OFFICE OF THE NEW YORK STATE COMPTROLLER

DIVISION OF STATE GOVERNMENT ACCOUNTABILITY

New York State Department of Health

Medicaid Claims Processing Activity
April 1, 2009 through September 30, 2009

Report 2009-S-21

Thomas P. DiNapoli

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State of New York
Office of the State Comptroller

Division of State Government Accountability

September 23, 2010

Richard F. Daines, M.D.
Commissioner
Department of Health
Corning Office Building
Empire State Plaza
Albany, New York 12237

Dear Dr. Daines:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Department of Health, entitled *Medicaid Claims Processing Activity April 1, 2009 through September 30, 2009.* This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

EXECUTIVE SUMMARY

Audit Objective

Our objective was to determine whether the Department of Health's (Department's) eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to the providers.

Audit Results - Summary

The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid eligible recipients, and generates payments to reimburse the providers for their claims. During the six months ended September 30, 2009, eMedNY processed approximately 180 million claims resulting in about $23 billion of payments to the providers. We performed audit work related to the system and the payments as part of the Comptroller's constitutional and statutory requirements to audit all State expenditures. Based on the results of our audit work of the weekly cycles of Medicaid payments made during the six months ended September 30, 2009, we concluded that the eMedNY system reasonably assured that Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to the providers. However, we also identified five reportable conditions. When audit exceptions were identified, these were communicated to Department officials who initiated appropriate actions to address them.

For example, the Department needed to improve eMedNY's controls for processing claims for vision care services. Because of a control weakness, eMedNY can reimburse vision care providers for treating the same Medicaid recipient more times than is allowable over a two-year period. We identified ten affiliated vision care providers in Brooklyn that exploited this control weakness to repeatedly bill for excess services, some of which may not actually have been provided. We also determined that the providers may have been colluding in their inappropriate billing practices. Because of the severity of this problem, we expanded our review of it to the period from January 15, 2004 through May 15, 2009. Based on the results of our work, we recommend the Department review all $3.2 million in Medicaid payments made to the ten providers over our expanded review period, and recover all inappropriate payments.

We also identified a complex inpatient claim from a hospital for a Medicaid recipient with an 11-year stay. Although the hospital obtained formal technical guidance from the Department and its fiscal agent prior to submitting the claim for processing, the hospital did not follow the

guidance. Consequently, there were errors in the dates of services provided that could have resulted in excess payments of about $2.6 million more than the claim's correct amount.

In New York State, there are eight hemophilic treatment centers that have been designated as federally-funded 340B entities in accordance with the Public Health Services Act. The eight centers are eligible to participate in the 340B Drug Pricing Program (or PHS Pricing) that requires drug manufacturers to provide outpatient drugs to the covered entities at reduced prices. However, one hospital repeatedly submitted claims and received payments for hemophilic blood products at costs that exceeded the PHS price limits. We alerted Department officials of the overpayments, and they initiated a review of hemophilic-related payments to the hospital dating back to 2002. As a result of their review, the officials identified $1,010,357 in overpayments for 1,089 excessively priced claims.

We further identified neonatal claims with low birth weights and unusually short lengths of stay that did not appear to be reasonable. Through our analysis of certain claims and medical records, we identified 11 claims with incorrect birth weights that resulted in overpayments totaling $495,485. As a result of our audit, several providers took action and submitted claim adjustments. As of October 7, 2009, 8 of the 11 claims were adjusted, resulting in recoveries totaling $482,936.

Many Medicaid recipients are also eligible for Medicare. Medicaid is the payer of last resort for medical claims, paying for unpaid balances after all other insurers, including Medicare, settle. However, we identified 13 claims for services provided to Medicare recipients in which an excessive amount of Medicaid was erroneously claimed and paid. As a result of our audit, the providers corrected their billing errors and submitted corrected claims, and $282,197 in excess Medicaid payments was recovered. The erroneous claims could have been identified, and the excess payments prevented, if Medicaid claims for Medicare recipients were routinely subject to a risk assessment when the claims indicate that Medicare paid zero.

Our report includes 11 recommendations to the Department to recover Medicaid overpayments, remove providers from the Medicaid program and improve the controls over payments in these areas. Detailed results of our audit were provided to Department and Office of the Medicaid Inspector General officials. Officials generally agreed with our recommendations and indicate that actions have been planned or taken to implement them.

