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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

March 12, 2013

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

Re: Medicaid Claims Submitted by Accordis, Inc. on Behalf of the New York City Health and Hospitals Corporation
Report 2011-S-29

Dear Dr. Shah:

We audited the New York State Medicaid Program to determine whether Accordis, Inc. (Accordis) submitted appropriate Medicaid claims on behalf of the New York City Health and Hospitals Corporation (HHC). This audit was performed in accordance with 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. Due to a limitation in the Medicaid claims processing and payment system, eMedNY, we were unable to fully complete our audit objective. Our report contains three recommendations to help your staff address this and other related deficiencies, and to recover unsupported payments.

Background

HHC is a public benefit corporation that provides healthcare services in the five boroughs of New York City. HHC provides medical, mental health and substance abuse services through 11 hospitals, 4 skilled nursing facilities, 6 large diagnostic and treatment centers and more than 70 community based clinics. Healthcare providers submit Medicaid claims to the Department of Health's eMedNY claims processing system for payment of their services. For various reasons, eMedNY denies payment of many claims. Claims that are denied can be modified and resubmitted to eMedNY for payment.

Medicaid allows healthcare billing companies, commonly referred to as service bureaus, to submit claims on behalf of medical providers. In March 2005, HHC hired Accordis to provide billing services for HHC-affiliated providers. Accordis' primary responsibility was to review and

resubmit outpatient claims that were originally submitted by HHC providers and denied by eMedNY. To accomplish this, Accordis determined the reason(s) for claim denials, reviewed pertinent patient medical files and claim information, and resubmitted the corrected claims to eMedNY for payment. For the three-year period ended December 31, 2010, Accordis submitted 192,296 claims totaling more than $26.2 million on behalf of HHC providers.

Results of Audit

eMedNY System Limitation

On July 24, 2012, we issued an audit report (2010-S-29) entitled *Inappropriate Medicaid Payments for Recipients with Multiple Identification Numbers and no Social Security Numbers*. In this report, we determined Accordis inappropriately changed claims, by applying a recipient's second Medicaid identification number, to obtain improper payments. Providers and their service bureaus can obtain improper payments by making other inappropriate modifications to previously denied claims as well. Given the extent of claims submitted by Accordis and its prior questionable practices, oversight authorities need the ability to identify changes Accordis made to claims that eMedNY previously denied (and subsequently paid) to determine if the changes and resulting payments were appropriate.

However, because of eMedNY system limitations, we were unable to readily identify and match denied claims to the amended claims that Accordis submitted and eMedNY paid. This significantly limited our ability to pinpoint the changes that Accordis made to the amended claims. Enhancing eMedNY to provide a direct link between denied claims and their related amended claims would allow for a systematic identification of all such claims and the changes that were made to them. Moreover, such a link would better enable oversight authorities to assess the propriety of the amended claims (whether submitted by providers or billing service bureaus) and the corresponding eMedNY payments.

Review of Claims Prior to Billing Service Submission

Service bureaus, such as Accordis, are required to enroll with Medicaid and comply with all applicable regulations and policies. Section 504.9(2)(b) of Title 18 of the New York Codes, Rules and Regulations requires healthcare providers to review their claims before service bureaus submit them to eMedNY for payment. We determined, however, that HHC providers were not reviewing the claims submitted by Accordis. As such, HHC officials had limited assurance that the claims submitted by Accordis on behalf of HHC providers were appropriate. Further, we have addressed this matter to the Department of Health in prior audit reports.

Unsupported Claim Payments

Because eMedNY lacks a mechanism to directly link a paid claim to a previously denied claim, we developed a methodology to identify potentially related claims. Specifically, we matched various claim data (such as Medicaid recipient identification number and date of service) from denied claims to the related paid claims. From this match, we identified a judgmental sample

of 30 claim payments totaling $3,515 for review. Based on our review, we concluded 6 claim payments totaling $533 (or 15.2 percent of the payments totaling $3,515) were not properly supported by the available medical records. As such, providers lacked sufficient evidence the services in question were actually provided, and therefore, the Department of Health should recover the $533 paid for these claims. Further, if the proportion (15.2 percent) of unsupported payments in our sample was consistent for the 192,296 claims submitted by Accordis (on behalf of HHC) during our three-year audit period, the amounts of the unsupported payments could have been significant.

