STATE OF WASHINGTON
PAYMENTS TO CLIENT SERVICE PROVIDERS

REPORT NO. 1006745

NOVEMBER 30, 2011

AUDITOR OF STATE
PLURIBUS UNUM
NOV 11, 1889
WASHINGTON

Table of Contents

Executive Summary

In fiscal year 2010 Washington State paid providers almost $7 billion for client services through its Medicaid and Workers' Compensation programs.

Some of this was paid to providers on behalf of some of the state's most vulnerable citizens and injured workers. It is important for the agencies that administer the programs have strong systems in place, known as internal controls, to protect against the loss of these resources.

Based on previous audits and through research, we identified overpayments to providers as an area at risk for unallowable payments.

Audit Results

This audit was designed to determine whether the Medicaid program, now administered by the Health Care Authority, and Workers' Compensation program, administered by the Department of Labor & Industries (L&I), are overpaying providers of client services.

We asked the following questions:

- Are state agencies making duplicate payments to providers?
- Are state agencies paying providers when services are not rendered?

Internal control deficiencies

This audit identified overpayments of $382,112 to providers. While this amount is small in comparison to the overall size of the programs, these overpayments point to significant internal control deficiencies in three areas that increase the risk of future overpayments:

- Labor and Industries' medical payment system lacks adequate internal controls to prevent overpayments to providers of interpreter services and physical and occupational therapy services.
- Medicaid's payment system lacks adequate internal controls to prevent overpayments to providers of certain durable medical equipment
- Untimely data sharing led to duplicate payments by Medicaid and L&I.

Other issues

We also performed audit work to determine if agencies were paying providers when no services were rendered.

We found that from July 1, 2009 to June 30, 2010, L&I paid providers more than $1.2 million for client no-show or late cancellation fees. We found L&I does not always attempt to collect no-show or late cancellation fees from clients who did not have good cause for missing required exams. Also, current law and administrative rules place limits on when the agency can recoup these fees.

Commendations

We found internal controls at both agencies were adequate to protect against issuing payments after a provider's death and to ensure providers are reimbursed properly for the durable medical equipment they supply to clients.

Why we did this audit

The State Auditor's Office is undertaking a new approach to its accountability audits of state government. We have shifted our focus to auditing and reporting on significant statewide issues, rather than individual agencies.

Using this approach, we identified state agencies' payments to client service providers as transactions that pose a higher risk of being overpaid or unallowable.

What's next?

We plan to continue our statewide approach to conducting accountability audits of state agencies. This may include following-up with agencies to determine if the agencies have taken corrective action to address the issues we identified in this audit.

Audit authority, scope and objectives

We performed this audit under the authority of state law (RCW 43.09.310), which requires the State Auditor to perform post-audits of state agencies. These audits are designed to assess whether agencies have systems in place to ensure accountability over state resources and comply with state laws and regulations.

This audit examines payments to providers of certain client services provided through programs state agencies administer. The programs we selected for audit were the Medicaid program, now administered by the Health Care Authority, and the Workers' Compensation program, administered by the Department of Labor & Industries.

Our scope generally included payments to these programs' providers between July 1, 2009 and June 30, 2010. However, we reduced or expanded the period for certain issues as noted throughout the report.

About the Medicaid program

Washington State has a number of programs that provide health-care coverage for low-income individuals, the largest of which is Medicaid.

From July 1, 2009 through June 30, 2010, the Medicaid program paid providers approximately $6.2 billion for the health care of approximately 1.2 million individuals. Federal and state dollars pay for Medicaid-covered services on a roughly 50-50 basis.

On July 1, 2011, the Medicaid Purchasing Administration was transferred to the Health Care Authority. Although the Department of Social and Health Services was responsible for overseeing payments to providers prior to and during this audit, we are addressing our recommendations to the Authority.

About the Workers' Compensation program

L&I administers the state's Workers' Compensation program, which provides medical and limited wage replacement coverage and disability benefits to workers with job-related injuries or illness.

As reported on L&I's website, in 2010 the program covered about 2.3 million employees working for 163,000 employers.

Funding for these benefits comes from:

- Quarterly premiums paid by employers.
- Payroll deductions from workers.
- Investment income.

When L&I accepts an injured worker's claim, allowable medical expenses are paid from the Medical Aid Fund.

From July 1, 2009 through June 30, 2010, L&I paid more than $650 million for client services from this fund.

Section 1- Internal control deficiences

Finding 1: Labor and Industries' medical payment system lacks adequate internal controls to prevent overpayments to providers of interpreter services and physical and occupational therapy services.

Background

We analyzed billing patterns of providers paid by the state and identified payments for interpretive and physical and occupational therapy services by L&I to be at risk of overpayment.

