

**Illinois Department of Healthcare and Family Services  
Office of Inspector General**

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**ABORTION BILLINGS STUDY**

*A STUDY OF INCREASED BILLINGS OF ABORTION PROCEDURES*

**JUNE 2009  
OIG # 09-0069**



**“In order to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct, the Inspector General shall oversee the Illinois Department’s integrity functions...”**

**PA 88-554**

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## **EXECUTIVE SUMMARY**

In April 2008, the Illinois Department of Healthcare and Family Services was contacted by the Medicaid Financial Management Branch of the federal Centers for Medicare & Medicaid Services regarding the unusually high number of abortion services billed to the Illinois Medical Assistance Program, as compared to previous years. In response to this inquiry, the HFS Office of Inspector General (HFS-OIG) launched a comprehensive study to investigate the increase in abortion procedures and to determine whether the abortion procedure billings were appropriate within the law and policy of the Illinois Medicaid Program. HFS-OIG's study included examining pertinent laws, policies and provider informational material, contacting other states to ascertain how they fund abortions, performing data analyses to determine billing patterns and conducting onsite quality of care and post payment compliance reviews of selected providers.

The onsite reviews of providers covered the service dates of 6/1/2005 through 1/31/2008. During this two and a half years time period only 1,134 abortion services for a total of \$206,741 were paid through the Illinois Medicaid program. The six providers reviewed comprised over 47% of all the abortion services provided, 52% of the recipients receiving abortions, and 50% of the monies spent on abortion procedures during this period.

HFS-OIG could not find any clear factors to explain the increase in abortion claims. Data analysis did not reveal any non-provider related causes. There were no program coverage and/or rate changes during the timeframe. Results of the study established that in nearly every case reviewed, providers had the requisite documentation to support the billed abortion procedures and that the documentation reviewed verified compliance with the billing policies for the procedures. By looking at the results of the survey of other states' Medicaid program coverage for abortion procedures, it can be seen that several states with large Medicaid populations do not use federal Medicaid monies to pay for abortions at all and Illinois is one of the few states that uses federal Medicaid dollars to pay for abortions for rape, incest, the physical health or life endangerment of the mother. These factors may account for Illinois' claims being disproportionately high in comparison to the abortion claims of other states across the nation.

In conclusion, this study did not reveal any systemic problems with abortion procedures paid through the Illinois Medicaid Program. However, as part of the reviews, a small number of documentation, billing and quality of care issues were noted and will be addressed through subsequent action by HFS-OIG. These actions are as follows:

- A full field audit will be performed for all services billed by the highest paid provider of abortion procedures. Billing and documentation findings for this provider's abortion procedures warrants an audit of all procedures.
- A data mining routine will be developed to identify where an office visit and abortion procedure were both billed on the same day for the same provider. Desk or field audits will be performed on providers identified through this routine.

- A letter of concerns will be sent to the family planning clinic with the highest number of Medicaid abortion procedures, notifying them of the quality of care concerns identified during the study. The HFS-OIG Peer Review section will perform a follow-up review of the facility and its records within 6 to 12 months of the letter being sent to the clinic.
- Referrals will be made to the HFS-OIG Bureau of Investigations on the individual cases identified as potential client fraud, for example multiple abortions within one month.
- The Bureau of Claims Processing will be notified of the specific cases with an unsigned HFS 2390 forms so that they can review their abortion claims processing procedures.

## **BACKGROUND**

### Federal Inquiry

In April 2008, the Illinois Department of Healthcare and Family Services (hereafter referred to as HFS or Department) Division of Medical Programs was contacted by the Medicaid Financial Management Branch (MFMB) of the federal Centers for Medicare & Medicaid Services (CMS). MFMB noted the unusually high number of abortion procedures billed to HFS as reimbursable by the Medicaid program, relative to previous years. The inquiry was subsequently referred to the HFS Office of Inspector General (HFS-OIG), which had not previously investigated claims specifically associated with abortion procedures due to the low volume of Medicaid reimbursements paid for abortion procedures relative to the overall Medicaid program. For example, for the two and a half years covered by this review, only 1,134 abortion services for a total of \$206,741 were paid through the Illinois Medicaid program.

