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

Division of State Government Accountability

Eye Care Provider and Family Inappropriately Enroll as Recipients and Overcharge for Vision Services

Medicaid Program
Department of Health

Report 2013-S-1 March 2016

Executive Summary

Purpose

To determine if the owner of a Medicaid eye care provider and the owner's associates inappropriately enrolled as Medicaid recipients and to determine if the provider inappropriately billed Medicaid for vision services. This audit covered the period January 1, 2008 through September 30, 2013.

Background

The Department of Health (Department) administers the Medicaid program in New York State. Medicaid provides a wide range of medical services, including vision care, to individuals who are economically disadvantaged and/or have special health care needs. For the fiscal year ended March 31, 2014, New York's Medicaid program had approximately 6.5 million enrollees and Medicaid claim costs for eye care services totaled about $10 million.

During the course of this audit, our fieldwork was temporarily suspended to avoid interfering with reviews conducted by other public oversight authorities of the matters addressed in this report.

Key Findings

We found numerous violations and questionable practices connected to the owner of a Medicaid eye care provider (Provider) and extending to the owner's family, including:

- The owner and family members submitted false income information to secure Medicaid coverage and other medical assistance benefits. During the period of enrollment for the owner and the owner's family, the State paid $68,483 in medical benefits on their behalf.
- The Provider received over $22,000 in improper Medicaid payments for claims with inappropriate coinsurance charges and/or for services not supported by medical records.
- The Provider allowed non-Medicaid-enrolled providers to render services, and on its claims to Medicaid identified a different, authorized, provider as the service renderer.
- The Provider used a non-Medicaid-enrolled billing service company to submit its claims. The owner of the Provider and the owner of the billing service company are married.
- The owner of the billing service company used other providers' Medicaid identification numbers to gain unauthorized access to the eMedNY claims system and bill over $700,000 in Medicaid claims on behalf of 55 providers.

Further, we identified five additional Medicaid recipients who had a business or personal connection to a member of the Provider's family and, we believe, submitted misleading information on their Medicaid applications to gain eligibility.

Also, recipients identified in this audit engaged in transactions that were not indicative of a person living at or below the income levels that qualify a person for Medicaid eligibility. For example, we identified over $400,000 in deposits made to the Provider's family's personal bank accounts (much of which appeared to be income). Additionally, in November 2012, the Provider's owner and the owner's spouse paid $105,000 toward the purchase of a condominium for one of their family members.

Key Recommendations

- We made eight recommendations to the Department to: assess the eligibility of the identified Medicaid recipients, deactivate ineligible Medicaid recipients and providers, conduct an expanded review of improper Medicaid claims, recover improper State payments, and improve claims processing controls.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Claims Processing Activity April 1, 2012 through September 30, 2012 (2012-S-24)

Department of Health: Overpayments of Certain Medicare Crossover Claims (2011-S-28)

Department of Health: Medicaid Claims Processing Activity April 1, 2009 through September 30, 2009 (2009-S-21)

State of New York
Office of the State Comptroller

Division of State Government Accountability

March 21, 2016

Howard Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Zucker:

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 *Eye Care Provider and Family Inappropriately Enroll as Recipients and Overcharge for Vision 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 local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the fiscal year ended March 31, 2014, New York's Medicaid program had approximately 6.5 million enrollees and Medicaid claim costs totaled about $50.5 billion, of which eye care claim costs totaled about $10 million. The federal government funded about 49.25 percent of New York's Medicaid claim costs; the State funded about 33.25 percent; and the localities (the City of New York and counties) funded the remaining 17.5 percent.

The State Department of Health (Department) administers Medicaid and various other medical assistance programs offered to New Yorkers. During the scope of our audit, individuals coordinated with their respective local district social services office (local district) to receive Medicaid and other medical assistance benefits. Local districts determined Medicaid eligibility based on several factors including household size and income. New York State has 58 local districts, each representing a county in all areas of the State except New York City. The five boroughs of New York City comprise one local district, which is overseen by the New York City Human Resources Administration (HRA).