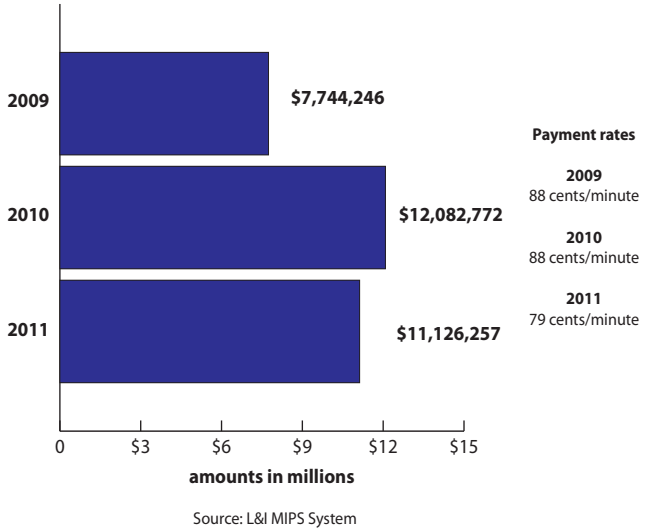
Interpreter Services

L&I offers interpreter services for non-English speaking injured workers. A health services provider or vocational provider determines if a client needs this service. Interpreters must be certified to provide the service and have an active account number with the Department.

L&I's payment policies and fee schedule explain the reimbursement process and documentation requirements (**see Appendix A**). Providers are eligible only for the actual time spent interpreting, in the waiting room, and for time completing forms.

L&I's Medical Information Payment System generates the payments based on how many minutes a provider reports spending with a client. For example, if an interpreter provides services for two consecutive hours, he or she is eligible to bill for 120 minutes. Providers may claim a maximum of 480 minutes (or eight hours) each day.

Table A-1
Workers Compensation Interpreter Services Payments

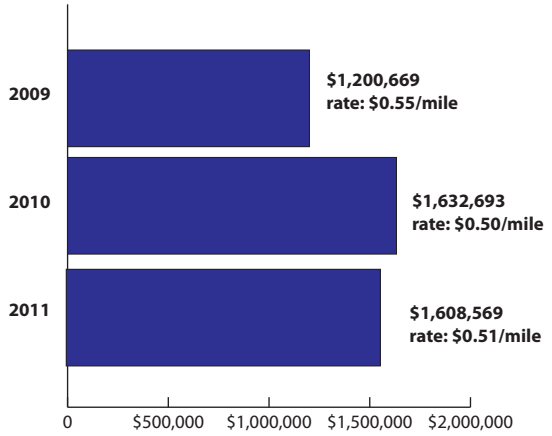


Source: L&I MIPS System

L&I's policies require interpreters to submit a report describing the services provided Table A-1 shows L&I paid more than $30 million to providers of interpreter services from July 1, 2008 through June 30, 2011.

Providers also are paid for mileage from their home to the client's appointment and back. They also can claim mileage for driving from one appointment to another. L&I's fee schedule explains the mileage reimbursement policies (one mile = one billing unit).

Table A-2
Interpreter Mileage Paid by Workers Compensation Program



Source: L&I MIPS System

Table A-2 shows the total amount L&I reimbursed interpreter service providers for mileage from July 1, 2008 through June 30, 2011. Total payments made to providers were more than $4.4 million.

The program places no maximum on the number of reimbursable miles per day. Providers report mileage on the Interpretive Services Appointment Record (ISAR) and must submit maps to support miles travelled.

What we found

We found L&I's Medical Information Payment System does not prevent providers from being paid for more than 480 minutes per day and does not routinely verify that it has received required reports from providers prior to paying invoices. L&I reviews bills when an interpreter claims mileage in excess of 200 miles per day.

Using data from the Medical Information Payment System, we identified the providers who were paid for the most minutes of interpreter services and selected the 32 highest-paid from each fiscal year between 2009 through March 2011 for examination.

L&I paid these 96 providers for more than the 480 minutes allowed per day. The following table shows total overpayments since July 2008 that we identified.

Table A-3
Interpreters billing for more than 480 minutes per day

Fiscal year	Providers reviewed	Minutes paid over the maximum	Total overpaid
2009	32	76,256	$67,105
2010	32	37,035	$32,591
2011*	32	23,293	$18,401
Total	**96**	**136,584**	**$118,097**

(Fiscal Year 2011 bills only through March 31, 2011)

We also looked at whether these same providers sent the required Interpreter Service Appointment Record forms to support their invoices. We found invoices totaling $188,477 were paid and not supported by required forms. Without these forms, L&I cannot ensure that payments were allowable.

The following table shows the total paid to providers from July 2008 through March 2011 for which L&I did not receive supporting documentation prior to paying invoices.

Table A-4
Required forms missing from claim files

Fiscal year	Days missing required forms	Total overpaid
2009	602	$164,788
2010	219	$19,000
2011*	23	$4,689
Total	**844**	**$188,477**

(Fiscal year 2011 bills only through March 31, 2011)

Interpreter mileage

Using payment data from the Medical Information Payment System, we identified the 10 highest-paid interpreters for each of fiscal years 2009, 2010 and 2011. We compared the number of reimbursed miles to supporting documentation from ISAR forms and found 21 providers out of 30 were overpaid by at least $14,371 between July 1, 2008 and March 31, 2011. About 60 percent of the overpayments are due to unreasonable mileage claimed. For example, we found:

- From July 1, 2008 to June 30, 2010, L&I paid one provider for 51,530 miles. To put this in perspective, had the provider worked 365 days during that year, he would have averaged 141 miles per day. It was common for this provider to claim he travelled daily from Salem to Portland, Ore. for multiple client appointments. During the audit, we confirmed the clients had allowable claims with L&I. Instead of splitting the mileage between each client, he would request reimbursement and be paid for the full mileage for each client's appointment.

