



New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Medicaid Claims Processing Activity October 1, 2010 through March 31, 2011

Medicaid Program Department of Health



Report 2010-S-65

April 2012

Executive Summary

Purpose of Audit

To determine whether the Department of Health'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 audit covered the period October 2010 through March 2011.

Background

The Department of Health (Department) administers the State's Medicaid program. Medicaid claims are processed and paid by an automated system, eMedNY, which is overseen by the Department. 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. During the six-month period ended March 31, 2011, eMedNY processed approximately 174 million claims resulting in payments to providers of about \$25 billion.

Key Findings

- Auditors identified almost \$6.3 million in overpayments resulting from:
 - claims that were inappropriately billed because of incorrect Medicare information;
 - claims for inpatient stays for high (intensive) levels of care that should have been based on less costly "alternate" levels of care;
 - claims with questionable payments for durable medical equipment rentals;
 - incorrect neonatal claims; and
 - claims with overpayments for transportation and vision care.
- Auditors took steps to recoup or stop more than \$3.2 million of these overpayments. Auditors also found 6 providers who were charged with abusing Medicaid, Medicare or other health insurance systems. The Department promptly terminated 2 of these providers, but the remaining 4 were still under review.

Key Recommendations

- We made 16 recommendations to the Department to recover the remaining inappropriate Medicaid payments and improve controls in the overpayment areas we identified.

Other Related Audits/Reports of Interest

[Department of Health Medicaid Claims Processing Activity: October 1, 2009 through March 31, 2010](#)

[Medicaid Claims Processing for the Six Months Ended September 30, 2009](#)

[Medicaid Claims Processing Activity](#)

[Medicaid Claims Processing for the Six Months Ended September 30, 2008](#)

**State of New York
Office of the State Comptroller**

Division of State Government Accountability

April 18, 2012

Nirav 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 Medicaid Program entitled *Medicaid Claims Processing Activity October 1, 2010 through March 31, 2011*. 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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Background

The Department of Health's (Department's) Office of Health Insurance Programs 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, 2011, eMedNY processed approximately 174 million claims resulting in payments to providers of about \$25 billion. The claims are processed and reimbursed in weekly cycles which averaged about 6.7 million claims and \$957 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 performs audit steps during each weekly cycle of eMedNY processing to determine whether eMedNY has reasonably ensured 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, our auditors work with Department staff to resolve the exceptions in a timely manner so 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 the Comptroller'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 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, 2011, we concluded eMedNY reasonably ensured 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 found overpayments pertaining to claims with inaccurate Medicare data, hospital claims for days of alternate levels of care, claims for durable medical equipment rentals, and neonatal claims with incorrect birth weights and patient discharge status codes. In total, we identified net actual and potential overpayments of approximately \$6.3 million. At the time our audit fieldwork concluded, about \$3.2 million of these overpayments were recovered. Further, we concluded the Department needs to take actions regarding certain providers who abused the Medicaid program.

Medicare-Related Claims

Many Medicaid recipients also have Medicare coverage. These recipients are called “dual eligibles.” When billing for a dual eligible person, 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, copayments and deductibles. If the recipient or the 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 on 217 claims for dual eligible recipients that resulted in \$2.9 million in incorrect and questionable payments. At the time our fieldwork concluded, 198 (of the 217) claims were corrected for a savings of \$2,357,580 and additional adjustments were still needed for 19 (of the 217) claims, corresponding to payments totaling \$534,297.

Specifically, we identified 158 claims with the wrong primary insurer. For 146 of these claims, Medicare was designated as the primary insurer when it should have been Medicaid. In some cases, the provider was not certified by Medicare at the time services were rendered, and thus, the claims should have been billed with Medicaid as the primary payer. In other cases, the recipients’ Medicare coverage began after the dates of service, and again, Medicaid should have been the primary payer. Nonetheless, providers submitted claims as though Medicare was the primary payer - and the coinsurance amounts charged to Medicaid were greater than the amounts Medicaid would have normally paid as the primary payer. We contacted the providers and notified them of the incorrect designations of Medicaid as the secondary payer. At the time of our review, the providers adjusted 144 of the 146 claims, resulting in Medicaid savings totaling \$470,531. At the time our fieldwork concluded, adjustments were still needed for the two other claim payments that totaled \$9,738.

