New York State Office of the State Comptroller

Thomas P. DiNapoli

Division of State Government Accountability

Medicaid Claims Processing Activity April 1, 2012 through September 30, 2012

Medicaid Program
Department of Health

Report 2012-S-24 October 2013

Executive Summary

Purpose

To determine whether the Department of Health's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to the providers. The audit covered the period April 1, 2012 through September 30, 2012.

Background

The Department of Health (Department) administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients, and it generates payments to reimburse the providers for their claims. During the six-month period ended September 30, 2012, eMedNY processed about 163 million claims resulting in payments to providers of about $25 billion. The claims are processed and paid in weekly cycles which averaged about 6.3 million claims and $950 million in provider payments.

Key Findings

Auditors identified about $2 million in overpayments resulting from:

- Claims billed with information from other health insurance plans that was inaccurate, which caused $675,265 in overpayments;
- Claims with incorrect billings for alternate levels of care, which caused $465,313 in overpayments;
- Claims for dental services that should have been covered by a managed care plan, which caused $336,780 in overpayments; and
- Claims with improper payments for inpatient services, physician-administered drugs, duplicate procedures, transportation services, eye care services, and nursing home and other services.
- At the time fieldwork was completed, auditors had recovered about $1.5 million of the overpayments that were identified. Thus, Department officials need to take actions to recover overpayments totaling about $500,000.

Key Recommendations

- We made 19 recommendations to the Department to recover the inappropriate Medicaid payments and to improve claims processing controls.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Claims Processing Activity April 1, 2011 through September 30, 2011 (2011-S-9)

State of New York
Office of the State Comptroller

Division of State Government Accountability

October 9, 2013

Nirav Shah, M.D., M.P.H.
Commissioner
Department of Health
Corning Office Building
Empire State Plaza
Albany, NY 12237

Dear Dr. Shah:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid Program entitled *Medicaid Claims Processing Activity April 1, 2012 through September 30, 2012*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

The New York State Medicaid program is a federal, state, and locally funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The federal government funds about 49 percent of New York's Medicaid costs, the State funds about 34 percent, and the localities (the City of New York and counties) fund the remaining 17 percent.

The Department of Health's (Department's) Office of Health Insurance Programs administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. During the six-month period ended September 30, 2012, eMedNY processed about 163 million claims resulting in payments to providers of about $25 billion. The claims are processed and paid in weekly cycles which averaged about 6.3 million claims and $950 million in provider payments.

When Medicaid claims are processed by eMedNY, they are subject to various automated edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate. For example, some edits verify the eligibility of the Medicaid recipient, other edits verify the eligibility of the medical service, and other edits verify the appropriateness of the amount billed for the service. In addition, some edits compare the claim to other related claims to determine whether any of the claims duplicate one another.

The Office of the State Comptroller performs audit steps during each weekly cycle of eMedNY processing to determine whether eMedNY has reasonably ensured the Medicaid claims were processed in accordance with requirements, the providers submitting the claims were approved for participation in the Medicaid program, and the amounts paid to the providers were correct. As audit exceptions are identified during the weekly cycle, our auditors work with Department staff to resolve the exceptions in a timely manner so payments can be made to providers. If necessary, payments to providers can be suspended until satisfactory resolution of the exceptions has been achieved.

In addition, the audit work performed during the weekly cycle may identify patterns and trends in claims and payment data that warrant follow-up and analysis as part of the Comptroller's audit responsibilities. Such follow-up and analytical audit procedures are designed to meet the Comptroller's constitutional and statutory requirements to audit all State expenditures.

Audit Findings and Recommendations

Based on the results of our audit work for the weekly cycles of Medicaid payments made during the six months ended September 30, 2012, we concluded eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to the providers. In addition, we identified the need for improvements in the processing of certain types of claims. For example, we found overpayments pertaining to: claims involving other insurance information that was inaccurate; hospital claims for services that should have been billed at lower reimbursing alternate levels of care; claims for dental services that should have been covered by a managed care plan; and claims with incorrect charges for physician-administered drugs. In total, we identified about $2 million in overpayments. At the time our audit fieldwork concluded, about $1.5 million of the overpayments had been recovered. Thus, Department officials still needed to take actions to recover the remaining overpayments totaling about $500,000.