Investigations

L&I has a Fraud Prevention and Compliance Program that investigates suspected billing fraud by providers. As of this audit, it:

- Had nine open cases regarding interpreter services.
- Completed an investigation in 2010 that involved an interpreter who allowed her brother to use her provider number to bill for services. The actual provider also billed for more minutes than allowed in a day. L&I's Program assessed a $14,000 penalty in this case.

- Is waiting to find out if criminal charges will be filed in a case that began in 2007 involving a group of interpreters, a medical clinic and an individual who assisted injured workers in filing claims with the L&I. The agency identified a loss of $2.6 million in this case. A $7.8 million civil penalty has been assessed.

L&I action on overpayments

When we notified L&I about the issues we found, it began a review of these claims and is attempting to recoup overpayments. We commend the agency for its timely response.

Physical and occupational therapy services

Washington Administrative Code and L&I payment policies allow providers to bill for physical and occupational therapy for injured workers.

The maximum allowable fee that can be paid to a provider per day for these services is $118.07. If both physical and occupational services are provided on the same day for the same client, the daily maximum applies once for each provider type.

Between July 1, 2009 and June 30, 2010 L&I paid providers of physical and occupational therapy more than $68 million.

What we found

L&I's Medical Information Payment System will not allow the same provider to be paid more than the daily maximum rate. However, during the audit period, the system did not prevent payment of bills from more than one physical or occupational therapist on the same date for the same client. For example, if two physical therapists bill L&I for the same client, on the same date of service, the payment system will pay both providers.

Using data from L&I's payment system, we identified 1,408 workers' compensation claims when multiple providers were paid for the same type of service for the same client on the same date. This is not allowable under L&I's payment policies.

Upon being notified of this internal control weakness, L&I immediately began a review of these claims and is attempting to recoup overpayments.

Table A-5	
Provider Type	**Amount paid in excess of maximum daily rate**
Physical therapists	$9,675
Occupational therapists	$9,812
Clinics	$4,488
	$23,975

Table A-5 shows, by provider type, the amount L&I confirmed as being overpaid to providers between October 2008 and June 2010.

During the audit, L&I established an internal control in its payment system to prevent overpayments. We commend the agency for responding to this issue quickly.

What is the effect?

Medical claim costs have a direct effect on rates employers and workers pay for industrial insurance. When unallowable charges are paid by L&I, it could cause these rates to be overstated.

According to L&I, the percentage of non-English reading and speaking clients increased from 4 percent in 2003 to 12 percent in 2010. If effective internal controls are not in place to ensure L&I pays only for allowable services, it will be at a higher risk of making overpayments.

Recommendations

We recommend L&I:

- Continue to recoup overpayments to providers.
- Ensure it obtains required reports to support payments for interpreter services and mileage reimbursements prior to paying for the services. These reports are necessary to ensure providers are paid in accordance with L&I's policies.
- Design its payment system to prevent providers from being overpaid or perform post-payment reviews of providers who bill more than eight hours per day across multiple claims.
- Require training for providers who continuously bill incorrectly.

Finding 2: Medicaid's payment system lacks adequate internal controls to prevent overpayments to providers of certain durable medical equipment.

Background

Durable medical equipment (DME) consists of items such as wheelchairs, hearing aids, and breathing devices designed to assist those with an illness or injury. During fiscal year 2010, Medicaid paid providers more than $23 million for DME.

In January 2009, Medicaid published new billing instructions for portable oxygen system rentals. Providers who supply clients with this equipment can submit reimbursement claims to Medicaid for a maximum of 36 months. After that, the provider must supply the equipment to the client until its five-year useful life has expired. The provider then may bill for an additional 36 months.

What we found

We found Medicaid's payment system does not have a control in place to identify when providers bill after the 36-month period expires. Between July 1, 2009 and May 9, 2010 providers were paid for 30,675 claims totaling $482,990 for this equipment.

Because of this weakness, we selected a random sample of 50 claims paid during the audit period and reviewed providers' billing history to determine if they were paid for claims that went beyond the 36-month limit.

From our sample we identified five instances (10 percent) in which overpayments occurred due to providers billing after the 36-month limit. Though the dollar amount in question is small, we consider the error rate of 10 percent very high and without adequate internal controls the risk of higher dollar overypayments in the future is increased.

What is the effect?

By not having adequate internal controls within its payment system, the Medicaid program is at risk of making additional overpayments to providers.

Recommendations:

We recommend the Health Care Authority:

- Design internal controls in its payment system to prevent future overpayments.

Finding 3: Untimely data sharing led to duplicate payments by Medicaid and L&I.

Background

Medicaid is the "payer of last resort" meaning providers are to identify other payment sources prior to submitting claims to Medicaid. Third-party liability refers to the legal obligation of third-party resources, usually insurance companies, to pay medical and pharmaceutical claims of Medicaid recipients prior to Medicaid coverage. This is to ensure non-Medicaid resources are the primary source of payment. Federal regulations require states to have processes to identify third parties liable for payment of services before Medicaid dollars are used (see **Appendix A**).

The state Workers' Compensation program, administered by L&I, is considered a third party when it accepts an injured worker's claim.

What we found

The Medicaid program and L&I do not share information in a timely manner. Timely sharing would make it possible for Medicaid to identify clients who have open L&I claims prior to paying medical expenses.