This report, dated September 23, 2010, is available on our website at:
http://www.osc.state.ny.us.
Add or update your mailing list address by contacting us at: (518) 474-3271 or
Office of the State Comptroller
Division of State Government Accountability
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Introduction

Background

The Department of Health (Department) administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid eligible recipients, and generates payments to reimburse the providers for their claims. During the six-month period ended September 30, 2009, eMedNY processed approximately 180 million claims resulting in payments to providers of about $23 billion. The claims are processed and reimbursed in weekly cycles which averaged 7 million claims and $876 million in Medicaid payments to the providers.

When Medicaid claims are processed by eMedNY, they are subject to various automated edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate. For example, some edits verify the eligibility of the Medicaid recipient, other edits verify the eligibility of the medical service, and other edits verify the appropriateness of the amount billed for the service. In addition, some edits compare the claim to other related claims to determine whether any of the claims duplicate one another.

The Office of the State Comptroller (OSC) performs audit steps during each weekly cycle of eMedNY processing to determine whether eMedNY has reasonably ensured that the Medicaid claims were processed in accordance with requirements, the providers submitting the claims were approved for participation in the Medicaid program, and the amounts paid to the providers were correct. As audit exceptions are identified during the weekly cycle, OSC auditors work with Department staff to resolve the exceptions in a timely manner so that payments can be made to providers. If necessary, payments to providers can be suspended until satisfactory resolution of the exceptions has been achieved.

In addition, the audit work performed during the weekly cycle may identify patterns and trends in claims and payment data that warrant follow-up and analysis as part of OSC's audit responsibilities. Such follow-up and analytical audit procedures are designed to meet the Comptroller's constitutional and statutory requirements to audit all State expenditures.

Audit Scope and Methodology

We audited selected Medicaid claims processed by the Department to determine whether the Department's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct

payments to the providers. The scope of our audit was from April 1, 2009 through September 30, 2009.

To accomplish our audit objective, we performed various analyses of claims from Medicaid payment files, verified the accuracy of certain payments and tested the operation of certain system controls. We interviewed officials from the Department, Computer Sciences Corporation (the Department's Medicaid fiscal agent), the Office of the Medicaid Inspector General (OMIG), the Office of Mental Retardation and Developmental Disabilities, and the Office of Mental Health. We reviewed applicable sections of federal and State laws and regulations, examined the Department's Medicaid payment policies and procedures, and tested medical records supporting provider claims for reimbursement. Our audit steps reflect a risk-based approach taking into consideration the time constraints of the weekly cycle and the materiality of payments. Our audit steps were designed to reasonably ensure that Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to the providers.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. Department officials generally agreed with our recommendations and indicated that actions have been planned or taken to implement them. Certain other matters were considered to be matters of lesser significance, and these were provided to the Department in a separate letter for further action.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Contributors to the Report

Major contributors to this report include Andrea Inman, Gail Gorski, Earl Vincent, Judith McEleney, Kate Merrill, Wendy Matson, Christopher Morris, Lauren Bizzarro, Mark Breunig, Anthony Calabrese, Taryn Davila-Webster, Stanley Goodman, Jackie Keeys-Holston, Elijah Kim, Sally Perry, Tracy Samuel, David Schaeffer, Rebecca Vaughn, Constance Walker, Emily Wood, Steven Sossei, Edward Durocher, Brian Mason and Dana Newhouse.

Audit Findings and Recommendations

Based on the results of our audit work for the weekly cycles of Medicaid payments made during the six months ended September 30, 2009, we conclude that eMedNY reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to the providers. In addition, we identified the need for improvements in the processing of certain types of claims, including: those from certain providers of vision-related services; a claim for an 11-year inpatient stay; those from a hospital that provides hemophilia treatment services; neonatal claims with errant birth weight data; and several that were Medicare-related.

Payments to Affiliated Vision Care Providers in Brooklyn

In accordance with the Department's vision care policies, Medicaid recipients are allowed one eye examination and one pair of eyeglasses every two years. Additional services during the two-year period may be payable if they are medically necessary. For instance, Medicaid will pay for the replacement of lost or destroyed eyeglasses.

To help ensure compliance with this two-year frequency limit, when a claim for vision services is processed by eMedNY, an edit should compare the claim to other vision service claims for the same recipient, even if the claims are from different providers. However, the Department has no such edit or other controls to ensure compliance with the two-year limit on vision services for the same Medicaid recipient. As a result, if a recipient goes, or is referred to, different vision care providers during a two-year period, there is risk that an excessive number of eyeglasses or eye examinations could be reimbursed for that recipient in that period.

