OFFICE OF THE NEW YORK STATE COMPTROLLER

DIVISION OF STATE GOVERNMENT ACCOUNTABILITY

Department of Health

Medicaid Claims Processing Activity
October 1, 2009 through March 31, 2010

Report 2009-S-71

Thomas P. DiNapoli

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State of New York
Office of the State Comptroller

Division of State Government Accountability

January 6, 2011

Mr. James W. Clyne, Jr.
Executive Deputy Commissioner
Department of Health
Corning Office Building
Empire State Plaza
Albany, New York 12237

Dear Mr. Clyne:

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 October 1, 2009 through March 31, 2010*. 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

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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 of Health'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 March 31, 2010, eMedNY processed approximately 194 million claims resulting in payments to providers of about $26 billion. 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 March 31, 2010, we concluded that eMedNY reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to providers.

We also identified 10 reportable conditions. When audit exceptions were identified, these were communicated to Department officials who initiated appropriate actions to address them. The reportable conditions pertained to actual and potential overpayments exceeding $6 million. At the time our audit fieldwork concluded, about $4.7 million of these overpayments were either prevented or recovered. The reportable conditions are detailed as follows:

- $2.6 million in avoided overpayments attributable to a reimbursement rate that was incorrectly data entered to the eMedNY system. We brought the matter to the attention of the Department and other State officials, and it was corrected before the affected claims were paid;
- $1,123,366 in overpayments resulting from claims for inpatient stays for high (intensive) levels of care that should have been based on less costly "alternate" levels of care;
- $951,189 in overpayments for claims that were inappropriately billed because of incorrect Medicare eligibility information, and $165,400 in overpayments for claims which had incorrect Medicare reimbursement amounts;

- $782,809 in overpayments resulting from durable medical equipment that was improperly billed for recipients residing in assisted living facilities;

- $433,182 in overpayments resulting from invalid neonatal inpatient claims that included incorrect claim information, such as errant birth weights of newborns;

- $392,010 in underpayments resulting from newborn claims involving consecutive inpatient stays with incorrect claim information, including errant birth weights;

- $174,027 in overpayments for recipients who do not live in New York State; and

- $172,004 in overpayments for certain transportation claims, vision care claims, and managed care premiums for deceased recipients.

We also advised the Department of 15 providers who were charged with abusing Medicaid, federal Medicare, or other health insurance systems. Although the Department had terminated 5 of these providers from the program, the statuses of the remaining 10 providers were still under review when our audit concluded. Six of these 10 providers received a total of $358,040 in Medicaid payments since January 1, 2010. Consequently, the Department should take prompt actions regarding the future participation of these providers in the Medicaid program.

As a result of our audit, we made 17 recommendations to the Department to recover Medicaid payments 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. In their response to our draft report, Department officials generally agreed with our recommendations and indicated that certain steps are planned or have been taken to address them.

This report, dated January 6, 2011, 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
110 State Street, 11th Floor
Albany, NY 12236

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 March 31, 2010, eMedNY processed approximately 194 million claims resulting in payments to providers of about $26 billion. The claims are processed and reimbursed in weekly cycles which averaged 7 million claims and $1 billion 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 Medicaid requirements, and resulted in correct payments to the providers. The scope of our audit was from October 1, 2009 through March 31, 2010.

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), and the Office of Alcoholism and Substance Abuse Services. 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. In their response, Department officials generally agreed with our recommendations and indicated that certain steps are planned or have been taken to address them. Our rejoinder to the Department's response is included in our State Comptroller's Comment. 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 Steve Sossei, Brian Mason, Andrea Inman, Theresa Podagrosi, Earl Vincent, Amanda Strait, Anthony Calabrese, Judith McEleney, Rebecca Vaughn, Mark Breunig, Stanley Goodman, Jackie Keeys-Holston, Brenda Maynard, Kate Merrill, Sally Perry, Lisa Rooney, Tracy Samuel, and Constance Walker.

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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 March 31, 2010, we concluded 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. For example, we determined that a retroactive payment rate for a provider was incorrectly data entered, and this could have cost Medicaid more than $2.6 million. Also, among other problems, we found hospital claims which did not disclose alternate levels of care, claims which included inaccurate Medicare data, and claims which included improper charges for durable medical equipment and supplies. In total, we identified net actual and potential overpayments exceeding $6 million. At the time our audit fieldwork concluded, about $4.7 million of these overpayments were either prevented or recovered. Further, we concluded that the Department needs to take actions regarding certain providers who abused the Medicaid program.

