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September 26, 2012

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

Re: Report 2012-F-8

Dear Dr. Shah:

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, we have followed up on the actions taken by officials of the Department of Health (Department) to implement the recommendations contained in our audit report, *Medicaid Claims Processing Activity April 1, 2009 through September 30, 2009* (Report 2009-S-21).

Background, Scope and Objective

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

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

The Office of the State Comptroller (OSC) performs audit steps during each weekly cycle of eMedNY processing to determine whether eMedNY has reasonably ensured that the Medicaid claims were processed in accordance with requirements, the providers submitting the claims were approved for participation in the Medicaid program, and the amounts paid to the providers

were correct. As audit exceptions are identified during the weekly cycle, OSC auditors work with Department staff to resolve the exceptions in a timely manner so that payments can be made to providers. If necessary, payments to providers can be suspended until satisfactory resolution of the exceptions has been achieved.

Our initial audit report, which was issued on September 23, 2010, examined whether the Department's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to the providers. For the six-month period ended September 30, 2009, we concluded that, overall, the 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. However, we also identified reportable conditions that caused about $4.5 million in overpayments. Specifically, we identified:

- An eMedNY control weakness which allowed reimbursement of vision care services over the allowable Medicaid limits. Ten providers exploited this weakness and repeatedly billed for excess services;
- A complex inpatient claim for an 11-year hospital stay that resulted in excess payments of about $2.6 million;
- A hospital that submitted claims for hemophilic blood products at costs that exceeded the limits of the federal 340B Drug Pricing Program, resulting in overpayments of about $1 million;
- 11 neonatal claims that had incorrect birth weights, resulting in overpayments of $495,485; and
- Claims with incorrect Medicare information that resulted in overpayments of $293,807.

During the initial audit, about $4.4 million of the $4.5 million in overpayments was recovered. The objective of our follow-up was to assess the extent of implementation, as of June 30, 2012, of the 11 recommendations included in our initial report.

Summary Conclusions and Status of Audit Recommendations

Department officials made some progress in addressing the problems we identified in the initial audit. However, further actions are still warranted. Of the eleven prior audit recommendations, six were implemented, and five were partially implemented.

Follow-up Observations

Recommendation 1

Recover the $38,298 in vision care overpayments.

Status - Partially Implemented

Agency Action - On June 4, 2012, the Office of the Medicaid Inspector General (OMIG) issued warning letters to the providers identified in our initial audit. The letters included the

details of the Medicaid violations noted in our initial report and instructed the providers to review their claims and return (or "self-report") overpayments to the OMIG, along with explanations for any overpayments. However, at the time of our follow-up, the providers had not yet returned any of the overpayments we identified.

Recommendation 2

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

Status - Partially Implemented

Agency Action - As noted previously, the OMIG sent warning letters to the providers which instructed them to review their claims and return any overpayments. The warning letters also informed the providers that OMIG might audit this issue if the providers did not take sufficient actions to address the problems identified by our initial audit. At the time of our follow-up, however, the OMIG had not formally assessed or recovered any of the payments (totaling $3.2 million) in question.

Recommendation 3

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

Status - Implemented

Agency Action - OMIG officials chose not to remove the ten providers from the Medicaid program. However, officials formally warned the providers that they may have violated Medicaid rules and regulations. Officials further noted that repeat violations would result in disciplinary actions and that corrective actions should be taken to prevent such violations in the future. OMIG officials also determined that it was not necessary to refer any provider employees to the State Education Department.

Recommendation 4

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

Status - Partially Implemented

Agency Action - The Department initiated a project to design a new eMedNY system edit to enforce compliance with the two-year frequency limit on vision care services. The edit will compare a submitted vision care claim to other paid vision care claims for the same recipient. If two years have not elapsed since the recipient's most recent vision care service, the service may not be covered by Medicaid (even if the claim is from a different

provider). In addition to the edit, the Department is pursuing development of a mechanism (using the Internet or telephone service) for providers to determine the date of a recipient's most recent vision care service.

Recommendation 5

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

Status - Implemented

Agency Action - The Department assessed the risk of complex or specially-handled claims and, as of December 2009, claims examiners manually review these claims (also known as "cost outliers") and determine payment amounts, consistent with the Department's prescribed Medicaid reimbursement policies.

Recommendation 6

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

Status - Implemented

Agency Action - Using information from the U.S. Department of Health and Human Services' Centers for Disease Control and Prevention, the Department established and regularly updates a list of all Medicaid providers (including their ID numbers) participating in the 340B Drug Pricing Program. Further, the Department uses the list to process 340B Program claims.

Recommendation 7

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

Status - Implemented

Agency Action - The Department formally assessed the risk of manually pricing claims for hemophilia treatment services and implemented new procedures to mitigate errors that occur during manual claim reviews. The new procedures include verification of drugs' National Drug Codes and a second review of each claim by the examiner's supervisor. To enhance the accuracy of pricing and paying claims, the Department also designed a new claim form that requires more detailed information about the drugs administered by the hemophilia treatment centers.

Recommendation 8

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

Status - Partially Implemented

Agency Action - A provider resubmitted one of the incorrect claims, which eMedNY properly paid (saving Medicaid $4,904). At the time of our follow-up, OMIG officials were working with other providers, who submitted the remaining two incorrect claims, to ensure the providers resubmitted the claims properly for correct payment.

Recommendation 9

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

Status - Implemented

Agency Action - The OMIG worked with the hospital officials to correct their billing system problems and, thereby, help ensure accurate reporting of neonatal information on Medicaid claims. Further, in April 2012, the Department implemented eMedNY system edits to help prevent the overpayment of a neonatal claim. These edits compare the birth weight related to the claim's diagnosis code to the actual birth weight recorded on the claim.

Recommendation 10

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

Status - Implemented

Agency Action - OMIG officials performed a risk assessment of claims for dual eligible recipients that indicate Medicare paid zero and hired a contractor to perform audit steps similar to those we conduct on such claims. Since February 2011, the contractor identified about 35,000 overpaid claims (including claims with service dates from April 1, 2009 through September 30, 2009) and recovered over $4 million from this review.

Recommendation 11

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

Status - Partially Implemented

Agency Action - OMIG officials had not recovered the overpayments (totaling $11,610) at the time of our follow-up. Officials advised us, however, that they intend to recover these overpayments in the future. Department officials also determined that the optometrist should not be removed from the Medicaid program. However, in November 2009, the Department designated the optometrist as an exception on the file of authorized Medicaid providers. Consequently, the optometrist's claims are now monitored by examiners for certain indicators which could preclude the claims' approval.

Major contributors to this report were Warren Fitzgerald, Earl Vincent and Emily Wood.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We also thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review**.**

Very truly yours,

Andrea Inman
Audit Manager

cc: Mr. James Cox, Medicaid Inspector General
Mr. Thomas Lukacs, Division of the Budget
Mr. Stephen Abbott, Department of Health
Mr. Stephen LaCasse, Department of Health