 31, 2013, United paid over $82.3 million for about 1.3 million services with modifier code 59.

Audit Findings and Recommendations

Improper Payments for Modifier 59 Services

Excessive use of modifier 59 can indicate inappropriate use of the modifier and an increased risk of improper payments for services that do not meet the criteria of being distinct or independent from another service performed on the same day. We determined that, during the one-year period September 1, 2012 to August 31, 2013, 1,818 medical providers applied modifier 59 to 50 percent or more of their claims. This included 804 providers who applied modifier 59 to 90 percent or more of their claims.

Table 1 summarizes the number of providers who used modifier 59 on 50 percent or more of their claims for the one-year period ending August 31, 2013. As the table indicates, United paid $22 million to providers who included modifier 59 on 50 percent or more of their claims. Of that amount, $9 million was paid to providers who used modifier 59 on 90 percent or more of their claims.

Table 1

	Percent of Claims With Modifier 59				Totals	
	50 – 89 Percent		90 – 100 Percent			
Number of Services Claimed	Number of Providers	Amounts Paid for Modifier 59	Number of Providers	Amounts Paid for Modifier 59	Number of Providers	Amounts Paid for Modifier 59
10-49 Services	588	$5,132,692	403	$1,474,010	991	$6,606,702
50-99 Services	139	$1,478,798	118	$685,749	257	$2,164,547
100-499 Services	244	$3,452,827	207	$2,141,525	451	$5,594,352
Over 500 Services	43	$2,946,590	76	$4,721,817	119	$7,668,407
Totals	**1,014**	**$13,010,907**	**804**	**$9,023,101**	**1,818**	**$22,034,008**

Based on our analysis of all claims United paid during the year ending August 31, 2013, we determined providers, on average, applied modifier 59 about 6 percent of the time. According to United, providers in certain medical specialties are more likely to use modifier 59 than providers in other specialties. Therefore, providers who apply modifier 59 to more than the overall average of 6 percent are not necessarily using modifier 59 incorrectly. However, because many providers applied modifier 59 to 50 percent or more of their claims (and some of those providers applied modifier 59 to more than 90 percent of their claims), we concluded there was considerable risk that United made improper payments because certain providers improperly applied modifier 59 to their claims.

To develop an estimate of the total overpayments resulting from medical providers' improper use of modifier 59, we selected a random sample of 245 claims. We determined United overpaid 13 claims (5.3 percent of the sample) because the services did not meet the established criteria of being distinct or independent from the other services performed on the same day. On one claim, for example, United paid a provider $28,094 for surgical procedures to remove a tumor and to repair blood vessels and a sciatic nerve that resulted from the removal of the tumor. However, the medical records did not support the provider's use of modifier 59 on two of the three procedures - the repair of the blood vessels and nerve - because they were not distinct or independent of the removal of the tumor. Consequently, the provider should not have billed (and United should not have paid) $6,250 for the repair of the blood vessels and nerve.

For the 13 improper claims we identified, United made overpayments totaling $39,345. United reviewed the 13 claims and agreed modifier 59 was incorrectly applied on all 13 claims. The aggregate amount of improper payments for many thousands of such claims could be significant. Thus, using statistical sampling techniques, we projected the 13 overpayments to the 272,282 claims for modifier 59 services (totaling $74.7 million) in our audit population. Based on this projection, we estimate (with a 90 percent confidence level) that United overpaid between $1.6 million and $5.2 million for services that included modifier 59 during the one-year period ending August 31, 2013.

As noted previously, United processes over 21 million claims annually for the Empire Plan. Because of the large volume of claims, United officials rely extensively on the integrity of providers to properly use modifier codes and submit correct claims. United has performed some outreach and education on the proper use of modifier 59. Specifically, United's website includes policies on the proper use of modifier 59, and the documentation required to support modifier 59 claims. In addition, United publishes Participating Provider Bulletins which have included articles on proper coding and modifier use. Nonetheless, the probable overpayments of millions of dollars, due to the improper use of modifier 59, warrants increased oversight and monitoring by United. Consequently, we encourage United to develop and implement cost-effective controls to help reduce improper modifier 59 claims and the corresponding overpayments. In addition, as priorities and resources permit, United should review the claims of higher risk providers and recover any overpayments identified.

In April 2012, we issued a report entitled "United HealthCare: Certain Claim Payments for Evaluation and Management Services" (Report 2010-S-67). As a result of that audit, in March 2014, United submitted a proposal to the Department outlining a new program designed to address providers' improper use of modifier 59 and other commonly used modifiers. United's proposal appears to align with the recommendations we make in this report. United's approach includes retrospective claim reviews to identify providers with aberrant billing patterns, pre-payment medical record reviews for providers with the most problematic billing patterns, and provider education for providers with less problematic billing patterns. At the time of our audit fieldwork, the Department was reviewing United's proposal.

In response to our preliminary audit findings, United officials expressed concern that the cost of reviewing hundreds of thousands of modifier 59 claims could exceed the savings realized from

such reviews. However, we do not recommend control mechanisms designed to review 100 percent of the claims submitted with modifier 59. Moreover, we acknowledge that any system of internal controls should be cost effective and thereby focus limited resources on the highest risk transactions. For example, limited audit resources could be focused on those providers submitting the largest numbers and highest percentages of claims including modifier 59. We believe the benefits of a properly designed, risk-based approach would justify the related costs. United's aforementioned proposal employs a risk-based approach.

Recommendations

1. Formally remind providers on the proper use of modifier 59 for claims preparation and submission.

2. Review and recover the $39,345 in overpayments on the 13 improper claims.

3. Perform a formal risk assessment of providers' use of modifier 59 and identify providers exhibiting unusual modifier 59 billing patterns. As priorities and resources permit, review the claims of higher risk providers and take appropriate actions, including (but not limited to) recovery of any overpayments identified and targeted provider education.

Audit Scope and Methodology

Our audit objective was to determine whether United paid for services designated with modifier 59 that were not distinct or independent from the other medical procedures provided on the same day. Our audit covered the period from September 1, 2012 to August 31, 2013.

For the period September 1, 2012 through August 31, 2013, United paid 21 million claims totaling $2.2 billion for services provided to Empire Plan members. This included payments totaling $82.3 million for approximately 924,000 claims with modifier 59. From the 924,000 modifier 59 claims, we eliminated about 458,000 claims totaling $5 million for reasons including (but not limited to): United paid as the secondary payer on the claim; the claim amount paid was $0; or no other service was provided on the date in question. We also eliminated about 194,000 low-dollar claims (paying $20 or less) totaling $2.6 million. From the remaining 272,282 claims for modifier 59 services (totaling $74.7 million), we randomly selected 245 claims (totaling $3.7 million in modifier 59 payments) for testing.

To accomplish our audit objective, and assess internal controls related to our audit objective, we interviewed United officials and reviewed relevant policies. We also asked United to obtain the medical records from the practitioners for each sampled claim. We used the State Comptroller's clinical staff to review the medical records and determine if the services met the requirements for a modifier 59 claim. United reviewed the same medical records and agreed with our determinations.

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 objective.

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 (some of whom have minority voting rights) to certain boards, commissions, and public authorities. 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 as set forth in 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 comments. Their comments have been taken into consideration in preparing this report. Within 90 days of the final release of this report, we request United officials to report to the State Comptroller advising what steps were taken to implement the recommendations included in the report.

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