Incorrect Retroactive Rate Adjustment

The eMedNY system processes claims submitted by certain Medicaid eligible programs licensed by the Office of Alcoholism and Substance Abuse Services (OASAS). The rates for these services are established by the affected agencies including the Department and OASAS. When Medicaid reimbursement rates of OASAS providers are retroactively revised on the eMedNY system, eMedNY automatically re-prices the providers' previously paid claims affected by the rate change.

We determined that the Department incorrectly entered a retroactive reimbursement rate into eMedNY that would have generated an overpayment totaling $2,602,800 to a certain OASAS program. Specifically, for rate code 4220 for the OASAS provider, the Department incorrectly entered a daily rate of $2,678.85, when the correct rate was only $268.85. Thus, the rate was overstated by $2,410. The incorrect rate change would have been applied retroactively for the period from February 22, 2009 to October 23, 2009 (the date we identified the incorrect retroactive rate on the eMedNY system), and it would have affected 308 of the provider's claims. However, we notified Department and OASAS officials of the error at that time, and the Department took prompt action to correct it before the 308 claims were processed and paid. Consequently, the overpayment of $2.6 million was prevented.

Most rate changes are loaded into eMedNY electronically. However, according to Department officials, this rate was incorrectly manually entered into the eMedNY system. Reports are available to users with eMedNY access to verify Medicaid reimbursement rates. If OASAS and the Department used these reports to identify and review disproportionate rate changes, rates at higher risk of being incorrectly entered could be verified for input accuracy. OASAS and Department staff did not notice the input error and without OSC intervention the rate would have been used to incorrectly pay the provider.

Recommendation

1. Routinely monitor available reports to ensure the accuracy of retroactive rate changes that are manually entered into eMedNY.

Alternate Level of Care

According to the Department's Medicaid Inpatient Policy Guidelines, hospitals are required to indicate a patient's "level of care" on claims to ensure accurate billing and payment. Certain levels of care are more intensive (and therefore more costly) than others. Hospitals should not bill for intensive levels of care for days when patients are in an alternate (lower) level of care setting. We identified three claims, totaling $1,837,092, for extended inpatient stays that Medicaid overpaid because the hospitals billed at a higher level of care than the patient actually received, as detailed as follows:

- One inpatient claim was paid $777,613 for 393 days of care; none of which represented alternate level of care days. However, we contacted the provider, who acknowledged that 314 (80 percent) of the 393 days were, in fact, for an alternate level of care. The provider adjusted the claim, and the payment was reduced to $303,132, resulting in a savings of $474,481.

- A second inpatient claim was paid $404,127 for 994 days of care. We also contacted this provider, who indicated that 980 (99 percent) of the 994 days were alternate level of care days. The provider adjusted the claim, which resulted in a savings of $395,885.

- The third claim for $655,352 listed a broad range of care dates; however, the billing codes did not correspond to the reported alternate level of care days. We contacted the provider who acknowledged that many of the days in question were, in fact, for alternate level of care days, and the excessive claim was the result of a data entry error. As of the conclusion of our audit fieldwork, the provider had still not adjusted the claim downward. Nonetheless, we estimate the claim's overpayment to be approximately $253,000. We forwarded pertinent data for this claim to the Department for review and payment recovery.

Recommendation

2. Review the $655,352 claim and recover the overpaid portion of the claim.

Third Party Insurance Coverage

Medicaid recipients with Medicare coverage (called dual eligibles) must inform their local social service district office of such coverage and any changes in the status of their Medicare coverage. Before a provider bills for dual eligible individuals, the provider must verify if the recipient has any Medicare coverage for the date of the service using the Department's Medicaid Eligibility Verification System (MEVS). If the individual has Medicare coverage, then Medicare is the primary insurer and must be billed first. If the individual does not have Medicare eligibility, Medicaid should be the primary insurer and should be billed first.

