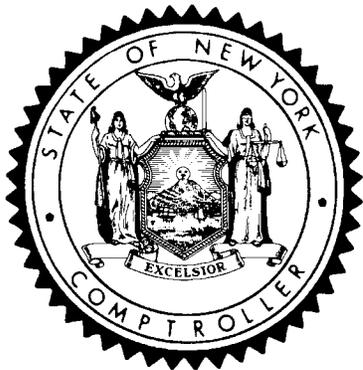


***State of New York  
Office of the State Comptroller  
Division of Management Audit  
and State Financial Services***

**DEPARTMENT OF HEALTH**

**PRIVATE DUTY NURSING SERVICES  
FOR MEDICAID RECIPIENTS**

**REPORT 99-S-16**



***H. Carl McCall***  
*Comptroller*



# State of New York Office of the State Comptroller

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## Division of Management Audit and State Financial Services

### Report 99-S-16

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

Dear Dr. Novello:

The following is our report on the Department of Health's controls over Medicaid payments to providers of private duty nursing care.

This 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. Major contributors to this report are listed in Appendix A.

*Office of the State Comptroller  
Division of Management Audit  
and State Financial Services*

August 3, 2000

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# Executive Summary

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## Department of Health

# Private Duty Nursing Services for Medicaid Recipients

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### Scope of Audit

The Department of Health (Department of Health) administers New York State's Medical Assistance Program (Medicaid), which was established in accordance with Title XIX of the Federal Social Security Act to provide medical assistance to needy people. Health's fiscal agent, Computer Sciences Corporation, uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims and pay providers for the medical services they render to eligible Medicaid recipients.

Private duty nursing services are included in New York State's Medicaid program. Federal regulations require that such services be furnished, with prior approval by the Department, under the direction of the Medicaid recipient's physician by either a registered nurse (RN) or a licensed practical nurse (LPN), both of whom must possess a State license. For the four-year period that ended on December 31, 1999, Medicaid reimbursed private duty nursing providers \$582 million in New York State.

Our audit addressed the following question regarding the payment of Medicaid claims from private duty nursing care providers for the period January 1, 1996 through December 31, 1999:

- ! Has the Department established adequate MMIS controls for the prevention of inappropriate payments for private duty nursing care services?

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### Audit Observations and Conclusions

Due to weaknesses and breakdowns in MMIS controls and procedures, we identified more than \$5.9 million in overpayments of Medicaid funds to private duty nursing care providers.

Using computer-assisted audit techniques, we identified more than 20,000 instances in which the MMIS had reimbursed more than 24 hours of care in a day for a Medicaid recipient, totaling more than \$2.5 million in overpayments to private duty nursing care providers. We also determined that the MMIS may have overpaid providers \$2.6 million for more than 16,000 duplicate claims. We further identified an additional \$834,000 in potential overpayments due to providers recording invalid nurses' license numbers on their claim forms.

Although the MMIS detects and prevents payment of any single claim billed for more than 24 hours of care in a day for one recipient, it allows providers

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to bill up to seven separate claims a day, each for 24 hours. In one instance, a provider billed four claims to Medicaid, which reimbursed the provider for 76 hours of care for a single day of service to one recipient. Further, the MMIS uses the license numbers of private duty nurses to check for duplicate claims. While the license numbers issued to nurses by the State Education Department are six numbers long, the MMIS allows providers to record any combination of numbers or letters up to eight characters on their claim forms. As a result, the MMIS accepted nurse license numbers such "999999" or with more than six numbers, thereby circumventing edits that detect duplicate claims. The MMIS also accepted obviously invalid license numbers such as "LPN 1997" and "NYS LICE." During the course of our audit, the Department asked its fiscal agent to develop controls that would address these weaknesses. (See pp. 5-10)

For selected private duty nurses, we requested documentation supporting their claims for Medicaid reimbursement; the documentation must be maintained for a minimum of six years, according to Federal law and State regulations. In several instances, the nurses could not support their claimed services, while others never responded to our inquiry. In one case, a nurse who could not supply us with any documentation stated that she did not perform some the services she billed for. Instead, she had a fellow nurse perform the services for her, and split the Medicaid fees with the other nurse. Such practices violate Federal law and State regulations. (See pp. 10-11)

In 32 of 50 prior approvals that we reviewed, Health employees either circumvented Department policies or made errors when recording prior approval information on the MMIS. Half of the folders we reviewed did not contain the documentation Health requires for approving private duty nursing care, such as the Medicaid recipient's physician's orders for private nursing care. In several cases, Health employees incorrectly recorded prior approval information on the MMIS, which led to Medicaid overpayments. (See pp. 15-18)

We made 8 recommendations to address the conditions we identified in this report.

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## **Comments of Department Officials**

In response to our draft report, Health officials agreed with our recommendations and indicated the steps they have taken or will take to implement them. A complete copy of the Department's response is included as Appendix B to this report.

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## Appendix A

Major Contributors to This Report

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## Appendix B

Response of Department of Health Officials

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# Introduction

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## Background

The Department of Health (Health or Department) administers New York State's Medical Assistance Program (Medicaid), which was established in accordance with Title XIX of the Federal Social Security Act to provide medical assistance to needy people. Health's fiscal agent, Computer Sciences Corporation, uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims and pay providers for medical services rendered to eligible Medicaid recipients. In New York State, the Federal government funds about half of all Medicaid costs; the State and local governments together fund the remainder. To receive Federal matching funds, a state's Medicaid program must offer certain mandatory benefits, such as inpatient hospital care, nursing home care and home health care. States may also receive Federal funding if they elect to provide other optional services such as private duty nursing care. However, Federal regulations allow states to limit the number of optional services they provide, and to restrict the delivery of such services without prior approval of a Medicaid provider's plan of care to determine its medical necessity and appropriateness.

New York's Medicaid program includes private duty nursing services, which are more comprehensive than the care that would be provided by a visiting nurse or that which is provided routinely by the nursing staff of a hospital or nursing home. According to Federal regulations, optional private duty nursing care is more individual and continuous than the care available under the home health care program, which offers part-time or intermittent nursing services. In addition, nursing services under the home health benefit must be provided only in the recipient's home, while the private duty nursing benefit allows nursing services to be provided in a hospital or nursing home as well as the recipient's residence. Federal regulations allow private duty nursing services to be provided in nursing home and hospital settings so long as the facility certifies that the requested care is not being used to supplant nursing services the facility is already required to provide. Health has never needed to approve private duty services in either type of institution because the institutions' staffs have been able to fill the requirements of the program.

If a state chooses to include private duty nursing services in its Medicaid program, Federal regulations require that they be provided by either a registered nurse (RN) or a licensed practical nurse (LPN) under the direction of the Medicaid recipient's physician. In New York State, an RN or LPN seeking permission to provide services covered by the Medicaid program must possess a license and meet the requirements outlined in Article 139 of the State Education Law. An RN, who must have earned a diploma or degree in professional nursing, provides a more-highly-skilled service and

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thus receives higher Medicaid fees than an LPN. Private duty nurses can be independent contractors, employees of a home care services agency, or participants in nurse registries, which are large agencies that schedule and coordinate the activities of private duty nurses, and continually seek employment for their clients. Services rendered can be billed to Medicaid either by the home care agency, the registry or the private duty nurse.

Health's regulations also require that the private duty services of either RNs or LPNs be approved before they are rendered. The responsibility for granting prior approvals for such services has been delegated by the Commissioner of Health to certain local districts (Broome, Erie, Oneida, Onondaga, Schenectady, Suffolk, Tompkins and Westchester). Once Health's Bureau of Medical Review and Evaluation (Bureau) or one of the local districts approves the provider's request, a budget of units of service (hours of nursing care) and associated costs is established and recorded on the MMIS for use in processing the provider's future claims. For the four-year period that ended on December 31, 1999, Medicaid reimbursed private duty nursing providers \$582 million. In 1999, about 2,800 Medicaid recipients received private duty nursing services.

