OFFICE OF THE NEW YORK STATE COMPTROLLER

DIVISION OF STATE GOVERNMENT ACCOUNTABILITY

Department of Health

Medicaid Claims Processing Activity
April 1, 2010 through September 30, 2010

2010-S-15

Thomas P. DiNapoli

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State of New York
Office of the State Comptroller

Division of State Government Accountability

August 22, 2011

Nirav R. Shah, M.D., M.P.H.
Commissioner
Department of Health
Corning Office Building
Empire State Plaza
Albany, New York 12237

Dear Dr. Shah:

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, 2010 through September 30, 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 Objectives

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-month period ended September 30, 2010, eMedNY processed approximately 163 million claims resulting in payments to providers of about $24 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 September 30, 2010, we concluded eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed according to requirements, and resulted in correct payments to providers.

We also identified seven 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 totaling almost $2.9 million. At the time our audit fieldwork concluded, about $2.3 million of these overpayments were recovered. The reportable conditions included:

- about $1.4 million in overpayments resulting from improper claims from out-of-state hospitals;
- $635,163 in overpayments for claims that had incorrect Medicare eligibility information or incorrect Medicare reimbursement amounts;
- $552,827 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;

- $214,414 in overpayments resulting from neonatal inpatient claims that included incorrect claim information, such as incorrect birth weights of newborns;
- $56,490 in overpayments for vision care claims; and
- $5,044 in overpayments due to forged prescriptions and billings for refills that were not provided to recipients.

We also advised the Department of 21 providers who were charged with abusing Medicaid, federal Medicare, or other health insurance systems. Although the Department had terminated 8 of these providers from the program, the statuses of the remaining 13 providers were still under review when our audit concluded. Six of these 13 providers received a total of $204,515 in Medicaid payments since April 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 ten 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 indicate actions have been planned or taken to implement them.

This report, dated August 22, 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 September 30, 2010, eMedNY processed approximately 163 million claims resulting in payments to providers of about $24 billion. The claims are processed and reimbursed in weekly cycles which averaged about 6.2 million claims and $931 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 Medicaid requirements, and resulted

in correct payments to the providers. The scope of our audit was from April 1, 2010 through September 30, 2010.

To accomplish our audit objectives, 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), and the Office of the Medicaid Inspector General (OMIG). 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.

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. Also, 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 David Hancox, Andrea Inman, Theresa Podagrosi, Earl Vincent, Amanda Strait, Wendy Matson, Michele Turmel, Jessica Turner, Lauren Bizzarro, Judith McEleney, Rebecca Vaughn, Stanley Goodman, Mark Breunig, Jackie Keeys-Holston, Kate Merrill, Sally Perry, Constance Walker, Steven Sossei and Brian Mason.

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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 September 30, 2010, we concluded 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 identified an out-of-state claim that was overpaid by $1.1 million because of an incorrect rate code. Also, among other problems, we found hospital claims which did not disclose alternate levels of care, claims which included inaccurate Medicare data, and neonatal claims which included incorrect birth weights. In total, we identified net actual and potential overpayments of nearly $2.9 million. At the time our audit fieldwork concluded, about $2.3 million of these overpayments were recovered. Further, we concluded the Department needs to take actions regarding certain providers who abused the Medicaid program.

Out-of-State Hospital Claims

For patients discharged on or after December 1, 2009, Medicaid pays claims from out-of-state hospitals according to reimbursement rates established for New York State facilities. Prior to this policy, Medicaid paid claims based on a percentage of the total charges submitted by the out-of-state hospital. The new payment method significantly reduced the amounts of payments to out-of-state hospitals for many services. Further, the Department changed the rate code that the out-of-state hospitals were to use to submit claims - from 2959 (Other DRG Exempt) to 2953 (Out-of-State Hospital DRG).

Nonetheless, an out-of-state hospital submitted an inpatient claim for services provided between October 20, 2009 and March 11, 2010 using rate code 2959. The claim paid $1,232,715 based on 91 percent of the submitted charges. However, because the patient was discharged after December 1, 2009, the hospital should have applied code 2953 (not 2959) to the claim. We contacted hospital officials, and they corrected the claim, which saved Medicaid $1,138,399. Further, as a result of our review, the Department deactivated code 2959 for this hospital. The Department has deactivated code 2959 for other providers as well.