Many of the State's Medicaid recipients are also enrolled in Medicare, the federal health care program for people 65 years of age and older and people under 65 years old with certain disabilities. Individuals enrolled in Medicaid and Medicare are commonly referred to as "dual-eligible." Generally, Medicare is the primary payer for medical services provided to dual-eligible individuals and Medicaid pays remaining balances, such as deductibles and coinsurance.

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. 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, others verify the eligibility of the medical service, and some verify the appropriateness of the amount billed for the service.

The Department requires health care providers seeking reimbursement for services to dual-eligibles to use the Department's automated Medicare/Medicaid crossover system. Under this system, which the Department implemented in December 2009, providers need only to submit claims to Medicare. After Medicare makes its payment, claims are then automatically forwarded to eMedNY, and Medicaid pays the remaining patient liability (typically a deductible or coinsurance). Prior to the crossover system, health care providers submitted claims to both Medicare and Medicaid. The Department relied on providers to direct-bill Medicaid and accurately self-report the amount Medicare paid and the corresponding amount Medicaid then owed. However, misreported claim information often led to Medicaid overpayments of Medicare coinsurance claims.

Audit Findings and Recommendations

We found numerous violations and questionable practices connected to the owner of a Medicaid eye care provider (Provider), and extending to the owner's family, including:

- The owner and family members submitted false income information to secure Medicaid coverage and other medical assistance benefits. During the period of enrollment for the owner and the owner's spouse and three other family members, the State paid $68,483 in medical benefits on their behalf.
- The Provider received over $22,000 in improper Medicaid payments for claims with inappropriate coinsurance charges and/or for services not supported by medical records.
- The Provider allowed non-Medicaid-enrolled providers to render services, and on its claims to Medicaid identified a different, authorized, provider as the service renderer.
- The Provider used a non-Medicaid-enrolled billing service company to submit its claims. The owner of the Provider and the owner of the billing service company are married.
- The owner of the billing company used other providers' Medicaid identification numbers (IDs) to gain unauthorized access to the eMedNY claims system and bill over $700,000 in Medicaid claims on behalf of 55 providers.

We also identified five additional Medicaid recipients who had a business or personal connection to a member of the Provider's family and, we believe, submitted misleading information on their Medicaid applications to gain eligibility.

We provided the Medicaid identification information of the ten recipients identified by this audit to the New York City Human Resources Administration (HRA). HRA officials investigated five of the ten recipients and determined they were ineligible for the Medicaid benefits they received. Subsequently, these recipients were disenrolled from the Medicaid program and ordered to repay $40,100 in restitution. Of the five recipients HRA had not investigated, two remained enrolled in the Medicaid program as of December 2015.

During the course of this audit, our fieldwork was temporarily suspended to avoid interfering with reviews conducted by other public oversight authorities of the matters addressed in this report.

Improper Medicaid and Family Health Plus Recipient Enrollments

Owner and Family Members of the Provider

Our audit determined the owner of the Provider and the owner's family were not eligible for Medicaid and other medical assistance benefits they received. From January 1, 2008 to August 15, 2013, Medicaid and Family Health Plus (FHP)[1] paid 323 claims totaling $68,483 for services provided to the family; a majority of the claims were managed care capitation payments. (During this time, the managed care plan that the family was enrolled in also paid its member providers

[1] During our audit scope, FHP was a public health insurance program for adults aged 19 to 64 who had income too high to qualify for Medicaid. (As a result of the Affordable Care Act, changes to the FHP program were made.)

an additional $20,751 for Medicaid and FHP services rendered to the family.)

The owner, the owner's spouse, and one family member (considered a dependent) were enrolled in FHP from January 1, 2008 to April 30, 2010, and in a Medicaid managed care plan from May 1, 2010 until January 22, 2014, when their case was closed (note: one family member remained in a Medicaid managed care plan until March 31, 2014). Two other family members were each separately enrolled in Medicaid since January 1, 2008, with enrollment ending August 20, 2010 for one and March 19, 2010 for the other. (We note that all five family members were enrolled in a medical assistance benefits program prior to our audit scope begin date of January 1, 2008. For the purposes of this audit, we did not assess the appropriateness of the family's enrollment prior to January 1, 2008.)