For the remaining 12 (of the 158) claims, Medicaid was incorrectly designated as the primary payer, when the primary payer was actually Medicare. Generally, primary payers pay more than secondary payers. We contacted the providers and advised them that the recipients had Medicare coverage when the services were provided, and therefore, Medicaid was incorrectly designated as the primary payer. At the time of our review, the providers adjusted 8 of the 12 claims, which saved Medicaid \$202,007. At the time our fieldwork concluded, adjustments were still needed for the remaining 4 claims, which totaled \$336,403.

In addition, we identified 59 other claims that had incorrect Medicare HMO information (including excessive amounts for coinsurance, copayments and deductibles) which caused overpayments. We contacted the providers and notified them of the incorrect claim information. At the time of our review, the providers adjusted 46 of the 59 claims, which saved Medicaid \$1,685,042. At the time our fieldwork concluded, adjustments were still needed for 13 (of the 59) claims, which Medicaid paid \$188,156. For many of these claims, the providers acknowledged problems with their billing systems and resulting payment data. Further, as a result of our audit, providers are working to correct these problems.

Also, many claims we reviewed were subjected to the eMedNY edit, "Medicare/MCO Payer Amounts Not Reasonable." However, we determined the edit is "set to pay" (as opposed to pend or deny) a claim. For instance, one of the improper claims was for an office visit that paid \$99,210 (when it should have paid only \$17.14). The overpayment likely occurred because the provider posted the procedure code (99213) in the field for the copayment amount - and, therefore, the copayment due was reported as \$99,213. Because the eMedNY edit to assess the reasonableness of the Medicare-related data was set to pay such claims, a significant overpayment was made.

Recommendations

1. Follow up on the 19 incorrect claims totaling payments of \$534,297 that were not adjusted at the time of our review and recover the overpayments, as appropriate.
2. Review the effectiveness of the edit that is designed to test the reasonableness of Medicare amounts and implement an eMedNY control to pend or deny claims with unreasonable Medicaid payment amounts.

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 \$2,281,971 in overpayments on claims for inpatient stays that Medicaid overpaid because providers billed at a higher level of care than what was actually provided.

Medicaid pays inpatient claims using two reimbursement methods: Diagnosis Related Groups (DRG) and DRG-exempt per diem (daily) rates. When we analyzed DRG claims, we identified \$397,502 in overpayments on four claims because providers failed to declare ALC days. For example, one claim paid \$815,419 for 393 days of acute psychiatric care. At our request, the provider reviewed and corrected the claim based on a physician's order for lower-cost ALC for the patient. This reduced the amount of acute psychiatric care claimed by 166 days (or to 227 days). The adjusted claim paid \$471,007, resulting in a savings to Medicaid of \$344,412. We asked providers to review the remaining three DRG claims, and they also identified ALC days which were not reported on the original claims. Two claims were corrected resulting in a total savings of \$50,064. The last claim with an estimated \$3,026 in savings had not been adjusted at the time our fieldwork concluded.

We also tested payments based on DRG-exempt per diem (daily) rates and identified overpayments of \$282,228 on 3 claims. Although the providers indicated some of the days claimed were for ALC, they billed (and eMedNY paid) them at higher-paying acute care rates. At our request, the providers reviewed and corrected the claims, which saved Medicaid \$282,228.

Because of the risk that eMedNY does not recognize 'provider indicated' ALC days on DRG-exempt per diem claims, we expanded our review of such claims. We analyzed claims with patient admission dates on or after January 1, 2006 that were billed to one of three acute care per diem rate codes: codes 2853 and 2848 (for rehabilitation care); and code 2852 (for psychiatric care). We then analyzed claims with ALC indicators sometime during the dates of service (excluding claims with third party insurance payments). We identified 138 claims that paid over \$3.4 million for review. We applied the correct reimbursement rates to the 138 claims' ALC days and determined they were overpaid by \$1,602,241.

A lack of formal Department guidance might have contributed to this problem. Department officials had no formal guidance for providers to use to ensure care levels on DRG-exempt per diem claims were correct. According to a provider we contacted, the Medicaid guidance on this matter was not adequate. Therefore, the Department should assess the need for formal guidance on this matter and publish such guidance timely.