In response to the inquiry by MFMB, the HFS-OIG initiated this study to investigate and assess the circumstances surrounding the increase in reimbursed abortion procedures and to determine potential causes for such increase. The study also investigated whether potential causes identified were proper and appropriate within the law and policy of the Illinois Medicaid program. To determine the propriety of the abortion billing procedures by providers, a special task force of HFS-OIG senior staff convened in April 2008 to develop the strategy for the study. Once approved by the HFS Inspector General, the plan was shared with both the HFS Medicaid Director and the manager of the MFMB.

### Study Overview

Pertinent laws, policies and the Medicaid Provider Handbooks were examined to ascertain the abortion procedures covered under the Illinois Medicaid Program and to confirm the established procedures and requirements for providers seeking reimbursement for these abortion services. Staff also reviewed HFS informational notices distributed as a means of informing providers of new policies and procedures associated with abortion claims. To obtain a thorough understanding of the billing process, as well as an understanding of the services associated with abortion procedures, HFS staff in the following areas were interviewed: Bureau of Claims Processing, Bureau of Comprehensive Health Services, Bureau of Rate Development and Analysis, Bureau of Federal Finance, Office of the General Counsel, and Office of Information Systems. Research was conducted on the established treatment standards for physicians performing abortions as well as the follow-up treatment recommended. Following the in-depth research and interviews, audit and peer review (quality of care) protocols were developed for use in the review and audit of provider records. The protocols were reviewed and commented on by an Obstetrician Gynecologist consultant under contract with the HFS-OIG.

Establishing a baseline was an important component of the study. A survey of other states was conducted to determine what abortion services, if any, are covered under their state's Medicaid program. Responses were obtained from 33 of the states contacted by phone. An administrative review of policy changes and HIPAA related coding changes was

completed to determine any potential impact on the claiming patterns of abortion services. Data analysis was also conducted to determine if non-provider related factors may have influenced the spike in abortion claims for Illinois.

Data runs were performed to determine when abortion procedures were being performed, who performed them, and what diagnosis and procedure codes were used when billing Medicaid. Analysis was performed to identify the specific codes appropriate for the study. The results of the analysis were used both to determine the providers to be reviewed and to assist in the development of the review protocols.

For selected providers, recipient medical records were examined by registered nurses in HFS-OIG's Bureau of Medicaid Integrity's (BMI) Peer Review Section. The nurses reviewed the records for elements determined to be pertinent to abortion cases. HFS-OIG also contracted with an experienced, board certified Obstetrician Gynecologist, who is licensed in the State of Illinois and is familiar with facilities that specialize in abortion procedures. The consultant assisted Peer Review staff in performing a more in-depth review of the medical records and provided feedback regarding the results of their reviews. The consultant also accompanied the staff on an onsite inspection of the clinic wherein the highest number of abortion procedures was performed.

A limited scope compliance audit of each selected provider was performed by BMI's Audit Section to verify that each claim was documented as an appropriate service in the medical chart and was provided and billed in compliance with Department policies and procedures. The auditors also searched for any indication that, if third party coverage existed, it was properly reported to HFS.

## **POLICIES AND PROCEDURES**

### Department Policy

The Department's provider handbooks and subsequent informational notices identify the policies and procedures that providers must follow to be reimbursed for abortion services. An induced abortion is a covered service only when, in the professional judgment of a licensed physician, the life of the mother would be endangered if the fetus were carried to term, or if the pregnancy is the result of rape or incest, or to protect the mother's health. The Department reimburses for a surgical abortion or the use of the drug Mifepristone, also known as RU486, to terminate a pregnancy when one of the preceding circumstances occur.

