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

Division of State Government Accountability

Medicaid Claims Processing Activity October 1, 2011 Through March 31, 2012

Medicaid Program
Department of Health

Report 2011-S-39 July 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 October 1, 2011 through March 31, 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 March 31, 2012, eMedNY processed approximately 233 million claims resulting in payments to providers of about $25 billion. The claims are processed and paid in weekly cycles which averaged about 9 million claims and $974 million in payments to providers.

Key Findings

- Auditors identified about $4.1 million in overpayments resulting from:
    - Incorrect retroactive rate changes that caused overpayments totaling $2.4 million;
    - Claims billed with information from other health insurance plans that was inaccurate, which caused $530,710 in overpayments;
    - Inpatient claims billed with high (intensive) levels of care that should have been based on less costly "alternate" levels of care, which caused overpayments of $412,737;
    - Claims for childcare services while the recipient was hospitalized, which caused overpayments of $256,510; and
    - Claims with improper payments for physician-administered drugs, inpatient services, duplicate procedures, medical equipment, transportation services and nursing home services.
- At the time the audit's fieldwork was completed, the auditors recovered about $3.8 million of the overpayments identified.
- Auditors also found providers in the Medicaid program who were charged with or found guilty of crimes that violate Medicaid program laws or regulations. The Department promptly terminated 17 of the providers we identified, but the status of another 19 providers was still under review.

Key Recommendations

- We made 17 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 October 1, 2010 through March 31, 2011 (2010-S-65)

State of New York
Office of the State Comptroller

Division of State Government Accountability

July 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 October 1, 2011 through March 31, 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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This report is also available on our website at: www.osc.state.ny.us

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 March 31, 2012, eMedNY processed approximately 233 million claims resulting in payments to providers of about $25 billion. The claims are processed and paid in weekly cycles which averaged about 9 million claims and $974 million in Medicaid payments to the providers.

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 March 31, 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: incorrect retroactive rate changes; 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 childcare services while the recipient was hospitalized; and claims with incorrect charges for physician-administered drugs. In total, we identified actual and potential overpayments of approximately $4.1 million. At the time our audit fieldwork concluded, about $3.8 million of these overpayments had been recovered.

Incorrect Retroactive Rate Changes

Medicaid reimburses certain providers through the use of rate codes. When rate code reimbursement amounts are updated and entered into the eMedNY system, eMedNY will automatically re-price a provider's previously paid claims that are affected by a retroactive rate change. If the rate updates are incorrect, overpayments can occur. During our audit, the Department made four incorrect retroactive rate changes that resulted in overpayments totaling $2.4 million to 14 providers.

Specifically, we determined that staff within the Department's rate setting units caused incorrect rates to be entered into eMedNY. One particular rate code, for example, is used by providers to bill in quarter-hour increments. However, when Department rate setters changed the rate amount, they incorrectly entered the full hourly amount of $78.66 instead of the quarter-hour amount of $19.67 ($78.66 / 4). This caused overpayments totaling $2.3 million to 13 providers. Also, Department rate setters incorrectly changed a provider's rate for a certain service from $3,009 to $6,300. Over a period of a year, this error caused overpayments to the provider totaling $78,980.

The Department also incorrectly processed two rate code changes for seven other providers by entering rate amounts that were at least 10 times more than the correct amounts. However, because the providers did not use the two codes in question, the errors did not result in overpayments.

We advised Department officials of the errant rates, and they confirmed that changes to the rates were made incorrectly. Moreover, the Department made the necessary corrections in eMedNY to recover the resulting $2.4 million in overpayments we identified.

Recommendation

1. Assess risks in the rate setting units associated with processing retroactive rate changes to ensure only authorized and accurate changes are implemented in eMedNY.

Other Insurance on Medicaid Claims

Many Medicaid recipients also have other health insurance coverage (mostly Medicare). When submitting Medicaid claims, providers must verify that 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. In this case, Medicaid (as the secondary insurer) generally covers the patient's normal financial obligation, including coinsurance, copayments and deductibles. If the recipient or the medical service is not covered by any other insurer, Medicaid is the primary insurer and should be billed first.