Other Insurance on Medicaid Claims

Many Medicaid recipients also have other health insurance coverage (mostly Medicare). When submitting Medicaid claims, providers must determine if such recipients have other insurance coverage on the dates of the services in question. If the individual has other insurance coverage, that insurer becomes the primary insurer and must be billed first. Medicaid then becomes the secondary insurer and generally covers the patient's normal financial obligation, including coinsurance, copayments and deductibles. If the recipient of the medical service is not covered by any other insurer, Medicaid is the primary insurer and should be billed first.

Errors in the amounts claimed for coinsurance, copayments, deductibles and/or designation of the primary payer will likely result in improper Medicaid payments. We identified such errors on 65 claims that resulted in improper and questionable payments totaling $675,265. Specifically, we identified overpayments totaling $467,219 on 34 claims that resulted from excessive charges for coinsurance and copayments for recipients covered by other insurance (in addition to Medicaid). We contacted the providers and notified them of the incorrect information on the 34 claims. At the time of our review, providers adjusted 22 of the claims, saving Medicaid $430,527. Providers, however, still needed to adjust 12 claims that were overpaid by at least $36,692.

For the remaining 31 (of the 65) claims, Medicaid was incorrectly designated as the primary payer when the primary payer was actually another insurer. Generally, primary payers pay more than secondary payers. We contacted the providers and advised them that the recipients had other insurance coverage when the services were provided and, therefore, Medicaid was incorrectly designated as the primary payer. The providers adjusted all 31 claims, which saved Medicaid $208,046.

At the time our fieldwork concluded, 53 (of the 65) claims were corrected, saving Medicaid $638,573. Adjustments were still needed for the remaining 12 claims, which Medicaid overpaid

by at least $36,692. Further, this audit identified similar errors found in prior audits, involving some of the same providers that submitted excessive claims. Thus, the Department needs to take prompt actions to ensure eMedNY prevents overpayments of this magnitude in the future.

Recommendations

1. Review and recover the unresolved overpayments (totaling at least $36,692) on the 12 claims with excessive charges for coinsurance and copayments.

2. Formally advise the providers identified in our audit how to verify current Medicare and other insurance eligibility and how to accurately bill recipients' financial obligations. As resources and priorities permit, monitor the submissions of such claims by these providers.

Alternate Level of Care

According to Department Medicaid guidelines, hospitals must indicate a patient's "level of care" on claims to ensure accurate processing and payment. Certain levels of care are more intensive (and therefore more expensive) than others. Hospitals should not bill for intensive levels of care for days when patients are in an alternate (lower) level of care (ALC) setting. Additionally, Medicare will sometimes pay for intensive care, but not ALC. When this occurs, a provider should submit one claim for the Medicare deductible or coinsurance for the intensive care and a separate claim for the ALC days at the standard Medicaid rate.

Medicaid overpaid three inpatient claims by $465,313 because three hospitals billed a more costly level of care than was actually provided or did not correctly bill for ALC days for recipients also covered by Medicare. On two of the three claims, the hospitals did not indicate any ALC days during long inpatient stays. Instead, they billed the entire length of the inpatient stay at high levels of care. At our request, the hospitals reviewed their records and determined that a significant number of the days were actually ALC.

In one case, Medicaid paid a hospital $164,054. However, if the claim was submitted properly for the ALC portion of the admission, Medicaid would have paid only $14,094. Thus, Medicaid overpaid the hospital $149,960 ($164,054 - $14,094). In another case, Medicaid paid a hospital $224,768; however, the amount would have been only $136,584 if ALC days were claimed correctly. Thus, Medicaid overpaid this hospital by $88,184 ($224,768 - $136,584). Medicaid paid $302,061 on the remaining claim for an admission that was partially covered by Medicare. However, Medicaid should have paid only $74,892 for the admission. Medicaid overpaid the hospital $227,169 ($302,061 - $74,892) because the hospital did not bill ALC days separately from the intensive care days that Medicare covered. We advised the hospitals of these errors and hospital officials corrected all three claims, saving Medicaid $465,313.