To receive payment for abortions, a provider must complete Form HFS 2390, Abortion Payment Application, and submit it with the billing statement. (Appendix A)

The Department will reimburse the physician a global rate for the three visits required to complete the procedure. The three visits consist of the initial visit, the two-day follow-up and two-week follow-up required under the FDA protocol. The modifier codes billed for the procedures are defined by:

- Abortion Performed Due to Rape
- Abortion Performed Due to Incest
- Abortion Performed Due to a Life Endangering Physical Condition Caused By, Arising From or Exacerbated By the Pregnancy Itself
- Abortion Performed Due to Physical Health of Mother That Is Not Life Endangering

### Processing of Abortion Claims

All claims identified by the Department's Medicaid Management Information System (MMIS) as having a billing code associated with an abortion procedure are systematically pended for manual review. The Bureau of Claims Processing's Problem Resolution Unit manually reviews these claims to ensure a properly completed HFS 2390 is attached to the billing. If the HFS 2390 is not properly completed or is not consistent with the information submitted in the billing, the claim is rejected. If the Unit's review finds the documentation is in compliance, the claim is released to be processed through the remainder of the MMIS claims processing system.



## **STUDY**

### Data Analysis

The Illinois Medical Data Warehouse (MDW) was the source for the data analysis performed by HFS-OIG's Bureau of Information Technology (BIT). The MDW is utilized to perform in-depth analysis and contains a broad range of Medicaid data including paid and rejected claims, diagnosis and procedure codes, provider, recipient, payee and drug information.

The first steps taken were to determine if the spike in abortion services could be explained through analysis of the data. One potential factor that was considered was the timing of the submission of claims by the providers. This was considered due to the federal inquiry based on the Quarterly Statement of Expenditures (CMS-64). In that providers have one year to remit claims and CMS-64 expenditures are based on when the claims are paid, each quarter's CMS-64 could be significantly influenced by provider billing patterns.

To determine if the provider billing patterns contributed to the spike noted by MFMB, data runs were performed for FFY 2004 through FFY 2007. The data was analyzed by payment date and by service date. The results indicated a significant increase in abortion billings in both sets of data, thereby affirming that provider billing patterns were not a material contributing factor.

Another potential explanation for the increase in abortion procedure claims was expansion of covered medical services. To address this, the FFY data runs included a breakdown of paid services by procedure codes within the federal fiscal years. The data analysis did not reveal any changes in the procedure codes utilized for abortion procedure billings. To confirm this, staff reviewed all Illinois Medicaid provider notices issued during FFY 2004 through FFY 2007. The provider notices did not reflect any new abortion procedure codes added during this timeframe. As a result, expansion of covered services was determined not to be a cause for the significant increase in Medicaid covered abortion services.

The next stage of the study focused on the provider reviews. The first step was to determine which specific procedure codes and diagnosis codes were appropriate for inclusion in the study. This analysis, along with research on the Department's policies, procedures and CPT code book information verified that the following codes would be appropriate for the study:

- 59840 – Induced Abortion by D & C
- 59841 – Induced Abortion by Dilation and Evacuation
- 59850 – Abortion by Amniotic Injections
- 59851 – Abortion Induced with D & C Evacuation
- 59855 – Induce Abortion Vaginal Suppository
- 59856 – Induced Abortion with D & C and/or Evacuation

- S0191 – Misoprostol Oral 2 Tabs/200 Mcg each

The data extraction for selecting providers to be reviewed was based on service dates over a three-year period, which reflects the Department's requirement for provider records retention. BIT performed data runs on the providers billing for the abortion services and the payees associated with those billings. The various data runs were produced by provider ID, provider city, procedure codes, and by provider ID within city. The resulting reports were utilized to select the providers who would be included in the onsite reviews.

Criteria for selection of the representative sample of providers included paid claim volume, procedure codes billed, modifier code (abortion reason), place of service (hospital, clinic, office) and city. For the review period 6/1/2005 through 1/31/2008, there were 1,134 Medicaid-paid abortion procedures performed by 91 different providers for a total of \$206,741.

To ensure the review was representative of the universe of abortion claims, a judgmental sample of providers and payees was selected. Six providers were selected for review, representing 537 abortion procedures or 47% of the overall Medicaid billed abortions and 50% of the dollars paid for abortion procedures for the period of review.