At the time of our audit, local districts determined Medicaid and FHP eligibility based on several factors including household size and income. Local districts determined household size by counting the person(s) applying for benefits who lived together plus any of their legally responsible relatives (who did not receive Safety Net Assistance, Aid to Dependent Children, or Supplemental Security Income) who resided with the applicant/recipient. Income was calculated as the entire household's combined amount of money, earned and unearned. Sources of income included wages, Social Security, pensions, unemployment, and child support. According to local district officials, on the initial Medicaid application, the income reported must be supported by documentation such as a pay stub. However, on the annual recertification, applicants could simply attest to their income. Local district officials informed us that even though additional resources such as savings accounts and property assets can be an indication of an applicant's wealth, these were not considered in determining eligibility for FHP and, as of January 1, 2010, were no longer considered for Medicaid eligibility.

To verify whether the owner and the owner's spouse and one family member were eligible for Medicaid and FHP, we reviewed their personal and business bank accounts as well as their HRA case files, which included Medicaid recipient recertifications as well as their Resource File Integration (RFI). The RFI is a tool used by local districts to assess recipient eligibility for medical assistance and other public benefit programs. The RFI contains unemployment benefits, Social Security income, accounts from participating banks, and wage information from the federal W-4 tax form.

The following table compares the family's self-reported monthly income with the income information on their RFI. It also shows Medicaid income eligibility limits for a family of three, as well as cash and check deposits to the family's personal and business bank accounts from 2008 up to the third quarter of 2012.

Year	RFI Average Monthly Income *	Self-Reported Monthly Income	Monthly Income Eligibility Limit	Check and Cash Deposits
2008	$3,253	$2,355	$2,200 (FHP)	$354,937
2009	3,360	0	2,289 (FHP)	442,509
2010	1,910	900	1,285 (Medicaid)	433,484
2011	2,500	840	1,285 (Medicaid)	528,110
2012	3,333**	960	1,333 (Medicaid)	710,662

* As reported on the W-4.

** Quarter 1 – Quarter 3.

For the entire period examined, the family's RFI income exceeded the program eligibility limits. Also, in 2008, the self-reported monthly income was greater than the monthly income eligibility limit. Further, we found discrepancies between the self-reported income information and the bank account information. For instance, the only proof of income reported by the family was in the form of checks from the owner's spouse's billing company, which the spouse signed. One of these checks, in the amount of $420, was submitted as income verification on recertification. We determined this check was never deposited. However, another check from the spouse's billing company for $2,710 – issued on the same date and made out to the spouse – was cashed but not reported as income on the family's Medicaid application.

Furthermore, the fourth family member's RFI showed earnings above the Medicaid eligibility limit for 2009 and 2010. (We also note that on November 2, 2012 this individual enrolled in the Medicaid program as a provider of speech therapy services.) The fifth family member reported a bi-weekly salary of $450 on their 2008 recertification, yet their RFI listed annual wages totaling $26,845, more than three times the Medicaid eligibility limit of $7,816.

We asked HRA officials how these recipients were able to continue receiving benefits despite their RFI showing income above the eligibility limits. Officials explained that income listed on the RFI is limited to the previous quarter, and eligibility determinations are based on income earned in the month prior to recertification. Furthermore, HRA officials estimated that they process over 70,000 recertifications each month, and thus a thorough review of each case is not possible. Therefore, case workers did not review RFIs extensively for all recertifications.

We reviewed the family's bank account information to identify whether transactions support the income levels reported on their Medicaid application and found the following:

- A total of $1.85 million in deposits were made to the spouse's billing company's bank accounts since January 2008 (over 99 percent of the deposits appear to be income-related transactions derived from physicians for billing services);
- The spouse reported an income of $50,000 on their 2009 application for a personal bank account;
- A total of $490,562 in deposits were made to the family's personal bank accounts since January 2008 (at a minimum, 56 percent, or $273,615, appears to be income-related

transactions, for instance derived from physicians for billing services); and
- In November 2012, the owner and the owner's spouse used $105,000 from their preferred money market account toward the purchase of a condominium for one of their family members.