We also reviewed a complex claim from another out-of-state hospital which paid $2,904,402. Because the patient's discharge date was before December 2009, the payment amount was based on 75 percent of the submitted charges. Moreover, due to the size and complexity of the

claim, we concluded there was a high risk that Medicaid overpaid it. We brought this claim to the attention of Department officials who referred it to a contractor, the Island Peer Review Organization (IPRO), for review. At the time our audit concluded, IPRO's review was not complete. However, preliminary results indicated that various parts of the claim were improper. Certain charges, for example, appeared to be duplicative. Due to the improper charges, Medicaid likely overpaid this claim by about $275,000.

Recommendation

1. Follow-up with IPRO regarding the out-of-state claim in question and, upon conclusion of IPRO's review, recover any overpayment, as warranted.

Medicare-Related Claims

Many Medicaid recipients also have Medicare coverage. These recipients are called "dual eligibles." When billing for a dual eligible, a provider must verify that the recipient has Medicare coverage for the date of the service in question. If the individual has Medicare coverage, Medicare is the primary insurer and must be billed first. In this case, Medicaid (as the secondary insurer) generally covers the patient's normal financial obligation, including coinsurance. If an individual (or medical service) is not covered by Medicare, Medicaid is the primary insurer and should be billed first. An error in a claim's designation of the primary payer and/or the amount of coinsurance will likely result in a Medicaid payment that is wrong. We identified errors in 50 claims for dual eligible recipients which resulted in overpayments totaling $635,163.

Specifically, we identified 42 claims with the wrong primary insurer. For 39 of these claims, Medicare was designated as the primary insurer when it should have been Medicaid. In these cases, the recipients' Medicare coverage terminated before the dates of service, but Medicaid continued to indicate that the recipients were Medicare eligible. When the Medicaid system indicates 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, however, providers submitted charges for coinsurance which were greater than the amounts Medicaid would have normally paid as the primary payer. Thus, for these 39 claims, we identified overpayments totaling $380,166 because Medicaid was incorrectly designated as the secondary payer.

For the remaining three (of the 42) claims, Medicaid was incorrectly designated as the primary payer, when the primary payer was actually Medicare. Generally, primary payers pay more than secondary payers. Because Medicaid was incorrectly designated as the primary payer, overpayments totaling $22,247 were made on the three claims. Moreover, the overpayments for all 42 improperly paid claims totaled $402,413

($380,166 + $22,247). We contacted the providers for the 42 claims and notified them of the recipients' correct Medicare eligibility statuses. At the time of our review, the providers adjusted 33 of these incorrect claims, saving Medicaid $315,820. However, adjustments were still needed for the other 9 claims with overpayments totaling $86,593.

In addition, we identified six other claims (from six different providers) which had incorrect Medicare HMO information - resulting in overpayments totaling $225,712. We contacted the six providers and requested them to correct their claims. At the time of our review, four providers corrected their claims, saving Medicaid $203,687. For the other two claims (with overpayments totaling $22,025) the providers acknowledged problems with the claims' Medicare HMO payment data. One of these providers was working with its billing vendor to address the matter and advised us that the claim would be corrected as soon as the matter was resolved. Regarding the remaining overpayment, however, the provider had taken no action to correct it.

We also identified two claim payments for durable medical equipment that indicated incorrectly that Medicare had paid $0 for the items in question. We contacted the providers of both claims, and they acknowledged that Medicare did, in fact, make payments for the items. At our request, the providers corrected the claims, which saved Medicaid a total of $7,038.

Recommendation

2. Follow up on the 11 incorrect claims (with overpayments totaling $108,618) that were not adjusted at the time of our review and recover the overpayments, as appropriate.

Alternate Level of Care

According to the Department's Medicaid Inpatient Policy Guidelines, hospitals must indicate a patient's "level of care" on claims to ensure accurate processing 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 (ALC) setting. However, we identified two claims (totaling $981,788) for extended inpatient stays that Medicaid overpaid by $552,827 because the hospitals billed at a higher level of care than the patient actually received. Those claims are detailed as follows:

- A claim paid $448,749 for 406 days of rehabilitation. However, medical records indicated the physician ordered lower-cost ALC for the patient. At our request, the provider reviewed and corrected the claim based on the available medical records. This reduced the amount of rehabilitation claimed by 315 days (or to 91 days). The adjusted claim paid $84,228, thus saving Medicaid $364,521.

