

MONITORING OF MEDICAID CLAIMS
USING ALL-INCLUSIVE CODE (T1015)

LOUISIANA DEPARTMENT OF HEALTH

STATE OF LOUISIANA



MEDICAID AUDIT UNIT
ISSUED OCTOBER 4, 2017

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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

October 4, 2017

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Taylor F. Barras,
Speaker of the House of Representatives

Dear Senator Alario and Representative Barras:

This report provides the results of our review of all-inclusive code (T1015) claims paid by the managed care plans. During this review, we identified \$150 million in payments by the managed care plans where the Louisiana Department of Health (LDH) claims data did not include required accompanying detail lines. Without the required detail lines, LDH could not monitor these claims to determine the specific services provided and ensure that the claims were paid for the proper amount. Considering rising state healthcare costs and limited budgets, it is important that LDH ensure that Medicaid dollars are appropriately spent.

The report contains our findings, conclusions, and recommendations. Appendix A contains LDH's response to this report. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of the LDH for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/ch

T1015 2017

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE



Monitoring of Medicaid Claims Using All-Inclusive Code (T1015)

October 2017

Audit Control # 80180006

Introduction

The Louisiana Department of Health (LDH) administers the Medicaid program, which provides health and medical services for uninsured and medically-indigent citizens. In Louisiana, rural health clinics (RHC) and federally-qualified health centers (FQHC)¹ were established to address concerns about adequate access to primary health care providers who serve Medicaid beneficiaries in rural and underserved areas.

Under both Medicaid fee-for-service (FFS) and managed care, RHC and FQHC Medicaid claims are reimbursed under a Prospective Payment System (PPS) and paid on a per visit basis. The PPS reimburses the clinics using a predetermined, fixed provider specific amount.²

Covered services provided in RHCs and FQHCs are reimbursed as encounters that must be billed using the all-inclusive procedure code, T1015, for medical and behavioral health services. The encounter reimbursements include all medical and behavioral health services provided to the recipient on that date of service and any services on a subsequent day incidental to the original encounter visit. **Reimbursement for all-inclusive T1015 claims totaled more than half a billion dollars from February 2012 through December 2016, as shown in Exhibit 1.**

Exhibit 1 RHC and FQHC T1015 Claims Detail – February 2012 through December 2016		
	Claim Count	Amount Paid
FFS	1,463,470	\$208,163,496
Managed Care	2,749,201	\$348,093,877
Totals	4,212,671	\$556,257,373
Source: Compiled by LLA staff using LDH claims data. Claims were pulled using the <i>Time Key</i> field of February 2012 through December 2016. For FFS claims, <i>Time Key</i> is paid date, and for MCO claims, <i>Time Key</i> is date of submission to LDH.		

¹ RHCs are defined as clinics located in an area that has a healthcare provider shortage and is certified to receive special Medicare and Medicaid reimbursement. FQHCs are defined as entities that receive a grant under Section 330 of the Public Health Service Act [also see §1905(1)(2)(B) of the Social Security Act].

² Louisiana Medicaid fee schedules can be found at http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm.