Using unique identifiers, such as Social Security numbers and dates of birth, we found Medicaid and L&I paid the bills for 7,555 of the same clients between July, 1, 2008 and May 9, 2010[1].

From this population, we selected the 75 most expensive claims paid by each program (150 total) for review to determine whether duplicate payments to providers occurred. We worked with the agencies and found duplicate payments were made for 14 claims (9 percent). The programs will recoup the following amounts from providers:

- L&I: $2,345
- Medicaid: $12,533

Additional tests

Based on our initial findings, we cross-matched payment information from Medicaid and L&I and identified 417 claims for which both programs paid providers between July 2008 and May 2010 when the following criteria was the same:

- Date of service.
- Client Social Security number.
- Medical procedure code and description.

1 Medicaid transitioned from the Medicaid Management Information System (MMIS) to the Provider One system on May 9, 2010.

We sent transactions for 45 most expensive claims, totaling $102,687 paid by L&I, for confirmation on whether the payments were allowable. L&I confirmed that $12,254 (12 percent) were overpayments.

We sent the same transactions to Medicaid, which paid $17,197 on these claims. DSHS confirmed L&I was liable for $10,059 (59 percent) of the transactions and duplicate payments had occurred.

This table summarizes overpayments we identified during the audit:

Table C-1

Labor and Industries	Medicaid	Total overpayments
$14,599	$22,592	**$37,191**

How did this happen?

State law and the federal Deficit Reduction Act of 2005 require the Medicaid Purchasing Administration to share eligibility and coverage information with insurers to determine if third-party coverage applies. In 2008, we first reported audit findings that the Administration was not complying with the requirements. This increases the likelihood it is paying claims that should have been paid by other parties.

What is the effect?

Federal requirements state Medicaid expenditures for duplicate payments are overpayments. Medicaid must refund overpayments to the federal grantor.

Medical claim costs have a direct effect on rates employers are required to pay for industrial insurance. When the Workers' Compensation program pays unallowable charges, it could cause the rates to be overstated.

Recommendations

We recommend the agencies:

- Pursue the collection of overpayments identified by the audit.
- Establish a data-sharing agreement that will provide more timely information about whether clients have Medicaid coverage or open claims with L&I.

SECTION 2 - OTHER ISSUES

Finding 4: The Workers' Compensation program pays providers when clients do not show up for appointments.

Overview

L&I paid more than $1.2 million from July 1, 2009 through June 30, 2010 to providers of independent medical examinations for clients who did not show up[2] for appointments or who cancelled appointments late.

We found L&I does not always attempt to collect no-show or late cancellation fees from clients who did not have good cause for missing required appointments. Current law and administrative rules place limits on what fees the agency can recoup.

Independent medical exams

L&I schedules independent medical exams (IMEs) for injured workers for a number of reasons, including when it needs to know the extent of medical impairments, has questions about the type treatment or its duration and when workers ask to have a claim re-opened or when a claim appears ready to close.

State law (RCW 51.32.110) requires clients to attend these appointments (Appendix B, page 18). From July 1, 2009 to June 30, 2010, L&I paid providers more than $19 million for these exams.

Client no-shows and late cancellations

When clients do not show up for their required appointments or cancel appointments late, L&I's payment policies allow providers to bill for no-show or late cancellation fees. In fiscal year 2010, these fees were as much as $325.56 for each provider.

L&I does not pay such fees for medical appointments other than IMEs. These fees are not payable if L&I notifies the provider within four business days that it has rescheduled the client's exam or if the provider filled the time slot of the cancelled appointment.

2 Chapter 388-502-0160 of the Washington Administrative Code does not allow the Medicaid program to pay providers for appointment no-shows.

Table D-1		
Fiscal year	**Amount paid to providers**	**Percent change from prior year**
2009	$1,484,233	---
2010	$1,227,208	21%
2011	$1,097,897	12%
Source: L&I's MIPS System		

This table shows that, between July 1, 2008 and June 30, 2011, L&I paid more than $3.8 million in no-show and late cancellation fees to providers. The table also shows that the amount paid per year has decreased in each of the past two years.

L&I attributes this decrease to the phone call reminders it began to make to clients during the audit period.

"Good cause" for missing IME

L&I has policies and procedures for evaluating IME no-shows and late cancellations. Its claims managers attempt to contact the client to determine why the exam was missed. If the client provides "good cause", the claims manager reschedules the IME and L&I will not recoup funds from the client.

A definition of "good cause" is not found in state law or regulations. L&I has an internal policy that defines "good cause" as an unforeseen or unavoidable event that prevented the client from attending the exam. The claims managers make these determinations.

L&I also accepts the following as good cause for a client missing an exam:

- Notice of the exam was not sent to the worker or the worker's representative 14 days in advance of the appointment.
- The worker waited more than one hour past the scheduled start time for the exam.

If the claims manager does not determine good cause for the appointment to be missed, L&I sends a letter to the client, or legal representative asking for a documented explanation of why the exam was missed.

Overpayments and reimbursements by clients

If a client fails to attend a scheduled IME without good cause, state regulations allow L&I to reduce a client's current or future time-loss compensation benefits by the amount of the no-show or late cancellation fee. Washington Administrative Code[3] defines this as non-cooperation. The basis for this regulation is found in state law (RCW 51.32.110) (**Appendix A**).