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## **Audit Scope, Objective and Methodology**

We audited the Department's policies and procedures, as well as related MMIS computer controls, for monitoring and controlling Medicaid reimbursements to providers of private nursing care for the period of January 1, 1996 through December 31, 1999. The objective of our performance audit was to determine whether MMIS controls are sufficient to ensure that Medicaid pays providers of private duty nursing services according to established Medicaid reimbursement policy. To accomplish our objective, we interviewed Department officials; and reviewed Department records, applicable Medicaid policies and pertinent Federal and State regulations. In addition, we developed computer programs that could verify the appropriateness of Medicaid claims paid on behalf of private duty nursing care recipients during our audit period. We examined a judgmental sample of billing records from 40 independent private duty nurses and 18 nurse registry providers, who were chosen through a methodology we developed that enabled us to highlight individuals who may have billed Medicaid inappropriately. We also reviewed a judgmental sample of 50 prior approvals that were processed during our audit period. We selected these prior approvals because they were at risk of authorizing overpayments to the providers who requested them. Using computer-assisted auditing techniques, we were able to determine that Health may have approved more hours of nursing care than the recipients' private duty nursing care providers had originally requested. In particular, we analyzed prior approval records to determine whether existing internal controls are sufficient to ensure that Medicaid pays providers according to its own established reimbursement policies.

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We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess Health’s operations included in our audit scope. Further, these standards require that we understand Health’s internal control structure and compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that have been identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, finite audit resources are used to identify where and how improvements can be made. Thus, little audit effort is devoted to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an “exception basis.” This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

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## **Response of Department Officials to Audit**

We provided draft copies of this report to Health officials for their review and comment. Their comments have been considered in preparing this report and are included as Appendix B.

Within 90 days after 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 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 therefor.



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# Computer Controls for Detecting Inappropriate Billings

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Reimbursement for private duty nursing services rendered by RNs or LPNs is based on hourly fees. During our audit period, Medicaid reimbursed RNs an average of \$25 an hour and LPNs an hourly average of \$21. To prevent inappropriate payments for Medicaid services, the MMIS uses computer controls and programs that verify the appropriateness of claims submitted by providers. To assess the effectiveness of these controls, we developed computer programs that enabled us to identify inappropriate billings such as those from providers who billed multiple claims for the same recipient for the same service date. In more than 20,000 instances, the total number of hours of care recorded on the claim forms exceeded 24 hours in a single day. We analyzed these Medicaid payments made during our audit period, and determined that the MMIS lacks sufficient controls for detecting providers that bill more than 24 hours in a day on behalf of the same Medicaid recipient. We also determined that MMIS lacks controls for detecting and preventing duplicate payments to private duty nursing providers. Because of these weaknesses, we determined that Medicaid may have overpaid providers of private duty nursing services more than \$5.9 million for the period of January 1, 1996 through December 31, 1999.

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## Payments Made for Excess Hours of Private Duty Nursing Care

The MMIS has computer controls (edits) designed to detect inappropriate claims from private duty nursing care providers and prevent them from being paid. However, these edits do not adequately detect all inappropriate claims submitted by private nursing care providers. The MMIS is programmed to allow the payment of as many as seven claims for each day a Medicaid recipient received care from a private duty nurse, taking into account that it is occasionally necessary for different nurses to care for the same recipient on the same day, but at different times. However, the system also allows the same provider to bill Medicaid seven separate claims each for a maximum of 24 hours of services, resulting in overpayments by MMIS.

We identified more than 20,000 instances in which the MMIS reimbursed more than 24 hours of private duty nursing care in one day for a single recipient. By submitting multiple claims for the same day of services, some providers were able to receive overpayments from Medicaid. For example, one provider who we found had established a pattern of overbilling Medicaid, was able to bill four separate claims and receive payment for 76 hours of care for a single day of service for one Medicaid recipient. In this case, we reviewed the recipient's care plan, and determined that the recipient had required 18 hours of private nursing care each day, Monday through Friday. The following table shows the provider's pattern for overbilling Medicaid.

During a one week period (Monday-Friday), this provider overbilled Medicaid a total of 214 hours, resulting in an overpayment totaling \$5,388.

<b>Day</b>	<b>Service Date</b>	<b>Claims Billed</b>	<b>Hours Billed</b>	<b>Medicaid Payments</b>	<b>Hours Over</b>	<b>Amount Overpaid</b>
Monday	09/20/99	4	48	\$1,224	30	\$792
Tuesday	09/21/99	4	51	\$1,278	33	\$846
Wednesday	09/22/99	5	60	\$1,512	42	\$1,080
Thursday	09/23/99	5	69	\$1,710	51	\$1,278
Friday	09/24/99	4	76	\$1,824	58	\$1,392
<b>5 DAY TOTAL:</b>		<b>22</b>	<b>304</b>	<b>\$7,548</b>	<b>214</b>	<b>\$5,388</b>

During our audit period, we found 23,261 instances in which private duty nursing care providers had billed for more than 24 hours of service in a single day, for a single recipient. We determined that Medicaid may have overpaid these providers \$2.5 million for at least 107,500 excess hours. Since our test only considered any hours over 24 in one day as being excess or overbilled, and because many Medicaid recipients do not require 24-hour care, we believe there is a significant risk of even greater overpayments.

## **Duplicate Payments Made to Private Duty Nursing Care Providers**

To detect duplicate payments for private duty nursing services, MMIS has computer programs and edits that verify the information recorded on claims submitted by providers. However, during our audit period, we found that some of the computer programs and edits had not been developed adequately, allowing questionable claims to bypass these controls.

Before MMIS pays any claim submitted by a private duty nursing agency or registry, it checks its files of previously-paid claims in an effort to detect and prevent a duplicate payment. According to Health policies and regulations, claims by providers of private duty nursing services must include the license number of the nurse who actually performed the service. When a check for duplicates is made, the MMIS computer programs compare this license number as well as other information recorded on the current claim with the license number recorded on previously-paid claims. If the MMIS determines that the license numbers are different, the current claim bypasses the duplicate edit logic provided in the system, allowing the claim to be paid.

We identified more than 16,000 potential duplicate claims paid by Medicaid to private duty nursing care providers. For example, one provider had

submitted four separate claims for the same day of nursing care rendered to one recipient. The provider billed for a total 48 hours of care — 12 hours on each claim — and was reimbursed by Medicaid a total of \$1,056 for the entire 48 hours. It appeared to us that two of the provider’s claims are duplicates that bypassed the MMIS duplicate claims checks, because different license numbers had been recorded on the duplicate claims, as shown in the following table:

<b>Claim</b>	<b>Patient</b>	<b>Nurse’s License No.</b>	<b>Date of Service</b>	<b>Fee Code</b>	<b>Hours Of Care</b>	<b>Medicaid Payment</b>
1	John Doe	484640	6/05/99	W9049	12 hours	\$246
2	John Doe	999999*	6/05/99	W9049	12 hours	\$246
3	John Doe	484640	6/05/99	W9050	12 hours	\$282
4	John Doe	999999*	6/05/99	W9050	12 hours	\$282
<b>Total:</b>					<b>48 hours</b>	<b>\$1,056</b>

*\*Invalid license number*

As shown in the table, we determined that Claim #2 was a duplicate of Claim #1, and Claim #4 was a duplicate of Claim #3. In this case, since the provider recorded a different license number on each of the duplicate claims, the claims bypassed the duplicate edit checks, resulting in a total of \$528 in Medicaid overpayments to the provider.