Recommendation

3. Formally advise the hospitals in question to ensure that ALC days are accurately reported on claims.

Incorrect Claims for Dental Services

Effective July 2, 2012, Medicaid managed care plans included coverage of most standard dental services. As a result, dental providers must submit their claims to the appropriate managed care plan rather than billing them directly to Medicaid. The Department is responsible for updating the scope of benefits for managed care plans in eMedNY to ensure that claims billed directly to Medicaid are not paid if the services are covered by a managed care plan. Errors in the scope of benefits will likely result in improper Medicaid payments.

We determined Medicaid overpaid providers $338,950 on 2,411 claims for dental services. Medicaid made overpayments totaling $336,780 on 2,409 claims for recipients enrolled in one particular managed care plan. According to Department officials, Medicaid incorrectly paid these claims because the plan's scope of benefits was not updated in eMedNY at the time dental services were integrated into managed care (on July 2, 2012). Department officials identified the error and corrected the scope of benefits for the plan in September of 2012. However, the Department did not correct the 2,409 claim payments in question.

For the remaining two claims, we identified overpayments totaling $2,170. One claim was overpaid by $2,000. The claim was manually reviewed and priced by the Department's Dental Unit. According to notations made by the Dental Unit, a charge of $2,000 on one of the claim's billing lines should not have been paid. Nevertheless, eMedNY accepted the charge and paid $2,000. The Dental Unit attributed the error to a lack of functionality in eMedNY that does not allow the denial of one claim line while approving another. The second claim was overpaid by $170 because the provider billed for a denture reline within six months of the delivery of a new denture. This is precluded by Department policy.

At the time we completed our fieldwork, the Department had not yet recovered the overpayments which totaled $338,950.

Recommendations

4. Review and recover the overpayments totaling $338,950 on the 2,411 dental claims.

5. Assess eMedNY functionality that precludes line by line manual pricing adjustments for errant dental claims. Correct the eMedNY system as necessary to permit such adjustments.

Inaccurate Patient Status Codes

When a hospital bills Medicaid, it must include a patient status code, which indicates whether

the patient was discharged or transferred to another healthcare facility. The patient status code is important because the reimbursement method (and amount) depends on whether a patient is discharged or transferred. When a patient is discharged, institutional medical treatment is ostensibly complete. When a patient is transferred, medical treatment has not been completed. Hence, a transfer claim often pays less (and sometimes significantly less) than a discharge claim. We determined that eMedNY paid $156,075 on one particular claim whose patient status code was incorrect. Although a hospital transferred the recipient to another health care facility, hospital staff applied a discharge code (instead of a transfer code) to the claim. At our request, the hospital reviewed and corrected the claim, which reduced the payment to $4,084 and saved Medicaid $151,991 ($156,075 - $4,084). The hospital's administrators plan to update their internal procedures to include more detailed descriptions of how to assign patient status codes.

Recommendation

6. Follow-up with this provider to ensure it completes its proposed update of internal procedures for assigning patient status codes.

Incorrect Diagnosis and Procedure Codes

On seven claims totaling $179,249, Medicaid overpaid four providers $126,725 because the providers applied incorrect diagnosis or procedure codes to their claims. The overpayments occurred under several scenarios, as follows:

- A hospital submitted a claim for inpatient services that paid $152,054. However, the diagnosis code on the claim was for a medical condition that was more severe than the problem the patient actually had. At our request, the provider reviewed and corrected the claim, saving Medicaid $101,743;
- A clinic submitted four claims totaling $18,657 that billed a procedure code for an entire course of radiation therapy, instead of a code for the individual sessions of radiation that were actually provided. At our request, the provider reviewed and corrected the claims, saving Medicaid $16,990;
- A clinic submitted a claim that paid $4,955. The claim included a procedure code that should not have been billed to Medicaid. At our request, the provider reviewed and corrected the claim, saving Medicaid $4,672; and
- A clinic submitted a claim that paid $3,583. The claim contained a procedure code outside the clinic specialist's area of practice. At our request, the provider reviewed and corrected the claim, saving Medicaid $3,320.

The four providers corrected all seven overpaid claims, saving Medicaid $126,725.