Errors in claim amounts 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 $530,709. At the time our fieldwork concluded, 57 (of the 65) claims were corrected, saving Medicaid $488,144. Adjustments were still needed for the remaining eight claims, corresponding to overpayments of at least $42,565.

Specifically, we identified overpayments totaling $372,470 on 56 claims (which originally paid $522,709) 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 56 claims. At the time of our review, the providers adjusted 50 of the claims, saving Medicaid $329,905. Adjustments were still needed on six claims, corresponding to overpayments of at least $42,565.

For the remaining nine (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. At the time of our review, the providers adjusted seven of the nine claims, which saved Medicaid $158,239. At the time our fieldwork concluded, adjustments were still needed for the remaining two claim payments which totaled $264,411.

We also concluded that the Department could have prevented most of the overpayments we identified with better eMedNY controls. For example, many claims we reviewed were subjected to the eMedNY edit "Medicare/MCO Payer Amounts Not Reasonable." However, the edit was "set to pay" (as opposed to pend or deny) a questionable claim. For example, two of the largest overpayments we identified (which accounted for $123,365 of the overpayments) were the result of unusually high copayments, and were detected by the edit. If this edit was set to pend or deny payment, eMedNY could have prevented these overpayments. We have identified similar errors

in prior audits. Thus, the Department needs to take prompt actions to ensure eMedNY prevents overpayments of this magnitude in the future. In addition, the Department should improve eMedNY processing to prevent overpayments when inaccurate primary insurer information is submitted on a claim.

Recommendation

2. Review and recover the unresolved overpayments (totaling at least $42,565) on the six claims with excessive charges for coinsurance and copayments and on the two claims totaling $264,411 where Medicaid was improperly designated as the primary payer.

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.

We identified overpayments totaling $412,737 on 13 inpatient claims because two hospitals billed a more costly level of care than what was actually provided. On the claims, the hospitals did not indicate any ALC days during long inpatient stays. Instead, they billed the entire length of the inpatient stay at higher levels of care. At our request, the hospitals reviewed their records and determined that a significant number of the days during the stays were actually ALC. In one case, Medicaid paid $168,318, but should have only paid $18,318 if the ALC days had been properly reported. In total, Medicaid paid $697,516 on the 13 claims, although it should have paid only $284,779. We advised the hospitals of the billing errors and hospital officials corrected all 13 claims saving Medicaid $412,737 ($697,516 - $284,779).

Recommendation

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

Overlapping Claims During Inpatient 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. However, we identified 2,143 claim payments (totaling $260,288) for early intervention and foster care services when the recipient was already admitted as an inpatient in a hospital. This resulted in Medicaid overpayments totaling $256,510.

One provider billed 2,141 of the 2,143 inappropriate claims. When contacted, the provider agreed the claims (which were for early intervention services) were incorrect and attributed the

errors to subcontractors it uses to bill claims. In response to our audit, the provider agreed to issue a reminder to its subcontractors that such billings should not be made while recipients are hospitalized. However, at the time our fieldwork concluded, the provider had not voided the 2,141 claims, corresponding to overpayments of $253,963. Further, we determined eMedNY has an edit to flag certain claims with dates of service that overlap inpatient stays. The claims for early intervention services were detected by the edit, however the edit is set to allow these claims to be paid.

The remaining two (of the 2,143) claims were submitted by a foster care provider for days of service when the child was hospitalized. We contacted the provider who agreed the claims were incorrect and attributed the errors to miscommunication with its billing vendor. The provider adjusted one claim, which resulted in a savings of $1,831. However, by the end of our fieldwork, the remaining claim (overpaid by $716) had not been corrected.

Recommendations

4. Review and recover the unresolved overpayments (totaling at least $254,679) on the 2,142 claims in question.

5. Strengthen eMedNY controls to prevent payment of claims for childcare services that are billed during a child's hospital inpatient stay.

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.