We identified 40 claims with inaccurate designations of the primary insurer; 31 with Medicare designated as the primary insurer when it should have been Medicaid, and 9 with Medicaid designated as the primary insurer when it should have been Medicare. Both types of errors resulted in overpayments by Medicaid. In certain instances, Medicaid was noted as a secondary payer, when it should have been listed as the primary payer. This usually occurred when a recipient's Medicare coverage terminated prior to the date of service; however, Medicaid continued to indicate that the recipient was Medicare eligible. When the Medicaid system indicates that a recipient has Medicare coverage (and Medicaid is therefore the secondary payer), eMedNY forces the claim to process and pay the coinsurance charges. In some cases, providers submitted charges for coinsurance which were greater than the amounts Medicaid would normally have paid as the primary payer. Consequently, when Medicaid was actually the primary payer, Medicaid overpaid these claims. For 31 (of the 40) claims, overpayments totaling $226,970 occurred because Medicaid was designated incorrectly as the secondary payer.

With regard to the remaining 9 claims, we identified Medicare eligibility for the recipients whose claims were inappropriately billed with Medicaid as the primary payer. In these instances, Medicare should have been the primary payer - and Medicaid the secondary payer. Because Medicaid was incorrectly designated as the primary payer, overpayments totaling $724,219 were made on these 9 claims. The overpayments for all 40 improperly paid claims totaled $951,189 ($226,970 + $724,219). We contacted the providers regarding the 40 claims and notified them of the correct Medicare eligibility statuses of the recipients for the dates of the services in question. At the time of our review, the providers adjusted 37 of these errant claims.

We also identified six other Medicare-related claims which included incorrect data and resulted in Medicaid overpayments of $165,400. On

one claim, for example, the provider entered the procedure code (instead of the proper dollar amount) in the field for coinsurance, and thereby, inadvertently billed Medicaid $99,212 for an office visit. Because the provider was entitled to only $15, the error resulted in an overpayment of $99,197. Various data entry errors resulted in overpayments totaling about $66,000 for the other five Medicare-related claims in question. At the time of our review, we contacted the providers and requested them to resubmit the six claims correctly to Medicaid. As a result, all six claims were resubmitted correctly, and Medicaid recovered the overpayments totaling $165,400.

Recommendations

3. Ensure Medicare eligibility is accurately updated on the Medicaid system in a timely manner.

4. Review the three remaining claims and recover the overpaid portions of the claims.

5. Remind providers to ensure that Medicare-related data is entered properly when submitting claims for dual eligible recipients to Medicaid.

Inappropriate Durable Medical Equipment (DME) Payments

According to the Department's Medicaid Assisted Living Program Policy Guidelines, separate reimbursement for certain medical supplies and equipment for recipients residing in Assisted Living Programs (ALP) is prohibited because these costs are included in the all-inclusive ALP reimbursement rate. For instance, costs for oxygen concentrators and blood glucose testing strips are included in the Medicaid reimbursement rates received by assisted living facilities, and consequently, medical equipment suppliers should seek reimbursement from assisted living facilities, and not from Medicaid.

We reviewed durable medical equipment (DME) claims for recipients residing in assisted living facilities for the five-year period ended April 12, 2010 and found that durable medical equipment and supplies were incorrectly billed by DME providers resulting in overpayments on 34,174 claims totaling $782,809. Furthermore, we concluded that the Department did not implement appropriate system controls in eMedNY to prevent this type of inappropriate billing. Claims for durable medical equipment and supplies can be processed as either a DME claim type or a pharmacy claim type. However, the Department implemented an eMedNY edit, on April 1, 2010, only to prevent separate billings for medical equipment and supplies processed as DME claim types. Consequently, eMedNY continued to process excessive pharmacy claims for durable medical equipment and supplies subsequent to April 1, 2010. After we shared our findings with the Department, officials expanded the edit on July 1,

2010 to prevent separate billings for DME claims processed as pharmacy claims.

Recommendation

6. Review the $782,809 in payments we identified and recover inappropriate payments.

Incorrect Information on Neonatal Claims

Inpatient claims for neonatal (newborn) care are reimbursed based upon several factors including, but not limited to, newborn birth weight and type of discharge (e.g., discharged to home or transferred to another facility). Healthy newborns with normal birth weights are typically discharged home 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, who often require longer periods of hospitalization and more complex levels of care. As a result, claims for neonatal care with inaccurate birth weights and/or patient status codes may cause inappropriate payments.

We identified 18 neonatal claims with low birth weights and short lengths of stay that resulted in a net overpayment of $433,182. Of the 18 claims, eight were submitted with an incorrect birth weight and ten were submitted with an incorrect patient status code. We contacted providers who submitted adjustments to eight claims, for a net reduction of $75,323. The remaining unrecovered amount of $357,859 was referred to the Department for recovery.