Recommendation

7. Formally advise the four providers in question to ensure the diagnosis and procedure codes applied to their claims are correct.

Physician-Administered Drugs

Medicaid requires providers to bill physician-administered drugs at their acquisition costs, including any discounts given by the drugs' manufacturers. To pay a claim for a physician-administered drug, eMedNY compares the drug's acquisition cost (as indicated by the provider) to the maximum allowable Medicaid fee and pays the lesser of the two amounts. Typically, a provider's drug acquisition cost is less than the maximum allowable Medicaid fee. Thus, when a provider overstates the acquisition cost of a physician-administered drug, there is a considerable risk that Medicaid will overpay the claim.

From 186 claim payments totaling $391,068, we identified overpayments totaling $118,586 made to 20 providers of physician-administered drugs. On these claims, the providers billed amounts well in excess of the drugs' actual acquisition costs, which also were generally less than the maximum Medicaid fee amounts. For example, one provider submitted a claim for $58,658 to administer several drugs to a recipient. Based on Medicaid's maximum allowable fees, eMedNY paid $3,299 on this claim. At our request, the provider reviewed its invoices and reported that the actual acquisition costs for the drugs totaled only $858. The provider corrected this claim, saving Medicaid $2,441 ($3,299 - $858).

At the time our fieldwork concluded, providers corrected 12 claims, saving Medicaid $15,751. In addition, we anticipate that the remaining 174 claims will be corrected, saving another $102,835. Also, we identified apparent overpayments on seven other claims totaling $28,291. At the time our fieldwork concluded, provider actions (including the provision of supporting documentation) were still needed to resolve these questionable claims.

Most providers cited problems with their billing systems as the reason for the improper claims. Four providers were already aware of the problems and have been working to correct their billing systems. Other providers attributed overcharges to human errors. No matter the reason, overpayments occur when providers overstate their actual drug acquisition costs on claims for physician-administered drugs. We have identified similar errors in prior audits. Thus, the Department needs to promptly strengthen eMedNY controls over claims for physician-administered drugs, particularly when providers' reported acquisition costs exceed the amounts of Medicaid's maximum allowable reimbursement.

Recommendations

8. Follow-up on and recover the $102,835 from the 174 claims which should be corrected. Resolve the potential overpayments on the other seven claim payments (totaling $28,291) and recover funds where appropriate.

9. Confirm that the four providers have taken corrective actions to prevent overpayments on physician-administered drugs. Formally remind the remaining 16 providers of the correct way to bill claims for physician-administered drugs and advise the providers to take corrective actions to prevent overpayments. As resources and priorities permit, monitor the submissions of such claims by these providers.

Duplicate Billings

From 42 claim payments totaling $123,859, Medicaid overpaid six providers $85,522 because the providers billed for certain procedures more than once. The duplicate payments occurred under several scenarios, as follows:

- Three providers repeatedly billed the same procedure code inappropriately, more than once per day per patient, on 19 claims, resulting in overpayments totaling $48,597;
- One provider repeatedly billed an incorrect procedure code for ventilator management on 19 claims, resulting in overpayments totaling $27,330;
- One provider billed for the same medical equipment to the same patient multiple times on three claims, resulting in overpayments totaling $7,607; and
- One provider billed for two hysterectomy procedures on the same patient in one claim, resulting in an overpayment of $1,988.

The six providers acknowledged their errors and corrected their overpaid claims, saving Medicaid the $85,522 in question. We have identified similar errors in prior audits. Thus, the Department needs to take prompt actions to ensure eMedNY prevents overpayments when providers bill for dupicate procedures.

Recommendation

10. Formally remind the six providers how to properly bill the procedures in question.

Overlapping Claims During Hospital Stays

The Department establishes all-inclusive hospital inpatient rates that generally cover the costs of all medical services provided to Medicaid recipients during the hospital stay. Under this type of arrangement, no additional payments should be made for services provided to recipients while they are hospitalized. Further, if a Medicaid recipient receives services in a hospital's emergency room or clinic and is then admitted as an inpatient to that hospital, the hospital should not submit a separate claim for emergency room or clinic services. Also, if a Medicaid recipient is initially treated in the emergency room and then requires ambulatory surgery outside of the emergency room that same day, the hospital should not bill separate claims for the emergency room and ambulatory services. Rather, the services should be billed on one claim for accurate pricing and payment.