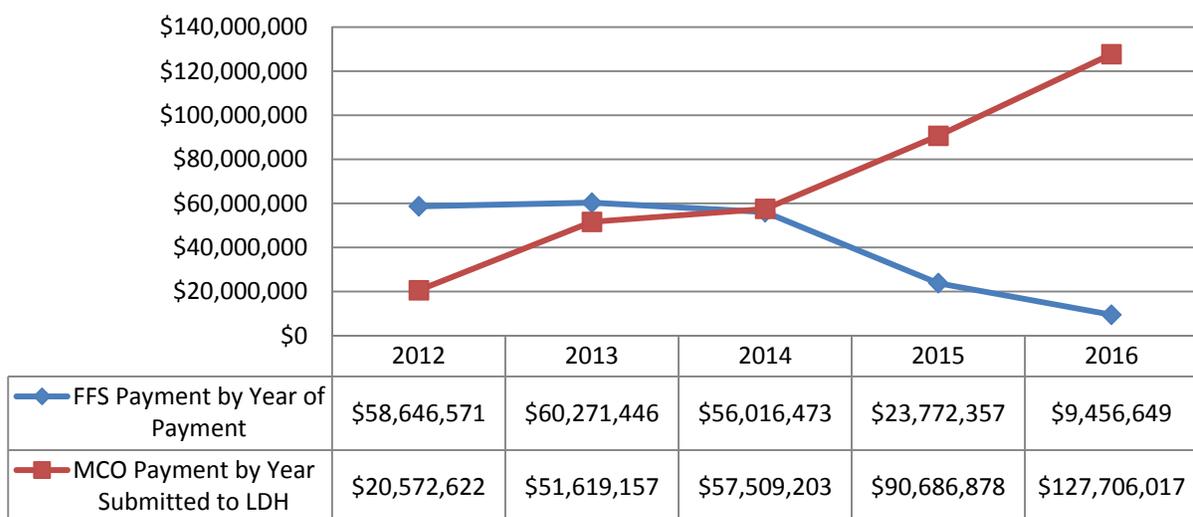
RHC and FQHC T1015 claims payment shifted to managed care in February 2012. According to their contracts, the managed care plans are responsible for payment of the claims and for submitting the encounters to LDH.

Despite the shift in payer from LDH to the managed care plans, **LDH remains responsible for the administration of the Louisiana Medicaid program.** As a result, the department remains responsible for monitoring the use of the T1015 all-inclusive code to ensure that appropriate services are delivered and that proper claims amounts are paid. Considering rising state healthcare costs and limited budgets, it is important that LDH ensure that Medicaid dollars are appropriately spent.

When billing a T1015 all-inclusive encounter procedure code claim, the provider must indicate the specific services provided by entering the individual procedure code and description, and a no charge or usual/customary charge for each service provided on subsequent lines. These subsequent lines are referred to as detail lines. The detail lines document the actual services performed.

The LDH provider manuals for RHC and FQHC services require submission of the detail lines with T1015 all-inclusive encounter claims so that the delivery of appropriate services can be monitored.³ Exhibit 2 shows the T1015 claims payments for RHCs and FQHCs, by year, from February 2012 through December 2016.

Exhibit 2
RHC and FQHC T1015 All-Inclusive Claims, by Year
February 2012 through December 2016



Source: Compiled by LLA staff using LDH claims data. Claims were pulled using the *Time Key* field of February 2012 through December 2016. For FFS claims, *Time Key* is paid date, and for MCO claims, *Time Key* is date of submission to LDH.

³ RHC provider manual - http://www.lamedicaid.com/provweb1/Providermanuals/RHC_Main.htm and FQHC provider manual - http://www.lamedicaid.com/provweb1/Providermanuals/FOHC_Main.htm

The purpose of our analysis was:

To determine if LDH is monitoring all-inclusive T1015 encounter claims to ensure appropriate services are delivered and proper claim amounts are paid.

Appendix A contains LDH’s response to this report, Appendix B details our scope and methodology, and Appendix C contains a list of previously-issued MAU audit reports.

Review of All-Inclusive T1015 Encounter Claims

Based on the results of our review, LDH did not monitor T1015 all-inclusive claims paid by the managed care plans from February 1, 2012, through December 30, 2016. Of the \$348,093,877 paid by the managed care plans for T1015 claims, the claims data submitted to LDH lacked accompanying detail lines for \$150,196,886 (43%). Without this claim detail, LDH could not adequately monitor T1015 all-inclusive claims paid by the managed care plans to ensure appropriate services were provided and proper claim amounts were paid.

Additionally, without the required detail lines linked to the T1015 claim, there is a risk that the detail lines were “unbundled,” meaning they were paid separately by the health plan rather than paid together using previously agreed-upon rates. There is also a risk that the services provided as part of the encounter were for non-covered services. These instances could represent improper payments by the health plans. Also for these instances, future payment rates could be impacted if encounter claim submissions that violated LDH policy were used as experience data in future rate setting. Managed care health plan claims submissions are used by an LDH contractor for premium rate setting.⁴

T1015 all-inclusive code encounter claims are paid at the provider specific agreed-upon rates under a PPS, with detail lines identifying specific services provided. The T1015 encounter line is linked to the detail lines by the 13-digit claim number. The first 11 digits are the same, and the last two are sequential. The example below shows a valid T1015 claim with appropriate supporting detail lines.

