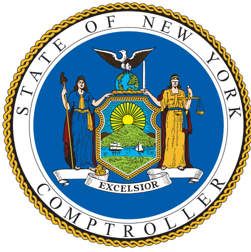

New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Medicaid Claims Processing Activity October 1, 2012 Through March 31, 2013

Medicaid Program
Department of Health

Report 2012-S-131 May 2014

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, 2012 through March 31, 2013.

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, 2013, eMedNY processed about 167 million claims resulting in payments to providers of about $26 billion. The claims are processed and paid in weekly cycles which averaged about 6.4 million claims and $995 million in payments to providers.

Key Findings

Auditors identified about $13 million in inappropriate or questionable Medicaid payments, including:

- $6,329,458 in questionable payments for claims that were not subjected to the appropriate edits and pricing logic due to eMedNY's incorrect designation of the claim type being processed;
- $2,965,300 in overpayments for claims billed with incorrect information pertaining to recipients' other health insurance coverage;
- $2,689,352 in inappropriate payments for lab services claims submitted well beyond the required time frame for submission;
- $488,837 in overpayments for claims for duplicate billings;
- $222,806 in overpayments for claims for a dialysis drug billed at 10 times the number of units actually provided; and
- Claims with improper payments for physician-administered drugs, hospital services, medical equipment and dental services.

By the end of the audit fieldwork, auditors recovered about $3.8 million of the overpayments identified.

Auditors also identified 26 providers in the Medicaid program who had been charged with or found guilty of crimes that violate health care programs' laws or regulations. The Department terminated 19 of these providers, but the status of the seven others was still under review.

Key Recommendation

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

Other Related Audits/Reports of Interest

Department of Health: Medicaid Claims Processing Activity April 1, 2012 Through September 30, 2012 (2012-S-24)
Department of Health: Controls Over eMedNY Edit Changes (2007-S-139)

State of New York
Office of the State Comptroller

Division of State Government Accountability

May 22, 2014

Howard Zucker, M.D.
Acting Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Zucker:

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, 2012 Through March 31, 2013*. 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. In State fiscal year 2012-13, the federal government funded about 48.5 percent of New York's Medicaid claim costs; the State funded about 34 percent; and the localities (City of New York and counties) funded the remaining 17.5 percent.

The Department of Health's (Department) 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, 2013, eMedNY processed about 167 million claims resulting in payments to providers of about $26 billion. The claims are processed and paid in weekly cycles, which averaged about 6.4 million claims and $995 million in payments to 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, 2013, 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. We found approximately $13 million in inappropriate or questionable payments pertaining to: claims that were not subjected to appropriate edits and pricing logic due to inaccurate eMedNY claim type assignments; lab claims submitted after the claim submission deadline; claims involving other insurance information that was inaccurate; claims for duplicate services; claims for a dialysis drug billed at 10 times the amount actually provided; claims with incorrect charges for physician-administered drugs; and improper hospital and other claims.

At the time the audit fieldwork concluded, about $3.8 million of the overpayments had been recovered. Department officials need to take additional actions to review the remaining payments (totaling about $9.2 million) in question, recover funds as warranted, and improve certain eMedNY claim processing controls.

Incorrect Claim Type Assignment

When Medicaid claims are submitted to eMedNY, the system assigns a claim type to each claim. The claim type designates the type of service that was provided, such as inpatient, dental, eye care, etc. Claim type is a key element because it determines the path a claim will take through eMedNY, including the edits and pricing algorithms to be applied.

Errors in assigning the claim type can result in improper Medicaid payments. We identified incorrect claim type assignments on 129,386 claims that resulted in improper and questionable payments totaling $6,329,458. Specifically, 128,612 of the 129,386 claims (totaling $6,212,550) were incorrectly assigned a claim type of “crossover professional” and 774 claims totaling $116,908 were incorrectly assigned a claim type of “transportation.” The claim types assigned by eMedNY were inconsistent with the claims’ procedure codes. For example, a claim submitted by a large hospital was processed by eMedNY as a transportation claim even though the services billed on the claim were for medical procedures such as x-rays.

Because the claims were assigned the wrong claim type, they were not subjected to the appropriate edits and pricing algorithms. As a result, the claims were not processed correctly, and there is considerable risk that some of them were overpaid. For example, a hospital was paid $1,156 for a claim that contained 29 procedure codes, 14 of which were inactive (i.e., the service is not covered by Medicaid). Because the system assigned the wrong claim type, eMedNY processed and paid $1,109 for the 14 invalid procedures. Also, because the claim was not subjected to the correct edit and pricing logic, the appropriateness of the payment for the 15 remaining procedure codes is not known because the claim, and those procedures, may be subject to different edits and pricing rules under the correct claim type assignment. Therefore, a total overpayment amount

cannot be calculated.

Until eMedNY's claim type assignment logic is corrected, other claims will be assigned an incorrect claim type and improper payments will continue. During the audit, we referred the issue to the Department to initiate immediate action to correct the problematic eMedNY claim type assignment and to correctly reprocess the claims we identified. Officials from the Department's Division of Systems acknowledged that eMedNY did not process the claims in question properly, and they advised us they would correct the problem. Also, in their response to our draft report, officials stated that the Department performed an initial evaluation of the claims in question and indicated that the majority of them were not overpaid. Officials added that the Department will further evaluate the claims and expects to complete the evaluation in July 2014.