However, we identified six claims that eMedNY overpaid by $25,416 due to overlapping medical services, as follows:

- Two hospitals were overpaid $23,560 on two claims because they billed Medicaid for both clinic and inpatient services for the same recipient on the same day. In one of these instances, the hospital never admitted the recipient as an inpatient;
- A private duty nursing service was overpaid $1,594 on three claims because it billed for

services on days when the recipient was hospitalized; and
- A hospital was overpaid $262 because it billed separate claims for an emergency room visit and an ambulatory surgery service for the same recipient on the same day.

At our request, the hospitals in question corrected their improper claims, saving Medicaid $23,822 ($23,560 + $262). The private duty nursing provider agreed the remaining three claims (overpaid by $1,594) were incorrect and advised us that the claims would be corrected. However, by the end of our fieldwork, the provider had not yet adjusted the claims. We have identified similar errors in prior audits. Thus, the Department needs to strengthen eMedNY controls over certain services provided to recipients on dates when they are admitted as inpatients.

Recommendations

11. Review and recover the overpayments totaling $1,594 resulting from the three improper claims for private duty nursing service.

12. Formally remind the providers in question how to correctly bill Medicaid when there are overlapping services for the same recipient on the same day.

Incorrect Claims for Transportation Services

Medicaid will pay the actual mileage to transport a recipient to and from the location where covered services are provided. In certain counties, the Department contracts for transportation management services to prior-authorize transportation services for Medicaid recipients. Such authorization includes a calculation of the billable mileage for medically-related transportation. We identified overpayments totaling $17,935 because transportation providers submitted claims for excessive mileage, as follows:

- On three claims, a provider misplaced a decimal point which resulted in the overstatements of mileage and overpayments totaling $14,007. Although the provider agreed the claims were incorrect, the provider had not corrected them at the time our fieldwork ended;
- A provider was incorrectly prior-authorized for excessive mileage on 25 claims, resulting in overpayments totaling $3,433. The Department and the prior-authorization contractor agreed the authorized mileage was excessive because an incorrect zip code was used to determine the travel distance. The Department informed the provider of the correct way to bill for mileage and required the prior-authorization contractor to submit a corrective action plan. However, by the end of our fieldwork, this provider had not corrected the claims; and
- Another provider entered incorrect mileage on one claim, resulting in an overpayment of $495. As a result of our audit, the provider corrected the claim, saving Medicaid $495.

At the time our fieldwork concluded, adjustments were still needed for 28 claims, which had overpayments totaling $17,440 ($14,007 + $3,433).

Recommendation

13. Review and recover the unresolved overpayments totaling $17,440 on the 28 transportation claims we identified.

Incorrect Claims for Eye Care

Although Medicaid pays for routine vision care services (such as eyeglasses and routine eye exams), Medicare generally does not. Consequently, for recipients who are enrolled in both Medicaid and Medicare, providers should receive no more than Medicaid's standard fee schedule amounts for claims for routine vision care services. If Medicare does cover a service, Medicaid is then the secondary insurer and will generally cover the patient's normal financial obligation, including coinsurance, copayments and deductibles. In all cases, providers must correctly report the patient's financial obligation amount. Providers are also required to keep detailed records of the services provided to Medicaid recipients.

We identified overpayments totaling $12,605 on 81 claims submitted by 20 providers. The overpayments occurred because providers incorrectly reported patients' financial obligations, lacked supporting documentation for services claimed, and applied codes for more expensive procedures than were actually performed.

Specifically, 15 (of the 20) providers improperly reported patient financial obligations on 62 claims, resulting in overpayments totaling $10,294. In one case, a provider submitted a $250 claim for coinsurance for an eye exam. However, Medicare denied the provider's claim for this eye exam because it was not covered. As such, Medicaid should have paid its standard amount ($44) for the exam. Because Medicaid paid the purported coinsurance amount ($250), the provider was overpaid $206 ($250 - $44). In another case, a provider reported an excessive amount ($392) for the Medicare deductible and coinsurance related to an eye exam and ocular photography. Because the actual deductible and coinsurance totaled only $196, Medicaid overpaid the claim for these services by $196 ($392 - $196).

