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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

August 6, 1999

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

Re: Report 99-F-18

Dear Dr. Novello:

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 reviewed the actions taken by officials of the Department of Health as of July 15, 1999, to implement the recommendations contained in our audit report, *Medicaid Payment for Selected Clinic Services Covered by Medicare Part B* (Report 97-S-43). Our report, which was issued on July 17, 1998, assessed Medicaid's policies and procedures for the payment of claims for Part B services for the period January 1, 1995 to February 13, 1998 for most of the claims examined, and for the period January 1, 1993 to February 13, 1998 for mental health clinic claims.

Background

The New York State Department of Health (Health) administers the State's Medicaid Assistance Program (Medicaid), which provides medical assistance to needy people. Health's fiscal agent uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay claims for services to Medicaid recipients. The Department of Social Services (Social Services) administered the Medicaid program and operated MMIS until October 1, 1996, when Health assumed this responsibility.

Medicare is a Federal health insurance program for persons who are age 65 and older or disabled. Medicare provides hospital insurance (Part A) and supplemental medical insurance (Part B) for physician, clinic and other services not covered by Part A. Although Part B covers a substantial portion of a service's cost, the Medicare enrollee must pay an annual deductible and a coinsurance amount for each service. If the enrollee is a Medicaid recipient, Medicaid pays the deductible and coinsurance costs.

Federal law and State regulations require that providers bill Medicare before submitting claims to Medicaid. Medicare requires that, for certain recurring outpatient and clinic services (such as outpatient surgery, hemodialysis or mental health services), providers must bill for all the services performed during the surgery, or for all of a similar type of service provided to the patient during the entire period. However, Health requires providers to use a different method from the one Medicare uses to report the costs of these services: providers must prorate the monthly determination data they receive from Medicare on a per-service basis, and then submit a crossover claim to MMIS for each individual service. For the 32-month period ended August 31, 1997, Medicaid paid $392 million to clinics for crossover claims, i.e., claims that involve both a Medicare and a Medicaid payment.

Summary Conclusions

In our prior audit, we found Health had not taken the steps necessary to control inappropriate Medicaid payment of crossover claims. Because Medicaid program officials did not implement recommendations we made in prior audits of such claims, MMIS potentially overpaid providers a total of about $10 million for our audit period. These overpayments occurred because certain providers routinely billed Medicaid for the Medicare-determined patient liability for the entire month on every individual bill they submitted for the month. Although Health is responsible for ensuring the MMIS pays providers correctly, we found that management had neither established preventive controls, such as monthly reimbursement rates and MMIS edits, nor monitored provider compliance with billing requirements.

In our follow-up review, we found that Health officials have made progress in implementing the recommendations contained in our prior audit report. Health officials began investigating and recovering the potential overpayments we identified in the prior audit. In addition, since our prior audit was completed, Health officials have identified an additional $13 million in provider overpayments relating to hemodialysis/epogen services, of which $10.6 million has been recovered by implementing our audit recommendations.

Summary of Status of Prior Audit Recommendations

Of the eight prior audit recommendations, Health officials have implemented three recommendations and partially implemented four recommendations. One recommendation was no longer applicable.

Follow-up Observations

Recommendation 1

Establish a rate that would allow Medicaid clinic providers to bill Medicare crossover claims for hemodialysis/epogen and mental health clinic services on a monthly basis. After developing this rate, establish an edit to ensure that providers properly bill Medicare crossover claims for such services.

Status - Partially Implemented

Agency Action - Effective December 1, 1998, Health officials implemented a monthly payment rate for the hemodialysis/epogen crossover claims. However, Health officials have not yet established a monthly rate to bill Medicare crossover claims for mental health clinic services.

Recommendation 2

Establish a rate that would allow Medicaid clinic providers to properly bill Medicare crossover claims for Product of Ambulatory Surgery services, and for periodic services, such as hyperbaric oxygen and physical therapy. After developing this rate, establish an edit to ensure that providers properly bill Medicare crossover claims for such services.