- A second claim paid $533,039 for 204 inpatient hospital days without any ALC days indicated. However, our review of the medical records indicated a physician ordered ALC to start 22 days into the patient's stay. Thus, the hospital should have claimed the remaining 182 days at a lower ALC rate. At our request, the provider reviewed and corrected the claim. The adjusted claim paid $344,733, thus saving Medicaid $188,306.

Recommendation

3. Formally remind the hospitals responsible for the two problematic claims to ensure their ALC-related claims are properly prepared upon submission to eMedNY. Monitor large ALC-related claims from these providers, as warranted, to help ensure compliance with correct claims processing procedures.

Incorrect Data on Neonatal Claims

Payments for inpatient claims for neonatal (newborn) care are based on several factors including (but not limited to) birth weight, diagnosis, and whether the billing facility is the birth hospital. Healthy newborns with normal birth weights are typically discharged home after a two-day length of stay. Generally, claim payments for healthy newborns are significantly 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.

On one neonatal claim, for example, a birth weight of 224 grams was reported when the actual birth weight was 2,240 grams. The lower birth weight triggered a Medicaid payment of $226,140. At our request, the provider corrected the claim (to $96,659), resulting in a savings of $129,481. We also identified 17 neonatal claims with low birth weights and unusually short lengths of stay. Of the 17 claims, eight were submitted with incorrect birth weights, which resulted in a net overpayment of $89,393. Regarding the remaining nine neonatal claims totaling $376,813, the providers did not provide medical records to confirm the recipients' birth weights. Consequently, we were unable to verify the propriety of the payments. We provided details of these 17 claims to Department officials for their review and recovery of overpayments, as warranted.

We also identified 10 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 eight of these claims had incorrect birth weights, and two had incorrect patient discharge status codes. We contacted the providers, and 8 of the 10 claims were corrected, saving Medicaid $2,785. Incorrect data on the remaining

two claims resulted in underpayments totaling $7,245 which we provided to the Department for review. In total, the 10 incorrect claims resulted in a net underpayment of $4,460 ($7,245 - $2,785).

We have reported on control weaknesses in the processing of neonatal claims in the past, and as a result, the Department has taken some steps to identify problematic claims and prevent overpayments. Nonetheless, a significant weakness still exists in eMedNY. For DRG MDC Code 15 'Newborns and Other Neonates with Conditions Originating in the Perinatal Period,' eMedNY does not compare the birth weight category diagnosis codes with the actual birth weights of newborns included on claims. Consequently, as detailed previously, overpayments were made for claims for newborns whose weights were under-reported. If automated and/or manual controls were developed to perform this comparison, the risk of overpayments could be decreased significantly.

Recommendations

4. Implement a control to verify the birth weight category diagnosis code against the birth weight on the claim.

5. Review the 10 incorrect claims we identified and make recoveries or adjustments, as appropriate. Also, follow-up on the 9 claims we were unable to verify because providers did not provide medical confirmation of birth weights.

Inappropriate Eye Care Claims

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 ten vision care providers who often indicated to Medicaid that Medicare paid nothing, and they requested reimbursements for coinsurance amounts which were higher than the amounts they should have claimed based on Medicaid fee schedules. The excessive payments made to these providers totaled $56,490. Moreover, at the time our fieldwork concluded, none of these overpayments were adjusted or recovered.

Nine of the ten providers submitted 707 claims during our 6-month audit period that resulted in overpayments totaling $28,646. Because the claims were prepared improperly, the payments exceeded the normal Medicaid fee schedule amounts for the procedure in question. We contacted five of the nine providers about the incorrect claims. Three providers acknowledged their claims were incorrect. However, the other two providers expressed confusion over the issue and did not agree they were overpaid.

These overpayments occurred because of a control weakness in eMedNY. If Medicare did or will not pay for a service, providers should "zero fill" the

amount of the Medicare payment on their Medicaid claim. Further, when Medicare does not pay for a service, there should not be a coinsurance or deductible amount on the claim, and consequently, eMedNY would pay the claim based on the standard Medicaid fee schedule. However, some providers indicated "zero fill" and then included a coinsurance or deductible on the claim. When the claim was processed, the co-insurance or deductible determined the payment amount, which often exceeded the standard Medicaid amount. Moreover, there is no edit within eMedNY or other compensating controls in place to prevent these overpayments from occurring.

