Audit Overview

OFFICE OF THE AUDITOR GENERAL
NEWFOUNDLAND AND LABRADOR

Objective

To determine whether the Department of Health and Community Services' claims system has controls in place to ensure physician and dentist claims are processed accurately, and whether the department is providing effective oversight of the Medical Care Plan (MCP) and Dental Health Plan.

Audit Period

April 1, 2021 to March 31, 2024

Why this Audit is Important

The Newfoundland and Labrador Medical Care and Provincial Dental Health Plans are publicly administered comprehensive medical and dental insurance plans provided to the province's residents. The Department of Health and Community Services' Audit and Claims Integrity Division is accountable for ensuring public health care funds are distributed appropriately to health care providers for services delivered to the plans' beneficiaries. As such, the division must have well designed and effective systems and controls to process health and dental claims. It must also exercise diligence in its administration of audit processes, including the collection of recoveries, thereby providing public assurance that health care funds are used appropriately.

Conclusions

The findings in this audit indicate that the Department of Health and Community Services is unable to ensure that public health care funds are distributed appropriately to health care providers for services provided to beneficiaries of the Medical Care and Dental Health Plans. Many of the same findings relating to audit and recoveries were noted in our last MCP report from 2014 - over 10 years ago.

MCP has been slow to develop strong control processes, including the prevention of double payments with WorkplaceNL. Controls around manual adult dental reimbursement are still not entirely sufficient to prevent potential fraud, similar to the occurrence between 2015 and 2019. IT system controls are not entirely reliable either; a third of the claims processing rules we looked at either served no purpose or did not work properly. Finally, the age and complexity of MCP's systems contribute to inefficiencies. Systems are old, built on outdated technology, with known issues, and would benefit from significant upgrades. There are no plans to replace them any time in the near future.

We found that the design of the claims audit processes is generally adequate. However, audits took a long time, with the reason for delays being difficult to understand. Moreover, not many audits are being completed by the audit division; at times only one or two a year. Once they are completed, there is very little success in recovering money. There are tools available that could improve the process that are seldom used, reducing overall effectiveness. With low productivity and insignificant recoveries, we question the effectiveness of the current audit function as an oversight measure for the MCP program.

Summary of Recommendations

We recommend that the Department of Health and Community Services:

1. Ensure the various information technology issues identified throughout this audit are addressed, such as the state of their aging systems, general control deficiencies, and the lack of data entry controls.
2. Work with WorkplaceNL to implement a process that would prevent and detect double billing of services.
3. Mitigate the risk of fraud by ensuring that any adult dental program payments made through the manual reimbursement process are approved by management prior to being issued.
4. Ensure their internal audit processes operate in the spirit and intent of their legislation, regulations, and policy.
5. Strengthen oversight processes, including the use of key performance indicators, to ensure that public funds are distributed appropriately to providers for Medical Care and Dental Health Plan services.
6. Implement adequate and timely overpayment collection processes, including the use of recovery tools such as payment interceptions and ministerial orders.

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What We Found

Claims Systems

IT General Controls

- MCP had a strong management control framework and a high level of operating effectiveness of IT general controls around access, segregation of duties, change management, and backup configurations for its claims processing system – meaning the controls around the environment were appropriate.
- We identified certain areas of weakness with respect to the effectiveness of IT general controls. Failure to complete comprehensive annual disaster recovery and business continuity plan testing was the most significant of these issues.

Application Controls

Age of IT Systems

- MCP's systems were dated.
- Updates to the MCP claims processing system were cumbersome given its age.
- There was no formalized plan to replace claims entry, processing, or monitoring systems with more modern applications.

Claims Entry Systems

- The Audit and Claims Integrity Division had limited awareness of data entry controls to ensure the accuracy or completeness of claims.

Claims Processing System

- The process of creating provider profiles for claims processing had a design flaw. The online provider profile registration form was outdated and missing a required sub-specialty field.
- The initial setup of providers in the claims processing system did not operate effectively.
- The process for linking profiles to fee codes during initial setup was properly designed.
- Fee codes added to physician profiles at a later time were not always supported.
- The claims processing system failed to prevent payment to ineligible fee codes in certain circumstances. The system was designed with capability to attach a stop date to a fee code; however there were cases of the system failing to recognize a stop date and claims being paid inappropriately.
- There were gaps in the design of the controls intended to ensure the appropriateness of processed claims.
- Edit and Provider & Fee Rules were not always appropriately designed, and therefore would not operate effectively.
- In one case, we found a rule intended to restrict billing for certain fee codes to particular physicians did not refer to the correct fee codes. This resulted in the inappropriate payment of 528 claims between April 2023 and March 2024, for a total of $11,966. We noted the rule had been in place since 1993, and had not been updated since 1994; meaning similar payments were likely made throughout the preceding 30 year period.
- Edit and Provider & Fee Rule documentation was often inaccurate.
- Patient History Rules were often not designed appropriately, and therefore would not operate effectively.
- Documentation for Patient History Rules was sometimes inaccurate or incomplete.