During our weekly reviews of the Medicaid claims processed during the six months ended September 30, 2009, we noted that some recipients were receiving multiple vision care services (i.e., eyeglasses and eye examinations) from more than one provider. A total of ten different vision care providers in Brooklyn were providing these multiple services for the same recipients. In addition, we identified other suspicious billing patterns by the ten providers. Accordingly, we expanded our review outside the six months ended September 30, 2009, and reviewed all $3.2 million in Medicaid payments received by the ten providers for the period January 15, 2004 through May 15, 2009.

We found that many of the Medicaid recipients served by these ten providers were receiving vision care services more frequently than is allowed by the Department. For example, 31 percent of the recipients

served by the providers in the five-and-one-half-year period had four or more dates of service during that period, including one recipient who had 28 different dates of vision care service at seven of the providers and another that was issued 35 different pairs of eyeglasses. While it is possible that some of the multiple eyeglasses and/or eye examinations were medically necessary, the fact that so many of the recipients received so many eyeglasses and/or eye examinations is suspicious.

To determine whether the providers were actually providing the services claimed, we visited seven of the ten providers and reviewed their medical records for a sample of claims. We reviewed the claims relating to a judgmental sample of 372 of the 21,553 Medicaid recipients served by the ten providers during the five-and-one-half year period. Our sample consisted of recipients who were served by more than one provider and/or received services that appeared to be part of questionable billing patterns. We reviewed a total of 4,173 claims totaling $57,282.

We found that 2,556 of the 4,173 sampled claim payments (61 percent) were not properly supported by the providers' medical records, as follows:

- There were no medical records for 1,072 (26 percent) of the 4,173 claims, even though providers are required by Medicaid regulations to retain such records for six years. Six of the seven providers lacked medical records for the sampled claims. At one of these providers, some of the claims lacking medical records were for services that were supposedly performed on weekends and holidays. However, the owner of the facility told us that the business was closed on the dates in question.

- For 852 (20 percent) of the claims reviewed, the date of service on the patient record did not match the date of service on the claim. Moreover, during one site visit, we observed the provider's employee altering the dates of service on records we requested for audit.

- For 632 (15 percent) of the claims, the medical records lacked the required doctor's signature and/or were otherwise incomplete.

In the absence of medical records properly supporting that the services were provided as claimed, there is no assurance that the services were, in fact, provided as claimed. We therefore recommend that the Department recover the $38,298 that was paid on these 2,556 unsupported, or improperly supported, claims.

In our review of the sampled claims, we also identified the following billing improprieties:

- If a serious retinal condition is suspected, an extended ophthalmoscopy can be billed. The procedure includes a comprehensive examination of the eye, a detailed drawing (or photograph) of the retina, and a thorough written report of the diagnosis. The procedure is not performed commonly for most patients. Nonetheless, six of the seven providers routinely billed for extended opthalmoscopies, and one provider billed this procedure for nearly 75 percent of its patients and as often as 40 times a day. We question whether the procedure was actually performed in many instances, as the documentation in the medical records often did not appear to support such a detailed examination (e.g., the required drawings of the retina were often crude and lacking in detail).

- Three providers repeatedly billed Medicaid twice for the same service by manipulating certain billing codes.

It thus appears that these providers may have routinely violated the Department's two-year limit on vision care services for the same recipient, may have routinely billed Medicaid for services that were not actually performed, and, in some cases, repeatedly double billed Medicaid for the same service. We recommend the Department review all $3.2 million in Medicaid payments made to the ten providers for the period January 15, 2004 through May 15, 2009, and recover all payments that are found to be inappropriate.

We also recommend the Department limit vision care providers' use of a billing code that effectively permits reimbursement for an unlimited number of replacement eyeglasses or eyeglass-related services for a single Medicaid recipient. This "replacement modifier" code was often used by these Brooklyn vision care providers (it was used on 32 percent of the claims from all ten providers and on 61 percent of the clams from one provider), and the abuse of the code may have enabled inappropriate reimbursements to be made.

In addition, we found indications the ten providers were affiliated, and contrary to requirements, did not disclose all their affiliations to Medicaid. Medicaid regulations require providers to disclose the name and address of each person with an ownership or controlling interest in the entity, but five of the providers had not done so, as ownership records filed by the providers with Medicaid did not agree with information we obtained during our site visits. This information indicated that the same individuals shared ownership in a number of the providers.