3 WAC 296-14-410(2)(a) – see Appendix A

When L&I determines that a client was not cooperative, is entitled to time-loss compensation benefits and is therefore responsible for the fee, it assesses an overpayment by issuing an order and notice. The client has 60 days to appeal the order.

L&I rarely receives reimbursement from clients missing required appointments without having good cause. We found that from July 1, 2009 to June 30, 2010, L&I issued $77,573 in overpayments for IME no-shows, but collected only $17,164 from clients, or 1.4 percent of the more than $1.2 million in no-show fees paid to providers during that time period.

We also found that L&I does not always assess overpayments when clients do not have good cause for missing an exam. As a result of this audit, L&I randomly selected and reviewed 509 out of more than 9,600 claims when no-show fees were paid from July 1, 2008 through March 31, 2011.

It found 132 (26 percent) of the claimants did not have good cause for missing the exam. In addition, L&I was unable to determine if 121 (24 percent) of the claimants provided good cause due to inadequate documentation in claim files. These numbers include claimants who were and who were not entitled to time-loss benefits.

Barriers to collecting overpayments owed from clients

Legal barriers prevent L&I from collecting no-show exam fees from clients. State law (RCW 51.32.110) and Washington Administrative Code[4] limit L&I to only collecting overpayments from a client's current or future time-loss benefits.

This means if the client does not have good cause for missing an exam and is no longer receiving time-loss benefits, L&I may not collect no-show fees from other Workers Compensation benefits. Examples of other benefits include a partial, permanent disability or pension. The law and Code also do not permit L&I to send a bill to the client, even though worker was non-cooperative and would otherwise be responsible for the no-show fee. It can only reduce current or future time-loss benefits.

4 *WAC 296-14-410(5), see Appendix A*

What is the effect?

Claim costs have a direct effect on rates employers pay for industrial insurance. When L&I pays unnecessary or unallowable charges, these rates could increase.

Recommendations

We recommend L&I:

- Always issue overpayment orders to clients who are entitled to time-loss benefits and who do not provide good cause for missing required appointments.
- Pursue the expansion of its collection efforts. This will require changes to state law, Washington Administrative Code and internal policies.

Payments after a provider's death

In 2009, a U.S. Government Accountability Office report highlighted fraud and abuse related to controlled substances in the Medicaid program in other states. An example of these activities included prescriptions that were written, filled and then paid for by Medicaid after the endorsing doctor had died.

We designed our audit to meet the following objectives:

- Do state agencies have effective internal controls to inactivate providers' accounts after their death?
- Are state agencies paying for services rendered after a provider's death?

We did a reconciliation of payments to supporting documentation and data-matching that compared payments made by multiple agencies.

Results

We commend both DSHS and L&I for having adequate internal controls in place to ensure payments are not made after a provider's death.

Durable medical equipment

One of our audit objectives was to determine whether clients received the proper durable medical equipment that was supplied by providers of the Medicaid and Workers' Compensation programs.

We sent questionnaires to 98 clients to determine if they received the proper equipment. We included information such as the type and description of the equipment, date of service, and the provider's name in the questionnaires.

Results

Of the 98 questionnaires we sent, 50 (51 percent) clients responded and all positively confirmed they received the proper equipment. We commend both agencies for having adequate internal to ensure clients receive the equipment providers were paid for by the state.

APPENDIX A: AGENCIES RESPONSES

FINDING NO.1

Labor and Industries' medical payment system lacks adequate internal controls to prevent overpayments to providers of interpreter services and physical and occupational therapy services.

LABOR AND INDUSTRIES RESPONSE:

Interpretive Services

L&I agrees with the State Auditor's recommendation to recoup overpayments for interpretive services identified during the audit. The recoupment of overpayments is almost two-thirds complete and is expected to be finished by the end of 2011.

As shown in the chart on page 7, overpayments related to missing documentation decreased from $164,788 in fiscal year 2009 to $19,000 in fiscal year 2010. This was due to a significant increase in the department's efforts to prevent inappropriate payments for interpretive services, beginning in late fiscal year 2009, through outreach to educate providers and follow up on patterns of incorrect billing. Between January 2010 and October 2011, L&I offered six billing workshops and training to several individual interpreters and interpretive service companies. L&I has directly contacted interpreters regarding billing issues and currently has 72 providers on pre-payment review.

L&I agrees with the auditors' suggestion to use post-payment review to identify providers who bill more than 480 minutes per day. This process will be implemented after we have completed work on the recoupments mentioned above.

Over half of the $14,371 identified as overpayments for interpreter mileage were related to one provider. A review of this particular provider uncovered other serious issues. The Department terminated the provider's eligibility to provide services for injured workers in July 2011.

Physical and Occupational Services

L&I agrees with the State Auditor's recommendation to recoup overpayments for physical and occupational therapy services identified during the audit. The recoupment of overpayments is expected to be completed by the end of 2011.

L&I implemented system edits on June 30, 2011 to address the internal control issue allowing overpayments for physical and occupational therapy services. These edits would have prevented the overpayments that the auditors identified.

Finding No. 2:

Medicaid's payment system lacks adequate internal controls to prevent overpayments to providers of certain durable medical equipment.