Example: T1015 All-Inclusive Encounter Claim with Detail Lines

Claim Number	Service Date	Procedure Code	Plan Paid Amount	Billed Charges Amount	
1023456789100	5/31/2012	T1015	\$130.58	\$88.00	
1023456789101	5/31/2012	99213	\$0.00	\$110.00	Detail Lines
1023456789102	5/31/2012	81003	\$0.00	\$15.00	

⁴ The managed care plans are paid a monthly per member per month (premium) payment to manage the care of recipients in the plan. The managed care plan is responsible for claims payments.

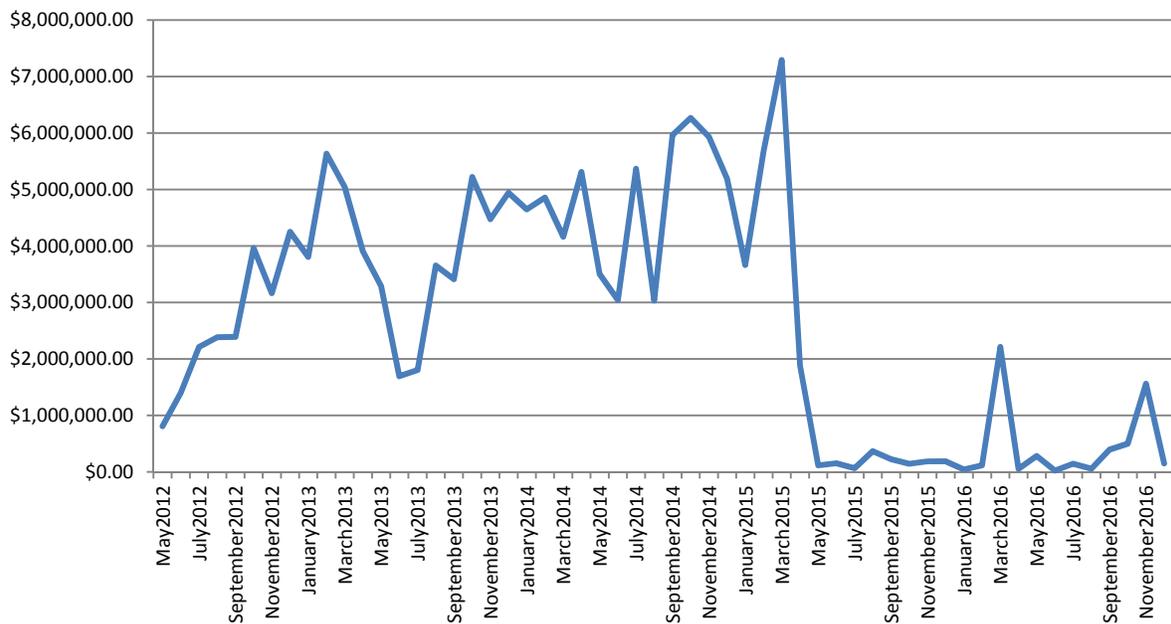
In the example on the previous page, procedure codes 99213 and 81003 are for outpatient office visit and urinalysis, respectively.

Exhibit 3 provides a breakdown of our results for managed care encounters using T1015.

Exhibit 3					
Managed Care T1015 All-Inclusive Code Encounter Claims					
	Paid T1015 Claims Total		Paid T1015 Claims Without Detail Lines		
	Claim Counts	Managed Care Plan Payments	Claim Counts	Managed Care Plan Payments	Percentage of Payments Without Detail Lines
Managed Care Totals	2,749,201	\$348,093,877	1,197,711	\$150,196,886	43%
Source: Compiled by LLA staff using LDH claims data – claims submitted (<i>Time Key</i> field) to LDH February 2012 through December 2016					

A majority of the T1015 all-inclusive encounter submissions without detail lines occurred prior to May 2015, with two subsequent spikes in March 2016 and November 2016, as noted in Exhibit 4. The spikes noted are likely related to bypasses of a system edit, as explained below.