We also observed during our site visits that eye examination sheets were faxed among the ten providers. For example, at one provider we noted the business emblem of one of the other providers on a faxed form and

found the same faxed examination form in a third provider's medical records. We note that one owner was associated with all three providers.

If individuals who own and operate multiple facilities do not disclose the affiliations to Medicaid, as required, they can readily share recipient information and inappropriately bill for numerous services on behalf of the same recipients out of different offices. We conclude that this was a frequent practice of these ten providers, and as a result, there were excessive billings for the same recipients (e.g., 7,219, or 33 percent, of the 21,553 Medicaid recipients served by the ten providers during the five-and-one-half year period were served by two or more of the providers, including 2,386 recipients who were served by three or more of the providers and 197 recipients who were served by five or more of the providers).

We recommend the Department determine whether the ten providers should be removed from the Medicaid program and whether any of the individuals working for the providers should be referred to the State Education Department's Office of the Professions for licensing review.

Recommendations

1. Recover the $38,298 in vision care overpayments.
2. Review all $3.2 million in Medicaid payments made to the ten providers for the period January 15, 2004 through May 15, 2009, and recover all payments that are found to be inappropriate.
3. Determine whether the ten providers should be removed from the Medicaid program and whether any of the individuals working for the providers should be referred to the State Education Department's Office of the Professions for licensing review.
4. Implement edits and other controls, such as limiting the providers' use of the replacement modifier code, to better ensure compliance with the two-year limit on vision care services for the same Medicaid recipient.

11-Year Inpatient Claim

A hospital submitted a complex inpatient claim for a Medicaid recipient with an 11-year hospital stay. Because of the complexity of the claim, the hospital requested and obtained formal technical guidance from the Department and its fiscal agent prior to submitting the claim for processing. However, when the hospital submitted the claim, it did not follow the Department's guidance. Consequently, there were errors in the dates (durations) of service. These errors would have resulted in a Medicaid payment of almost $5 million - about $2.6 million more than the claim's correct amount.

The Department did not detect these errors when it reviewed the claim, and consequently, it could have overpaid the claim. However, prior to payment, we audited the claim (including the related hospital records) and found the errors. Thus, we stopped the overpayment before it was made, and the hospital was requested to submit a corrected claim, which was $2,616,858 less than the original claim.

Recommendation

5. Formally assess the risk of complex or specially-handled claims to ensure they are submitted accurately and proper payment is processed.

Hemophilia Treatment Services

Medicaid reimburses providers for outpatient hemophilia treatment services such as infusions of anti-hemophilic blood products. Typically, medical providers buy blood products from pharmacies or manufacturers, and Medicaid reimburses them for the blood products based on the actual acquisition costs. Providers are required to submit invoices with their claims to Medicaid. The Department manually reviews the claims and invoices and then authorizes payments.

In New York State, there are eight hemophilic treatment centers that have been designated as federally-funded 340B entities in accordance with the Public Health Services Act, established by Section 602 of the Veterans Health Care Act of 1992. The eight centers are eligible to participate in the 340B Drug Pricing Program (or PHS Pricing) that requires drug manufacturers to provide outpatient drugs to the covered entities at a reduced price. The 340B price is a ceiling price, meaning it is the highest price a covered entity would have to pay for a given outpatient drug. When reviewing claims from the 340B entities, the Department must ensure that the price of the blood product billed does not exceed its ceiling PHS price.

However, one hospital repeatedly submitted claims for hemophilic blood products at costs that exceeded the PHS price limits. Although Department officials manually reviewed these claims, they authorized payments above the PHS limits because they were unaware the hospital was affiliated with a 340B entity, and therefore qualified for PHS pricing. We alerted Department officials of the overpayments, and they initiated a review of hemophilic-related payments to the hospital dating back to 2002. As a result of their review, the officials identified $1,010,357 in overpayments for 1,089 excessively priced claims. The provider agreed with the audit finding and the total overpayment was refunded in full.

We also identified two claims from another 340B entity that were not priced correctly by the Department. One claim was overpaid by $254 and the other was underpaid by $63,099. The Department did not price

the two claims correctly because of human errors in manual processing. The net underpayment for the two incorrectly priced claims was $62,845. After our review, the Department adjusted these claims.

Recommendations

6. Establish and regularly update a list of all the Medicaid Provider IDs affiliated with the 340B entities that bill Medicaid for outpatient hemophilia treatment services, and use the list when processing claims for these services.