Recommendations

3. Recover the \$1,605,267 (\$3,026 + \$1,602,241) in overpayments from the DRG-exempt per diem claims and the DRG claim we identified with issues related to ALC.
4. Expand the review of inpatient claims billed as DRG-exempt per diem (daily) rates that are at risk of having ALC segments during the inpatient stay, and recover any additional overpayments.
5. Correct the eMedNY control weakness that allows DRG-exempt per diem claims to be paid at excessive rates (for acute and other non-ALC care) when ALC is indicated on a claim.
6. Issue a Medicaid Update instructing providers how to correctly bill DRG-exempt per diem claims, particularly those including days of ALC.

Durable Medical Equipment Rentals

Durable medical equipment (DME) refers to equipment that can withstand repeated use for an extended period of time. Usually, DME is not fitted, designed or fashioned for a particular individual's use; however, when DME is intended for use by only one patient, it may be either custom-made or customized. DME can be rented when a recipient needs equipment on a short-term basis or to determine whether the equipment is appropriate for the recipient prior to purchase. According to the Medicaid DME Manual, the total accumulated monthly rental charges may not exceed the actual purchase price of a DME item. Further, all DME rental payments (including those from Medicare and other third parties) must be deducted from the purchase price when billing Medicaid. DME is generally considered purchased at the tenth consecutive month of the rental period, when the rental payments would equal the item's purchase price.

For the five-year period ending November 2010, we analyzed payments for nine forms of DME to determine if rental payments exceeded the related purchase prices. The selected DMEs included nutrition infusion pumps, bed and air mattresses, breathing devices, and wheelchairs. We identified \$1.1 million in DME rental payments for 748 recipients (or 12,710 claims) for review because of the high risk that they exceeded the purchase prices of the items in question. In the aggregate, the Medicaid payments exceeded the purchase prices of the selected items by \$289,000 (or 26 percent of the \$1.1 million paid). Moreover, many of the payments we reviewed were for dual eligible persons. When we deducted the Medicare payments reported on the claims from the cost of the DME items, we found that the Medicaid paid \$625,000 (57 percent) more than necessary for them.

We determined there is no edit to deny DME payments when the Medicaid Fee Schedule Purchase Price has been met. We found 449 of the 748 recipients in our sampled claims (who represented 84 percent of the overpayments we identified) rented DMEs for more than 10 consecutive months (monthly rental fees are generally 10 percent of the purchase price; at 10 months, the rental payments equal the purchase price).

For example, beginning in February 2007, Medicaid paid a provider \$396.17 (per month) to rent a powered pressure-reducing air mattress. Through November 2007 (after 10 months of rent), the total payments equaled the mattress's purchase price of \$3,962, and as such, Medicaid should have determined the mattress to have been purchased. However, using a claim modifier code, the provider charged Medicaid rent for 34 additional months (from January 2008 through October 2010) at \$396.17 per month - resulting in excessive payments totaling \$13,470.

Moreover, we determined that the use of modifier codes enabled claims for DME rentals to bypass certain eMedNY system edits. In 227 instances, providers double-billed Medicaid (a total of \$44,182) by using a modifier code to bypass system edits designed to prevent duplicate payments. In these instances, providers submitted one DME claim without a modifier code and second claim (for the same recipient, DME item and date) with a modifier. We concluded that eMedNY did not compare claims with a modifier code to claims without the modifier for the same recipient, DME item and date.

Also, Medicaid allows the rental of DME for up to four months without prior approval. DME rentals of more than four months must have prior approval. However, eMedNY does not deny DME rental claims of more than four months - when there is no prior approval - if a modifier code is added to the claim. We identified 174 DME rental claims (paying \$241,000) with a modifier that exceeded the four-month limit without prior approval. The Medicaid system does not have a control in place to force a provider to get prior approval after the fourth month of rental payments when a modifier code is used.

Recommendations

7. Review the \$625,000 in problematic payments we identified and recover overpayments as warranted.
8. Develop and implement eMedNY controls to prevent: payments for DME rental fees which exceed the purchase price of equipment; and the double-billing of DME claims through the use of modifiers.
9. Strengthen the prior approval process and controls to force a provider to get prior approval after the fourth month of rental payments.