#### Record Review Protocol

The intent of this study was to determine the validity of the abortion claims and HFS 2390 attachment. HFS-OIG recognized that the standard protocols utilized in their post-payment compliance audits and quality of care reviews of providers would need significant modifications. The first task undertaken was research into Department policies and procedures established for abortion services. The applicable Provider Handbook sections and Provider Notices were reviewed. In addition, staff conducted research on published literature regarding the recommended testing, treatment and follow-up for sexual assault victims and sought input from an obstetrician physician consultant under contract with HFS-OIG. Based on the results of the research and obstetrician consultation, a detailed Abortion Checklist was developed for use when reviewing the documentation to support a Medicaid-covered abortion. Three data sources would be utilized to evaluate the elements in the checklist; the claim record, the HFS 2390 attachment to the claim and the provider's medical records.

The registered nurses from the Peer Review Section took the lead role in the review of the provider's abortion services. They modified their standard quality of care protocol for this abortion study. As part of their review, the nurses analyzed the information submitted on the 2390 form and claim record, verified information in the medical records and completed the Abortion Checklist. They also reviewed the medical records for completeness, legibility and order, as well as compared them to the data submitted on the billing claims. The nurses required the providers under review to complete a Physician's Information Questionnaire and supply copies of their medical license, controlled substance license, DEA Certification and CMEs. They also verified provider enrollment,

eligibility of the Medicaid recipient, and that the service was covered and paid by Medicaid.

A Program Integrity auditor from the BMI Audit Section was responsible for the post-payment compliance audit of the abortion records as part of the record review. The auditor checked the MMIS system for billing abnormalities, reviewed records and documentation/coding for any potential concerns and/or findings. Documentation was examined to note any occurrences of abnormalities such as double billing, inconsistencies with dates and provided services, lack of documentation to substantiate billings and to ensure the billed provider number was consistent with the physician who actually performed the procedure. Additional review was performed to determine instances of missing medical records and missing signature(s). Other potential abnormalities were listed as observations.

NOTE: The typical Illinois Medicaid audit utilizes standard sampling methodology and extrapolation. These standard protocols were not employed as a 100% of the universe of abortion claims were audited for each of the providers reviewed in this study.

#### Record Review

The record retention requirement for providers in Illinois is three years. The date of service range chosen for the onsite reviews was 06/01/2005 through 01/31/08. This range was adjusted slightly in the later reviews to stay in sync with the record retention requirements. A determination was made to approach this study in two phases:

- Phase 1 goals
  - Conduct onsite medical record reviews
  - Validate the peer review and audit protocols
  - Obtain a better understanding of how abortions are documented in patient records
  
- Phase 2 goals
  - Modify the original protocols based on Phase 1 results
  - Conduct additional data analysis as needed based on Phase 1 results
  - Conduct additional onsite medical record reviews

NOTE: For each selected provider, 100 % of their paid abortion procedures and all related services were reviewed. All other services billed by the selected providers were excluded from the review.

#### Phase 1

The criteria for selection of the providers that would be reviewed in Phase 1 of the study included paid claim volume, procedure codes billed, modifier code (abortion reason) and place of service (hospital, clinic, office). It was important to select providers with a relatively small number of abortion services to test the validity of the newly established protocols. It was equally important to review these services for the various reasons,

procedures and place of service to better understand the possible problem areas. Three providers were chosen for review under Phase 1 (Providers A, B, and C).

Copies of the 2390 forms submitted by the three selected providers were requested from the Bureau of Claims Processing. BIT produced a Provider Claim Detail (PCD) report for each of the three selected providers. The PCD included all abortion claims billed for the established dates of service. All services associated with the abortion procedure were also included in the review. A Recipient Claim Detail (RCD) report was then produced for each recipient that appeared on the PCD. The run date for the RCDs was 4 months prior to and 2 months after the abortion procedure. The RCD included all claims submitted for the recipient, not just the provider under review. The RCD included other provider services during the extended timeframe so that the reviewers could gain a better understanding of the care provided to the recipient around the time of the abortion.

NOTE: These forms and reports would be obtained for providers reviewed in subsequent phases.

The Peer Review nurses conducted the Quality Medical Care Review, examining provider's records for elements determined to be pertinent to abortion cases. The Program Integrity auditor reviewed the provider's medical records to verify that each service was documented properly and billed in compliance with Department policies and procedures. For the three providers included in Phase 1, a total of 54 abortion procedures and all related services were reviewed. Specifically, Providers A and B each performed 10 procedures, and Provider C performed 34 procedures.

