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

Division of State Government Accountability

Overpayments of Claims for Selected Professional Services

Medicaid Program

Department of Health

Report 2010-S-73 April 2012

Executive Summary

Purpose

To determine whether inappropriate Medicaid payments were made for selected providers who also received payments from Medicare. The audit primarily covers the period January 2010 – December 2011. We also reviewed certain claim payments and records for the period January 2006-December 2009.

Background

On December 3, 2009, the Department implemented an automated Medicare/Medicaid crossover system. It was designed to reduce problems with processing and paying claims involving Medicare, which have historically caused significant Medicaid overpayments. Prior to the crossover system, Medicaid relied on providers to self-report accurate information to eMedNY (Medicaid's claims processing and payment system) regarding how much Medicare paid and how much Medicaid owed for deductibles and coinsurance. With the new crossover system, providers no longer need to submit separate claims to both Medicare and Medicaid for services to individuals with both Medicare and Medicaid coverage. Rather, providers bill claims directly to Medicare. Medicare reimburses its portion to the provider and then the provider's claim information is automatically forwarded (crossed over) to eMedNY for the payment of deductible and coinsurance amounts.

Key Findings

- Although the Department implemented the new automated crossover system in December 2009 to reduce Medicaid overpayments, it was flawed. As a result, we identified potential and actual overpayments of $100,387 for 12,715 duplicate claims that were billed by selected professional services such as podiatrists, physical therapists and occupational therapists during the calendar years 2010 and 2011.
- We tested $6,794 (of the $100,387) in payments for 663 apparent duplicate claims billed between January 12, 2010 and August 9, 2010 by one podiatrist. In all instances, the Department paid both the podiatrist and the podiatrist's medical group for the same services. This occurred because redundant claims for the same service were submitted through the crossover system under the podiatrist's group provider identification number and then also billed directly to Medicaid using the provider's individual identification number.

Key Recommendations

- Correct the flaw in the eMedNY claims processing system that allows duplicate payments of Medicare/Medicaid crossover claims submitted by medical groups and their individual providers.
- Review the $100,387 in duplicate payments and recover funds where appropriate.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Payments for Medicare Part A Beneficiaries (2009-S-36)
Department of Health: Medicaid Payments for Dual Eligible Individuals (2009-S-64)

State of New York
Office of the State Comptroller

Division of State Government Accountability

April 20, 2012

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 Medicaid Program; entitled *Overpayments of Claims for Selected Professional Services*. 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 New York State Medicaid program is a federal, State, and locally funded program which provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. In recent years, Medicaid enrollments and costs have grown significantly. For the fiscal year ended March 31, 2011, New York Medicaid had more than 5 million enrollees and costs totaled approximately $53 billion. The federal government funds about 49 percent of New York's Medicaid costs; the State funds about 34 percent; and the localities (the City of New York and counties) fund the remaining 17 percent.

The Department of Health (Department) administers the Medicaid program in New York State. Many of the State's Medicaid beneficiaries are also eligible for Medicare. Such beneficiaries are referred to as "dual eligibles." Medicaid is the payer of last resort for medical claims, paying for any balance unpaid after all other insurance, such as Medicare, settles. Therefore, a medical provider should bill Medicare first for these dual eligible patients, and Medicaid should be billed only after the amount to be paid by Medicare is known. Medicaid will typically pay an amount based upon the portion of the bill not covered by Medicare.

Each week, the Department's Medicaid claims processing system, called eMedNY, uses automated controls or "edits" to detect and prevent inappropriate Medicaid claims from being paid. To detect duplicate claims, these edits check and compare information on Medicaid claims such as the physician's unique provider identification number, the medical service provided and the date of the service.