We identified $206,288 in overpayments Medicaid made on 100 claims submitted by 26 providers of physician-administered drugs. On these claims, the providers billed amounts well in excess of the drugs' actual acquisition costs, which were generally less than the maximum Medicaid fee amounts. For example, one provider submitted a claim and charged $86,680 for administering several drugs to a recipient. Based on Medicaid's maximum allowable fees, eMedNY paid $9,352 on this claim. However, based on the provider's drug invoices, we determined the actual acquisition costs for the drugs totaled only $867. At our request, the provider corrected this claim, saving Medicaid $8,485 ($9,352 - $867).

At the time our fieldwork concluded, providers corrected 64 claims (saving Medicaid $184,368), and corrections on another 32 claims, which would save another $21,920 are expected. Further actions, including the presentation of supporting documentation, are still needed to resolve

apparent overpayments on four other claims totaling payments of $14,636.

There were several reasons for the improper claims. For example, eight providers indicated they were not aware that Medicaid required providers to bill physician-administered drugs at cost. Nine other providers indicated they were aware of this requirement, but cited problems with their billing systems. In other cases, 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

6. Review and recover the $21,920 in expected corrections. Resolve the potential overpayments on the remaining four claims (totaling $14,636) and recover funds where appropriate.

7. Formally instruct the 26 providers identified by our audit of the correct way to bill claims for physician-administered drugs. Actively monitor the submissions of such claims by these providers.

Inaccurate Patient Status Codes

When a hospital bills Medicaid, it must include a patient status code (code) which indicates whether the patient was discharged or transferred to another healthcare facility. The 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 identified two claims (totaling payments of $97,687) with inaccurate status codes. In one case, the hospital entered a discharge code instead of a transfer code. In the other case, another hospital incorrectly indicated a transfer to a critical access hospital rather than a standard transfer. At our request, both hospitals corrected their claims, reducing their payments to $8,483, which realized a Medicaid cost savings of $89,204 ($97,687 - $8,483).

Recommendation

8. Formally remind the two hospitals to ensure the patient status codes on their claims are correct.

Incorrect Claim for Out-of-State Inpatient Services

When inpatient care is needed outside of New York, prior authorization is required unless the provider agrees to accept the New York State Medicaid reimbursement rates. An out-of-state provider submitted a claim for inpatient services that paid $101,979. However, the provider did not have a prior Medicaid authorization and, therefore, should have submitted the claim at New York's inpatient rate ($23,824). At our request, the provider adjusted the claim, saving Medicaid $78,155 ($101,979 - $23,824).

Recommendation

9. Formally advise the provider to request prior approval from New York Medicaid unless the provider agrees to accept the New York State Medicaid reimbursement rates.

Duplicate Billings

Medicaid overpaid eight providers a total of $77,765 on 18 claims because the providers billed for certain procedures more than once. The duplicate payments occurred under several scenarios. Specifically, we determined the providers billed:

- the same procedure code more than once on the same day, resulting in overpayments on seven claims totaling $36,303;
- the same procedure on different dates or on different claims, resulting in overpayments on six claims totaling $31,259; and
- anesthesia services multiple times on individual claims when it can only be billed once per claim. This resulted in overpayments on five claims totaling $10,203.

The eight providers acknowledged their errors and corrected the overpaid claims, saving Medicaid $77,765.

Recommendation

10. Formally instruct the eight providers how to properly bill the procedures in question.

Incorrect Claims for Medical Equipment

We identified $27,648 in Medicaid overpayments on four claims for medical equipment (totaling payments of $28,248) because the provider did not bill according to the Medicaid guidelines. The guidelines state the medical equipment should be billed once per month up to a maximum of $100 per month. However, the provider billed for the equipment more frequently and over the amount allowed. At the time our fieldwork concluded, the provider made adjustments to three of the four claims, saving Medicaid $19,186. We estimate further adjustments will result in an additional savings of 8,462.