By not testing the validity and reasonableness of the license data providers record on their claims, Health has little assurance that MMIS is detecting all duplicate claims properly and preventing overpayments. Using computer-assisted audit techniques, we identified 16,092 claims totaling \$2.6 million that might be duplicates. We developed computer programs that compared claims that had been submitted by the same provider for the same recipient on the same date of service, detecting only slight changes in the way the provider had recorded the nurse’s license number on the duplicate claim. Specifically, our programs compared only the first six digits of each license number. In one example, a provider was able to receive a duplicate payment by adding an additional digit to the nurse’s license number, as shown in the following table:

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<b>Claim</b>	<b>Patient</b>	<b>Nurse's License No.</b>	<b>Date of Service</b>	<b>Fee Code</b>	<b>Hours Of Care</b>	<b>Medicaid Payment</b>
First claim	Jane Doe	498813	2/26/99	W9046	6 hours	\$141
Duplicate claim	Jane Doe	4988131*	2/26/99	W9046	6 hours	\$141
<b>Total:</b>					<b>12 hours</b>	<b>\$282</b>

*\*Invalid license number*

Even though license numbers issued to nurses by the State Education Department (Education) are six digits long, the MMIS is programmed to accept numbers as long as eight digits. The license number field on Medicaid claim forms may be used for several purposes; under some circumstances, providers are instructed to either record their Medicaid provider's identification number or leave this field blank.

The license number is a critical control used by the MMIS to pay claims properly, and to detect duplicate claims submitted by private duty nursing care providers. However, Health does not check the license information recorded on claims by the providers before it authorizes reimbursement. Providers are allowed to record any combination of letters or numbers as the nurse's license number on their claims. In addition, there is no limit to the number of claims a provider can bill using the same nurse's license number. For example, one provider billed 25 separate claims for the same day, recording the same nurse's license number on each claim. According to the provider's claims, one nurse rendered 240 hours of care on one day on November 15, 1996, to 21 different Medicaid recipients. During our audit period, we identified 944 instances (i.e., service dates) in which a provider used the same nurse's license numbers to bill 100 or more hours of care on the same day.

We designed our analysis of possible duplicate claims to detect slight changes in license number entries, and the use of the number "999999." Providers are not restricted in what they can record as nurses' license numbers on Medicaid claims, and our test considered the possibility that some of the number combinations used to identify certain nurses' licenses could be invalid. In our judgment, there is a significant risk that the MMIS has paid even more duplicate claims than our audit identified.

We determined that the MMIS does not verify or edit the license information recorded by private duty nursing care providers to identify invalid or nonsensical license numbers. Although MMIS does have edits that test the validity of license numbers recorded on claims submitted by other types of

Medicaid providers, such tests are not performed on claims submitted by private duty nursing registries. During our audit period, we determined that the MMIS paid 7,335 claims totaling \$1.4 million in which the providers recorded invalid license numbers. On 5,442 of these claims, totaling \$893,778, the providers had recorded invalid license numbers consisting of the number 9. We previously identified 3,018 of these claims, totaling \$521,319, in this report as potential duplicates. However, the remaining 2,424 claims, totaling \$372,459, should also be investigated by the Department. In one case, a provider had billed 12 separate claims for 101 hours of service rendered to several Medicaid recipients on January 9, 1999, using the license number of 999999.

In addition, we identified 1,893 claims, totaling \$461,052, that contained invalid license numbers consisting of nonsensical combinations of letters, which are not used in the six-digit license numbers Education issues to nurses. Some of the invalid license “numbers” used in claims paid by the MMIS during our audit period are listed in the following table:

<b>Claim</b>	<b>Nurse's License No.</b>	<b>Date of Service</b>	<b>Fee Code</b>	<b>Hours Of Care</b>	<b>Medicaid Payment</b>
1	0000000?	6/04/97	W9045	4 hours	\$58
2	LPN 1997	8/07/97	W9045	5 hours	\$90
3	N	12/24/99	W9045	8 hours	\$168
4	LIC#	12/25/99	W9045	12 hours	\$276
5	N/C	8/28/99	W9045	3 hours	\$63
6	NYS LICE	5/24/99	W9045	4 hours	\$80
7	0000MEDI	11/25/99	W9049	7 hours	\$147

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These invalid license numbers further illustrate the need for Health to take steps to ensure the validity of such numbers.

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## **Verification of Claims**

To evaluate the effectiveness of Health's procedures for preventing inappropriate reimbursements, we selected 165 claims submitted by 40 independent private duty nurses and 2,214 claims submitted by 18 nurse registries during our audit period. We judgmentally selected these claims from a group of about 103,500 claims, totaling \$20.4 million, that MMIS paid during our audit period. From our analysis of duplicate claims and claims for more than 24 hours of care in a single day, we knew that the billings for a portion of this population were inappropriate. For example, in the previously-mentioned case of the provider who had billed 4 claims each for 12 hours, for a total of 48 hours, it is apparent that at least 2 of the claims were billed inappropriately.

According to Federal law and State regulations, all Medicaid providers are required to maintain documentation supporting their claims for a minimum of six years. We asked the selected providers to supply us with the documentation to support their claims, including the financial and health records that would fully disclose the extent of services, care and supplies provided to Medicaid recipients. In addition to these requirements, private duty nurses must maintain a copy of the physician's written orders for a minimum of six years.

Of the 2,214 claims submitted by the nurse registries, we found that 649 claims were not properly supported. In these cases, either the registries did not have records that would support the services for which Medicaid was billed, or the registries claimed more hours of private nursing care than the providers' records supported. For these claims, we determined that Medicaid overpaid nurse registries \$104,270.

Of the 165 claims selected for our test of Medicaid reimbursements to independent private nurses, we found that 102 claims were not fully supported. Specifically, we found that:

- ! A total of 42 claims had been billed improperly, because the provider claimed more hours of service than were supported by the medical records supplied to us. We determined that, in these cases, Medicaid was overbilled by \$6,927.
  
- ! For another 42 claims totaling \$14,460, the provider supplied us with inappropriate documentation. The nurses were able to supply us only with copies of the claim forms they used for billing Medicaid, or copies of the remittance statements the providers received along with

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their Medicaid payments, instead of their nursing notes or other required medical records.

- ! For 18 claims submitted by 5 private nurses, the nurses either did not respond to our request for documentation that would support the claimed services, or informed us they did not have any supporting documentation available. These claims totaled \$6,468.

We contacted one of the nurses who did not respond to our initial request for documentation. A private duty nurse, she informed us that she could not provide us with any records supporting her Medicaid claims selected as part of our review. Failing to maintain the records necessary to fully disclose the extent of the care or services performed is a violation of Medicaid reimbursement rules. The private duty nurse also informed us that she herself did not perform some of the services she billed Medicaid for. Instead, she said, she assigned the tasks to a fellow nurse who was not an enrolled Medicaid provider — also a violation of Medicaid reimbursement rules. According to her claims, from March 17, 1997 through March 31, 1997, the private duty nurse was providing care to two different recipients. However, using Medicaid eligibility records maintained by Health, we determined that the recipients' homes were located about 30 miles from each other. For 15 consecutive days, the private duty nurse billed Medicaid for 20-28 hours of service each day. She said she billed Medicaid for both the services she performed and the services rendered by the other non-Medicaid nurse, and then split the Medicaid reimbursement with the other nurse. In addition, information we obtained from Education indicates that, even though the non-Medicaid nurse was an LPN, her services were billed at the higher RN rate.

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## **Recommendations**

1. Investigate the over \$5.9 million in overpayments identified in this report. As warranted, take steps to recover overpayments.
2. Develop and implement computer controls necessary to:
  - ! detect duplicate payments and prevent Medicaid from reimbursing private duty nursing providers for more than 24 hours of care in a day for a single Medicaid recipient, and
  - ! detect invalid Medicaid service-identification numbers (nurses' license numbers) that private duty nursing care providers have recorded on their claims.
3. Instruct Medicaid providers on the proper way to record Medicaid service-identification numbers on their claims.

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## Accuracy of the MMIS License Master File

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Organizations with large-scale computer systems should establish procedures for ensuring that information entered into the systems is reliable, valid and complete before it is converted into machine-readable format and used in processing transactions. These procedures should include: (1) testing or editing data for valid limits or reasonableness; (2) reconciling output records with input entries; (3) detecting and correcting errors; (4) accumulating rejected transactions; and (5) reviewing and resolving these transactions. The MMIS has already implemented many of these edits. However, due to a flaw in the process of updating license data received from the State Education Department, the MMIS license master file does not contain license information for all of the nurses who are providing care to Medicaid recipients. We also determined that, although Education supplies Health with license information on all nurses in New York State, including their license numbers, the MMIS does not use such information to verify license information recorded on Medicaid providers' claims.

