



Legislative Post Audit Performance Audit Report Highlights

Statewide Medical Expenditures: Reviewing Medicaid Expenditures for Fraud and Abuse

Report Highlights

December 2008 • 08CC02

Audit Concern

The Legislative Post Audit Committee has directed us to use “data mining” techniques to search for potential fraud, abuse, and non-compliance in various areas of State spending.

Key Facts & Findings

- *More than 10,000 clients whose income appeared to exceed program limits received more than \$10 million in claims.*
- *266 clients who didn't provide a valid Social Security number received almost \$700,000 in claims.*
- *Doctors may have “upcoded” some office and emergency room visits at a higher level of service than they provided, costing Medicaid almost \$600,000.*
- *Almost \$435,000 in non-hospital claims were paid for clients who were hospitalized at the time the service was provided.*

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Estimated Potential
Cost Savings as a
Result of This Audit:

\$3.1 million per year

AUDIT QUESTION 1: Do There Appear To Be Significant Instances of Fraud, Abuse, or Non-Compliance Within the State's Medicaid Expenditures?

AUDIT ANSWER:

- We found a total of almost \$13 million in suspicious Medicaid claims for federal fiscal year 2006.
- More than \$11 million of the problematic claims involved clients whose income appeared to exceed program limits while they were receiving benefits, or who hadn't provided a valid Social Security number.
- We identified more than \$1 million in suspicious claims submitted by providers, including potentially “upcoded” office and emergency room visits, and claims for non-hospital services when a client was hospitalized.
- We identified 519 clients who received more than \$600,000 in prescriptions for controlled substances from five or more doctors in one year, which may be indicative of potential abuse.
- The potential savings to the State if these questionable claims were all found to be inappropriate would be about \$3 million.

We Recommended

- The Health Policy Authority should develop systems to compare Medicaid clients to income and death certificate data to identify ineligible or deceased clients.
- The Authority should work with its contractors and other agencies to review and improve system edits.
- The Authority should review its systems for detecting suspicious claims, and consider if those systems could be enhanced by incorporating the techniques used in our analyses.

Agency Response: In general, the Authority agreed with the report and our final recommendations.

- *There were 31 instances where a client received 20 or more fillings, crowns, or root canals in a single day, resulting in more than \$55,000 in claims.*
- *415 clients whose date of death hadn't been recorded in the system still were listed as eligible for benefits.*

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**DO YOU HAVE AN IDEA FOR
IMPROVED GOVERNMENT EFFICIENCY OR COST SAVINGS?**

If you have an idea to share with us, send it to ideas@lpa.ks.gov, or write to us at the address shown. We will pass along the best ones to the Legislative Post Audit Committee.