These transactions are not indicative of individuals living at or below the income levels that qualify a person for Medicaid eligibility, and provide further evidence that this family likely understated their monthly income when applying for Medicaid benefits.

Subsequent to our review of the family's Medicaid recipient case files, HRA officials investigated four of the five family members and determined they were ineligible for the Medicaid benefits they received. As a result, in 2013, HRA disenrolled three of the recipients from Medicaid and ordered them to repay $34,000. The remaining two family members disenrolled from Medicaid prior to HRA's investigation.

Additional Ineligible Medicaid Recipients

In addition to the five recipients noted previously, our audit identified five other Medicaid recipients who had a business or personal connection to the Provider's family and, we believe, submitted misleading information on their Medicaid application to gain eligibility. HRA officials investigated one of the five recipients and determined the recipient was ineligible for the Medicaid benefits he received. Subsequently, this recipient was disenrolled from Medicaid and ordered to repay $6,100 in restitution. Of the four remaining recipients HRA had not investigated, two remained enrolled in the Medicaid program as of December 2015. During the period covered by the audit, the State paid $67,673 in health insurance benefits for the four recipients.

Recommendation

1. Coordinate with HRA officials to investigate the five identified recipients who had not yet been investigated. Such coordination should include an assessment of the recipients' Medicaid eligibility, deactivation of the Medicaid identification numbers of those determined to be ineligible for benefits, and the recovery of any improper payments identified.

Improper Claim Payments to the Provider

Medicaid covers routine vision care services, such as eyeglass frames, lenses, and fittings, whereas Medicare generally does not. We determined the Provider inappropriately billed Medicaid for Medicare coinsurance charges for eye care services that were not covered by Medicare and submitted claims for unsupported services (this included claims for services provided to the owner of the Provider and the owner's spouse as Medicaid recipients). In addition, we determined the Provider did not accurately reflect the providers rendering the services billed under its Medicaid provider ID.

Inappropriate Medicare Coinsurance Charges

We examined Medicaid payments to the Provider totaling $22,317 that represented 244 services provided between November 3, 2011 and March 5, 2013. The 244 services involved claims for Medicare coinsurance charges for eye care services that were not covered by Medicare. Because the services were not covered by Medicare, the Provider should not have direct-billed Medicaid for coinsurance charges. (When providers are owed Medicare coinsurance, they are required to use the automated Medicare/Medicaid crossover system, implemented in 2009 – we note the Provider was aware of the required crossover system and used it for other claims for Medicare coinsurance.)

When submitting a claim to Medicaid for a service that is not covered by Medicare, providers should bill the standard Medicaid reimbursement fee for the service, not Medicare coinsurance. By direct-billing Medicaid for coinsurance charges, the Provider was able to self-report Medicare payments and amounts Medicaid then owed. We determined 244 services were overpaid by $17,875 because the amount claimed exceeded Medicaid's fee for the services. For example, the Provider billed Medicaid for Medicare coinsurance totaling $150 on 33 different eyeglass-fitting procedures. Medicaid typically pays $20 for this service, and thus overpaid $130 ($150 - $20) for each of the 33 services, totaling $4,290 in overpayments. We note that although the eMedNY system has an edit designed to detect the type of inappropriate claims we identified, it is currently set to pend – as opposed to deny – such claims. When claims are pended, the eMedNY system temporarily suspends processing of the claims, which enables the Department to conduct a further review of the appropriateness of the claims, if deemed warranted.

After our initial conversation with the Provider, the Provider voided 175 of the 244 services we identified. The remaining 69 unadjusted services account for a total of $2,050 in overpayments.

Based on our findings, the Office of the Medicaid Inspector General (OMIG) began monitoring the Provider's claim activity prospectively. However, past claims submitted by the Provider were not subject to OMIG's review and no recoveries have been made.