Incorrect Data on Neonatal Claims

Medicaid bases payments for inpatient neonatal (newborn) services on several factors, including (but not limited to) birth weight and patient status code (i.e., discharge home or transfer to another hospital). Incorrect claim data for either the birth weight or discharge status code can result in excessive Medicaid payments to providers. We identified 37 problematic newborn claims which resulted in potential overpayments totaling \$454,698. At the time our fieldwork concluded, adjustments were made on 2 of the 37 claims, saving Medicaid \$112,410. The Department needed to take actions on the remaining 35 questionable claims with potential overpayments totaling \$342,288.

For 28 (of the 37) newborn claims, the birth weights appeared to be incorrect and resulted in a potential net overpayment of \$203,166. We contacted one provider who agreed the birth weight was incorrect. This provider adjusted the claim for a savings of \$90,823. The remaining 27 claims, with a potential overpayment of \$112,343, were forwarded to the Department for review and recovery, as appropriate.

We also identified 9 newborn claims that appeared to have incorrect patient (discharge) status codes resulting in a potential net overpayment of \$251,532. For example, one inpatient claim had a patient status code of '01' (discharge to home) that paid \$152,253. However, the patient was actually transferred to another hospital (and not discharged home). The provider corrected the claim and changed the patient status code to '02' (transfer to a hospital). The adjusted claim paid \$130,666, saving Medicaid \$21,587. We provided details of the remaining 8 claims, with potential overpayments totaling \$229,945, to the Department for further review.

The eMedNY system relies on provider-submitted information to properly process claims. Moreover, on multiple occasions, we have reported on weaknesses in eMedNY's processing of neonatal claims in the past. Consequently, Department officials should take prompt and effective steps to improve eMedNY controls (either manual and/or automated) to prevent such overpayments in the future.

Recommendations

10. Review the remaining 35 questionable claims we identified (with potential overpayments totaling \$342,288) and recover overpayments, as appropriate.
11. Design and implement adequate eMedNY controls to prevent overpayments of neonatal claims, such as those identified in this report.

Inappropriate Transportation Billings

According to the Medicaid Transportation Manual, reimbursements will be made only when: transportation services are actually rendered; transportation is to or from covered services; acceptable records (verifying a trip's occurrence) are complete and available. Further, supporting documentation for transportation claims must include: the Medicaid recipient's name and identification number; the origination of the trip and time of pickup; the destination of the trip and time of drop off; the vehicle license plate number; and the full printed name of the driver providing the transportation.

We reviewed 162 transportation claims totaling \$26,895 for services provided to a recipient and found 98 (60 percent) of them were improper. The improper claims were submitted between June 14, 2010 and January 28, 2011 and totaled \$12,495. The following summarizes the improper payments:

- 35 claims (that paid \$5,470) had no trip records to document the transportation service. Further, 25 (of the 35) claims did not have a corresponding medical service based on the records from medical facility that purportedly treated the recipient;
- 33 claims (that paid \$5,460) had no record of a corresponding medical service based on the records from the facility that purportedly treated the recipient; and
- 30 claims were paid based on an incorrect recipient address. As a result, the claims were overpaid by about \$50 each - for a total overpayment of \$1,565. The correct recipient address was closer to the destination medical facility and the provider was reimbursed for a longer trip than what was actually performed.

The transportation provider did not keep trip records that met the Department's prescribed requirements. Also, the prior authorization agent at the local county social service district office did not recognize the recipient's address change timely (nor did the provider notify the prior authorization agent of the recipient's address change). This caused prior authorizations with the incorrect address to be issued and then used for claim submission. This provider was previously

cited by us in a prior audit. As a result, the OMIG has been in contact with this provider to correct problems identified by our office and repay improper claims.

Recommendations

12. Review the 98 improper claims totaling \$12,495 and recover overpayments, as appropriate.
13. Formally notify the provider of the requirement to keep complete and verifiable records, as prescribed by the Department.

Inappropriate Vision Care Claims

Although Medicaid pays for routine vision care services (such as eyeglasses and routine eye exams), 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 14 vision care providers who often indicated to Medicaid that Medicare paid nothing, and they requested reimbursements for coinsurance which were higher than the amounts allowed by Medicaid fee schedules. We reviewed supporting documentation (such as Explanations of Benefits or EOBs) for 23 claims that paid \$7,330 and found overpayments totaling \$4,196.