Each week, Education sends Health a file containing license information for all LPNs and RNs practicing in New York State. In addition to the nurse's license number, Education supplies Health with information on newly-licensed nurses, as well as nurses who can no longer practice because their licenses have been suspended or revoked. Although Health updates its license master file with this information, this file is incomplete because some entries are rejected. In addition, a flaw in the system that incorrectly identifies some data as duplicate, prevents some of the records Education supplies from being recorded on the MMIS license master file.

When we reviewed the programming logic used to update the MMIS with license information, we determined that a procedure intended to prevent duplicate transactions actually causes certain new entries to be rejected. Health's programs check for duplicate records by comparing the nurses' licenses numbers. However, according to Education officials, two individual nurses may have the same six-digit license number if one is an LPN and the other an RN; and Health's programs ignore an additional two-digit profession code, assigned by Education and supplied to Health, that distinguishes one group from the other.

As part of our audit, we sought to determine whether Medicaid was reimbursing private duty nursing providers for services performed by nurses with revoked or suspended licenses. During our audit, Education supplied us with a list of more than 900 nurses whose licenses had been revoked or suspended for some period of time since 1977. When we compared this list with Health's license master file, we found that, although many of the numbers on Education's list matched the numbers on Health's file, several

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of the names associated with those numbers did not match. Because Health's license file contains inconsistent data and the providers have sometimes recorded inappropriate license information on their claims, we could not perform our test with any certainty.

Unless the license information obtained from Health is adequate, the MMIS cannot check the validity of nurses' licenses while claims are being processed. To assure Health that nurses with suspended or revoked licenses are not being reimbursed, this flaw in the update process must be corrected so that the information Education supplies each week can be used to verify claims.

### **Recommendations**

4. Correct the flaw in the license-updating process, making sure that all valid license information supplied by the New York State Education Department is updated accurately.
5. Develop and implement controls that match license information recorded on providers claims with information supplied by Education. Use these controls to prevent Medicaid from reimbursing private duty nurses who have suspended or revoked licenses.

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# Evaluation of Prior Approval Process

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To assess the adequacy of Health's procedures for approving and controlling private nursing services for Medicaid recipients, we judgmentally selected for analysis 50 prior approvals processed during our audit period. Our examination found significant control weaknesses that might be causing MMIS to overpay providers of private duty nursing services. Of the 50 prior approvals we selected, Health workers could not locate 6 files; and just 12 of the 44 prior approvals that were available for us to test had been processed in accordance with Health's policies and procedures. In the remaining 32 cases, Health and local district employees either circumvented Medicaid policies for approving private duty nursing care or made errors in updating the MMIS with prior approval information.

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## Policies and Procedures

Generally, Health approves private duty nursing services for Medicaid recipients for up to six months at a time. Health has established policies and procedures that its staff and local districts are supposed to follow when approving private duty nursing services for Medicaid recipients. For example, before approving a request for such care, Health requires: (1) a written medical justification from the recipient's physician; (2) a care plan indicating the amount, duration and level of care needed; (3) a completed prior approval request form; and (4) an in-home patient assessment for each case performed by a Certified Home Health Agency (CHHA), which is a community-based home care service agency that provides preventive, therapeutic or rehabilitative services to Medicaid recipients. CHHAs are regulated by Health, which relies on them to determine whether private nursing services are appropriate for individual Medicaid recipients.

Before Medicaid providers can receive reimbursement for private duty nursing services, recipients' prior approval information must be entered into the MMIS, which provides controls for checking provider claims against prior approval information maintained by the Bureau of Medical Review and Evaluation and the eight designated local districts. For provider claims to be paid properly, the following information must be entered into the MMIS: (1) the service dates (the days on which the care will be provided); (2) the maximum number of hours of care to be provided; and (3) the skill level of nursing care required (either RN or LPN). Our analysis found several instances in which Health and district employees had updated the MMIS with inaccurate prior approval information. For example, we found that employees had entered more hours of care than ordered by the Medicaid recipient's physician, entered duplicate prior approvals for the same recipient, and made inappropriate adjustments or changes to existing prior approvals. If this information is not recorded accurately, MMIS may make incorrect reimbursements to private duty nursing care providers.

For instance, one recipient's physician had ordered 24 hours of private nursing care each day from August 8, 1999 through February 4, 2000, for a total of 4,392 hours. However, when employees in one local district updated the MMIS, they entered a total of 6,552 hours, or 2,160 excess hours for this recipient, as shown in the following table:

<b>Private Duty Nursing Care</b>	<b>Nursing Hours</b>	<b>Associated Cost</b>
Approved and updated to the MMIS	6,552	\$167,733
Ordered by recipient's physician {24 hours x 183 days}	4,392	\$103,212
<b>Excess hours</b>	<b>2,160</b>	<b>\$64,521</b>

Medicaid will pay provider claims as long as the maximum amount of care recorded on the MMIS is not exhausted. In this case, Medicaid was at risk of making substantial overpayments because an excess number of hours had been recorded on the MMIS.

Health employees informed us that, to accommodate the work schedules of Medicaid providers, they often inflate or add more hours of care to providers' prior approval requests. For example, two or more providers may be required to render nursing care to the same recipient on an alternating basis. If one provider has to work extended hours because the other is unable to work or provide the scheduled services, Health inflates each provider's prior approval request. In such cases, if the original prior approval request had not been inflated, it would be necessary to make an adjustment to allow payment for the extended hours.

According to staff of Health's Bureau of Medical Review and Evaluation, maintaining and adjusting prior approval records on the MMIS is a time-consuming process that requires more employees than the Department can commit. Inflating the providers' original requests and updating the MMIS with excess hours, in anticipation of conflicts between providers' work schedules, is intended to save time. Moreover, Bureau staff pointed out to us that changes in a recipient's medical condition might mean that he or she requires more care than originally ordered. Instead of seeking a physician's determination of whether more care is necessary, Health staff inflate the provider's original request and update the MMIS with the excess hours. In one case, a Health worker had instructed the parent of a Medicaid recipient to keep track of the hours worked by multiple private nursing providers assigned to the case. In a memo to the recipient's parent, Health officials stated that they could not keep track of changes in the providers' work schedules, and instructed the parent to send completed prior approval request forms for each provider to them at the end of each month, after the services

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were performed. Such arrangements are against Medicaid reimbursement policy; no payment is to be made if the request for prior approval is submitted after the service is rendered.

We also found cases in which employees had entered duplicate prior approval information into MMIS. Although Medicaid recipients receiving LPN-level services may also need the more-highly-skilled services of an RN, each level of care must be authorized by a separate prior approval, and the combined hours of services for both levels of care should not exceed the maximum number ordered by the recipient's physician. During our review, we found several cases in which Health had updated the MMIS with two prior approvals, one for LPN care and one for RN care. However, each prior approval had been entered with the maximum number of hours ordered by the recipient's physician, thus doubling the total number of hours ordered.

For example, one Medicaid recipient's physician ordered LPN-level care for 24 hours a day starting on March 16, 1999 and ending June 14, 1999, for a total of 2,184 hours. Shortly after the private nursing care began, the recipient's medical condition changed, requiring periodic RN-level care. Instead of updating the MMIS by entering the specific new RN requirement, Health employees doubled the number of hours ordered by the physician, entering an additional 2,184 hours of RN care. As a result, the MMIS was programmed to pay for up to 4,368 hours of care during the approved time period, or 48 hours of care a day (24 for the LPN and 24 for the RN) for 91 days. When we investigated this case further, we determined that the provider billed Medicaid for 48 hours of care each day from March 16, 1999 through April 17, 1999, submitting separate claims for 24 hours of RN care and 24 hours of LPN care supposedly provided on the same day. Then, from April 18, 1999 through May 1, 1999, the provider billed for 36 hours of care each day: 24 RN hours and 12 LPN hours. During this time, Medicaid reimbursed the provider a total of \$49,986; however, we determined that this amount included an overpayment of between \$21,000 and \$29,000, depending on the actual amount of RN-level care provided. The entering of excess hours or duplicate prior approvals in the MMIS results in an unnecessary risk that Medicaid will make overpayments.