Unsupported Medicaid Services

According to Department policy, vision care practitioners performing eye exams and the opticians providing eyeglasses are required to maintain patient records for a minimum of six years. These records should include eyeglass or contact lens prescriptions; examination findings; visual field charts; and lens and frame specifications (model or style name, manufacturer, and/or catalogue number).

We selected a judgmental sample of 551 services to review for supporting records. Selection criteria included services that were performed on weekends and holidays, dates of service that showed high numbers of eye care services were performed, claims for recipients who received high numbers of eye care services, seven services provided to the family members of the Provider, and claims that contained inappropriate Medicare coinsurance. Based on our review, we determined 309 of the 551 services did not have supporting documentation, including:

- All 110 services for frames or lenses;
- 29 of the 33 (88 percent) gonioscopy procedures; and
- 74 of the 86 (86 percent) ophthalmoscopy procedures with retinal drawing.

The Provider was overpaid $11,451 for the 309 services that were not supported by medical records: $7,008 of this amount involved coinsurance overpayments for 84 services and was included in the coinsurance overpayment detailed previously. Thus, we identified an additional $4,443 in overpayments through our review of supporting documentation.

Inaccurate Provider Information

According to Department policy, providers are responsible for notifying Medicaid of any changes in pertinent provider information, including new providers joining the practice, business change of address, and changes in business ownership/management, within 15 days of the change to ensure provider information is up-to-date. During the scope of our audit, the Provider moved to a new location and the Provider's existing business location was sold. The new owner told us they purchased the business location in October 2012 and moved in during February 2013. However, we found no information in eMedNY indicating that either party contacted the Department to advise them of the change. Although eMedNY did record an attempt by the Provider to add an additional address to its provider profile, there was no attempt to close the original service location. Additionally, the new location request was denied twice for administrative reasons, and as of May 2014, the Provider had not made the necessary adjustments so the request could be approved by the Department.

The Department's vision care billing guidelines also instruct providers to enter on the Medicaid claim the Medicaid provider ID of the optician or optometrist who rendered the services. We found the Provider did not adhere to Department policy by not always accurately identifying the rendering provider. For 30 of the 551 services in our judgmental sample, the individual listed was not the provider who rendered the service, and the provider who actually performed the service was not enrolled as a Medicaid provider. Title 42 of Federal Regulation requires all providers servicing Medicaid recipients to be enrolled in Medicaid and have a Medicaid provider ID.

Recommendations

2. Review and recover the improper Medicaid payments made to the Provider including 69 services totaling $2,050 in overpayments that the Provider did not void and $4,443 in Medicaid payments that did not have supporting documentation.

3. Review the remainder of the Provider's Medicaid claims (not tested as part of the audit) to determine the extent to which the Provider submitted other improper claims, and recover improper payments, as warranted.

4. Assess the appropriateness of the Provider's future participation in the Medicaid program, and take the necessary steps to remove the Provider from the program if warranted.

5. Assess whether the eMedNY system edit noted in this report should be set to deny inappropriate and/or excessive claims.

6. Formally advise the providers noted in this report of the Department's requirements for updating changes to business ownership, address, and/or affiliations.

Service Bureau Violations

Medicaid allows medical care providers to use billing companies, or service bureaus, to submit claims on their behalf. According to State Medicaid regulations, persons submitting claims, verifying client eligibility, or obtaining service authorizations for or on behalf of a provider must enroll in Medicaid as a service bureau and comply with all applicable regulations and policies. Enrolled service bureaus and providers can submit claims electronically, and must apply to the Department for a unique Electronic Transmitter Identification Number (ETIN), which will allow them access to the eMedNY claims processing system. Providers must certify each ETIN that can submit claims on their behalf and must recertify them each year.