We also visited the remaining provider and tested medical records supporting 165 claims that paid $14,762. We identified overpayments totaling $2,358 from 48 (29 percent) of the 165 claims tested. For many of the claims, there was insufficient supporting documentation for the procedures purportedly performed. Further, on other occasions, the provider sent duplicate claims to Medicaid for the same patient, procedure code, and date of service. The provider received duplicate payments because one of the claims referenced Medicare, but the other did not. Because of the high exception rate, we expanded our review of this provider to payments (totaling about $94,000) made from April 2005 through March 2010. We identified overpayments of $25,486 from 433 improper claims for this period. Thus, we identified a total of $27,844 ($25,486 + $2,358) in overpayments received by this provider.

Recommendations

6. Review the $56,490 in payments we identified and recover inappropriate payments.

7. Instruct the ten providers on how to fill out claims when third party insurance does not cover the procedure. Increase monitoring of these providers' future claims to ensure they are properly prepared.

8. Implement a payment control to prevent providers from inputting amounts in the co-insurance field when the claim is 'zero-filled.'

Fraudulent Prescriptions From Kings Pharmacy

Providers should only bill Medicaid for legitimate prescriptions that were actually dispensed to Medicaid recipients. NYCRR Section 504.3 requires pharmacies to prepare and maintain accurate records supporting claim payments for the drugs dispensed. The records must disclose the precise nature and extent of the drugs dispensed and all other pertinent information regarding the claims submitted for payment. Further, our recent audit of claim payments to Kings Pharmacy under the New York State Health Insurance Program identified extensive improprieties and overpayments.

We judgmentally selected a sample of 20 Medicaid prescriptions billed by Kings Pharmacy from the pharmacy's highest billing prescriber. Our sample of 20 prescriptions included 64 claims totaling $35,359 that were billed to Medicaid from June 2008 through July 2010. We obtained copies of the sampled prescriptions and other documentation maintained by Kings Pharmacy. We shared these prescriptions with the prescribing doctor and asked him to verify the authenticity of the signatures. We also reviewed relevant medical charts for our sampled patients to determine whether or not the patients actually received the medications that Kings Pharmacy billed to Medicaid.

We determined that Kings Pharmacy was overpaid $5,044 for 30 of the 64 sampled claims. We concluded that personnel from Kings Pharmacy forged the doctor's signature on prescriptions for 21 claims, and they billed refills that were not dispensed to patients for another 8 claims. For the remaining claim, Kings Pharmacy did not have a prescription on file, nor did the medical charts indicate the patient was receiving the medication that was billed.

We also noted that the Federal Bureau of Investigation (FBI) and the Drug Enforcement Administration (DEA) had investigated Kings Pharmacy and its former owner. The investigations determined that Kings Pharmacy received about $2.5 million in fraudulent payments from Medicare, Medicaid and private insurance from 2006 through mid-2009. Moreover, law enforcement officials required the former owner to surrender his license. In recent years, Medicaid payments to Kings Pharmacy averaged more than $1 million annually. Given the apparent risk of overpayments, we believe the Department should formally consider reviews of payments to Kings Pharmacy that were outside of our judgmental sample. Further, based on the results of a review, the Department should recover any inappropriate payments.

Recommendation

9. Recover the $5,044 in overpayments to Kings Pharmacy we identified. Also, expand the review of this provider, as warranted, and recover any inappropriate payments.

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 engaged in 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 all claims to be reviewed manually before payment. Exclusion from the Medicaid program is immediate if the provider has been terminated or excluded from the Medicare program.

We identified 15 providers with an active status in the Medicaid program and 6 providers with an inactive status (i.e., two or more years of no claims activity and, therefore, required to seek re-instatement from Medicaid to submit new claims) that were either charged with or found guilty of abusing the Medicaid, Medicare, or the private health insurance systems. We advised Department officials of these providers, and the Department promptly terminated eight of them. At the end of our audit fieldwork, the Department was determining the status of the remaining 13 providers. Six of these 13 providers received Medicaid payments totaling $204,515 between April 1, 2010 and September 30, 2010. Consequently, the Department should take prompt actions regarding the future participation of these providers in the Medicaid program.

Recommendation

10. Finalize the determinations of the status of the remaining 13 problem providers relating to their future participation (or non-participation) in the Medicaid program.

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

April 29, 2011

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 2010-S-15 on "Medicaid Claims Processing Activity April 1, 2010 – September 30, 2010."

Thank you for the opportunity to comment.