7. Formally assess the risk of pricing claims for hemophilia treatment services manually, and determine whether it would be better to automate part or all of the process.

Birth Weight Information on Neonatal Claims

Inpatient claims for neonatal (newborn) care are reimbursed based upon several factors, including, but not limited to, newborn birth weight. Healthy newborns with normal birth weights are typically discharged after a two-day length of stay. Generally, claim reimbursements for healthy newborns are less than the amounts paid for very low birth weight newborns, which often require longer periods of hospitalization and more complex levels of care. As a result, claims for neonatal care with inaccurate birth weights may cause inappropriate payments.

During our audit, we identified neonatal claims with low birth weights and unusually short lengths of stay that did not appear to be reasonable. Through our analysis of the claims and our review of the medical records, we identified 11 claims submitted during our audit period with incorrect birth weights that resulted in overpayments totaling $495,485. As a result of our audit, several providers took action and submitted claim adjustments. As of October 7, 2009, 8 of the 11 claims were adjusted, resulting in recoveries totaling $482,936. The remaining three claims, totaling $12,549, were forwarded to the Department for future recovery.

During our review, we identified a hospital that submitted four claims with unreasonably low birth weights. According to hospital officials, a billing system problem causes birth weight errors on certain neonatal claims they submit to eMedNY. The officials further indicated that they rely on a manual hospital review of submitted claims, and they adjust the claims whenever an incorrect birth weight is found. Two of the four claims we identified were adjusted by the hospital through its manual review - and the birth weights were increased to the correct amounts. However, the other two claims were adjusted only after we informed the provider of the birth weight errors. The provider's manual review did not identify and correct these two claims.

As a result of our findings, Department officials began taking actions to address this longstanding issue that we have reported on previously. In

December 2009, the Department activated an edit to handle claims with unreasonable birth weights. Further, the Department began selecting newborn claims for post-payment review and can now adjust claim payments as necessary.

Recommendations

8. Ensure appropriate payments and initiate recoveries for the remaining three claims, totaling $12,549, that were inappropriately paid.

9. Ensure that the hospital with recurring billing errors corrects its billing system problem to accurately report birth weight information on neonatal claims submitted to Medicaid.

Medicare-Related Payments

Many Medicaid recipients are also eligible for Medicare. Such recipients are referred to as dual eligible recipients. Medicaid is the payer of last resort for medical claims, paying for unpaid balances after all other insurers, including Medicare, settle. Thus, Medicaid will pay Medicare co-pays, deductibles and coinsurance costs.

However, we identified 13 claims for services provided to dual eligible recipients in which an excessive amount of Medicaid had erroneously been claimed and paid. As a result of our audit work, the providers corrected their billing errors and submitted corrected claims, and the $282,197 in excess Medicaid payments was recovered. The erroneous claims could have been identified, and the excess payments prevented, if claims for dual eligible recipients were routinely subject to a risk assessment when it was indicated that Medicare paid zero (as was the case for these 13 claims) but the claim payment amount was not reasonable when compared to the Medicaid fee schedule (as was also the case for these 13 claims).

Medicare generally does not pay for routine eye care, such as frames, lenses or fittings. Consequently, Medicaid claims for dual eligible recipients for these types of services should be submitted using the prescribed Medicaid procedure codes and fee amounts.

We identified 674 claim payments submitted by an optometrist for which Medicaid paid $22,950 during our audit period. We reviewed the records for 10 of the 674 claims and determined that the provider often billed excessive amounts to Medicaid. He indicated to Medicaid that Medicare paid him nothing and requested reimbursements in the amounts of his standard service charges, which were higher than the amounts he should have claimed based on Medicaid fee schedules. We analyzed each of the 674 payments and determined that net overpayments totaling $11,610 resulted. Furthermore, the optometrist acknowledged that he does not bill Medicaid correctly because he wants full reimbursement of his standard charges.

Recommendations

10. Perform a risk assessment of claims for dual eligible recipients when it is indicated that Medicare paid zero but the claim payment amount was not reasonable when compared to the Medicaid fee schedule.

11. Recover the $11,610 in claim overpayments made to the optometrist; review all Medicaid claims submitted by the optometrist and recover all other overpayments; and determine whether the optometrist should be removed from the Medicaid program.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

September 8, 2010

Brian E. Mason, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's draft audit report 2009-S-21 on "Medicaid Claims Processing Activity April 1, 2009 through September 30, 2009."