During the scope of our audit, the Provider used a non-Medicaid-enrolled billing service company to submit its claims. We found that the owner of the billing company is also the spouse of the owner of the Provider. We further determined the owner of the billing company submitted applications for ETINs using the Medicaid provider IDs of two other physicians to gain access to the eMedNY system. The following is a breakdown of claim activity using the two ETINs that the owner of the billing company established inappropriately:

- Through ETIN A, from January 1, 2008 to April 30, 2013, there were 28,179 claims submitted on behalf of 54 providers, with Medicaid payments totaling $703,072;
- Through ETIN B, from January 1, 2008 to May 3, 2013, there were 883 claims submitted on behalf of five providers, with Medicaid payments totaling $19,008; and
- From ETIN A and ETIN B, from January 1, 2008 to May 15, 2013, Medicaid denied 23,194 claims totaling $14,152,556 submitted on behalf of 37 providers.

We interviewed the physician associated with one of the ETINs and provided the physician with a copy of a recertification form from eMedNY that contained the physician's signature. According to the physician, the signature on the form was not the physician's. In addition, the physician did not know the notary public who had notarized the form. Furthermore, the physician was not aware that the owner of the billing company was using the physician's ETIN to bill for other Medicaid providers.

Recommendations

7. Deactivate the two ETINs that the owner of the billing company established.

8. Using a risk-based approach, assess the propriety of claims billed through the two ETINs that the owner of the billing company established.

Audit Scope and Methodology

The objectives of our audit were to determine whether the owner of the Provider and the owner's family members and associates inappropriately enrolled as Medicaid recipients and to determine whether the Provider billed Medicaid in accordance with the Medicaid program's policy and guidelines. The scope of our audit was from January 1, 2008 through September 30, 2013.

To accomplish our audit objectives and assess the related internal controls, we reviewed applicable sections of federal and State laws and regulations, examined the Department's Medicaid payment policies and procedures, analyzed paid Medicaid claims, and tested medical records supporting provider claims for reimbursement. We also reviewed Medicaid recipient case files, examined the Department's Medicaid recipient eligibility policies and procedures, and interviewed officials from local districts about the Medicaid recipient application process.

During the course of this audit, our fieldwork was temporarily suspended to avoid interfering with reviews conducted by other public oversight authorities of the matters addressed in this report.

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 have been and will be taken to

address them. Our rejoinders to certain Department comments are included in the report's State Comptroller's Comments.

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 This 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 OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

February 19, 2016

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2013-S-1 entitled, "Eye Care Provider and Family Inappropriately Enroll as Recipients and Overcharge for Vision Services."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2013-S-1 entitled,
Eye Care Provider and Family Inappropriately Enroll as Recipients and Overcharge for Vision Services

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2013-S-1 entitled, "Eye Care Provider and Family Inappropriately Enroll as Recipients and Overcharge for Vision Services."

Background

New York State is a national leader in its oversight of the Medicaid Program. With the transition to care management, the Office of the Medicaid Inspector General (OMIG) continues to improve upon our processes and direct our resources to match this changing direction in the Medicaid program. In conjunction with the Department, NYS will continue its focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse wherever it exists.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,405,500 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,868 in 2014, consistent with levels from a decade ago.

General Comments

* Comment 1

It should be noted the Department does not agree with the following statement made on page 8 in the draft report:

"Therefore, case workers are not required to look at RFIs for recertifications."

As stated in 08 Office of Health Insurance Program (OHIP)/ADM-4, Department policy does require districts to verify the accuracy of the income information provided by recipients in order to re-determine Medicaid eligibility. This is done by using current information accessible to the Local Department of Social Services (LDSS), such as Resource File Integration (RFI) and the Work Number. When using RFI, districts must only consider information from the most recent calendar quarter (i.e., the calendar quarter immediately preceding the current calendar quarter as current). If there is a discrepancy between reported income and RFI, and budgeting the amount on RFI would result in ineligibility for both Medicaid and Family Health Plus, the district must request documentation of the current income using a documentation requirements form (LDSS-2642) and give ten (10) days for the client to provide the documentation. If the client fails to submit the requested documentation, the case may be closed with a timely notice.