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## **Documentation for Prior Approvals**

We reviewed 44 prior approval folders included in our test to determine whether they contained documentation that the units of service recorded on the MMIS were accurate and reasonable and had been approved in accordance with Health's policies and procedures. We determined that half of the folders we reviewed did not contain the necessary documentation to support the private duty services approved by the Bureau. Several of the folders contained no medical justification, such as a care plan or physician's orders for the services approved. In some cases, physicians' orders were more than four years old; other folders contained care plans or physician's orders without a physician's signature.

In other instances, we found no evidence that a required patient assessment had been conducted at the recipient's residence before the services began or while the recipient was receiving the care. In one case, the only patient assessment on file was more than three years old. Beyond the initial patient care assessment, Health performs little monitoring of private duty nursing providers, in contrast to the oversight that Federal and State regulations require of home care providers working in the Medicaid CHHA program. Patients should be assessed regularly to ensure that they are being cared for properly in an appropriate setting, and to determine whether the private nursing resources available in the recipient's community are adequate.

We also found several cases in which Health and local district staff had adjusted existing prior approvals inappropriately. In these situations, prior approvals were adjusted upward, with significantly more hours than required by the recipient's care plan despite the lack of documentation supporting the increase. We checked six prior approvals included in our test that had been adjusted during our audit period, and compared the hours order by each of the recipients' physicians with the related claim paid by the MMIS. We found that, in five cases, providers had been reimbursed for more hours of care than were ordered by the recipients' physicians. As a result, Medicaid may have overpaid about \$10,000 in these five cases alone. In addition, we found several instances in which the MMIS was updated with the wrong level of nursing care. For example, Health staff updated the MMIS with the more-costly RN-level care despite documentation that the recipient's physician had ordered LPN care. These weaknesses increase the potential for errors in the prior approval process that may cause the MMIS to make overpayments.

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### **Recommendations**

6. Implement appropriate procedures for ensuring that all prior approval requests for private duty nursing services are reflected appropriately on the MMIS in accordance with the orders of the Medicaid recipients' physicians.
7. Maintain proper documentation to support all prior approval determinations.
8. Determine whether the staffing resources responsible for approving private duty nursing care for Medicaid recipients are adequate.

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## **Major Contributors to This Report**

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Kevin McClune  
Lee Eggleston  
Donald Paupini  
Warren Fitzgerald  
William Warner  
Ottavio Nicotina  
Gail Gorski  
Lisa Rooney  
David Amedio  
Marticia Madory



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

July 24, 2000

Kevin M. McClune  
Audit Director  
Office of the State Comptroller  
Alfred E. Smith State Office Building  
Albany, New York 12236

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 99-S-16, entitled "Private Duty Nursing Services for Medicaid Recipients".

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read 'D. Whalen', with a long horizontal flourish extending to the right.

Dennis P. Whalen  
Executive Deputy Commissioner

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Department of Health  
Comments on the  
Office of the State Comptroller's  
Draft Audit Report  
99-S-16 Entitled  
"Private Duty Nursing Services  
for Medicaid Recipients"

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The following are the Department of Health's (DOH) comments in response to the Office of the State Comptroller (OSC) Draft Audit Report 99-S-16 entitled "Private Duty Nursing Services for Medicaid Recipients".

**Recommendation #1:**

Investigate the over \$5.9 million in overpayments identified in this report. As warranted, take steps to recover overpayments.

**Response #1:**

A recovery effort will necessitate a staff intensive investigation of patient records and the examination of voluminous documentation and will require a review of OSC's back-up material to avoid duplicate recovery actions. Any payments found to be inappropriate will be recovered.

**Recommendation #2:**

Develop and implement computer controls necessary to:

- ◆ detect duplicate payments and prevent Medicaid from reimbursing private duty nursing providers for more than 24 hours of care in a day for a single Medicaid recipient, and
- ◆ detect invalid Medicaid service-identification numbers (nurses' license numbers) that private duty nursing care providers have recorded on their claims.

**Response #2:**

OMM agrees with this recommendation, and has ordered systems projects that will:

- ◆ implement new edits to prevent payment of nurse and nurse registry claims on the same date of service, for the same recipient, to prevent payment for more than 24 hours of care.

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**Response #2 (cont'd):**

- ◆ modify an existing edit in order to better detect invalid license numbers

See Attachment A

**Recommendation #3:**

Instruct Medicaid providers on the proper way to record Medicaid service-identification numbers on their claims.

**Response #3:**

In December 1999, the Bureau of Medicaid Review and Payment began including mail inserts to providers receiving prior approval notices. These reminders instructed providers as to the correct way to record service-identification numbers on their claims. The May edition of the ***Medicaid Update*** contains an article that instructs nursing registries that claim forms will be required to have a valid nurse license number and license type effective July 1, 2000.

See Attachments B and C

**Recommendation #4:**

Correct the flaw in the license-updating process, making sure that all valid license information supplied by the New York State Education Department is updated accurately.

**Response #4:**

Ongoing discussions between the DOH and the State Education Department (SED) have centered on SED's assignment of license numbers that are duplicative for different profession codes. Conversion protocols were developed by Computer Sciences Corporation and the Department; however, it was recently discovered that some new profession codes were created by SED for nursing services that were not part of this conversion. A meeting with CSC, DOH, SED and HSASC was held to discuss the problem and develop solutions. A solution to the problem of missing license numbers is forthcoming.

**Recommendation #5:**

Develop and implement controls that match license information recorded on providers' claims with information supplied by Education. Use these controls to prevent Medicaid from reimbursing private duty nurses who have suspended or revoked licenses.

**Response #5:**

OMM is actively involved in developing a method for correlating SED license numbers and professional codes with MMIS categories of service and provider type codes. This issue will be discussed in the Joint Application Design sessions of the Replacement Medicaid System. In the interim, the Department will rely on notification from SED to prepare for any new profession codes that will need to be converted for MMIS purposes.

**Recommendation #6:**

Implement appropriate procedures for ensuring that all prior approval requests for private duty nursing services are reflected appropriately on the MMIS in accordance with the orders of the Medicaid recipients' physicians.

**Response #6:**

A directive outlining the required policies and procedures was issued to OMM review staff and local districts who prior approve private duty nursing services. It specifies that only receipt-specific prior approvals will be issued for the appropriate category of service, for no more than the total number of hours within the approved period of service according to current and documented physician orders.

See Attachment D

**Recommendation #7:**

Maintain proper documentation to support all prior approval determinations.

**Response #7:**

OMM agrees with this recommendation. The directive cited above stresses the need for proper documentation to support all prior approvals, and that documentation is required to support exceptions (as when aid continuing is granted pending a fair hearing decision, or the services are court-ordered).

**Recommendation #8:**

Determine whether the staffing resources responsible for approving private duty nursing care for Medicaid recipients are adequate.

**Response #8:**

OMM continues to evaluate staffing of the prior approval function in light of both need and resource availability.

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Response to OSC Audit 99-S-16  
Private Duty Nursing

**Attachment A**  
**Systems Project Requests**

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*MBQ / Unit  
Styh*

TRANSMITTAL NO. F-7700  
PROJECT NO. LS012100

TO: Dave Bolevice *MBQ*  
FROM: Mary Beth Quinn  
DATE: March 24, 2000  
SUBJ: Edit Decision Table Update for Nurse Unit Editing

The above named project requires the addition of a new edit to the Claims Weekly Subsystem:

- Edit 01328 - "NURSE UNITS EXCEED 24 HOURS"

Edit 01328 will fail for nurse and nurse registry claims with Category of Service (D.E. 2019) equal to '0521' thru '0524', on the same Date of Service (D.E. 3013), for the same Recipient Id (D.E. 1010), with Units billable (D.E. 3029) exceeding 24 for a given day.