Sincerely,

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: James Sheehan
Jason A. Helgerson
Robert W. Reed
Diane Christensen
Stephen Abbott
Dennis Wendell
Stephen LaCasse
Mary Elwell
Irene Myron
Lynn Oliver

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2010-S-15
on Medicaid Claims Processing Activity
April 1, 2010, through September 30, 2010

The following are the New York State Department of Health's (Department) comments on the Office of the State Comptroller's (OSC) draft audit report 2010-S-15 on "Medicaid Claims Processing Activity April 1, 2010, through September 30, 2010."

Recommendation #1:

Follow-up with Island Peer Review Organization (IPRO) regarding the out-of-state claim in question and, upon conclusion of IPRO's review, recover any overpayment, as warranted.

Response #1:

The Office of the Medicaid Inspector General (OMIG) will follow-up with IPRO, review any overpayments identified and pursue appropriate recoveries.

Recommendation #2:

Follow-up on the 11 incorrect claims (with overpayments totaling $108,618) that were not adjusted at the time of our review and recover the overpayments, as appropriate.

Response #2:

Of the 11 incorrect claims noted, four totaling $49,490.86 were voided in either September 2010 or January 2011. The remaining seven are being referred to OMIG's third-party contractor for inclusion in the newly-implemented Medicare Part B coinsurance payment integrity initiative, with confirmed Medicaid overpayments recouped as appropriate.

Recommendation #3:

Formally remind the hospitals responsible for the two problematic claims to ensure their alternate level of care (ALC) related claims are properly prepared upon submission to eMedNY. Monitor large ALC-related claims from these providers, as warranted, to help ensure compliance with correct claims processing procedures.

Response #3:

The Department will remind the hospitals as recommended by OSC, referring them to the Billing Guidelines section of the eMedNY Inpatient Provider Manual. In addition, OMIG will monitor large ALC-related claims from these providers, as warranted, to help ensure compliance with correct claims processing procedures.

Recommendation #4:

Implement a control to verify the birth weight category diagnosis code against the birth weight on the claim.

Response #4:

The Department agrees and has initiated the process for developing eMedNY edits to verify the birth weight category diagnosis code against the birth weight on the claim, and to deny the claim whenever the birth weight is under either 1,500 grams or 2,500 grams and specified birth weight category diagnosis codes are present.

Recommendation #5:

Review the 10 incorrect claims we identified and make recoveries or adjustments, as appropriate. Also, follow-up on the 9 claims we were unable to verify because the providers did not provide medical confirmation of birth weights.

Response #5:

The OMIG agrees that there may be overpayments, as well as underpayments, resulting from hospitals' misreporting birth weights on the 19 claims identified by OSC. The OMIG will coordinate with the Department on review of the claims and any inappropriate payments identified will be recovered either through IPRO (via claim resubmission) or through the normal OMIG audit process.

Recommendation #6:

Review the $56,490 in payments we identified and recover inappropriate payments.

Response #6:

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

Recommendation #7:

Instruct the ten providers on how to fill out claims when third party insurance does not cover the procedure. Increase monitoring of these providers' future claims to ensure they are properly prepared.

Response #7:

Once OSC identifies the ten specific providers involved, the Department will coordinate providing the recommended instruction on completing claim forms correctly in situations where

third party insurance does not cover the procedure. Subsequently, the Department will monitor and review the providers' billing patterns as necessary.

Recommendation #8:

Implement a payment control to prevent providers from inputting amounts in the co-insurance field when the claim is "zero-filled."

Response #8:

Version 5010 of the HIPAA standards is planned for eMedNY implementation in July 2011 (EP1312), the functionality of which is expected to accomplish OSC's recommendation.

Recommendation #9:

Recover the $5,044 in overpayments to Kings Pharmacy we identified. Also, expand the review of this provider, as warranted, and recover any inappropriate payments.

Response #9:

The OMIG will recover confirmed overpayments as well as expand review of the provider's claims as warranted. It is additionally relevant to note that Kings Pharmacy's participation in the Medicaid program has been terminated.

Recommendation #10:

Finalize the determinations of the status of the remaining 13 problem providers relating to their future participation (or non-participation) in the Medicaid program.

Response #10:

Three of the 13 providers are currently excluded from participation in the Medicaid program, with OMIG's review of the remaining ten ongoing. Where appropriate, the providers either already have been, or will be, sanctioned timely and in a just and consistent manner.