Recommendations

1. Implement eMedNY enhancements that provide a mechanism for linking paid claims with previously denied claims.

2. Formally remind HHC to review the propriety of claims prior to Accordis (or any other service bureau) submitting them to eMedNY, as required by New York State regulations.

3. Review the $533 in payments we identified and recover inappropriate payments.

Audit Scope and Methodology

The objective of the audit was to determine the propriety of claims submitted by Accordis on behalf of HHC providers for the three-years ended December 31, 2010. We sought to review the original (denied) claims to determine whether changes Accordis made to claims' data (such as Medicaid recipient identification numbers, dates of service, etc.) and the resulting claim payments were appropriate. Because of certain eMedNY system limitations, we were unable to identify and match all original denied claims to the corresponding amended claims Accordis submitted. As a result, we were unable to fully accomplish our audit objective.

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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

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.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials indicated that certain actions will be taken to address two of our report's three recommendations. Officials also indicated, however, that requirements of the Health Insurance Portability and Accountability Act preclude them from acting on the remaining recommendation. Our rejoinder to certain Department comments is included as a State Comptroller's Comment.

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.

Major contributors to this report include Andrea Inman, Dennis Buckley, Mostafa Kamal and David Schaeffer.

Very truly yours,

Brian E. Mason
Audit Director

cc: Mr. James Cox, Medicaid Inspector General
Mr. Thomas Lukacs, Division of the Budget
Mr. Stephen Abbott, Department of Health

Agency Comments

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

Sue Kelly
Executive Deputy Commissioner

December 28, 2012

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

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments regarding Office of the State Comptroller's Draft Audit Report 2011-S-29 on "Medicaid Claims Submitted by Accordis, Inc. on Behalf of the New York City Health and Hospitals Corporation."

Thank you for the opportunity to comment.

Sincerely,

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Michael Nazarko
James C. Cox
Jason A. Helgerson
Diane Christensen
Stephen Abbott
Dennis Wendell
Stephen LaCasse
Ronald Farrell
Michelle Contreras
Irene Myron
John Brooks

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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2011-S-29 on
Medicaid Claims Submitted by Accordis, Inc. on Behalf of the
New York City Health and Hospitals Corporation

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2011-S-29 on "Medicaid Claims Submitted by Accordis, Inc. on Behalf of the New York City Health and Hospitals Corporation."

Recommendation #1:

Implement eMedNY enhancements that provide a mechanism for linking paid claims with previously denied claims.

Response #1:

Limitations with national claim processing data standards required by the Health Insurance Portability and Accountability Act prevents the Department from developing and implementing an eMedNY enhancement that could accurately and efficiently link a new claim to one that was previously denied. Further, since there is no limit on the number of data elements that can be altered on a denied claim prior to resubmission or on the number of times that a denied claim can be resubmitted over a given time span, any systematic attempt to link a new claim to one that was previously denied is likely to result in a high number of mismatches considering the volume of transactions processed by eMedNY.

* Comment 1

Recommendation #2:

Formally remind the New York City Health and Hospital Corporation (HHC) to review the propriety of claims prior to Accordis (or any other service bureau) submitting them to eMedNY, as required by New York State regulations.

Response #2:

The Department will include an article in its Medicaid Update monthly publication reminding all providers, including HHC, as well as service bureaus, of the requirement for service bureaus to have claims reviewed by the provider prior to submission in order to afford the provider the opportunity to correct any inaccurate claims, delete improper claims, or otherwise revise the intended submission to ensure that claims submitted for reimbursement are for care, services and supplies actually delivered.

Recommendation #3:

Review the $533 in payments we identified and recover inappropriate payments.

* See State Comptroller's Comment, Page 8.

Response #3:

The Office of the Medicaid Inspector General (OMIG) will review the six associated claims and recover overpayments as appropriate.

State Comptroller’s Comment

1. We acknowledge that the Department must comply with the claims processing data standards established under the Health Insurance Portability and Accountability Act. Further, a change to such standards could require approval of Federal oversight authorities. Hence, the Department could request Federal authorities to approve a change to claims data (to link denied and corresponding paid claims) that would strengthen control over Medicaid payments. Also, to implement such a link, the Department could consider an approach similar to the one eMedNY uses for adjusted claims. When an adjusted claim is submitted, a suffix is added to the claim’s original identification number.