The proposed Edit Status Table setting for Edit 01328 will be '80' (Deny) for all applicable Invoice Types. Attached is a general Edit Decision Table update. Please review this resolution procedure and respond with your approval as soon as possible.

Attachment

cc: J. Guy S. Hayford  
M. Hotaling  
T. Peters

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NEW YORK STATE DEPARTMENT OF HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM

PEND RESOLUTION PROCEDURES - DECISION TABLE			DATE 3/21/2000
<u>PEND REASON</u>	<u>CORR CODE</u>	NURSE UNITS EXCEED 24 HOURS	
01328		UNITS (field #0036), CATG SERV (field #0007), and RECIP ID (field #0010)	

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*Copies for Jof/  
Ron Hansen / Ruth /  
Vince*

TRANSMITTAL NO. F-7502  
PROJECT NO. LS012100

TO: Dave Bolevice  
FROM: Douglas Heim *DH*  
DATE: December 14, 1999  
SUBJ: Effort Assessment for Nursing Units Editing  
REF: (A) Transmittal N-8942

Attached is the result of our assessment of the Systems Development impact for the above project as documented in Reference (A). This project will be scheduled at your request, in accordance with available resources.

If you require any further information, please do not hesitate to call.

DH:lp

Attachment

cc: J. Guy

C. Hartman  
S. Hayford  
V. Potter  
P. Tashjian

Assessment for Nursing Units Editing (LS012100)

	Claims Daily	Claims M. F.	Claims Weekly	SURS Monthly	SURS Qrtly.	MARS	On-line	Platform Dev.
Total Effort (months)	2.0		2.5					
Duration (months)	3.0		3.5					

Summary of Claims Daily Impacts:

Currently, editing does not exist in the Claims Daily Area that will enforce an entry in the Service License Type field (D.E. C239) for nursing registry Categories of Service (0523, 0524) (D.E. 2019). Editing does exist that ensures an entry is present in the Service Provider ID/License Number field (D.E. C198) for nursing registry claims.

Edit 00263 – SERVICE PROVIDER ID NUMBER MISSING is failed for claims submitted with nursing registry Categories of Service when the Service Provider ID/License Number field is equal to spaces or zeros. This edit will be modified to fail nursing registry claims if the Service License Type field is equal to zeros or is blank. The Pend and Remittance Messages will be changed to be 'SERVICING PROV LICENSE NUMBER AND TYPE ARE REQUIRED'.

A new edit will be added to the Claims Daily System that will fail claims billed with nursing services Categories of Service 0521-0525 which contain in-state Service Provider ID/License Numbers that are not numeric. A value of '0', '2', or '4' in the first byte of the Service License Type field will be used to identify an in-state license number.

Edit 00260 – MMIS SERVICE PROV ID REQUIRED fails claims billed for nursing registry (0523, 0524) and optical establishment (0401, 0423) Categories of Service (D.E. 2019) if the Service License Type field contains an entry. This edit is also failed the Service License Type field is equal to spaces and the Service Provider ID/License Number field is not numeric or equal to zeros. This edit was implemented on November 9, 1980 with an approved status ('10') for all Invoice Types. The status was changed to not applicable ('02') for all Invoice Types effective January 12, 1991. The logic for this edit will be removed.

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Summary of Claims Weekly Impacts:

Currently, there is no editing logic to prevent submitting claims totaling more than 24 hours (Units D.E. 3029) for the same Recipient ID (D.E. 1010), on the same Date of Service, (D.E. 3013) across Categories of Service 0521 – 0524.

To restrict these types of claims submissions, modifications to CWP210 will involve the creation of a new edit. The logic for this new edit will include using a working storage accumulator to total the number of Units. When an Activity Claim is encountered with a Category of Service 0521 – 0524, the working storage accumulator will be initialized to have the value of Units from the Activity Claim. History Records for the same Recipient ID on the same Date of Service, across Categories of Service 0521 – 0524 will have their Units added to the accumulator. If the total Units is greater than 24, the Activity Claim will fail the new edit.

**ASSESSMENT OF IMPACT ON FISCAL AGENT OPERATING DEPARTMENTS FOR LS012100**  
**Nursing Units Editing**

DEPARTMENT	PROJECT IMPACT			DESCRIPTION OF IMPACT
	NONE	MINOR	SIGNIFICANT	
Impacts Common to All Departments	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pre-Screening	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Data Entry	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I/O Control	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	The Edit Status, Pend Message, and Remit Message Tables will require updating due to the new and modified edits.
Operations	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Distribution	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Claims Review	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	An increase in pended claims may result from the addition of the new edit.
Provider Relations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Must be aware of the new and modified edits and the related logic for provider inquiry.
State	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	The State will have to be made aware of the new and modified edits and the associated logic. The State will be responsible for initiating changes to the Edit Status, Pend Message, and Remittance Message Tables. The State will be responsible for any provider notification.

Any issues identified above must be resolved before the project is implemented. Impact assessments are based on a preliminary analysis and are subject to revision when project specifications are completed.

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TRANSMITTAL NO. F-7781  
PROJECT NO. LS013500

TO: Dave Bolevice  
FROM: Carol Hartman *CH*  
DATE: May 8, 2000  
SUBJ: Refinement of MMIS Edit 00519 Project  
REF: Transmittal N-9226

A project has been initiated to modify Edit 00519 –  
**ORDERING/REFERRING/PRESCRIBING PROVIDER LICENSE NUM INVALID.**

The project requirements outline a request to add the following criteria to the edit:

- All characters in the License Number field must be alphabetic (A-Z) or numeric (0-9).
- License Number must be at least six bytes in length.
- License Number cannot be completely alphabetic.

Further discussion between you, Dr. Joe Guy, and Paul Tashjian on April 16, 2000, resulted in the following request for additional criteria to fail Edit 00519:

- Ordering/Referring Provider (D.E. 3004), Service Provider (D.E. C198), and Prescribing Provider (D.E. 3005) Licenses and **NYS MMIS IDs** are to be subjected to the edit.
- The edit is to apply to both **in-state** and out-of-state providers.
- All Invoice Types are to be subjected to Edit 00519.

Current Edit 00519 logic is as follows:

- If the Invoice Type equals 09 or 10 (pharmacy), the Prescribing License Type (D.E. 3246) and the Prescribing License Number are moved to hold fields. For all other Invoice Types, the Ordering/Referring Provider Type (D.E. 3246) and the Ordering/Referring Provider Number are moved to the hold fields.

- 
- The Prescribing License Number or the Ordering/Referring Provider Number, based upon Invoice Type, is tested to determine whether one of the following “nonsense number” values is present:
    - 00000000, 12345678, 999999, 99999, 00999999, 00099999, 99999999.
    - If the field contains one of these values and
      - the hold field for Provider Type contains a ‘1’ or ‘3’ in the first byte, indicating an out-of-state license number, Edit 00519 is failed
      - OR -
      - the Invoice Type is 09 or 10 (pharmacy) and a value is present in the hold field for Provider Type, indicating a License Number has been entered, Edit 00519 is failed.

Research has been done to determine impacts resulting from the logic modification requests. The following information is for review to determine if all modifications are necessary.

- In regard to the requirement that Provider License Numbers must be at least six bytes in length, the following values were found on the License File on 4/19/00:
  - 157,789 License Numbers were found that have three leading zeros
  - 51,911 License Numbers were found that have four leading zeros
  - 4,695 License Numbers were found that have five leading zeros
  - 428 License Numbers were found that have six leading zeros.

Based on the number of License Numbers that contain less than six non-zero digits, the request for the License Number to be at least six digits in length may not be practical.