Recommendations

11. Review and recover the unresolved overpayments totaling $8,462.

12. Formally instruct the provider how to properly bill the medical equipment in question.

Incorrect Claims for Transportation Services

We identified $25,702 in overpayments on 40 claims for transportation services (totaling $57,011). The overpayments occurred for various reasons. We found, for example, that:

- A Pennsylvania provider submitted seven claims using Pennsylvania's Medicaid method to calculate reimbursable mileage instead of the method prescribed by New York. Under New York's method, the seven claims should have totaled $24,092. However, the provider claimed and was paid $45,372, resulting in an overpayment of $21,280 ($45,372 - $24,092). Although the provider agreed the claims were incorrect, the provider had not adjusted them through eMedNY at the time our fieldwork ended;
- A provider submitted 29 claims (totaling $1,749) that did not have adequate records to support the claims. As such, the Department should recover the payments of $1,749;
- Another provider's claim was processed incorrectly due to a scanning error (misread of a procedure code). In this case, eMedNY paid the provider $3,420, although the correct payment amount was $2,033. We advised the Department of the error, and the Department corrected the claim, saving Medicaid $1,387 ($3,420 - $2,033); and
- Two providers submitted three claims (totaling $6,470) that included dates when services were not provided due to recipient cancellations or absences. Because the claims should have totaled $5,184, the overpayments amounted to $1,286 ($6,470 - $5,184). At the time of our fieldwork, one provider voided two of the incorrect claims, saving Medicaid $1,008. Actions were still needed on the remaining claim, which should save Medicaid $278.

At the time our fieldwork concluded, adjustments were still needed for 37 claims, which could save Medicaid $23,307.

Recommendation

13. Review and recover the unresolved overpayments (totaling $23,307) on the 37 claims.

Incorrect Claims for Nursing Home Services

Medicaid overpaid three providers $15,516 on 22 claims because the providers either used an incorrect rate code, failed to deduct the amount of the patient's liability from the claim, or submitted duplicate claims for the same recipient. At the time our fieldwork concluded, providers corrected 20 of the 22 claims, saving Medicaid $14,187.

The majority of the overpayments (19 of the 22 claims) were caused by one provider billing an incorrect rate code. The provider acknowledged the error and adjusted the claims. The claims originally paid $251,920, but were adjusted to payments totaling $239,479, saving Medicaid $12,441. On another claim, a provider failed to correctly account for the patient's liability. The claim originally paid $22,795. At our request the provider corrected the claim, reducing the payment to $21,049, and saving Medicaid $1,746.

Regarding the remaining two payments, on two occasions a nursing home submitted a claim for a resident for a particular month, and a hospice provider submitted a claim for the same resident for the same services for a day in the same month. Thus, Medicaid paid a total of $1,329 to both providers for the same service. Further, both providers maintain that their claims for the dates in question were correct. Nonetheless, Medicaid paid twice for the same service, and it is unclear which provider should amend their claim. We brought this matter to the attention of Department officials during the course of our audit fieldwork. However, at the time our fieldwork ended, the matter had not been resolved.

Recommendations

14. Determine if the nursing home or the hospice provider should not have billed Medicaid for the service dates in question. If either entity should not have billed Medicaid, recover the payments of $1,329.

15. Formally review Medicaid billing guidelines for dates when recipients receive services from both nursing homes and hospice providers. As necessary, clarify the guidelines to prevent claims from nursing homes and hospice providers for the same service.

Status of Providers Who Abuse the Program

If a Medicaid provider has violated statutory or regulatory requirements related to the Medicaid or Medicare programs (or has engaged in other unacceptable insurance practices), the Department can impose sanctions against the provider. These sanctions can range from excluding the provider from the Medicaid program to imposing participation requirements, such as requiring all claims to be reviewed manually before payment. If no action is taken, the provider remains active to treat Medicaid patients (either as a direct medical provider or as a Medicaid managed care plan provider), ultimately placing recipients at risk of poor quality care and obtaining Medicaid payments.