The remaining providers submitted 14 claims which lacked adequate supporting documentation of the services provided and resulted in overpayments totaling $2,007. For example, a provider received a claim payment of $295 for an eye exam and glasses. However, the provider stated that the claim was billed in error because there were no records of services for the recipient on the date in question. In addition, four providers applied incorrect procedure codes to five claims, resulting in overpayments totaling $304. For example, on a claim for an exam of an established patient, a provider applied a code normally reserved for the more extensive exam of a new patient. This coding error caused an overpayment of $205.

Five providers said they used a service bureau (or billing agent) to submit their Medicaid claims, and therefore, they were not familiar with Medicaid billing guidelines. Regardless of who submits claims on behalf of a provider, it is the provider's responsibility to ensure their claims are accurate and payments are correct. Further, at the time our fieldwork concluded, providers corrected 25

claims (saving Medicaid $4,396), and corrections were still needed on the remaining 56 claims, with overpayments totaling $8,209.

Recommendations

14. Review and recover the unresolved overpayments totaling $8,209 on the 56 eye care claims.

15. Formally instruct the 20 providers how to properly bill claims for eye care services they provide to recipients who also have Medicare coverage. Also, advise the five providers who use billing agents that providers are responsible for the accuracy of claims submitted on their behalf to Medicaid.

Incorrect Claims for Nursing Home Services

Medicaid overpaid five providers a total of $10,245 on 13 claims because the providers either failed to deduct the amount of the patient's liability from the claim or used an incorrect rate code. At the time our fieldwork concluded, providers corrected 12 of the 13 claims, saving Medicaid $8,912.

Of the 13 improper claims, 11 occurred because four providers underreported the amounts of recipients' liabilities for their care. As a result of our audit, three of the four providers corrected 10 claims, saving Medicaid $8,632. At the time our field work concluded, the fourth provider had not corrected a claim with an overpayment of $1,333. Another provider billed the wrong rate code on the remaining two claims. Although the recipient in question had Medicare coverage, the provider billed the code used for recipients with Medicaid coverage only, instead of the code for recipients with Medicare. The provider acknowledged the error and corrected the claims, saving Medicaid $280.

Recommendations

16. Review and recover the unresolved overpayment of $1,333.

17. Formally remind the providers in question of the requirements to correctly report recipient liabilities and to verify Medicare eligibility prior to billing Medicaid.

Recipient Residing in Massachusetts

According to NYCRR Title 18, Section 360-3.2, a recipient's state of residence is responsible for providing public medical assistance. Hence, a Medicaid recipient must be a resident of New York State to receive benefits under New York's Medicaid program. Further, a recipient's New York eligibility should be terminated if another state has determined the person is a resident of that state for Medicaid purposes.

We identified recurring claims from out-of-state providers for a recipient who was no longer

a resident of New York and, therefore, was not eligible for New York Medicaid benefits. The recipient resided in Massachusetts and was also enrolled in Massachusetts' Food Stamp program at the time the payments were made by New York. In fact, the recipient had been a resident of Massachusetts since 2010. As a result, New York should not have paid 34 claims totaling $4,610 for services rendered while the recipient was living out-of-state.

In New York State, local social service districts (including the New York City Human Resources Administration) are responsible for ensuring applicants meet eligibility requirements, enrolling them in Medicaid, and ensuring their enrollment information is current. Further, reports from the federal government's Public Assistance Reporting Information System identify persons who are enrolled in public assistance in two or more states at the same time. When that occurs, local social service officials should determine if such persons are still program-eligible or should be terminated from their State's programs. Human Resources Administration officials, however, did not identify the person in question and remove that person from New York's Medicaid program. Consequently, eMedNY made the improper payments totaling $4,610.

Recommendations

18. Review and recover the $4,610 in Medicaid payments for the person who resides in Massachusetts.

19. For the person in question, contact Human Resources Administration officials and resolve the recipient's Medicaid eligibility status, as appropriate.