Exhibit 4
T1015 All-Inclusive Encounter Submissions
Without Detail Lines, by Month of Submission to LDH



Source: Compiled by LLA staff using LDH claims data using *Time Key* field for February 2012 through December 2016.

Our review focused on procedure code T1015, which LDH policy indicates should be used by RHCs and FQHCs. We noted that some of the managed care claims utilizing the T1015 code and cited as violations above had provider types other than RHC and FQHC. LDH should investigate the appropriateness of managed care claims payments for provider types other than RHC and FQHC.

While LDH appears to have edits in place to prevent paying fee-for-service T1015 claims without detail lines, effective edits are lacking for managed care encounters.

It appears LDH has working edits in place to substantially prevent paying FFS T1015 claims without detail lines. For example, our analysis noted only 183 FFS claims totaling approximately \$4,600 for T1015 all-inclusive claims that were paid despite not having detail lines. However, effective edits are lacking for the managed care encounters.

For T1015 all-inclusive claims paid for by the managed care plans and submitted to LDH, an edit (Edit 136) was set to deny noncompliant claims submissions without detail lines for February 2012 through May 2012. In June 2012, LDH switched Edit 136 to an educational status, which allows the T1015 all-inclusive claims submissions without detail to be accepted as a paid claim. An educational edit generates feedback to the claim submitter instructing them for future claims filing and also generates a report for LDH to use for monitoring. Edit 136 was not switched back to deny noncompliant claims until October 2015.

Edit 136 identifies T1015 all-inclusive claims using the servicing provider type. Once identified as a T1015 claim by the claims system, the claim is evaluated electronically for detail lines. If the system does not identify the claim as a T1015 claim using the servicing provider, the claim bypasses Edit 136. As noted previously, the two spikes in 2016 noted in Exhibit 4 are likely related to bypasses of Edit 136.

While the focus of this report is T1015 all-inclusive claims *without detail lines*, we noted approximately \$845,000 in payments for claims *with detail lines* that appear to violate established policy and are potential improper payments by the health plans that LDH should look into further.

For managed care T1015 claims submitted *with detail lines*, we noted instances of:

- T1015 claim and detail lines both with payment amounts
- T1015 paid at zero with detail lines with payment amounts

LDH should determine if these incidences were improper payments and take appropriate action. Additionally, LDH should determine if the detail lines with payments were used in rate setting.

The FQHC provider manual contains conflicting instructions to providers for the filing of annual cost reports.

During our research, we inquired whether T1015 claims without detail lines might have any cost report settlement implications. *Section 22.2, Provider Requirements*, indicates cost reports are only required with requests for a change of scope, while *Section 22.4, Reimbursement*, indicates the FQHC is required to file a cost report within five months of the clinics fiscal year-end.

The section includes a reference to *Appendix A*, which indicates annual cost reports are to be submitted to LDH's contracted auditor of cost reports, LRCA.

According to LDH, annual cost report submissions from FQHCs have not been required since the mid-2000s. LRCA only performs procedures on FQHC cost reports when requested, such as in change of scope requests. LDH should ensure provider manuals are updated timely and do not contain conflicting information.

Recommendation 1: LDH should investigate the instances of encounter claims without detail lines noted in this report and determine appropriate action.

Recommendation 2: LDH should frequently review claims edits related to managed care claims submissions to ensure edits are aligned with adequate monitoring of the Medicaid program. LDH should also monitor for potential bypasses of established edits and address bypasses accordingly. Based on limited errors noted for FFS T1015 claims, LDH should consider similar edits for managed care claims submissions.

Summary of Management's Response: In its response, LDH management noted a commitment to monitoring the managed care program through appropriate management controls. LDH management addressed each report recommendation by noting corrective action already taken and outlining future actions. See Appendix A for management's full response.

APPENDIX A: MANAGEMENT'S RESPONSE



State of Louisiana
Louisiana Department of Health
Bureau of Health Services Financing

September 25, 2017

Daryl G. Purpera, CPA, CFE
Legislative Auditor
P.O. Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Monitoring of Medicaid Claims Using All-Inclusive Code (T1015)

Dear Mr. Purpera,

Thank you for the opportunity to respond to the findings of your Medicaid Audit Unit on Monitoring of Medicaid Claims Using All-Inclusive Code (T1015). The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF), the agency which is responsible for management of the Medicaid Program in Louisiana, is committed to monitoring the managed care program through appropriate management controls.