Project staff and senior HFS-OIG management met to discuss the process and findings from the three physicians reviewed in Phase 1. Preliminary findings indicated that one of the physicians who only administered anesthesia may have used some erroneous billing codes. Additional policy research revealed that the surgeon, attending physician and anesthesiologist are allowed to bill separately under their respective role for a single abortion service. The role code in the claim is a critical element in understanding the abortion billings. It was determined that the anesthesiology services, supported by the role code, were adequately supported by the documentation and properly billed. The three provider reviews confirmed that the abortion services provided were supported by the medical and billing documentation. Further, the staff found that the documentation reviewed verified the provider's compliance with the Department's billing policies for abortion procedures. Additionally, the review established that the providers had no quality of care issues. Appropriate care and counseling referrals for the rape victims were documented. The reviews completed in Phase 1 provided validation of the review procedures and prepared staff for the next phase of the review.

## Phase 2

The information obtained about provider role codes was factored into the selection of providers for review in Phase 2. Less than two percent of all billed abortion procedures involved an attending physician and would not affect the increase in abortion claims submitted. Although anesthesiologist billings for abortions accounted for approximately

ten percent of the abortion procedures billed, the focus of this study was the actual abortions so no further anesthesiologists were reviewed.

For Phase 2, the five providers with the highest number of abortion billings during the review period were selected for onsite medical review. Only through a review of the higher volume providers did HFS-OIG expect to gain insight to explain the increase in abortion billings.

Upon completion of the first two provider reviews (Providers D and E) in Phase 2, the staff noticed subtle differences between abortion procedures performed in hospitals and specialized clinics (family planning clinics). A total of 201 abortion procedures – 71 performed by Provider D and 130 performed by Provider E – and all related services were examined. The reviews completed by the nurses and auditor determined that the procedures were supported by adequate documentation.

It was noted during the review, however, that a significant number of abortion services were provided at specialized clinics as a result of rape being asserted by the client, and therefore a covered Medicaid claim. The reviewers findings confirmed that specialized clinics performed a higher number of abortion procedures based upon reported sexual assaults than did hospitals. Additionally the nurse identified that there was inconsistency in the screening treatment provided to patients reporting rape as a basis for the abortion procedure.

Due to the concerns identified by the staff reviews, an Obstetrician Gynecologist on contract with HFS-OIG was consulted. The consultant is both experienced and board certified, as well as familiar with facilities that specialize in abortion procedures. The obstetrician was contacted to perform a more in-depth review of a sampling of the medical records for Providers D and E. The consultant reviewed 25 cases in which the abortion was performed in a specialized clinic and identified concerns regarding the consistency of care provided.

Project staff and senior HFS-OIG management met to discuss the findings from the staff and consultant reviews of these two providers. Results of the reviews established that in nearly every case reviewed, Providers D and E had the requisite documentation to support the billed abortion procedures and that the documentation reviewed verified compliance with the billing policies for the procedures. As such, a decision was made to shift the study's focus to concerns surrounding the specialized clinics and to address concerns regarding the high volume of rapes reported as a basis for the billed abortions, and the inconsistency in the care provided.

### Phase 3

An additional phase was added to address the concerns of the high number of reported rapes as a basis for the abortion procedure. The focal point of Phase 3 was a determination of whether the reported rape by the recipient could be verified by documentation in the medical record. Importantly, the HFS-OIG sought to identify any evidence of fraud, including potential recipient fraud, or coaching by the facility. It was

therefore necessary to conduct a review of the physician's billing, as well as the clinic facility.

Since the focus shifted to include the clinical setting, additional data analysis was conducted to better understand the various clinics performing abortions. Although the claim includes the place of service, it does not include the detail needed to determine the specific clinic where the abortion procedures were performed. Therefore, payee information on the claim was used to derive the clinic association. The data runs revealed that 65% of all the abortion procedures billed during the established review period were performed by a specific family planning clinic. This clinic is part of a Not-For-Profit corporation that has several locations throughout Illinois. The data revealed that three of the five providers reviewed thus far in the study were associated with the specialized clinic identified above. The decision was then made to review the top billing provider (Provider F) who also performed abortions at this same clinic.