Audit Scope and Methodology

We audited selected Medicaid claims processed by the Department to determine whether the Department's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to the providers. The scope of our audit was from April 1, 2012 through September 30, 2012. Additionally, claims and transactions outside of the audit scope period were examined in instances where we observed a pattern of problems and high risk of overpayment.

To accomplish our audit objectives, we performed various analyses of claims from Medicaid payment files, verified the accuracy of certain payments and tested the operation of certain system controls. We interviewed officials from the Department, Computer Sciences Corporation (the Department's Medicaid fiscal agent), and the Office of the Medicaid Inspector General. We reviewed applicable sections of federal and State laws and regulations, examined the Department's Medicaid payment policies and procedures, and tested medical records supporting provider claims for reimbursement. Our audit steps reflect a risk-based approach taking into consideration the time constraints of the weekly cycle and the materiality of payments.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient,

appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. Department officials generally concurred with our recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinder to certain Department comments is included in the report's State Comptroller's Comment. Also, certain other matters were considered to be of lesser signifiance, and these were provided to the Department in a separate letter for further action.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

August 13, 2013

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

Dear Mr. Mason:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2012-S-24 entitled, "Medicaid Claims Processing Activity for the Period April 1, 2012 through September 30, 2012."

Thank you for the opportunity to comment.

Sincerely,

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2012-S-24 Entitled
Medicaid Claims Processing Activity for the Period
April 1, 2012 through September 30, 2012

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2012-S-24 entitled, "Medicaid Claims Processing Activity for the Period April 1, 2012 through September 30, 2012."

Recommendation #1:

Review and recover the unresolved overpayments (totaling $36,692) on the 12 claims with excessive charges for coinsurance and copayments.

Response #1:

The Office of the Medicaid Inspector General's (OMIG) recovery audit contractor (RAC) has recovered $8,463. Efforts to recover additional money will continue.

Recommendation #2:

Formally advise the providers identified in our audit how to verify current Medicare and other insurance eligibility and how to accurately bill recipients' financial obligations. As resources and priorities permit, monitor the submissions of such claims by these providers.

Response #2:

Computer Science Corporation (CSC) will be asked to contact the six providers identified in the OSC audit that failed to verify Medicare eligibility and instruct them on how to confirm patients' Medicare status once the list of providers has been obtained from the OSC. The OMIG may monitor for compliance based on resources.

* Comment 1

Recommendation #3:

Formally advise the hospitals in question to ensure that ALC days are accurately reported on claims.

Response #3:

The OSC states in their audit finding that the providers corrected their ALC days on the claim. In addition, the Department issued a Medicaid Update article in May 2013.

* See State Comptroller's Comment, page 24.

Recommendation #4:

Review and recover the overpayments totaling $338,950 on the 2,411 dental claims.

Response #4:

The OMIG is in the process of recovering these overpayments. Draft Audit Reports were issued in May 2013 to dental providers who billed inappropriately.

Recommendation #5:

Assess eMedNY functionality that precludes line by line manual pricing adjustments for errant dental claims. Correct the eMedNY system as necessary to permit such adjustments.

Response #5:

The Department will evaluate current eMedNY functionality and request a systems enhancement, if warranted. However, due to other Department priorities (Medicaid Redesign Team (MRT) projects, Federal mandates and the need for extensive systems modifications and enhancements to accommodate interface with the New York Health Exchange), a potential solution will be addressed at a future date.

Recommendation #6:

Follow-up with this provider to ensure it completes its proposed update of internal procedures for assigning patient status codes.

Response #6:

Social Services Law 363-d and Social Service regulation Part 521 requires Medicaid providers to adopt and implement effective compliance programs when a substantial portion of their business operation is Medicaid. A provider's compliance plan must include a system for identification of compliance risk and self-evaluation of potential risk areas. This includes internal and external audits and evaluation of actual non-compliance as a result of such self-evaluations and audits. The compliance program must also include a system for taking corrective action. We will follow up with the provider to ensure they have taken corrective action

Recommendation #7:

Formally advise the four providers in question to ensure the diagnosis and procedure codes applied to their claims are correct.

Response #7:

The OSC identified four providers who entered incorrect procedure and diagnosis codes on their Medicaid claim which resulted in an overpayment. The OSC states in their audit finding that all of the overpayments were recovered.