Health Care Authority response:

On December 24, 2008, the Department published Memo 08-84 with the corresponding changes in the Oxygen/Respiratory billing instructions for stationary and portable oxygen systems. The effective date was January 1, 2009. This information has been in each billing instruction update since that time. Permanent rules for the Oxygen WAC were started on January 29, 2009, and the CR101 was filed on June 17, 2009. Due to a multitude of factors, this rewrite is still in process and the goal is to have it completed by the end of this year, December 31, 2011.

Prior to these 2008 changes the Department paid vendors a monthly rental rate for oxygen equipment, for as long as the client needed it. Following Medicare's policy, the Department instituted the 36 month capped rental rate for this equipment. As you are aware, after the 36 months, the provider must supply the equipment (without billing) for the following 24 months (until the five year reasonable useful life) is reached. The vendor then could restart the 36 month rental period.

The Department has been working on the implementation of a new payment system, Provider One, for several years. The first "go-live" was scheduled for December of 2005. This was postponed, and there was a prolonged period of time in which no changes could be made to the system. These changes (edit for limiting payments to 36 months) are currently being made to the system. In the meantime, referrals have been made to audit for recoupment of overpayments. Audit will need to determine if recoupment can be made based only on the published memo and billing instructions.

Finding No. 3

Untimely data sharing led to duplicate payments by Medicaid and L&I.

Health Care Authority response:

For those overpayments that have not already been returned from providers, HCA staff are actively pursuing collection on the remaining overpayments identified in this SAO audit report. Also, prior to this report and on-going, HCA staff have and will pursue collection on overpayments as they are identified.

HCA and L&I had previously engaged in discussions and initiated plans to establish a data-sharing agreement. However, due to hiring freeze and other priorities, further actions on this item have not continued. The two agencies will need to re-engage and continue to pursue establishing an agreement.

In addition to a data sharing agreement, HCA also proposes the following to improve communication between the two agencies which will increase cost recovery and avoidance:

- HCA staff have the ability to data match L&I records monthly or quarterly or through an interface that will show if a Medicaid client is receiving L&I benefits, Crime Victims benefits, or self insured benefits;
- L&I notify the HCA's Casualty Unit when a claim settles or is allowed;
- HCA staff have access to the allowed and disallowed diagnosis codes;
- HCA staff work with L&I's third party unit to consolidate efforts in obtaining information.

Labor and Industries response:

All overpayments identified during the audit have been recouped.

L&I is happy to work with HCA to establish data-sharing arrangements. In March 2011, L&I began an arrangement with the Centers for Medicare and Medicaid Services to share information on Medicare clients who are receiving L&I benefits. This could be used as a model to share information on allowed claims and diagnosis codes for Medicaid clients.

Finding no. 4:

The Workers' Compensation program pays providers when clients do not show up for appointments.

Labor and Industries response:

L&I agrees overpayment orders should be issued to clients who are entitled to time-loss benefits and who do not provided good cause for missing required independent medical examination (IME) appointments.

We will be providing staff training following other changes in the format for requesting IMEs. The format changes should be done in early 2012. We will incorporate into this training the steps claim managers are to take on every IME no-show or late cancellation.

The Department has several efforts underway to improve the IME process overall and reduce the number of no-shows and late cancellations. In January 2009, we began collecting information from customers on how to improve IME requests, the quality of information received from the examiner, reduce no-shows and late cancellations, and improve the customer's experience.

In May 2010, a pilot was implemented in two units. Injured workers were called and the IME process was explained. They were informed of why the IME was being scheduled and about the importance of attending. The results were very positive and further evaluation is underway to determine a program-wide implementation plan.

In June 2010, we implemented an IME reminder call. When an IME is scheduled, staff call the injured workers three to four days before the exam date to remind them of the time and place of their examination.

A six-month study on why injured workers no show for IME appointments is being conducted. The study runs July 2011 through January 2012. We anticipate information from this study will identify why workers miss IMEs so we can mitigate barriers.

L&I partially agrees with the recommendation that we pursue the expansion of collection efforts. We will research the history and intent of the current law that limits instances where we are able to assess and recover no-show fees from injured workers. We will update the Workers' Compensation Advisory Committee to get their input on whether legislative change should be considered.

APPENDIX A: AGENCIES RESPONSES

Changes in rules cannot be pursued, without meeting exemption criteria, during the Governor's Executive Order establishing a moratorium through 2012.

We will review current internal policies and related training materials concerning IME no-show fees for clarity, and will update the information where appropriate.

APPENDIX B: CRITERIA

Finding 1 - Labor and Industries' medical payment system lacks adequate internal controls to prevent overpayments to providers of interpreter and physical and occupational therapy services.

Department of Labor and Industries Payment Policies for Services Providers to Injured Workers and Victims of Crime

Information for Health Care and Vocational Providers

Workers or crime victims (insured individuals) who have limited English proficiency or sensory impairments may need interpretive services in order to effectively communicate with providers. Interpretive services do not require prior authorization.

Under the Civil Rights Act of 1964, the health care or vocational provider will determine whether effective communication is occurring.

If assistance is needed, the health care or vocational provider:

- Selects an interpreter to facilitate communication.
- Determines if an interpreter (whether paid or unpaid) accompanying the insured meets the communication needs.

If health care or vocational provider determines a different interpreter is needed:

- The insured may be consulted in the selection process.
- Sensitivity to the insured's cultural background and gender is encouraged when selecting an interpreter.
- Ultimate decision rests with health care or vocational provider.