We contacted six of the providers about the incorrect claims. Three providers acknowledged their claims were incorrect. Two providers stated they did not bill and were not paid by Medicare; and therefore, they did not have an EOB. A representative of the remaining provider did not understand the issue, and consequently, did not agree that Medicaid overpaid the claims in question. Moreover, at the time our fieldwork concluded, none of the overpayments (of \$4,196) were adjusted or recovered.

In addition, we have reported on control weaknesses in the processing of vision care claims for dual eligible recipients in the past, and as a result, the Department is taking steps to enhance eMedNY controls to help prevent overpayment of such claims in the future.

Recommendations

14. Recover the \$4,196 overpayments we identified.
15. Instruct the 14 providers on proper claim preparation when third party insurance does not cover the procedure in question. Increase monitoring of these providers' future claims to ensure they are properly prepared.

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 two providers with an active status in the Medicaid program and four 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 private health insurance systems. We advised Department officials of these providers, and the Department promptly terminated two of them. At the end of our audit fieldwork, the Department was determining the status of the remaining four providers. The Department should move expeditiously to take actions (including sanction or program termination), as warranted, regarding these providers.

Recommendation

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

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, 2010 through March 31, 2011.

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 actions are planned or have been taken to address them. According to officials, the Office of the Medicaid Inspector had recovered nearly \$863,000 through actions, subsequent to the completion of our audit fieldwork, that have already been taken. Also, certain other matters were considered to be 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 the Department 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

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

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

NEW YORK
state department of
HEALTH

Sue Kelly
Executive Deputy Commissioner

December 8, 2011

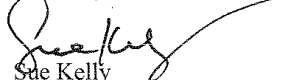
Brian E. Mason, Audit Director
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110 State Street – 11th Floor
Albany, New York 12236

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-65 on "Medicaid Claims Processing Activity October 1, 2010 through March 31, 2011."

Thank you for the opportunity to comment.

Sincerely,



Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: James C. Cox
Jason A. Helgeson
Robert W. Reed
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Department of Health
Comments on the Office of the State Comptroller's
Draft Audit Report 2010-S-65
on Medicaid Claims Processing Activity
October 1, 2010 through March 31, 2011

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2010-S-65 on "Medicaid Claims Processing Activity October 1, 2010 through March 31, 2011."

Recommendation #1:

Follow up on the 19 incorrect claims totaling payments of \$534,297 that were not adjusted at the time of our review and recover the overpayments, as appropriate.

Response #1:

The Office of the Medicaid Inspector General (OMIG) has recovered \$471,171 relative to 10 of the 19 claims identified by OSC, and has referred the 9 remaining claims to its Third Party Contractor for follow-up. Further recoupments will occur as warranted. It is relevant to note that besides the claims identified by OSC, OMIG's contractor recovered an additional \$391,510 relative to 24 Medicare Part C claims with dates-of-service within the OSC review period. The Department will follow-up with OMIG on these overpayments and evaluate how they can be avoided in the future.

Recommendation #2:

Review the effectiveness of the edit that is designed to test the reasonableness of Medicare amounts and implement an eMedNY control to pend or deny claims with unreasonable Medicaid payment amounts.

Response #2:

System changes scheduled for implementation on December 29, 2011 are expected to prospectively prevent the type of billing error identified by OSC. Medicaid reimbursements to hospital outpatient departments and diagnostic and treatment centers for services provided to dual eligibles will be limited so that combined Medicaid/Medicare reimbursements do not exceed that which Medicaid would pay for the service in Medicaid-only cases. Additionally, new pre-adjudication edits will deny claims which are incompatible with pricing edits.

Recommendation #3:

Recover the \$1,605,267 (\$3,026 + \$1,602,241) in overpayments from the DRG-exempt per diem claims and the DRG claim we identified with issues related to ALC.

Response #3:

The OMIG will review the overpayments identified by OSC and pursue recoveries as warranted.

Recommendation #4:

Expand the review of inpatient claims billed as DRG-exempt per diem (daily) rates that are at risk of having ALC segments during the inpatient stay, and recover any additional overpayments.