I have provided a response to each of the LLA's recommendations below.

Recommendation 1: LDH should investigate the instances of encounter claims without detail lines noted in the report and determine appropriate action.

LDH Response: LDH has investigated the instances of encounter claims without detail lines noted in the report and determined that it will work with its Managed Care Organizations and fiscal intermediary contractor to collect, to the maximum extent practical on a retrospective basis, the missing detail lines on T1015 encounter claims submitted prior Edit 134 being switched to deny in 2015.

Recommendation 2: LDH should frequently review claims edits related to managed care claims submission to ensure edits are aligned with adequate monitoring of the Medicaid program. LDH should also monitor for potential bypasses of established edits and address bypasses accordingly. Based on limited errors noted for FFS T1015 claims, LDH should consider similar edits for managed care claims submissions.

LDH Response: LDH routinely reviews FFS claims edits and managed care encounter edits to ensure edits are aligned with adequate monitoring

Daryl G. Purpera
September 25, 2017
Page 2

of the Medicaid program. It was a comprehensive review by LDH that resulted in Edit 136 being switched from educational to deny noncompliant claims in 2015, preventing encounter submissions without detail lines on a prospective basis. In a focused review, LDH investigated the spikes noted in Exhibit 4, and found opportunities to strengthen Edit 134. The change is currently in testing and will be implemented by December 31, 2017.

Should you have any further questions or concerns, please feel free to contact Alicia Prevost, Benefits and Covered Services Section Chief, at (225) 342-3892 or via e-mail at Alicia.Prevost@la.gov.

Sincerely,

A handwritten signature in blue ink that reads "Jen Steele". The signature is written in a cursive, flowing style.

Jen Steele
Medicaid Director

APPENDIX B: SCOPE AND METHODOLOGY

The objective of our work was:

To determine if LDH is monitoring all-inclusive T1015 encounter claims to ensure appropriate services are delivered and proper claim amounts are paid.

The scope of our project was significantly less than that required by *Government Auditing Standards*. However, we believe the evidence obtained provides a reasonable basis for our findings and conclusions. To conduct this analysis, we performed the following steps:

- Obtained an electronic copy of Medicaid claims paid by the managed care plans from Molina Health Solutions, LDH's fiscal intermediary.
- Obtained LDH provider manuals for RHCs and FQHCs from LAMedicaid.com.
- Obtained Managed Care RFP and contract documents from LDH website.
- Used software (e.g., SQL and Excel) to extract claims data including all T1015 encounter claims without accompanying detail lines and all T1015 encounter claims with accompanying detail lines. Also identified RHCs and FQHCs using servicing and/or bill provider type 72, 79, or 87.
- Worked with LDH personnel throughout the project to ensure that the proper criteria were used for analysis.
- Contacted LDH contractor LRCA to gain an understanding of RHC and FQHC cost report and audit procedures.
- Provided results to LDH officials to validate our findings and conclusions and for further investigation.

APPENDIX C: PREVIOUSLY ISSUED MAU REPORTS

Issue Date	Title	Report
October 26, 2016	<i>Medicaid Recipient Eligibility - Managed Care and Louisiana Residency</i>	Click here
March 22, 2017	<i>Program Rule Violations in the Medicaid Dental Program</i>	Click here
March 29, 2017	<i>Duplicate Payments for Medicaid Recipients with Multiple Identification Numbers</i>	Click here
July 12, 2017	<i>Prevention, Detection, and Recovery of Improper Medicaid Payments in Home and Community-Based Services</i>	Click here
September 6, 2017	<i>Improper Payments in the Medicaid Laboratory Program</i>	Click here
<p>Source: MAU reports can be found on the LLA’s website under “Reports and Data” using the “Audit Reports by Type” button. By selecting the “Medicaid” button, all MAU reports issued by LLA will be displayed. https://www.la.la.gov/reports-data/audit/audit-type/index.shtml?key=Medicaid</p>		