Recommendation #8:

Follow-up and recover the $102,835 from the 174 claims which should be corrected. Resolve the potential overpayments on the other seven claim payments (totaling $28,291) and recover funds where appropriate.

Response #8:

The OMIG will review these payments and initiate recovery as appropriate.

Recommendation #9:

Confirm that the four providers have taken corrective actions to prevent overpayments on physician-administered drugs. Formally remind the remaining 16 providers of the correct way to bill claims for physician-administered drugs and advise the providers to take corrective actions to prevent overpayments. As resources and priorities permit, monitor the submissions of such claims by these providers.

Response #9:

All of the providers identified in the OSC audit were notified by the OSC of the potential overpayments. According to the OSC audit, each of the providers acknowledged the billing problems and indicated they were taking corrective action to prevent future overpayments.

In addition, a Medicaid Update article was published in June 2013 reminding providers that they are required to bill acquisition costs by invoice for physician administered drugs.

The OMIG may monitor for future billings, based on staffing resources.

Recommendation #10:

Formally remind the six providers how to properly bill the procedures in question.

Response #10:

The OSC identified six different providers who provided incorrect procedure code information on their clinic APG claim. In each instance, the OSC notified the provider of the incorrect billing and the provider took corrective action by correcting the errors and submitting claim adjustments. The corrective action taken by the each of the providers indicates that the providers are aware of the billing errors they previously committed and are now cognizant of the correct way to bill for the services in question. No additional billing instructions are indicated at this time.

Recommendation #11:

Review and recover the overpayments totaling $1,594 resulting from the three improper claims for private duty nursing service.

Response #11:

The OMIG will review these payments and initiate recovery as appropriate.

Recommendation #12:

Formally remind the providers in question how to correctly bill Medicaid when there are overlapping services for the same recipient on the same day.

Response #12:

CSC Provider Services staff will be asked to contact the three hospital providers noted in the report to provide appropriate reminders, notifications, education and/or instructions on the billing matters specified for each of the related finding areas once the list of providers has been obtained from the OSC.

* Comment 1

The private duty nursing service was notified in a July 29, 2013 letter how to correctly bill Medicaid when there are overlapping services for the same recipient on the same day.

Recommendation #13:

Review and recover the unresolved overpayments totaling $17,440 on the 28 transportation claims we identified.

Response #13:

The OMIG will review these payments and initiate recovery as appropriate.

Recommendation #14:

Review and recover the unresolved overpayments totaling $8,209 on the 56 eye care claims.

Response #14:

The OMIG will review these payments and initiate recovery as appropriate.

Recommendation #15:

Formally instruct the 20 providers how to properly bill claims for eye care services they provide to recipients who also have Medicare coverage. Also, advise the five providers who use billing agents that providers are responsible for the accuracy of claims submitted on their behalf to Medicaid.

Response #15:

All Medicare/Medicaid crossover claims submitted by the eye care providers identified in the OSC audit report are now on pre-payment review to insure the accuracy of their claims.

Recommendation #16:

Review and recover the unresolved overpayment of $1,333.

Response #16:

The OMIG has referred the claim to our third party RAC to initiate recovery.

Recommendation #17:

Formally remind the providers in question of the requirements to correctly report recipient liabilities and to verify Medicare eligibility prior to billing Medicaid.

Response #17:

The Department will ask CSC to contact the nursing homes identified in the OSC audit that failed to verify Medicare eligibility and instruct them on how to confirm patients' Medicare status when the list of providers has been obtained from the OSC.

* Comment 1

Recommendation #18:

Review and recover the $4,610 in Medicaid payments for the person who resides in Massachusetts.

Response #18:

Since the individual was enrolled in New York State Medicaid at the time of service, no recoveries can be made.

Recommendation #19:

For the person in question, contact Human Resources Administration officials and resolve the recipient's Medicaid eligibility status, as appropriate.

Response #19:

The Department verified the consumer has an out of state address. The Medicaid case was closed on April 26, 2013.

State Comptroller's Comment

1. During the course of the audit, the Office of the State Comptroller provided Department officials with lists of the providers in question. We will resubmit the lists to the Department.