On December 3, 2009, the Department implemented an automated Medicare/Medicaid crossover system which was designed to reduce long-standing problems with processing and paying Medicaid claims for dual eligibles. These problems have resulted in significant Medicaid overpayments. Prior to the crossover system, Medicaid relied on providers to self-report accurate information to eMedNY regarding how much Medicare paid and how much Medicaid owed for deductibles and coinsurance. With the new crossover system, providers no longer need to submit separate claims to both Medicare and Medicaid for services to dual eligible persons. Rather, providers submit claims directly to Medicare. Medicare pays its portion to the provider, and the provider's claim information is then automatically forwarded (crossed over) to eMedNY for payment of deductible and coinsurance amounts.

Audit Findings and Recommendations

Payments of Duplicate and Unsupported Claims

Although the Department implemented a new automated crossover system in December 2009 to reduce certain Medicaid overpayments, we found it was flawed. As a result, we identified potential and actual overpayments of $100,387 for 12,715 duplicate claims over the two years from January 2010 through December 2011. Since we did not review all provider claim types, we believe there is a strong potential the Department made more overpayments and will continue to do so until corrective action is taken.

Under the crossover process, when a provider submits a claim to Medicare for a dual eligible person, Medicare pays the claim, applies the appropriate deductible or coinsurance amount, and then automatically forwards (crosses over) the claim to eMedNY. However, we determined that providers can submit separate claims directly to Medicaid for dual eligible recipients, thereby circumventing the crossover system's edit controls. As a result, we identified 12,715 duplicate claims, billed in 2010 and 2011, for selected professional services such as podiatrists, physical therapists and occupational therapists. In each case, both the provider and the provider's affiliated medical group received Medicaid payments for the same service. One party billed Medicare and received a payment through the crossover system, and the other billed Medicaid directly and received a second payment - resulting in overpayments totaling $100,387.

We determined the Department needs to fix a gap in eMedNY that allows certain crossover claims to be paid twice. System edits are used to detect duplicate claims when one claim is billed as part of the automated crossover system and a second claim is submitted directly to eMedNY for payment. However, the edits did not prevent the duplicate claim payments we identified because each duplicate claim contained a different 'entity' (or provider) identification number. More specifically, the individual provider claims had identification numbers that differed from the identification numbers of their affiliated medical groups. However, because eMedNY system edits prevent a duplicate payment only when the entity identification number is the same on two or more redundant claims, eMedNY made duplicate payments for the services in question.

For example, a podiatrist billed separate claims to both Medicare and Medicaid for nail debridement services provided on January 12, 2010 to a dual eligible recipient. One claim was billed under the podiatrist's group identification number to Medicare; and the second claim was billed to eMedNY under the podiatrist's individual identification number. Medicare approved the $42.87 service, but did not pay the claim because the recipient's Medicare deductible had not been met. Medicare automatically crossed over the claim to eMedNY for processing, and eMedNY paid $42.87 to the podiatrist's group practice. In the meantime, the podiatrist submitted a separate (duplicate) claim, under his individual identification number, to eMedNY for the same service, and eMedNY paid another $42.87 for the service.

This podiatrist was paid a total of $6,794 for 663 duplicate claims billed between January 12 and August 9, 2010. In all of these instances, the Department paid both the podiatrist and

the podiatrist's medical group for the same services. We note that each week, eMedNY sends all providers Medicaid payment remittances showing which claims were paid or rejected, and related patient information such as the recipient's name, services provided and service dates. The podiatrist received this and duplicate payments, but still claimed he was unaware of the duplicate payments. We provided the Office of the Medicaid Inspector General with detailed information about the 663 duplicate Medicaid claims for their investigation and recovery of the $6,794 in Medicaid overpayments.

In addition to the issue of duplicate payments, we also site visited this podiatrist to test his supporting documentation for nail debridement services. From a sample of 199 claims (totaling $1,974) billed between January 6, 2006 and December 31, 2010, we found the podiatrist could not provide support for 18 claims (9 percent of the sample) totaling $260. Medicaid rules and regulations require all providers to maintain medical records for a period of six years and to furnish any medical record to Medicaid oversight agencies upon request. However, the podiatrist told us he did not keep the required records. Instead, the podiatrist relied on the nursing homes where his patients lived to maintain the medical records necessary to support his Medicaid claims.