We identified 44 Medicaid providers who were charged with or found guilty of crimes that violate Medicaid program laws or regulations. Thirty-seven of these providers had an active status in the Medicaid program and 7 providers had an inactive status (i.e., two or more years of no claims activity and, therefore, they would be required to seek re-instatement from Medicaid to submit new claims). We advised Department officials of these providers, and the Department terminated 17 of them from the Medicaid program. Prior to program termination, Medicaid paid 3 (of the 17) providers a total of $2,950. Also, the Department determined 8 of the 44 providers should

not be terminated. At the time our audit fieldwork ended, the Department had not resolved the program status of the remaining 19 providers (3 of whom received a total of at least $8,809 from Medicaid after they were charged or indicted).

Recommendations

16. Determine the status of the remaining 19 providers relating to their future participation in the Medicaid program.

17. Investigate the propriety of the payments (totaling $11,759) made to the 6 providers who violated Medicaid laws or regulations. Recover any improper payments, 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 October 1, 2011 through March 31, 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. In their response, Department officials generally concurred with our recommendations and indicated that certain actions have been and will be taken to address them. Also, certain other matters were considered to be of lesser significance, 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.

Contributors to This Report

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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

May 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 New York State Department of Health's comments regarding Office of the State Comptroller's Draft Audit Report 2011-S-39 entitled, "Medicaid Claims Processing Activity October 1, 2011 Through March 31, 2012."

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
Dennis Wendell
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Department Of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2011-S-39 entitled
Medicaid Claims Processing Activity
October 1, 2011 Through March 31, 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 2011-S-39 entitled, "Medicaid Claims Processing Activity October 1, 2011 Through March 31, 2012."

Recommendation #1:

Assess risks in the rate setting units associated with processing retroactive rate changes to ensure only authorized and accurate changes are implemented in eMedNY.

Response #1:

The Department's Office of Health Insurance Programs (OHIP) will assess the risks in all rate setting units associated with processing retroactive rate changes in order to ensure only authorized and accurate changes are implemented in eMedNY. This risk assessment will take place over the next six months. The Department will also assess how many rates are manually placed in the system and will create a plan to reduce the potential of human error. Further, the Department is also attempting to decrease the number of retroactive rate adjustments in the Medicaid Managed Care (MC) program. Moreover, the enacted 2013-14 budget centralized all Medicaid rate setting functions within OHIP and this will decrease incorrect rate changes moving forward.

Recommendation #2:

Review and recover the unresolved overpayments (totaling at least $42,565) on the six claims with excessive charges for coinsurance and copayments and on the two claims totaling $264,411 where Medicaid was improperly designated as the primary payer.

Response #2:

The Office of Medicaid Inspector General (OMIG) will review the unresolved claims and initiate recovery of funds as appropriate.

Recommendation #3:

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

Response #3:

The Department will request Computer Sciences Corporation (CSC) to provide training on the appropriate billing procedures of alternate level of care (ALC) days to all hospitals in order to ensure hospitals indicate a patient's "level of care" on claims to ensure accurate processing and payment. The Department will also draft a Medicaid Update in the May issue to educate providers on appropriate billing procedures of ALC days.

The Department's provider manual outlines ALC billing instructions. The citation can be found at the following: eMedNY New York State UB-04 Billing Guidelines Inpatient Hospital Manual (Version 2012-01, 1/11/2012), Section 2.3.3.1, Alternate Level of Care (ALC), pages 9-10, https://www.emedny.org/ProviderManuals/Inpatient/PDFS/Inpatient_Billing_Guidelines.pdf.

Recommendation #4:

Review and recover the unresolved overpayments (totaling at least $254,679) on the 2,142 claims in question.

Response #4:

The provider has agreed to reimburse all overpayments via self-disclosure.

Recommendation #5:

Strengthen eMedNY controls to prevent payment of claims for childcare services that are billed during a child's hospital inpatient stay.

Response #5:

The Department will work with OHIP Systems staff to strengthen eMedNY controls to prevent payment of claims for childcare and Early Intervention services billed during a child's hospital inpatient stay. By strengthening these controls, overpayments related to "overlapping" during inpatient stays will be prevented.