Staff nurses revised their protocol to include additional analysis for medical documentation consistent with sexual assault. Additionally, the HFS-OIG obtained the at-issue policies pertaining to the clinic's care of patients reporting sexual assault. This information was also incorporated into the review protocol. A total of 282 abortion procedures and all related services were reviewed for Provider F. To facilitate the larger volume of records and the additional information that was to be analyzed, all of the physician's records were copied and brought to the HFS-OIG office for review. To supplement the review, additional Peer Review nurses were reassigned to the project. The review undertaken by the nurses, as well as the audit of this provider, confirmed that, with rare exception, the abortion procedures were supported by the medical and billing documentation.

After the staff completed their review of the records, data was compiled and statistical analysis was performed to examine whether the documentation could either confirm the veracity of the reported rape, or support findings of fraud on the part of the facility or provider. The nurses also conducted a retrospective analysis, using the revised protocol, of a sampling of cases for the two providers reviewed in Phase 2. It should be noted that with Providers D, E and F, there were instances where the Medicaid recipient's medical records indicated the recipient had undergone abortion procedures not submitted for payment through the Illinois Medicaid program.

Additionally, HFS-OIG requested that the obstetrician medical expert consultant perform a review of the quality of care provided to recipients who had undergone an abortion by Provider F at the facility. In connection with this peer review, a sample of medical records for the provider and at-issue facility was provided. Additionally, the medical expert and the Peer Review nurses conducted a joint onsite review of the abortion facility. The consultant was also asked to give her professional opinion as to whether the medical record documentation was consistent with care of sexual assault patients and to consider potential recipient and/or provider fraud. To this end, the onsite review included examination of the facility's verification of the recipient's Medicaid information. The assessment also included a review as to the facility's overall abortion procedures,

including any indication of procedures in place that allowed for coaching, their verification of a recipient's Medicaid information, compliance with quality of care standards relating to treatment provided during abortion procedures, laboratory testing and anesthesia procedures.

## **NATIONAL SURVEY**

The onsite reviews and subsequent analysis did not yield any explanation for the increase of abortion procedures in the State of Illinois. As a result, it was determined that a national survey should be conducted in an attempt to put into perspective how Illinois' Medicaid covered abortion services compares nationally. HFS-OIG sought to understand whether the varied reimbursement of abortion procedures across States could possibly explain the noted disparity. To assist in determining the extent to which Medicaid funding is claimed for abortion services in other states, all 49 states were contacted to identify how they fund abortion services. Of the states surveyed, 33 responded.

Six states, (California, New York, New Jersey, Massachusetts, Washington and Montana), indicated that they do not use federal Medicaid dollars to pay for abortions, but utilize a separate state program to fund abortions. The state abortion program requirements in these states are generally much less restrictive than the qualifications followed by states that pay for abortions with Medicaid dollars.

The remaining 27 states responded that they do pay for abortions using federally matching Medicaid funds. Of these, four states (Alabama, Nevada, South Dakota and Virginia) only pay for abortions when the life of the mother is at risk and 21 states (Arkansas, Colorado, Delaware, Idaho, Iowa, Kansas, Kentucky, Louisiana, Minnesota, Missouri, Nebraska, New Hampshire, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Wisconsin and Wyoming) fund abortions if the life of the mother is at risk, or if the pregnancy is the result of rape or incest. The two remaining states which indicated that they pay for abortions with Medicaid dollars reported having fewer restrictions. Maryland responded that they pay for abortions with Medicaid dollars when the mother's life, future health or mental health is in danger, the fetus is deformed or if the pregnancy is the result of rape or incest. Oregon reported that they use Medicaid dollars to pay for all categorical abortions, except late-term abortions.