We visited the two nursing homes where the podiatrist provided the services in question and determined that the homes could not provide documentation for the 18 unsupported claims. According to Department officials, since the podiatrist billed the Medicaid program directly, the podiatrist was responsible to document and ensure the medical records were available for audit. Hence, we recommend the Department recover the $260 in unsupported Medicaid claims. We also reviewed samples of claim payments for two other podiatrists and determined that the payments were adequately supported by the available medical records.

Recommendations

1. Correct the flaw in the eMedNY claims processing system that allows duplicate payments of Medicare/Medicaid crossover claims submitted by medical groups and their individual providers.

2. Review the $93,593 in potential duplicate payments we identified and recover where appropriate.

3. Recover the $6,794 in duplicate payments from the podiatrist. Review all claims for the podiatrist where there was no supporting documentation and recover payments, as appropriate.

4. Remind providers they should not rely on nursing homes to maintain their medical records and other documentation to support their Medicaid claims.

Audit Scope and Methodology

The objective of our audit was to determine whether Medicaid overpayments were made for selected professional services. Our audit primarily covered the period from January 2010 through December 2011. We also reviewed certain claim payments and records for the period January 2006 through December 2009.

To accomplish our objective, we interviewed officials from the Department and the Office of the Medicaid Inspector General. We reviewed applicable sections of federal and State regulations, and examined the Department's relevant Medicaid policies and procedures.

We reviewed claims billed by podiatrists, physical therapists and occupational therapists during calendar years 2010 and 2011 that appeared to be duplicative. We also analyzed and examined Medicaid claim payments for nail debridements (to reduce toe nail thickness and length) submitted by all podiatrists participating in Medicaid during the five years ending December 31, 2010. To determine if Medicaid payments for nail debridements were appropriate, we judgmentally selected 350 claims from the top three providers of such services for review. We also site visited the offices of the three podiatrists and examined medical records supporting the selected claims.

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 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 concurred with our recommendations and indicated that certain actions are planned or have been taken to address them.

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

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Vision

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

Agency Comments

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

March 15, 2012

Brian E. Mason, Audit Director
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 Office of the State Comptroller Draft Audit Report 2010-S-73 on "Overpayments of Claims for Selected Professional Services."

Thank you for the opportunity to comment.

Sincerely,

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: James C. Cox
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Department of Health
Comments on the Office of the State Comptroller's Draft Audit Report 2010-S-73 on Overpayments of Claims for Selected Professional Services

The following are the Department of Health's (Department) comments in response to Office of the State Comptroller (OSC) Draft Audit Report 2010-S-73 on "Overpayments of Claims for Selected Professional Services."

Recommendation #1:

Correct the flaw in the eMedNY claims processing system that allows duplicate payments of Medicare/Medicaid crossover claims submitted by medical groups and their individual providers.

Response #1:

This issue is being addressed as part of the Office of Medicaid Inspector General's (OMIG) Medicaid Redesign Team (MRT) Project 154-8 (Medicare Coordination of Benefits with Provider Submitted Duplicate Claims) and Evolution Project 1625 which should address most of these claims. The OMIG will continue to monitor for further system weaknesses and will recommend additional changes as appropriate.

Recommendation #2:

Review the $93,593 in potential duplicate payments we identified and recover where appropriate.

Recommendation #3:

Recover the $6,794 in duplicate payments from the podiatrist. Review all claims for the podiatrist where there was no supporting documentation and recover payments, as appropriate.

Responses #2 and #3:

Under the above noted MRT and evolution projects, crossover claims, including those identified by OSC in this audit, will be monitored for duplicate payments and recovered as necessary.

Recommendation #4:

Remind providers they should not rely on nursing homes to maintain their medical records and other documentation to support their Medicaid claims.

Response #4:

The Department will include an article in the May 2012 edition of its monthly Medicaid Update provider publication reminding podiatrists to maintain medical records and other documentation in support of their claims.