As a result of the Nurse Units Editing Project (LS0121), system modifications are currently underway to always right-justify and zero-fill the Service ID field regardless of containing an MMIS ID or License Number. Therefore, any value less than six bytes in length should be removed from the existing project requirements. Please advise us if this action is appropriate.
- The Provider Master File was searched for the presence of any of the previously mentioned “nonsense” numbers and none were found.
- The Provider License File was searched for the presence of any of the previously mentioned “nonsense” numbers and two were found: 00099999 and 12345678. The two “nonsense” license numbers have been assigned to nurse practitioners and appear to contain “bogus” information.. Whether claims are billed and denied with these License Numbers has not been determined.

- 
- The current Service Provider ID edits are as follows:  
**00061 – SERVICE PROVIDER ID NUMBER NOT NUMERIC**  
This edit is currently set to a pend/deny status for Invoice Types 15, 16, 35, and 36. This edit is failed for these Invoice Types when
    - the Category of Service is not equal to 0401 and 0423, AND
    - the Service ID Type is equal to spaces, AND
    - the Service ID is not equal to spaces, AND
    - the Service ID is not numeric.Edit 00061 will disallow a Service MMIS Provider ID billed with alphas.

- 00062 – SERVICE PROVIDER ID NUMBER INVALID**  
This edit is currently set to a pend/deny status for Invoice Types 13, 14, 15, 16, 35, and 36. It is set to an approved status ('10') for Invoice Type 01. This edit is failed for these Invoice Types when
  - the Category of Service is equal to 0401 or 0423, AND
  - the Service ID Type is equal to spaces, AND
  - the Service ID is numeric and greater than zeros, AND
  - the check digit for the Service ID is incorrect.

This edit is also failed when

- the Invoice Type is not equal to '01', AND
- the Category of Service is not equal to 0401 or 0423, AND
- the Service ID Type is equal to spaces, AND
- the Service ID is not equal to spaces, AND
- the Service ID is numeric and greater than zeros, AND
- the check digit for the Service ID is incorrect.

This edit will ensure the billed Service MMIS Provider ID is on the NYS Provider Master File for private dentist, dental clinic, and eyecare Invoice Types. Referred ambulatory claims were extracted from the Weekly Paid/Denied File that contain zeros in the Service Provider ID field. The Service Provider ID edits are not applicable to these Invoice Types, as well as other Invoice Types.

Should we modify Edit 00519 to fail invalid Service Provider IDs for these specific Invoice Types, or should we allow Edits 00061 and 00062 enforce validity for the applicable Invoice Types?

- The current editing for Ordering/Referring Provider ID is as follows:  
**00032 – REFERRING PROVIDER ID NUMBER NOT NUMERIC**  
This edit is currently set to a pend/deny status for all Invoice Types excluding 21, 22, and 23. Logic exists to allow Categories of Service 0263, 0264, and 0265 to bypass Edit 00032. This edit is failed when
  - the Ordering/Referring Provider ID Type is equal to spaces, AND

- 
- the Ordering/Referring Provider ID is not equal to spaces, AND
  - the Ordering/Referring Provider ID is not numeric.
- This edit will disallow an Ordering/Referring MMIS Provider ID billed with alphas.

**00078 – REFERRING PROVIDER ID NUMBER INVALID**

This edit is currently set for all Invoice Types except 21. Logic exists to allow Categories of Service 0263, 0264, and 0265 to bypass Edit 00078. The edit is failed when

- the Ordering/Referring ID Type is equal to spaces, AND
- the Ordering/Referring Provider ID is not equal to spaces, AND
- the Ordering/Referring Provider ID contains all zeros OR
- the check digit for the Ordering/Referring MMIS Provider ID is incorrect.

This edit will disallow an Ordering/Referring MMIS Provider ID to be billed with zeros and will ensure the billed Ordering/Referring MMIS Provider ID is on the NYS Provider Master File. Edits 00032 and 00078 will fail claims billed with alphas and zeros. Is it necessary to subject Ordering/Referring Provider IDs to Edit 00519?

- The current editing for Prescribing MMIS Provider ID is as follows:  
**00938 – PRESCRIBER TYPE BLANK / PRESCRIBING PROV ID NON-NUMERIC**

This edit is currently failed for pharmacy Invoice Types 09 and 10. The edit is failed when

- the Prescriber Type is equal to spaces, AND
- the Prescribing License Number/ID is not numeric.

This edit will disallow a non-numeric Prescribing MMIS ID.

**00525 – PRESCRIBER LICENSE NUMBER MISSING**

This edit is currently failed for pharmacy claims

- if the Prescribing License Number/ID is equal to spaces.

**00897 – PRESCRIBING PROVIDER ID NOT ON MMIS PROVIDER FILE / PRESCRIBER TYPE BLANK**

This edit is currently set for pharmacy claims and is failed when

- the Prescribing License Number/ID is numeric, AND
- the check digit for the Prescribing MMIS ID is incorrect.

The above edits will disallow approval of pharmacy claims that contain non-numeric or invalid Prescribing MMIS IDs. Is it necessary to subject Prescribing MMIS IDs to Edit 00519?

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Currently, license editing exists in the Claims Daily System that will enforce proper license entries in the Ordering/Referring, Prescribing, and Service Provider fields. We suggest that the existing license editing be examined for the possibility of setting the edits to an enforced status for the Invoice Types that you are concerned with.

Please call me if you have any questions or comments. This project was requested to be done as soon as possible, and a decision as to the final requirements is essential to begin the edit modification. Thank you.

cc: J. Guy

S. Hayford

T. Rivera

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Response to OSC Audit 99-S-16  
Private Duty Nursing

**Attachment B**

**Mail Inserts**



**STATE OF NEW YORK  
DEPARTMENT OF HEALTH**

Coming Tower, The Governor Nelson A. Rockefeller Empire State Plaza, Albany, New York 12237  
99 Washington Avenue, Suite 800 Albany, New York 12210-2808

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

Dennis P. Whalen  
*Executive Deputy Commissioner*

**Reminder to Private Duty Nursing Registries:**

Please be sure to enter the nurse's valid and current license number (for the nurse who actually worked the specific hours being claimed) in the Service Provider Field of Claim Form A when billing. A separate claim form will be necessary for each nurse when multiple nurses are utilized on the same case.

(12/99 BMR&P)

**Reminder to Private Duty Nursing Registries:**

Please be sure to enter the nurse's valid and current license number (for the nurse who actually worked the specific hours being claimed) in the Service Provider Field of Claim Form A when billing. A separate claim form will be necessary for each nurse when multiple nurses are utilized on the same case.

(12/99 BMR&P)

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Response to OSC Audit 99-S-16  
Private Duty Nursing

**Attachment C**  
**May Medicaid Update Article**

**SMOKING AND DIABETES**

For many years, health risks associated with smoking and smokeless tobacco use have been identified and include chronic lung disease, coronary heart disease, stroke, and various cancers. More recently, increased health risks associated with smoking in the diabetic population have been identified. Smoking may contribute to the cardiovascular burden and the microvascular complications associated with diabetes. All persons with diabetes should be urged to not start smoking or to quit smoking. The following information is provided to help you assist your diabetic patients. Additional information regarding smoking and diabetes can be found at the American Diabetes Association website: [www.diabetes.org](http://www.diabetes.org).

Recommendations Adapted from the American Diabetes Association Regarding Diabetes and Smoking

**Assessment of smoking status and history**

- ❖ Systematic documentation of a history of tobacco use should be obtained from all adolescent and adult individuals with diabetes.

**Smoking prevention and cessation**

- ❖ The Agency for Healthcare Research and Quality has guidelines regarding smoking cessation which are available at [www.ahrq.gov](http://www.ahrq.gov). All health care providers should be aware of and familiar with these guidelines.
- ❖ All health care providers should advise individuals with diabetes not to start smoking. This advice should be consistently repeated to prevent smoking and other tobacco use among children and adolescents with diabetes under age 21.
- ❖ Smokers should be advised, as a routine component of diabetes care, to quit smoking. Every smoker should be urged to quit in a clear, strong, and personalized manner that describes the added risks of smoking and diabetes.
- ❖ Every diabetic smoker should be asked if he or she is willing to quit at this time.