Claims Monitoring System

- There were issues with the system that monitors the appropriateness of claims billed under MCP, including inadequate details and instruction to physicians when documentation was requested, and administrative burden created by the volume of requests for documentation.
- The Claims Monitoring System was not used to monitor dental claims.

Other Systems and Controls

- The division lacked a process to prevent or detect possible double billings between MCP and the WorkplaceNL workers compensation program. The development of a process had not been completed 10 years after being recommended in our 2014 report.
- We found a deficiency in the design of controls for payments made through the adult dental manual reimbursement process. New controls implemented subsequent to adult dental fraud noted in 2015 to 2019 did not fully mitigate the risks inherent in the manual process used.

Oversight

Monitoring

- The department failed to make significant progress on oversight issues identified in the 2014 Auditor General's report.

Audit Processes

- The division generally had adequate audit processes.
- The division's policies were not updated regularly.
- The division did not have an operational plan to assist it in focusing activities toward achieving identified objectives. It also did not have goals, targets, or key performance indicators for physician or dental audits.
- There were no formal monitoring or quality control processes relating to the administration of MCP audits.
- There was no formal audit selection process, and the division did not use all the tools at its disposal to identify audits.
- In the absence of defined procedures to identify audits, an inadequate number of audits were selected. Audits were initiated on less than 2.6 per cent of fee-for-service providers in 2024, and well under one per cent in 2023 and 2022. Our 2014 report had a similar finding.

Audits

- Audits took a long time to complete. Only 43 per cent of preliminary audits were completed within the 3.5 month benchmark considered reasonable, and only 11 per cent of comprehensive audit assessments finished within the 8.5 month benchmark considered reasonable.
- The eight preliminary audits that exceeded reasonable timeframes took over 1.6 years to complete on average, and three took over three years.
- The 16 comprehensive audits that exceeded reasonable timelines took 4.2 years on average to complete, with the longest requiring almost six years.
- Three comprehensive audits were abandoned during the audit period, with no samples collected and no assessment made on an amount owing.
- Audit results were often not communicated to the Newfoundland and Labrador Medical Association within legislated timelines.
- Our 2014 report also noted that audits took a long time to complete.
- Audits were sometimes delayed by the failure of the Medical Consultants' Committee to meet regularly, which was also noted in our 2014 report.
- During our audit period audits waited for approximately half a year on average before presentation to Medical Consultants' Committee, with the longest being delayed by almost three years.

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Audit Review and Recovery

Alternative Dispute Resolution

- Our 2014 Auditor General's report found the alternative dispute resolution process, which is intended to be completed within 90 days, was taking considerably longer. This is still an issue 10 years later.
- The alternative dispute resolution processes completed during our audit period took an average of 767 days (over 2.1 years); the longest taking 1,383 days (over 3.5 years).
- The 27 files in active alternative dispute resolution at the end of our audit period were, on average, approximately 4.4 years old. The oldest had been ongoing for seven years.
- The division routinely agreed to extensions to the alternative dispute resolution process beyond 90 days, which may not have been permissible under legislation.

Audit Review Board

- The Audit Review Board did not serve a functional purpose during our audit period - there has not been a review board hearing since 1997.

Physician Claims Intervention Program

- The Audit and Claims Integrity Division made very little use of the Physician Claims Intervention Program. Only four physicians were referred to the program throughout our audit period, for an average of 1.3 referrals per year.

Audit Recoveries

- The division collected very little of the balances owing from providers. Across our three-year audit period only $146,598 was collected, representing approximately seven per cent of the balance owing on March 31, 2024.
- No recoveries at all were made in 2023.
- Collections were not completed in a timely manner. For example, the funds recovered across our audit period had been outstanding for an average of approximately five years before being collected.
- Similarly, the balances that remained outstanding were old; more than 3.5 years old on average, with the oldest outstanding for over seven years. These findings were similar to those of our 2014 report.
- The division did not use available tools to collect balances owing from providers. The division did not recommend the use of ministerial orders throughout our audit period.

After reading this report, you may want to ask the following questions of government:

Given its responsibility for oversight of the Audit and Claims Integrity Division, how will the Department of Health and Community Services:

1. Manage the IT systems, the identified control weaknesses, and process inefficiencies?
2. Ensure that enough audits are undertaken to provide confidence that public health care funds are distributed appropriately and potential fraud is detected?
3. Address issues with the collection of overpayments to physicians and dentists, to ensure that funds are consistently recovered on a timely basis?