NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

April 26, 2013

Andrea Inman, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, New York 12236

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-up Report 2012-F-8 on Department actions relative to the recommendations contained in earlier OSC Report 2009-S-21 on "Medicaid Claims Processing Activity April 1, 2009 through September 30, 2009."

Thank you for the opportunity to comment.

Sincerely,

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Nirav R. Shah, M.D., M.P.H.
Jason Helgerson
James C. Cox
Michael Nazarko
Stephen Abbott
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Stephen LaCasse
Ron Farrell
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Department of Health
Comments on the
Office of the State Comptroller's
Follow-Up Audit Report 2012-F-8 on
Medicaid Claims Processing Activity
April 1, 2009 through September 30, 2009

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2012-F-8 on "Medicaid Claims Processing Activity April 1, 2009 through September 30, 2009" (2009-S-21).

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") overpayment 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.

Response #1:

OMIG will analyze the overpayments identified, and make recoveries as appropriate.

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.

Response #2:

OMIG will analyze the overpayments identified and make recoveries as appropriate.

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.

Response #3:

The Department and the OMIG confirm agreement with this recommendation.

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.

Response #4:

Per advice from the Division of Legal Affairs, the Department cannot arbitrarily deny replacement eyeglasses to a Medicaid recipient. However, to help support the integrity of the Medicaid program and in response to the OSC audit findings, the Department has requested that the successful replacement Medicaid Management Information System (MMIS) contractor be able to systematically support plan limitations and give providers the ability to determine a member's benefit claims history via a web based functionality or telephone service. As noted by OSC, the current policy limits replacing eyeglasses to one pair every two years.

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.

Response #5:

The Department confirms agreement with this recommendation.

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.

Response #6:

The Department confirms agreement with this recommendation.

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 a 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.

Response #7:

The Department confirms agreement with this recommendation.

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.

Response #8:

The OMIG recovered the three remaining overpayments on 10/19/12, 03/10/12, and 12/11/10.

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.

Response #9:

The Department and the OMIG confirm agreement with this recommendation.

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.

Response #10:

The Department and the OMIG confirm agreement with this recommendation.

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 claim's approval.

Response #11:

The OMIG is preparing a collection letter to recover the overpayments.