Either paid or non-paid interpreters may assist with communications. In all cases:

- Paid interpreter selected must meet the credentialing standards contained in this policy.
- Persons identified as ineligible to provide services in this policy may not be used even if they are unpaid.

APPENDIX B: CRITERIA

Fees, Service Descriptions and Limits

The coverage and payment policy for interpretive services is listed below:

Code	Description	Units of Service	Maximum Fee	L&I Authorization & Limit Information
9989M	Individual interpretation direct services time between insured and health care or vocational provider, includes wait and form completion time, per minute	1 minute equals 1 unit of service	$0.79 per minute	Limited to 480 minutes per day does not require prior authorization
9986M	Mileage, per mile	1 mile equals 1 unit of service	State rate	Mileage billed over 200 miles per claim per day will be reviewed Does not require prior authorization

When billing for Individual Interpretation Services:

- Only the time spent actually delivering those services may be billed.
- You must bill all services for the same client, for the same date of service, on one bill to avoid bill denial.
- Time is counted from when the appointment is scheduled to begin or when the interpreter arrives, whichever is later, to when the services ended.
- If there are breaks in service due to travel between places of service delivery, this time must be deducted from the total time billed.

Interpretive Services Appointment Record form and mileage verification must be in the claim file at the same time you bill the insurer or your bill may not be paid.

WAC 296-23-220 Physical therapy rules

Practitioners should refer to WAC 296-20-010 through 296-20-125 for general information and rules pertaining to the care of workers.

Physical therapy treatment will be reimbursed only when ordered by the worker's attending doctor and rendered by a licensed physical therapist or a physical therapist assistant serving under the direction of a licensed physical therapist. In addition, physician assistants may order physical therapy under these rules for the attending doctor. Doctors rendering physical therapy should refer to WAC 296-21-290.

The Department or self-insurer will review the quality and medical necessity of physical therapy services provided to workers. Practitioners should refer to WAC 296-20-01002 for the Department's rules regarding medical necessity and to WAC 296-20-024 for the Department's rules regarding utilization review and quality assurance.

The Department or self-insurer will pay for a maximum of one physical therapy visit per day. When multiple treatments (different billing codes) are performed on one day, the Department or self-insurer will pay either the sum of the individual fee maximums, the provider's usual and customary charge, or $118.07 whichever is less. These limits will not apply to physical therapy that is rendered as part of a physical capacities evaluation, work hardening program, or pain management program, provided a qualified representative of the Department or self-insurer has authorized the service.

The Department will publish specific billing instructions, utilization review guidelines, and reporting requirements for physical therapists who render care to workers.

Billing codes and reimbursement levels are listed in the fee schedules.

WAC 296-23-230 Occupational therapy rules.

Practitioners should refer to WAC 296-20-010 through296-20-125 for general information and rules pertaining to the care of workers.

Refer to WAC 296-20-132 and 296-20-135 for information regarding the conversion factors.

Occupational therapy treatment will be reimbursed only when ordered by the worker's attending doctor and rendered by a licensed occupational therapist or an occupational therapist assistant serving under the direction of a licensed occupational therapist. In addition, physician assistants may order occupational therapy under these rules for the attending doctor. Vocational counselors assigned to injured workers by the Department or self-insurer may request an occupational therapy evaluation. However, occupational therapy treatment must be ordered by the worker's attending doctor or by the physician assistant.

An occupational therapy progress report must be submitted to the attending doctor and the Department or self-insurer following twelve treatment visits or one month, whichever occurs first. Occupational therapy treatment beyond the initial twelve treatments will be authorized only upon substantiation of improvement in the worker's condition. An outline of the proposed treatment program, the expected restoration goals, and the expected length of treatment will be required.

The Department or self-insurer will review the quality and medical necessity of occupational therapy services. Practitioners should refer to WAC 296-20-01002 for the Department's definition of medically necessary and to WAC 296-20-024 for the Department's rules regarding utilization review and quality assurance.

The Department will pay for a maximum of one occupational therapy visit

per day. When multiple treatments (different billing codes) are performed on one day, the Department or self-insurer will pay either the sum of the individual fee maximums, the provider's usual and customary charge, or $118.07 whichever is less. These limits will not apply to occupational therapy which is rendered as part of a physical capacities evaluation, work hardening program, or pain management program, provided a qualified representative of the Department or self-insurer has authorized the service.

The Department will publish specific billing instructions, utilization review guidelines, and reporting requirements for occupational therapists who render care to workers.

Billing codes, reimbursement levels, and supporting policies for occupational therapy services are listed in the fee schedules.

Finding 3 - Untimely data sharing led to duplicate payments by the Medicaid and Worker's Compensation programs.

Title 42, United States Code, Part 1396a (a) (25):

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 1167(1) of Title 29), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including...

Revised Code of Washington (RCW) 74.09A.005:

The legislature finds that:

(1) Simplification in the administration of payment of health benefits is important for the state, providers, and health insurers;

(2) The state, providers, and health insurers should take advantage of all opportunities to streamline operations through automation and the use of common computer standards;

(3) It is in the best interests of the state, providers, and health insurers to identify all third parties that are obligated to cover the cost of health care coverage of joint beneficiaries; and

(4) Health insurers, as a condition of doing business in Washington, must increase their effort to share information with the Department and accept the Department's timely claims consistent with 42 U.S.C. 1396a(a)(25).