We also identified 34 newborn claims that reported consecutive inpatient stays (i.e., no breaks in the provision of care), but different birth weights and/or incorrect patient status codes. These claims were submitted by the facilities where the children were born and by the facilities where they were subsequently transferred. Our review showed that 25 of these claims had incorrect birth weights, and 9 had incorrect patient discharge status codes. For 26 claims, the incorrect data resulted in underpayments totaling $406,925, which we provided to the Department for review. Incorrect data on the remaining eight claims resulted in overpayments totaling $14,915 to six providers. We contacted the providers, and they corrected their claims. In total, the 34 incorrect claims resulted in a net underpayment of $392,010 ($406,925 - $14,915).

The Department contracts with an outside firm, Island Peer Review Organization (IPRO), to review certain higher risk claims, including those for neonatal care, to ensure they are paid properly. However, we concluded that IPRO, as well as the eMedNY system, lacked the processes necessary to ensure the accuracy of information on neonatal claims involving consecutive inpatient stays with different birth weights indicated and/or incorrect patient status codes.

Recommendations

7. Formally assess the risk associated with newborn claims for consecutive inpatient stays that include inconsistent birth weights and/or incorrect patient status codes between transferring and admitting facilities. Determine if controls and the contractor's review need to be updated to identify such potentially problematic neonatal claims to prevent overpayments.

8. Take actions to recover and correct the inappropriate payments for the 36 remaining claims identified by our report.

Recipients Residing in Other States

According to NYCRR Title 18, Section 360-3.2, a recipient's state of residence is responsible for providing public medical assistance, and recipients must be residents of New York State as a condition of eligibility for New York Medicaid. However, we identified four recipients with recurring claims from out-of-state providers, and consequently, we questioned if these recipients were still residents of New York and eligible for New York Medicaid benefits. Through contacts with Medicaid officials in other states, we determined that the four recipients resided outside of New York, and they were enrolled in the other states' Medicaid programs at the time of the payments made by New York. Consequently, these recipients were not eligible for New York Medicaid benefits, and New York should not have paid claims for the services they received, which cost $174,027.

We determined, for example, that one of the recipients resided in Florida and had Florida Medicaid eligibility since February 1, 2008. We further determined that Florida Medicaid was responsible for more than $85,000 in services paid by New York between February 1, 2008 and March 3, 2010. Our inquiry prompted an investigation of this recipient by the New York City Human Resources Administration (HRA) in September 2009. The investigation of this case was completed in March 2010, at which time HRA stated the New York eligibility would be closed. However, as of July 6, 2010 the case remained open.

When Medicaid recipients leave New York they do not always notify their local social service district office that they are moving and, therefore, recipients are not always appropriately "disenrolled" from Medicaid. However, reports from the Federal government's Public Assistance Reporting Information System (PARIS) are available to identify individuals who are enrolled in two or more states' Medicaid program during the same time. We conducted an audit of this process in New York State (Report No. 2008-S-4, issued March 3, 2009) and found the Department needed to make major improvements to its oversight of this program. Although the Department has strengthened efforts to address this issue, additional actions appear needed to prevent large Medicaid

payments for services provided to recipients who are not residents of New York.

Recommendations

9. Recover the $174,027 in inappropriate payments made on behalf of recipients who were no longer living in New York and had Medicaid eligibility in another state.

10. Close the case for the recipient identified as residing in Florida and enrolled in Florida's Medicaid program.

Inappropriate Transportation Billings

According to the Medicaid Transportation Manual, reimbursements will only be made for transportation services actually rendered, transportation to or from covered services, and mileage incurred when actually transporting the recipient. Transportation providers should not bill for mileage incurred when driving from the company's facility to the recipient's residence prior to a transport for medical service. Further, transportation providers should not request prior authorization directly from the prior authorization agent. Instead, requests for authorization must be initiated by the ordering practitioner or other designated requestor, and the authorization process should ensure that the least costly plan of transportation is arranged.