## **FINDINGS**

### Documentation and Billing Findings

The limited scope audits performed by the Audit Section and the Quality of Care reviews by the Peer Review Section identified discrepancies and/or concerns. These instances were as follows:

- Seven total instances were noted for Providers A, D, and F where the patient either received prenatal care and/or delivered a baby within 6 months of the performed abortion.
- Eleven instances were found for Provider F where documentation of ultrasounds was incomplete or missing from the medical record.
- One instance was found for Provider F in which it was reimbursed for an abortion service actually performed by a different practitioner.
- Five total instances were noted for Providers A, C, E, and F where more than one abortion was performed for the same recipient ID number within one month or less.
- Eleven occurrences were found for Provider F where billed medication was not properly documented in the medical chart.
- Seven total instances were noted for Providers C, E, and F where an office visit and an abortion service were both billed, whereas Department policy states the abortion procedure is considered to be "all-inclusive".
- Six cases for Provider F were noted to have procedure documentation missing for the date of service.
- Two instances for Provider F were found where the physician did not sign the HFS 2390 form.
- Two occurrences for Provider F were noted where the provider double billed for procedures.

Although these findings did not impact the spike of abortion services to a material degree, the issues will be addressed through follow-up procedures by the HFS-OIG. Additional concerns relative to recipient quality of care were noted during the Peer Review Section's examination of recipient records.

### Quality of Care Findings

The following concerns were noted for Providers D, E, and F:

- Failure to perform proper laboratory screening for sexually transmitted diseases (STD)
- Failure to provide adequate prophylactic treatment for patients reporting sexual assault
- Failure to provide consistent testing and/or treatment to patients reporting sexual assault
- Inadequate documentation of laboratory testing and results
- Failure to document appropriate post-anesthesia monitoring in patients receiving intravenous anesthesia.
- Incomplete and/or illegible documentation, medical history and/or signatures

### Medical Consultant Findings

The following concerns were noted by the consultant following the review of 25 case records for Providers D and E:

- Services provided were verified through the medical and billing documentation.
- Failure to consistently perform proper laboratory screening for sexually transmitted diseases (STD)
- Failure to consistently perform adequate prophylactic treatment for patients reporting sexual assault

The following concerns were noted by the consultant following the review of 15 case records for Provider F and the onsite review and observation of the family planning clinics:

- Failure to consistently perform proper laboratory screening for sexually transmitted diseases (STD)
- Failure to consistently provide adequate prophylactic treatment for patients reporting sexual assault
- Failure to consistently provide proper counseling and/or treatment to patients reporting sexual assault
- Failure to consistently offer HIV testing to patients with a reported sexual assault.
- Failure to provide adequate post-anesthesia monitoring documentation
- Failure to have adequate and/or legible physician documentation.
- Failure to properly document laboratory testing and results.
- Failure to adequately clean the procedure tables and the recovery room sink.

## CONCLUSIONS

The intent of this study was to investigate the increase in abortion procedures and to determine whether the abortion procedure billings were appropriate within the law and policy of the Illinois Medicaid Program. In total, 91 providers submitted and were paid for abortion procedures provided during 6/1/2005 through 1/31/2008. During the course of this study, HFS-OIG conducted onsite quality of care and post payment compliance reviews on six of these providers. These six providers' abortion billings comprise over 47% of all the abortion services provided, 52% of the recipients receiving abortions, and 50% of the monies spent on abortion procedures during this timeframe. Results of the study established that in nearly every case reviewed, providers had the requisite documentation to support the billed abortion procedures and that the documentation reviewed verified compliance with the billing policies for the procedures. Further, the medical records contained medical evidence consistent with the report of sexual assaults wherein rape was asserted as a basis for the abortion procedure. Because the sample size was over 47%, it is believed that continued review of abortion services would not provide any additional insight.

As part of the study, an HFS-OIG medical expert consultant reviewed a sample of the abortion procedure billings and medical records from the providers under review. The consultant also performed a joint onsite medical review of the facility and its services. As part of her evaluation, the expert was requested to evaluate both the medical and statistical data in order to opine on the validity of the reported sexual assaults, and further, to review the quality of care provided to recipients undergoing abortions. After the review, the consultant reached the conclusion that the medical documentation did not support a finding of recipient or provider fraud. In her opinion, the overall medical and statistical documentation was consistent with patients having reported sexual assault. While the consultant did find notable the number of reported rapes, she was unable to reach the conclusion that this factor alone was indicative of provider or recipient fraud. Additionally, the consultant concluded that it would not be reasonable based upon the documentation and onsite review, to proceed with further individual investigation of the recipients. Based upon the medical records, pertinent statistical data, and her onsite review, the consultant did not find that the veracity of the reported rape could be successfully challenged.