Therefore, the legislature declares that to improve the coordination of

benefits between the Department of Social and Health Services and health insurers to ensure that medical insurance benefits are properly utilized, a transfer of information between the Department and health insurers should be instituted, and the process for submitting requests for information and claims should be simplified.

Washington Administrative Code 388-501-0200 states:

(1) MAA requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(4) The provider may not bill MAA or the client for a covered service when a third party pays a provider the same amount as or more than the MAA rate.

(5) When the provider receives payment from the third party after receiving reimbursement from MAA, the provider must refund to MAA the amount of the:

(a) Third-party payment when the payment is less than MAA's maximum allowable rate; or

(b) MAA payment when the third-party payment is equal to or greater than MAA's maximum allowable rate.

(6) MAA is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills MAA, except as described under subsections (2) and (3) of this section.

Finding 4 - The Workers' Compensation program pays providers when clients do not show up for appointments.

Revised Code of Washington 51.32.110 Medical examination – Refusal to submit – Travelling expenses – Pay for lost time

(1) Any worker entitled to receive any benefits or claiming such under this title shall, if requested by the Department or self-insurer, submit himself or herself for medical examination, at a time and from time to time, at a place reasonably convenient for the worker and as may be provided by the rules of the Department. An injured worker, whether an alien or other injured worker, who is not residing in the United States at the time that a medical examination is requested may be required to submit to an examination at any location in the United States determined by the Department or self-insurer.

(2) If the worker refuses to submit to medical examination, or obstructs the

same, or, if any injured worker shall persist in unsanitary or injurious practices which tend to imperil or retard his or her recovery, or shall refuse to submit to such medical or surgical treatment as is reasonably essential to his or her recovery or refuse or obstruct evaluation or examination for the purpose of vocational rehabilitation or does not cooperate in reasonable efforts at such rehabilitation, the Department or the self-insurer upon approval by the Department, with notice to the worker may suspend any further action on any claim of such worker so long as such refusal, obstruction, noncooperation, or practice continues and reduce, suspend, or deny any compensation for such period: PROVIDED, That the Department or the self-insurer shall not suspend any further action on any claim of a worker or reduce, suspend, or deny any compensation if a worker has good cause for refusing to submit to or to obstruct any examination, evaluation, treatment or practice requested by the Department or required under this section.

Washington Administrative Code 296-14-410

Reduction, suspension, or denial of compensation as a result of noncooperation.

(1) **Can the Department or self-insurer reduce, suspend or deny industrial insurance benefits from a worker?** The Department or the self insurer, after receiving the Department's order, has the authority to reduce, suspend or deny benefits when a worker (or worker's representative) is noncooperative with the management of the claim.

(2) **What does noncooperative mean?** Noncooperation is behavior by the worker (or worker's representative) which obstructs and/or delays the department or self-insurer from reaching a timely resolution of the claim.

(a) Noncooperation can include any one of the following:

(i) Not attending or cooperating with medical examinations or vocational evaluations requested by the Department or self-insurer.

(5) **What are the actions the Department can take if a worker (or a worker's representative) is determined to be noncooperative?** If the worker does not respond in thirty days to the letter asking for justification for not cooperating or it is determined there is no good cause the Department or self insurer, after receiving the Department's order, may take the following action:

(a) Reduce current or future time-loss compensation by the amount of the charge incurred by the Department or self-insurer for any examination, evaluation, or treatment that the worker failed to attend.

(b) Reduce, suspend or deny all or part of the time-loss benefits.

(c) Suspend or deny medical benefits.

APPENDIX B: CRITERIA

WAC 296-20-010 General information.

(1) The following rules are promulgated pursuant to RCW 51.04.020 and 51.04.030. The Department or self-insurer may purchase necessary physician and other provider services according to the fee schedules. The fee schedules shall be established in consultation with interested persons and updated at times determined by the Department in consultation with those interested persons. Prior to the establishment or amendment of the fee schedules, the Department will give at least thirty calendar days notice by mail to interested persons who have made timely request for advance notice of the establishment or amendment of the fee schedules.

(5) No fee is payable for missed appointments unless the appointment is for an examination arranged by the Department or self-insurer.

CONTACTS

State Auditor Brian Sonntag, CGFM
(360) 902-0361
Brian.Sonntag@sao.wa.gov

Chuck Pfeil
Director of State and Local Audit
(360) 902-0366
Chuck.Pfeil@sao.wa.gov

Kelly Collins
Deputy Director of State and Local Audit
(360) 725-5359
Kelly.Collins@sao.wa.gov

Mindy Chambers
Director of Communications
(360) 902-0091
Mindy.Chambers@sao.wa.gov

To request public records:

Mary Leider
Public Records Officer
(360) 725-5617
PublicRecords@sao.wa.gov

GENERAL INFORMATION

Headquarters
(360) 902-0370

Website
www.sao.wa.gov

Twitter
@WAStateAuditor

AMERICANS WITH DISABILITIES

In accordance with the Americans with Disabilities Act, this document will be made available in alternate formats. Please call (360) 902-0370 for more information.

THE STATE AUDITOR'S OFFICE MISSION

The State Auditor's Office independently serves the citizens of Washington by promoting accountability, fiscal integrity and openness in state and local government. Working with these governments and with citizens, we strive to ensure the efficient and effective use of public resources.