We found four providers engaging in improper transportation billings, totaling $60,438 in inappropriate claims, as follows:

- A provider inappropriately billed 757 times between July 30, 2005 and March 28, 2010 for ambulette services that did not have a matching medical service. These claims were for one recipient and totaled $39,016;

- A provider billed for 31 services between October 8, 2009 and November 27, 2009 at the Medicaid rate of $250 per round trip for one person. However, these services were provided in conjunction with group rides, and therefore, Medicaid should have paid only $20 per round trip. The provider also billed seven times for recipients when no medical service was provided. These errors resulted in a total overpayment of $8,880;

- A provider billed 18 times between November 4, 2009 and January 18, 2010 at $350 per trip for transportation of a recipient within the same town. The correct rate, however, was $30 per trip. Additionally, three trips were billed for the same recipient on dates when no medical service was provided. Moreover, the recipient's prior authorization form was modified improperly to allow one long distance trip at $350 and a local trip at $30 on the same day, and the modified authorization

was used to justify transportation claims at $350 per trip. These claims resulted in overpayments totaling $6,810; and

- A provider billed excessive mileage on 67 claims for services rendered to three recipients between May 1, 2009 and December 29, 2009, resulting in an overpayment of $5,732. Contrary to Department policy, the recipient's fiscal district accepted prior authorization requests directly from the transportation provider and did not review the requests for appropriateness of the amount of mileage requested. The provider was previously cited for the same issue in a prior audit and was directed on the correct billing regulations.

We believe that some of the aforementioned overpayments resulted from deliberate efforts to overcharge Medicaid for transportation services. Consequently, Department officials are formally assessing the circumstances pertaining to these claims and determining if formal actions should be taken with regard to the providers in question.

Recommendations

11. Review the $60,438 in overpayments we identified and recover them.
12. Formally assess the circumstances pertaining to the overpayments and determine if the providers in question should be sanctioned by or terminated from the Medicaid program.
13. Remind local social service district offices of the appropriate procedures for prior authorization of medical transportation services.

Inappropriate Eye Care Billings

Although Medicaid pays for routine vision care services (including eyeglass frames, lenses and fittings), Medicare generally does not. Consequently, Medicaid requires providers to apply the program's standard fee schedules when submitting claims for routine vision care services provided to dual eligible recipients. However, we identified six vision care providers that frequently claimed (and were paid) amounts in excess of the applicable Medicaid fee schedules. For the six months of our audit, these six providers applied excessive fee rates to 3,222 claims, which resulted in overpayments totaling $60,383.

Recommendation

14. Review the $60,383 in overpayments we identified and recover them.

Premiums Paid For Deceased Managed Care Enrollees

According to the Department's standard Medicaid Managed Care and Family Health Plus contract, local social service district offices are responsible for ensuring that recipients are removed from the managed care programs (rolls) in a timely manner upon death. When a disenrollment is not made timely, a retroactive disenrollment is required. In this instance, the managed care contractor is responsible for submitting an adjustment to return any previously paid premiums for the period of retroactive disenrollment.

We identified four long deceased Medicaid recipients for whom $51,183 in premium payments had been made for coverage provided long after the recipients had died. At the time of our audit, three of the four recipients had been dead for nearly 11 years, and the remaining recipient was dead for nearly eight years. The following table summarizes the pertinent details of the managed care premiums paid by Medicaid for the deceased recipients.

Enrollee	Year of Death	Period of Premium Payments	No. of Months Premiums Paid	Amount of Payments
No. 1	1998	11/01/06 - 07/30/09	33	$14,481
No. 2	1998	03/01/07 - 06/30/09	28	$12,900
No. 3	1998	06/01/07 - 07/30/09	26	$11,583
No. 4	2001	06/01/07 - 07/30/09	26	$12,219
Totals			113	$51,183

Recommendations

15. Recover the $51,183 in managed care premiums made on behalf of the deceased enrollees.

16. Remind local social service district offices to ensure that Medicaid managed care recipients are disenrolled timely upon death.

Status of Providers Who Abuse the Program

If a Medicaid provider has violated statutory or regulatory requirements related to the Medicaid or Medicare programs, or has committed other unacceptable insurance practices, the Department can impose sanctions against the provider. These sanctions can range from excluding the provider from the Medicaid program to imposing participation requirements, such as requiring that all billing be reviewed manually before payment. Exclusion from the Medicaid program is immediate if the provider has been terminated or excluded from the federal Medicare program.