HFS-OIG could not find any clear factors to explain the increase in abortion procedure claiming. There was an immaterial impact noted from the analysis of provider billing patterns and no program coverage and/or rate changes were noted during the review period.

By looking at the results of the survey of other states' Medicaid program coverage for abortion procedures, it could be seen that several states with large Medicaid populations do not use federal Medicaid monies to pay for abortions at all and Illinois is one of the few states that uses federal Medicaid dollars to pay for abortions for rape, incest, the physical health or life endangerment of the mother. These factors may account for

Illinois' claims being disproportionately high in comparison to the abortion claims of other states across the nation.

In conclusion, this study did not reveal any systemic problems with abortion procedures paid through the Illinois Medicaid Program. However, as part of the reviews, a small number of documentation, billing and quality of care issues were noted and will be addressed through subsequent action by HFS-OIG. These actions are as follows:

- A full field audit will be performed for all services billed by Provider F.
- A data mining routine will be developed to identify where an office visit and abortion procedure were both billed on the same day for the same provider. Desk or field audits will be performed on providers identified through this routine.
- A letter of concerns will be sent to the family planning clinic notifying them of the quality of care concerns identified. The HFS-OIG Peer Review section will perform a follow-up review of the facility and its records within 6 to 12 months of the letter being sent to the clinic.
- Referrals will be made to the HFS-OIG Bureau of Investigations on the individual cases identified as potential client fraud, for example multiple abortions within one month.
- The Bureau of Claims Processing will be notified of the specific cases with an unsigned HFS 2390 forms so that they can review their abortion claims processing procedures.



**Abortion Payment Application**

Recipient Name \_\_\_\_\_

Recipient Address \_\_\_\_\_

Case Identification No. \_\_\_\_\_ Recipient Identification No. \_\_\_\_\_

I performed an abortion for the patient named above at  
 \_\_\_\_\_ on \_\_\_\_\_  
 Location (Name, City) Date

The abortion was performed because:

	(Check one code only)	
	<u>Surgical</u>	<u>Mifepristone</u>
The abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.	<input type="checkbox"/>	<input type="checkbox"/>
The recipient reported that the pregnancy was the result of rape.	<input type="checkbox"/>	<input type="checkbox"/>
The recipient reported that the pregnancy was the result of incest.	<input type="checkbox"/>	<input type="checkbox"/>
The abortion was necessary to protect the woman's health.	<input type="checkbox"/>	<input type="checkbox"/>

**I understand that completion of this form is for Medical Assistance payment purposes only.**

\_\_\_\_\_  
 Physician performing abortion (Please Print) Medicaid Provider Number

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City State Zip

\_\_\_\_\_  
 Signature of physician performing abortion Date

Completion mandatory, 305ILCS 5/1-1 et. seq. Penalty non-payment.  
 Form approved by the Forms Management Center.

## COMPLETION OF FORM HFS 2390 ABORTION PAYMENT APPLICATION

Note: If any of the following items are not completed as outlined below, the invoice and the Payment Application Form will be returned to the provider. Entries must be typed or printed in black ink.

<b>ITEM</b>	<b>INSTRUCTIONS</b>
Recipient Names	Must be recipient's first and last name.
Recipient's Address	Must be completed with recipient's address.
Recipient's Case Identification Number	Must be completed with recipient's case identification number.
Recipient I.D. Number	Must be completed with the recipient's I.D. number. Must match recipient's I.D. number on invoice.
Location	Must be the facility name and address where the procedure was performed. If procedure was performed in an office setting, enter name and address of the physician or clinic.
Date	Must be the date service was performed.
Abortion Reason	Circle on procedure code only indicating why and how the procedure was performed. Must match procedure code on the invoice.
Physician Performing Abortion	Print the physician's full name.
Medicaid Provider	Enter the provider's medicaid number or state license number.
Street Address	Enter the provider's office street address.
City, State, Zip	Enter the provider's office city, state and zip code.
Signature of Physician Performing Abortion	This is an original signature in black ink of the physician who performed the abortion.
Date	Enter the date the physician signed the application.