Recommendation #1

Coordinate with HRA officials to investigate the five identified recipients who had not yet been investigated. Such coordination should include an assessment of the recipients' Medicaid eligibility, deactivation of the Medicaid identification numbers of those determined to be ineligible for benefits, and the recovery of any improper payments identified.

See State Comptroller's Comments, Page 20.

Response #1

OMIG will coordinate with the New York City Human Resources Administration (HRA) officials to investigate the five identified recipients who had not yet been investigated.

Recommendation #2

Review and recover the improper Medicaid payments made to the Provider including 69 services totaling $2,050 in overpayments that the Provider did not void and $4,443 in Medicaid payments that did not have supporting documentation.

Response #2

OMIG will review if improper Medicaid payments were made to the Provider, and seek recovery, as appropriate.

Recommendation #3

Review the remainder of the Provider's Medicaid claims (not tested as part of the audit) to determine the extent to which the Provider submitted other improper claims, and recover improper payments, as warranted.

Response #3

OMIG will review the remainder of the Provider's Medicaid claims to determine if other inappropriate payments were made, and recover as warranted.

Recommendation #4

Assess the appropriateness of the Provider's future participation in the Medicaid program, and take the necessary steps to remove the Provider from the program if warranted.

Response #4

OMIG will assess the appropriateness of the Provider's future participation in the Medicaid program, and take the necessary steps to remove the Provider from the program if warranted.

Recommendation #5

Assess whether the eMedNY system edit noted in this report should be set to deny inappropriate and/or excessive claims.

Response #5

The edit referenced in the draft audit report is not directly identified, however, Claim Edit Code 02015 (Medicare Payment Required) is the most likely system edit that meets the definition and description provided. Claim Edit Code 02015 was activated April 1, 2015, with a Pend disposition for all media types of Eye Care claims. Department staff performing adjudication reviews of the pended eye care claims have identified a consistently high rate of denials, indicating the edit is effectively identifying and suspending these claims from payment. Therefore, the Department

* Comment 2

requested Computer Sciences Corporation change the disposition for all media types of eye care claims that hit edit 02015 be changed to deny.

Recommendation #6

Formally advise the providers noted in this report of the Department's requirements for updating changes to business ownership, address, and/or affiliations.

Response #6

The Department formally notified the Providers identified in this audit report of the requirements for updating changes to business ownership, address, and/or affiliations.

Recommendation #7

Deactivate the two ETINs that the owner of the billing company established.

Response #7

The Department will determine the appropriate next steps with regard to this Provider's claims submissions.

Recommendation #8

Using a risk-based approach, assess the propriety of claims billed through the two ETINs that the owner of the billing company established.

Response #8

Since 2013, the Department's Bureau of Medical Review had placed the providers identified in this audit on pre-payment review and continue to review all vision claims submitted. Payment is only made when proper documentation is submitted from the provider. The Department will review a random selection of claims from the audit sample that are still currently available on the Medicaid Management Information System. After this review, OMIG will recover any claims deemed inappropriate.

State Comptroller's Comments

1. We were aware of policy 08 OHIP/ADM-4, which requires districts to verify the accuracy of the income reported by recipients to re-determine Medicaid eligibility. In particular, the policy states, "In lieu of income documentation, local social services districts must verify the accuracy of the income information provided by the recipient by comparing it to information to which they have access, such as RFI (Resource File Integration) …" data. As detailed on page 8 of our report, the family we identified provided a check as proof of income upon recertification. Given the documentation provided, we questioned HRA officials why the recipients continued receiving benefits despite their RFI, which showed income above the eligibility limits. HRA officials responded that HRA processed over 70,000 recertifications each month, and therefore, a thorough review of each case was not possible. Also, based on the Department's comments, we modified the pertinent statements on page 8 of the report, as appropriate.
2. On July 16, 2014, we provided written preliminary audit observations to the Department which identified the edit in question as "edit 02015," the same edit identified in the Department's response. Moreover, we are pleased the Department activated edit 02015 in April 2015 and has requested the claims administrator to deny claims which hit that edit.