Thank you for the opportunity to comment.

Sincerely,

James W. Clyne, Jr.
Executive Deputy Commissioner

Enclosure

cc: James Sheehan
Robert W. Reed
Donna Frescatore
Diane Christensen
Stephen Abbott
Ron Farrell
Mary Elwell
Irene Myron
Lynn Oliver

Department of Health
Comments on the Office of the State Comptroller's Draft Audit Report 2009-S-21 on Medicaid Claims Processing Activity April 1, 2009 through September 30, 2009

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2009-S-21 on "Medicaid Claims Processing Activity April 1, 2009 through September 30, 2009."

Recommendation #1:

Recover the $38,298 in vision care overpayments.

Recommendation #2:

Review all $3.2 million in Medicaid payments made to the ten providers for the period January 15, 2004 through May 15, 2009, and recover all payments that are found to be inappropriate.

Recommendation #3:

Determine whether the ten providers should be removed from the Medicaid program and whether any of the individuals working for the providers should be referred to the State Education Department's Office of the Professions for licensing review.

Recommendation #8:

Ensure appropriate payments and initiate recoveries for the remaining three claims, totaling $12,549, that were inappropriately paid.

Recommendation #11:

Recover the $11,610 in claim overpayments made to the optometrist; review all Medicaid claims submitted by the optometrist and recover all other overpayments; and determine whether the optometrist should be removed from the Medicaid program.

Responses #1, #2, #3, #8 and #11:

The Office of the Medicaid Inspector General (OMIG) will review the payments identified by OSC and pursue appropriate recoveries. The OMIG will consider additional actions including the imposition of sanctions, as warranted, following completion of the reviews.

Recommendation #4:

Implement edits and other controls, such as limiting the providers' use of the replacement modifier code, to better ensure compliance with the two-year limit on vision care services for the same Medicaid recipient.

Response #4:

The Department agrees with the recommendation and will explore limiting providers' use of the replacement modifier code as well as other possible methods of better ensuring compliance with the two-year limit on vision care services.

Recommendation #5:

Formally assess the risk of complex or specially-handled claims to ensure they are submitted accurately and proper payment is processed.

Response #5:

The Department agrees with the recommendation and will formally assess the risk of complex or specially-handled claims to ensure they are submitted accurately and proper payment is processed. It is relevant to note that Department review of the specific claim identified in the audit findings did not detect any issues with eMedNY's functionality.

Recommendation #6:

Establish and regularly update a list of all the Medicaid Provider IDs affiliated with the 340B entities that bill Medicaid for outpatient hemophilia treatment services, and use the list when processing claims for these services.

Response #6:

A list of PHS 340B providers including all associated National Provider Identifiers and Medicaid IDs has been established and will be utilized by examiners when processing claims. This list will be maintained and periodically updated by accessing the entire list of federally funded Hemophilia Treatment Centers available on the Department of Health and Human Services' Centers for Disease Control and Prevention website at https://www2a.cdc.gov/ncbddd/htcweb/main.asp.

Recommendation #7:

Formally assess the risk of pricing claims for hemophilia treatment services manually, and determine whether it would be better to automate part or all of the process.

Response #7:

The Department has implemented changes that are designed to mitigate the occurrence of human error during the manual review of hemophilia treatment services claims. These include adding the National Drug Code (NDC) to the claim form, permitting examiners to validate information on the claim by comparing the NDC billed for the product to the "J" procedure code, as well as requiring every blood product claim that is manually priced by a reviewer to be reviewed by a supervisor. In addition, eMedNY evolution project 142 is scheduled for implementation on November 18, 2010, and will include the new "EMEDNY-150003" paper claim form with the expanded unit

field accommodating up to 999,999 submitted units of a blood product. Further, evaluating the feasibility of automating part or all of the process will be a future Department consideration.

Recommendation #9:

Ensure that the hospital with the recurring billing errors corrects its billing system problem to accurately report birth weight information on neonatal claims submitted to Medicaid.

Response #9:

The Department will contact the hospital to reinforce the importance of submitting claims that contain accurate information, and will follow-up at a later date to verify that the problem has been adequately addressed.

Recommendation #10:

Perform a risk assessment of claims for dual eligible recipients when it is indicated that Medicare paid zero but the claim payment amount was not reasonable when compared to the Medicaid fee schedule.

Response #10:

The OMIG will explore the possibility of including these types of claims in its targeted payment integrity reviews.