Response #4:

The OMIG will expand the review of such claims and recover any additional overpayments as warranted. Additionally, the Department will consider this OSC recommendation in updating the claims selection criteria utilized by its quality assurance review contractor, Island Peer Review Organization (IPRO). Potential changes to the selection criteria will be weighed in context to the universe of contracted inpatient claims review and the relative risk and cost-effectiveness of each review.

Recommendation #5:

Correct the eMedNY control weakness that allows DRG-exempt per diem claims to be paid at excessive rates (for acute and other non-ALC care) when ALC is indicated on a claim.

Response #5:

The Department has initiated development of an eMedNY evolution project to prevent these overpayments.

Recommendation #6:

Issue a Medicaid Update instructing providers how to correctly bill DRG-exempt per diem claims, particularly those including days of ALC.

Response #6:

The Department will include guidance on the proper billing for per diem stays in the Billing Guidelines section of the Inpatient Provider Manual. When finalized, the guidance will be reinforced via a Medicaid Update article.

Recommendation #7:

Review the \$625,000 in problematic payments we identified and recover overpayments as warranted.

Response #7:

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

Recommendation #8:

Develop and implement eMedNY controls to prevent: payments for DME rental fees which exceed the purchase price of equipment; and the double-billing of DME claims through the use of modifiers.

Response #8:

The Department has researched and developed eMedNY utilization review edits limiting cumulative rental or purchase payments for equipment over its useful life to the total purchase price of the equipment. These edits have been set to deny status as of December 8, 2011, with providers notified via the eMedNY website.

Recommendation #9:

Strengthen the prior approval process and controls to force a provider to get prior approval after the fourth month of rental payments.

Response #9:

The Department will monitor and assess the impact of the new utilization review edits noted above, as well as finalize a separate eMedNY evolution project enhancing control over the payment and reporting of certain claims. The resultant data will be utilized to evaluate whether further strengthening of prior approval and controls, such as recommended by OSC, is warranted.

Recommendation #10:

Review the remaining 35 questionable claims we identified (with potential overpayments totaling \$342,288) and recover overpayments, as appropriate.

Response #10:

The OMIG will coordinate with the Department on review of the claims and the recovery of overpayments as warranted, either through the Department's contract with IPRO or through an OMIG audit process.

Recommendation #11:

Design and implement adequate eMedNY controls to prevent overpayments of neonatal claims, such as those identified in this report.

Response #11:

The Department acknowledges the concerns of OSC and the recommendation that the overpayment of neonatal claims should be prevented. Controlling this problem from a claim system perspective is problematic since the patient status field is reported by the provider and at this point in time the Department has not been able to identify a way of systematically validating its accuracy. If the Department is able to identify a systematic fix, it will pursue the feasibility of implementing necessary changes.

Recommendation #12:

Review the 98 improper claims totaling \$12,495 and recover overpayments, as appropriate.

Response #12:

Following OMIG review, a warning letter was issued in August 2011 for unacceptable practices and filing false claims, and the case was closed as of September 20, 2011.

Recommendation #13:

Formally notify the provider of the requirement to keep complete and verifiable records, as appropriate.

Response #13:

On November 14, 2011, the Department formally notified the provider of the requirement to keep complete and verifiable records.

Recommendation #14:

Recover the \$4,196 overpayments we identified.

Response #14:

The OMIG will review the overpayments identified and pursue recovery as warranted.

Recommendation #15:

Instruct the 14 providers on proper claim preparation when third party insurance does not cover the procedure in question. Increase monitoring of these providers' future claims to ensure they are properly prepared.

Response #15:

The Department will ensure that the 14 providers are instructed on proper claim preparation when third party insurance does not cover the procedure in question, and will coordinate with OMIG on monitoring these providers' future claims.

Recommendation #16:

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

Response #16:

The OMIG has excluded two of the providers and is in the process of excluding another. The Department terminated enrollment of the two excluded providers as of October 2011, and will terminate a third once OMIG finalizes its actions. Regarding the final provider, OMIG has been unsuccessful in obtaining court documents from the State of Florida. The OMIG will take action on this provider if and when the Office of Professional Medical Conduct takes an action. It should be noted that the final provider is currently in "inactive" status in New York State and has not generated any billing or ordered services to the Medicaid program since 2008.