We identified 11 providers with an active status in the Medicaid program, and four providers with an inactive status, that were either charged or found guilty of abusing the Medicaid, federal Medicare, or the private health insurance systems. We advised Department officials of these providers, and the Department promptly terminated five of them. As of the conclusion of our audit fieldwork, the Department was in the process of determining the termination status of the remaining ten providers. Six of these ten providers have received Medicaid payments totaling $358,040 since January 1, 2010. Consequently, the Department should take prompt actions regarding the future participation of these providers in the Medicaid program.

Recommendation 17. Ensure that assessments of providers that abuse the Medicaid and other health insurance programs and the resulting Department actions, including sanction or removal from the program, are performed timely.

Agency Comments

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

December 16, 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-71 on "Medicaid Claims Processing Activity October 1, 2009 – March 31, 2010."

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
Dennis Wendell
Stephen LaCasse
Ron Farrell
Mary Elwell
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Lynn Oliver

Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2009-S-71 on Medicaid Claims Processing Activity October 1, 2009 through March 31, 2010

The following are the Department of Health's (Department) comments on the Office of the State Comptroller's (OSC) draft audit report 2009-S-71 on "Medicaid Claims Processing Activity October 1, 2009 through March 31, 2010."

Recommendation #1:

Routinely monitor available reports to ensure the accuracy of retroactive rate changes that are manually entered into eMedNY.

Response #1:

Established controls within the Office of Alcoholism and Substance Abuse Services (OASAS) would have likely uncovered the error behind this recommendation involving an OASAS rate that was incorrectly updated by the Department, had OSC not uncovered it first. OASAS generates quarterly revenue reports capturing Medicaid reimbursements for all of its enrolled providers, which are reviewed and analyzed for anomalies by OASAS field office staff. If an overpayment such as the potential one identified by OSC had actually been made, it likely would have been identified by the field office and communicated to the OASAS fiscal office for recovery. The Department and OASAS, nonetheless, consider this OSC finding an opportunity for improvement, and are taking action accordingly. In particular, while Department controls already require manually-keyed rates to be verified by a second staff member, the importance of carefully entering and verifying the data was reinforced with the affected Department personnel. In addition, OASAS is implementing new procedures that utilize a Medicaid Transaction Form for communicating necessary rate changes to the Department. OASAS fiscal staff will complete and forward the form to the Department and routinely perform follow-up to verify that requested changes have been timely and accurately updated, ensuring the accuracy of Medicaid billings by OASAS' providers.

Recommendation #2:

Review the $655,352 claim and recover the overpaid portion of the claim.

Response #2:

The Office of the Medicaid Inspector General (OMIG) will review the claim and pursue appropriate recovery.

Recommendation #3:

Ensure Medicare eligibility is accurately updated on the Medicaid system in a timely manner.

Response #3:

Effective with the system changes which the Department implemented at the approximate mid-point of the OSC audit period, Medicare eligibility is routinely updated in the Medicaid system based on data received directly from the Federal Centers for Medicare and Medicaid Services.

Recommendation #4:

Review the three remaining claims and recover the overpaid portions of the claims.

Response #4:

The OMIG will review the claims identified and pursue appropriate recoveries.

Recommendation #5:

Remind providers to ensure that Medicare-related data is entered properly when submitting claims for dual eligible recipients to Medicaid.

Response #5:

The Department agrees and will include the recommended reminder in an upcoming edition of its monthly Medicaid Update provider publication.

Recommendation #6:

Review the $782,809 in payments we identified and recover inappropriate payments.

Response #6:

The OMIG will review the payments identified and pursue appropriate recoveries.

Recommendation #7:

Formally assess the risk associated with newborn claims for consecutive inpatient stays that include inconsistent birth weights and/or incorrect patient status codes between transferring and admitting facilities. Determine if controls and the contractor's review need to be updated to identify such potentially problematic neonatal claims to prevent overpayments.

Response #7:

The Department agrees with the recommendation and will determine the course of action needed to accomplish it. The Department will also assess whether existing controls and its contractor's review procedures are sufficient for identifying potentially problematic neonatal claims to prevent overpayments.

Recommendation #8:

Take actions to recover and correct the inappropriate payments for the 36 remaining claims identified by our report.

Response #8:

The Department agrees and will work with its contractor to review the 36 remaining claims identified by OSC and to recover any inappropriate payments.

Recommendation #9:

Recover the $174,027 in inappropriate payments made on behalf of recipients who were no longer living in New York and had Medicaid eligibility in another state.