Status - No Longer Applicable

Agency Action - Health officials studied our recommendation, and found that it was not feasible. Health officials stated their belief that due to the variations in the way these services are billed to Medicare, a single crossover rate would not be appropriate and that these crossover billings need to be controlled through instructions to providers and audit procedures.

Recommendation 3

Provide billing instructions to Medicaid clinic providers and their billing contractors to properly prorate patient responsibility for all multiple Medicare crossover claims.

Status - Implemented

Agency Action - Health published articles in the August and December 1998 editions of the Medicaid Update concerning "Hemodialysis Clinic Crossover Billing Changes." These articles detailed the use of the new monthly payment rate for hemodialysis Medicare/Medicaid crossover claims. In addition, a letter was sent to all hemodialysis providers informing them of revisions in the manner in which hemodialysis providers should bill Medicaid for Medicare coinsurance deductibles.

Recommendation 4

Investigate and recover as necessary overpayments for the following services: hemodialysis/epogen, mental health clinic services, hyperbaric oxygen therapy, Products of Ambulatory Surgery services and other clinic services.

Status - Partially Implemented

Agency Action - Health officials have recovered $4 million in overpayments for hemodialysis/epogen and hyperbaric oxygen therapy services and expect to recover the remaining $1.3 million in hemodialysis/epogen overpayments in the near future. However, Health officials have not initiated recovery activities concerning the $4.7 million in potential overpayments for mental health, Product of Ambulatory Surgery and other clinic services.

Recommendation 5

Identify and recover any overpayments for the above services that occur between September 1, 1997 and the implementation of preventive controls in MMIS.

Status - Partially Implemented

Agency Action - Health officials performed a post-period audit for the hemodialysis/epogen crossover claims between September 1, 1997 and the implementation of the new monthly rate code and identified $13 million in overpayments relating to hemodialysis/epogen services. Health officials have collected $10.6 million of these overpayments and have begun collection efforts to recover the $2.4 million balance. However, Health officials have not performed post-period audits to identify and recover any overpayments for the mental clinic services, hyperbaric oxygen therapy, Product of Ambulatory Surgery and other clinic services.

Recommendation 6

Examine the billing practices of the providers with the most overpayments and determine if investigation of their billing practices by the Attorney General is warranted.

Status - Implemented

Agency Action - After examining the billing practices of the providers with the most overpayments, Health officials sent a copy of our report to the Attorney General's Office on June 15, 1998.

Recommendation 7

Review the contractual arrangement between the provider of hyperbaric oxygen therapy services and its billing service and assess the appropriateness of a contract that provides billing services with financial incentives to increase Medicaid/Medicare revenues. Determine if this billing arrangement warrants investigation by the Attorney General's Office.

Status - Implemented

Agency Action - After careful review of this matter, Health legal staff concluded that this contractual arrangement does not violate Federal or State law. Because the payments are made directly to the provider (New York City Health and Hospitals Corporation), and not the billing agent (Health Management System), it is permissible for the contract to allow for a contingency fee. Therefore, Health officials did not make referral to the Attorney General's Office.

Recommendation 8

Investigate establishing a computer control (edit) which would allow MMIS to prevent multiple Medicare crossover clinic claims for the same date of service payments. If such an edit is not feasible, establish a process, such as a periodic audit, to detect such inappropriate payments.

Status - Partially Implemented

Agency Action - Health officials have investigated and determined that there is presently no feasible way to structure an edit which could implement this recommendation, because it is entirely appropriate that some multiple clinic claims are submitted for the same date of service. Claims that are inappropriate will be recovered through audit and recovery procedures. However, Health officials have not established or performed a periodic audit process to detect or control such inappropriate crossover payments.

Major contributors to this report were Lee Eggleston, Bill Clynes and Ottavio Nicotina.

We would appreciate your response to this report in 30 days, indicating any actions planned or taken to address any unresolved matters discussed in this report. We also 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,

Kevin M. McClune
Audit Director

cc: Charles Conaway