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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

September 7, 2006

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Duplicate Medicaid Payments to Clinics 2006-S-35

Dear Dr. Novello:

According 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 audited Medicaid claims for outpatient clinic services performed in diagnostic and treatment centers (Clinics) during the five year period ended March 31, 2006.

A. Background

The New York State (State) Department of Health (Department) administers the State's medical assistance program (Medicaid), which was established under Title XIX of the Federal Social Security Act to provide needy people with medical assistance. In this State, this program is funded jointly by the federal, State, and local governments. Its management information and claims processing functions are handled through the State's eMedNY system, which the Department implemented on March 24, 2005

Clinics are independent facilities that provide preventive, diagnostic, therapeutic, or rehabilitative services to recipients on an outpatient basis. For many of the services performed by Clinics, Medicaid pays a per visit all-inclusive rate. When billing Medicaid, Clinics are required to complete the claim using the Medicaid all-inclusive rate code and the appropriate medical procedure code for the services provided to the recipients. According to the Department's billing guidelines, Clinics are allowed to bill only one claim for each Medicaid recipient per day. During claims processing, eMedNY checks for duplicate claims by comparing several claim fields on the current claim to the same claim fields on previously paid claims.

B. Audit Scope, Objective and Methodology

We audited Medicaid Clinic claims for services provided during the five year period ended March 31, 2006. The objective of our audit was to determine if Clinics billed for services according to the billing policy set forth in the Department's guidelines.

We did our audit according to generally accepted government auditing standards. To accomplish our audit objectives, we extracted claims for Clinic services from the Medicaid payment files and verified the accuracy of the payments. We interviewed Department officials, reviewed medical records at one Clinic, reviewed applicable sections of federal and State laws and regulations, and examined the Department's relevant payment policies and procedures.

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, several of which are performed by the Division of State Services. 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.

C. Results of Audit

We identified six Clinics that submitted duplicate Medicaid claims resulting in inappropriate duplicate payments of nearly $336,000. We determined the first claim submitted by the providers complied with the Department's billing guidelines and the claims paid properly. In these claims, the provider completed the claim with the required billing rate code and the medical procedure code. However, eMedNY paid the second claims inappropriately because the providers neglected to include the procedure code on the Medicaid claim. Without the required procedure coding information, eMedNY could not detect the services submitted on the first Clinic claim were identical to the services on the second claim resulting in a duplicate payment. The eMedNY lacks the necessary edit controls to detect duplicate Clinic payments when providers neglect to provide all the required claim information.

Recommendations

1. *Recover the $336,000 duplicate payments identified.*

2. *Design and implement eMedNY controls to prevent this type of duplicate payment from occurring.*

We provided a draft copy of this report to Department officials for their review and comment. Department officials generally agreed with our recommendations and indicated actions planned and taken to implement them. A complete copy of the Department's response is included as

Appendix A. Appendix A also contains a State Comptroller's comment which addresses a matter contained in the Department's response.

Within 90 days after the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department 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 therefore.

Major contributors to the report include Steven Sossei, Warren Fitzgerald, and Earl Vincent. We wish to thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this review.

Very truly yours

Sheila A. Emminger
Audit Manager

cc: Lisa Ng, Division of the Budget
Tom Howe, Department of Health

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

August 4, 2006

Sheila A. Emminger, Audit Manager
Office of the State Comptroller
Division of State Services
State Audit Bureau
110 State Street, 11th Floor
Albany, New York 12236

Dear Ms. Emminger:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report (2006-S-35) on "Duplicate Medicaid Payments to Clinics."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix A

cc: Mr. Charbonneau
Mr. Griffin
Mr. Howe
Ms. Napoli
Ms. O'Connor
Mr. Reed
Mr. Seward
Mr. Wing

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
2006-S-35 on
"Duplicate Medicaid Payments to Clinics"

The following are the Department of Health's (DOH) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2006-S-35 on "Duplicate Medicaid Payments to Clinics."

Recommendation #1:

Recover the $336,000 duplicate payments identified.

Response #1:

The Office of Medicaid Inspector General (OMIG) proposes to test a sample of cases from each of the six clinics utilizing the data warehouse and/or case record reviews to determine if duplicate payments were, in fact, made. It is possible there might be justification for two claims being submitted for the same recipient on the same day. If duplicate payments were made, the OMIG will advise the providers in question and seek restitution of overpayments.

*** Comment**

Recommendation #2:

Design and implement eMedNY controls to prevent this type of duplicate payment from occurring.

Response #2:

The OMIG and the Office of Medicaid Management will work to develop an edit within the Health Insurance Portability and Accountability Act (HIPAA) standards requirements to preclude the problem from recurring.

State Comptroller's Comment:

According to the Department, it is possible there might be justification for two claims submitted for the same recipient on the same day. However, we would expect such claims would be from different providers for different services. Our review determined the billings duplicated a previously submitted claim from the same provider for the same recipient, same service, on the same day. When we reviewed the records for the provider responsible for 96 percent of the duplicate payments ($324,000 of $336,000), the provider agreed the claims were billed incorrectly and agreed to take the appropriate steps to correct the duplicate payments.