**Smoking Cessation Follow-up**

- ❖ Follow-up procedures designed to assess and promote quitting status should be arranged for all diabetic smokers.

**Reminder:** As a commitment to provide assistance to Medicaid recipients who want to stop smoking, Medicaid now covers prescription and non-prescription smoking cessation agents. We appreciate your participation in helping to make New Yorkers healthier. If you would like more information about the Medicaid program's Smoking Cessation Initiative, please contact the Bureau of Program Guidance at 518-474-9219.

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**ATTENTION: NURSING REGISTRIES**

Effective July 1, 2000, nurse registries (categories of service 0523, Hospital Registry LPN, and 0524, Hospital Registry RN) will be required to complete on their claim forms the "Service Provider" field with, and only with, a valid "NURSE LICENSE NUMBER". A MMIS provider identification number will no longer be accepted in this field. Also, contrary to the current Private Duty Nursing Provider Manual instructions pertaining to leaving the field blank, the "LICENSE TYPE" field must now be completed with the nursing license type code of "42". Whether billing via paper or electronically, the "Service Provider" field should be right justified with zeroes filling those otherwise blank spaces at the left of the field (Ex 0 0 3 2 1 5 4 6). Failure to follow these license completion requirements will result in your claims failing edit 01327, In-State Servicing Provider License Number Not Numeric. If you need additional information concerning this matter, contact Computer Sciences Corporation (CSC), Institutional Services Unit at 1-800-522-1892 or (518) 447-9810.

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Response to OSC Audit 99-S-16  
Private Duty Nursing

**Attachment D**  
**Instruction Guidelines for**  
**Private Duty Nursing Services**

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### General Instructions for Review of PDN

- I. All requests should be submitted in writing for review. A complete packet includes:
- A. Letter of medical justification from ordering physician or nurse practitioner. Letter should be timely and stipulate specific skilled needs, level of care required, number of hours, and duration of need. It must give a pertinent medical history background, including current diagnosis and prognosis.
  - B. Assessment from a certified home health agency (CHHA) or other assessment agency. There is no special form for this, as long as the key issues are addressed i.e., complete nursing assessment, review of skilled needs, any social issues, review of the home environment, level of care and amount of hours recommended.
  - C. Statement of Backup Plan. Adequacy of plan will depend on extent of recipient's needs. Key issues: 1) Backup caregiver must be completely trained and able to meet all the patient's nursing needs in absence of PDN; 2) In case of a child or non-self-directing individual, backup caregiver must live in household. If these parameters aren't met, the safety of a home care plan is questionable.
  - D. A completed prior approval request form (DSS-3615) from a licensed home care agency (LICSA) or individual nurse provider.
  - E. Nursing care plans or activity sheet reflecting skilled care to be given by the LICSA or individual nurse provider. This is optional per reviewer's discretion.
- II. If any of the above documents are missing, or raise questions, a missing information letter is then sent out to the provider along with the DSS-3615 request form. Sending the missing information letter is necessary to stop the 21 day "clock". Health regulation 10 NYCRR 85.38 requires all requests to be reviewed and have action taken within 21 days of receipt by the office (based on date stamp on PA form).
- III. Once all issues are clarified and a medical determination has been made, the prior approval is ready to be processed. It will either be approved, denied or modified.
- A. Approval - The DSS-3615 must be reviewed for accuracy. Refer to provider manual. Some comments:
    - 1. Field 1: a) prescriber signature - not necessary if a signed letter/order is part of packet.  
b) If 'yes' is checked that recipient is resident of Medical or Nursing care

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facility - PDN is considered only as part of a discharge plan. PDN is not approved within a facility (eg, Article 28 hospital or nursing facility, or Article 31 developmental centers).

2. Field 3: Quantity, times and amount approved should never be more than requested. If there is a legitimate reason for doing so, totals on request side should be changed by reviewer and action code A2 used. Explanatory comment in Field 4 should be made.

After reviewer signs off on the request, it must be sent to Data entry where the prior approval number is assigned.

The entire process must be completed within 21 calendar days from date of receipt, as previously explained.

**B. Denial**

1. Denial letter - If a denial is going to be issued, a notice must be sent to the recipient. See attached "Denial Letter". This form is completed and mailed directly to recipient's address. A copy must also go to the requesting provider and the ordering physician.
2. Prior Approval request form - This still needs to be completed by writing A5 in action code and completing field 4. A prior approval number must be assigned. The pink and yellow copies accompany the denial letter going to the provider. The recipient is then entitled to call for a Fair Hearing.

**IV. General Rules**

- A. Initial requests - generally done for a 3 month period of service then must be reassessed. However, this is up to reviewer's discretion.
- B. Renewal requests - generally done for a 6 month period of service, which is a maximum length of approval. A shorter period can be approved at reviewer discretion.
- C. Amounts approved - PDN is reimbursed at an hourly fee basis. Each county DSS Commissioner negotiates fees locally and submits for final approval to DOH. This is separate from the prior approval process. Some counties assign blanket fees for all providers. Other Counties assign provide specific fees. Approved fees will be routed to the designated counties through the Bureau of Medical Review

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and Evaluation. A rate book, organized by county, is kept in the unit. It should be referred to before completing all requests to verify applicable rate.

- D. Shared Rate Cases - If more than 2 recipients are approved for PDN in the same location at the same time, a shared rate must be applied. The hours approved for each person will be the full amount of hours the PDN is on site. The time is not divided. The rate is calculated as follows: Base Rate X 1.50 (50% increase) -- 2. This will give you the shared, or enhanced, rate. This rate applies to as many recipients as necessary. For example, the increased base rate is not divided by 3 if 3 people are receiving care.
- E. Non-provider specific approvals - whenever feasible each provider should have their own P.A. number for actual hours they provide. However, sometimes this is too unrealistic due to several providers swapping hours in order to cover the case. In this situation, a non-provider specific P.A. can be assigned. This means one P.A. is processed for total hours approved. Any one of the agencies provider ID numbers can be data entered. This option is only possible when a blanket fees exists and there is one level of nursing and provider type involved.
- F. RN and LPN mix - Sometimes the level of care is determined appropriate for both RN and LPN. Separate approvals must be processed for each due to different categories of service. The total hours approved cannot exceed the total hours approvable for the period of service.
- G. Premium vs. Regular fee - Some counties offer both fees, and application of fee is the discretion of the reviewer. Most cases should be assigned the regular fee, but some more difficult cases deserve the premium fee. Examples are (not all inclusive):
  - 1. Recipient dependent on ventilator support, or other highly technical equipment (O2 alone, feeding pumps, I.V. pumps not acceptable).
  - 2. Care provided on a holiday can be allowed premium. Holidays allowed are the nine legal (Federal) holidays:
    - a. New Year's Day
    - b. Martin Luther King Day
    - c. President's Day
    - d. Memorial Day
    - e. Independence Day

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- f. Labor Day
  - g. Veteran's Day
  - h. Thanksgiving Day
  - i. Christmas Day
3. Difficult to serve client as generally defined by having multiple technical and critical care needs, and a higher level of training required by PDN. Other criteria may be considered on an individual basis.

Premium rate should only be considered if requested by provider.

- H. Care at Home Waiver - Children in this program are exempt from this process. CAH staff administers that program.
- I. Training and Over Time - Not covered by Medicaid.
- J. Driving - Medicaid does not approve PDN's to drive a recipient as part of a plan of care. PDN may accompany a recipient during transport if medically necessary.
- K. Level of Care - The level of care (RN vs. LPN) is decided based on professional judgement and skilled tasks required. It isn't always necessary to approve what the MD orders. They frequently order RN when an LPN is sufficient. In general, LPN's are appropriate for most cases.