Moreover, Medicaid claims processed through New York's current Medicaid information system will be reduced dramatically over the next three years. The Department has established a goal of having all Medicaid enrollees served in care management by April 2016. This initiative, deemed *Care Management for All*, began in State Fiscal Year 2011-12 with major state law changes. As a result of this initiative, fee-for-service (FFS) spending will ultimately drop to only 15 percent of all Medicaid spending by 2016. The Department will continue to make eMedNY edits to correct issues during this transition, and it is anticipated the transition will dramatically decrease the impact of eMedNY edit issues in the future.

Recommendation #6:

Review and recover the $21,920 in expected corrections. Resolve the potential overpayments on the remaining four claims (totaling $14,636) and recover funds where appropriate.

Response #6:

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

Additionally, the Department will draft a Medicaid Update to outline its billing policy stating Medicaid requires providers to bill physician administered drugs at their acquisition costs.

Recommendation #7:

Formally instruct the 26 providers identified by our audit of the correct way to bill claims for physician-administered drugs. Actively monitor the submissions of such claims by these providers.

Response #7:

The Department will draft a Medicaid Update advising providers of the OSC audit findings and the correct billing and claiming processes.

The OMIG will continue to monitor and assess claim submissions by Medicaid providers for aberrant behavior.

Recommendation #8:

Formally remind the two hospitals to ensure the patient status codes on their claims are correct.

Response #8:

The Department will request CSC to provide training on the appropriate billing procedures of Patient Status Codes to the hospitals in question.

The Department will also draft a Medicaid Update to outline its billing policy to ensure the patient status codes on hospitals claims are correct.

Recommendation #9:

Formally advise the provider to request prior approval from New York Medicaid unless the provider agrees to accept the New York State Medicaid reimbursement rates.

Response #9:

The Department will formally advise the provider to request prior approval from New York Medicaid unless the provider agrees to accept the New York State Medicaid reimbursement rates.

Recommendation #10:

Formally instruct the eight providers how to properly bill the procedures in question.

Response #10:

The Department will formally instruct the eight providers how to properly bill the procedures in question.

Recommendation #11:

Review and recover the unresolved overpayments totaling $8,462.

Response #11:

The Department will follow up with the provider to adjust the remaining claim in question.

Recommendation #12:

Formally instruct the provider how to properly bill the medical equipment in question.

Response #12:

The Department will request CSC to train the provider regarding the proper billing procedures for medical equipment.

Beginning April 1, 2012, the Department required prior authorization to prevent any duplicate rental payments.

Recommendation #13:

Review and recover the unresolved overpayments (totaling $23,307) on the 37 claims.

Response #13:

The OSC found instances in which certain transportation providers either overbilled for services rendered, or billed for trips with inadequate or no documentation. While some claims were subsequently adjusted or voided by the transportation provider, a number of inappropriate claims require review and recovery. The OMIG will review the overpayments and pursue recovery as appropriate.

Recommendation #14:

Determine if the nursing home or hospice provider billed Medicaid in error for the service dates in question. If Medicaid should not have been billed by either entity, recover the payments of $1,329.

Response #14:

The OMIG will determine if the providers billed incorrectly and recover any overpayments.

The Department will research the back-up materials associated with these duplicate billings and make any necessary changes to prevent further errors.

Recommendation #15:

Formally review Medicaid billing guidelines for dates when recipients receive services from both nursing homes and hospice providers. As necessary, clarify the guidelines to prevent claims from nursing homes and hospice providers for the same service.

Response #15:

The Department will formally review Medicaid billing guidelines for dates when recipients receive services from both nursing homes and hospice providers.

Recommendation #16:

Determine the status of the remaining 19 providers relating to their future participation in the Medicaid program.

Response #16:

The OMIG will review the Medicaid participation status of the providers.

Recommendation #17:

Investigate the propriety of the payments (totaling $11,759) made to the 6 providers who violated Medicaid laws or regulations. Recover any improper payments, as appropriate.

Response # 17:

The OMIG has made determinations on the remaining providers and will pursue further administrative action for reimbursement of any improper payments.

The Department will also investigate the propriety of the payments made to the 6 providers who violated Medicaid laws or regulation.