Response #9:

The OMIG will review the payments identified by OSC and pursue appropriate recoveries.

Recommendation #10:

Close the case for the recipient identified as residing in Florida and enrolled in Florida's Medicaid program.

Response #10:

The Department contacted the New York City Human Resources Administration and was informed that the case was closed in August 2010.

Recommendation #11:

Review the $60,438 in overpayments we identified and recover them.

Response #11:

The OMIG will review the overpayments identified and pursue appropriate recoveries.

Recommendation #12:

Formally assess the circumstances pertaining to the overpayments and determine if the providers in question should be sanctioned by or terminated from the Medicaid program.

Response #12:

The report includes four bullets summarizing OSC's findings relative to each of four specific providers. Regarding the first and fourth findings, the OMIG will assess the circumstances pertaining to the overpayments and take appropriate action as warranted. Regarding the second and third findings, the Department does not agree that the associated providers should be sanctioned or excluded.

The circumstances behind the second finding indicate that the third-party contractor utilized by the local district for prior authorizing non-emergency transportation erroneously approved a second recipient for the full amount. Based on this approval, the provider billed the full amount for both recipients of a group ride. While the claims in question are incorrect, the provider assumed that the authorized information was correct. New procedures requiring the verification of amounts and the number of persons in the vehicle prior to payment have already been implemented. Additionally, the Department reviewed the circumstances behind the third OSC finding and concluded that the overbilling is the result of the provider misunderstanding the billing procedures. The Department will ensure that changes are implemented to prevent a reoccurrence.

It appears based on information in the report that OSC assumed that for a transportation service to have been rendered there must be a corresponding medical claim for the same date-of-service, which is not a valid assumption. For example, some dialysis claims for Medicaid enrollees who are eligible for Medicare are reimbursed entirely by Medicare, although Medicare does not reimburse for the cost of transportation to and from the treatment. As a further example, Medicaid reimbursement for ambulatory surgical services includes all follow-up care attributed to the surgery. While the medical claim is reimbursed based on the date of surgery, the date-of-service for transportation claims associated with subsequent follow-up care will not correspond with that of the medical claim. These and other situations can result in legitimate, stand-alone transportation claims.

* Comment

Recommendation #13:

Remind local social service district offices of the appropriate procedures for prior authorization of medical transportation services.

Response #13:

The Department agrees and will remind all local social services districts of the appropriate procedures for prior authorization of medical transportation services. It is additionally relevant to note that the Department is currently in the preliminary stages of implementing a new statute permitting the Commissioner of Health to procure transportation management services. It is

* See State Comptroller's Comment, page 29.

anticipated that this new management capacity will begin in early 2011, and will result in significantly improved oversight of transportation authorizations as well as compliance with the Department's payment policy and rate assignment.

Recommendation #14:

Review the $60,383 in overpayments we identified and recover them.

Response #14:

The OMIG will review the overpayments identified and pursue appropriate recoveries.

Recommendation #15:

Recover the $51,183 in managed care premiums made on behalf of the deceased enrollees.

Response #15:

The Department's Retro Disenrollment Project, in coordination with the OMIG and the local social services districts, has recovered over $1.3 million to date, including the $51,183 identified by OSC. Furthermore, the OMIG plans on conducting additional analysis to determine if any other payments similar to those in this finding should also be recovered.

Recommendation #16:

Remind local social services district offices to ensure Medicaid managed care recipients are disenrolled timely upon death.

Response #16:

Medicaid Managed Care/Family HealthPlus plans, per contract, are not entitled to premiums as of the month following the month of death. The local social services districts have been instructed to make the effective date of disenrollment the first day of the month following the month of death.

Recommendation #17:

Ensure that assessments of providers abusing Medicaid and other health insurance programs, and the resulting Department actions, including sanction or removal from the program, are performed timely.

Response #17:

The Department timely refers allegations of abuse to the OMIG for investigation, and takes appropriate and necessary actions upon finalization of OMIG's investigation. The OMIG will continue to, where appropriate, sanction providers in a timely manner.

State Comptroller's Comments

We acknowledge that, in certain instances, a transportation service is eligible for Medicaid reimbursement although there is no corresponding Medicaid claim for medical treatment on the date transportation is provided. Nonetheless, neither of the examples presented by the Department applies to the cases we detail in our report. Moreover, as the Department acknowledges, each of the claims we cited were, in fact, incorrect.