Recommendations

1. Review eMedNY claim type assignment logic over all claim types and, where necessary, develop and implement corrective action.

2. Reprocess the 129,386 identified claims (totaling $6,329,458), as well as all other claims incorrectly processed under an improper claim type, and recover any overpayments identified.

Inappropriate Claims for Lab Services

Medicaid regulations require claims to be submitted within 90 days of the date of service unless the claim is delayed due to circumstances outside the control of the provider. Claims submitted over the 90-day deadline must include an appropriate HIPAA[1] delay reason code and must be submitted within 30 days from the time the delay came within the control of the provider. Overdue claims without approved reasons are not valid and, therefore, are not entitled to payment.

There are 11 approved HIPAA delay reason codes that indicate acceptable reasons why a claim was not submitted within the required deadline. It is the provider's responsibility to determine and report the appropriate delay reason code. For example, delay reason code 4 (delay in certifying provider) indicates the delay was caused by a change in the provider's enrollment status. When using delay reason code 4, the claim must be submitted within 30 days from the date of notification of the change in the provider's enrollment status.

We identified 43,264 claims, totaling $2,689,352 in payments to a lab company, that were submitted over one year from the original dates of service (which ranged from December 1, 2010 to July 20, 2011) and appear to have been submitted using incorrect delay reason codes. Of the 43,264 claims, 43,221 claims totaling $2,687,299 were billed using delay reason code 4 (delay in certifying provider). The remaining 43 claims totaling $2,053 were billed using four other delay reason codes.

Most all of the claims were billed using delay reason code 4 (delay in certifying provider). However, the lab company does not appear to have an appropriate reason to use this delay reason code.

[1] Health Insurance Portability and Accountability Act.

While the lab company was acquired by another company in December 2010, there was no delay caused by the Department in certifying the new provider. The new provider submitted an enrollment application in April 2011 and promptly received two new provider IDs effective July 2011. Further, the original company's provider IDs, effective since 1995, remained open during this process. Therefore, the application of delay reason code 4 (delay in certifying provider) to these claims does not appear valid.

Department officials agree the lab company does not appear to have an appropriate reason to submit the old claims. In November 2012, OSC alerted the Department to a large payment totaling $2,506,473 about to be released to one of the lab company's original provider IDs for the old claims processed using the inappropriate delay reason codes. As a result, Department officials held the payment. However, the Department subsequently released the payment and determined the matter would be addressed on a post-audit basis.

Subsequent to the November 2012 payment ($2,506,473) we identified two other payments totaling $182,879 to the lab company's two other original provider IDs. The three payments comprised the aforementioned $2,689,352 in claims. The inappropriate payments occurred because, at the time the claims were submitted, the eMedNY edits associated with 90-day delay reason codes did not function properly. Specifically, four edits were set to a "pay" status due to post-edit implementation changes that were still needed. In addition, two edits set to "deny" had known problems which allowed the claims to be paid even though the claims should have failed the edits. According to Department officials, the problems with these edits have since been corrected and all four delay reason codes that were set to "pay" were subsequently set to a "deny" or "pend" status.

Recommendation

3. Review the potential overpayments totaling $2,689,352 to determine whether the claims are valid and appropriate for payment. Recover improper payments as warranted.

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. Medicaid then becomes the secondary insurer and 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 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 38 claims that resulted in improper payments totaling $1,744,918. Specifically, we identified overpayments totaling $994,665 on 32 claims (for which Medicaid paid $1,066,597) that resulted

from excessive charges for coinsurance and copayments for recipients covered by other insurance. We contacted the providers and as a result of our inquiry, they adjusted 31 of the 32 claims, saving Medicaid $992,516. One provider, however, still needed to adjust one claim that was overpaid by $2,149.

We also identified four claims (totaling Medicaid payments of $580,509) in which 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 the audit fieldwork concluded, providers adjusted three of the four claims, saving Medicaid $485,525. One provider, however, still needed to adjust the remaining claim that was overpaid by $1,250.

We also identified two claims (which Medicaid paid $271,499) in which providers incorrectly submitted the claims with Medicare Part C insurance information, when they should have been submitted with Medicare Part A insurance information. We contacted the providers and notified them of the incorrect Medicare Part C insurance information. The providers adjusted both claims, which saved Medicaid $263,478.

This audit identified similar errors found in prior audits, involving some of the same providers who submitted excessive claims. Thus, the Department needs to take prompt actions to ensure eMedNY prevents overpayments of this magnitude in the future.

Recommendations

4. Review and recover the unresolved overpayments (totaling $3,399) on the two incorrect claims.

5. Formally instruct the providers identified in our audit how to verify current Medicare eligibility and how to accurately bill recipients' financial obligations. As resources and priorities permit, monitor these providers' claims submissions.

Incorrect eMedNY Claim Adjustment Reason Code Mapping

Many Medicaid recipients are also enrolled in Medicare Part C. Under Medicare Part C, managed care plans administer enrollees' Medicare benefits. The plans have networks of participating providers that they reimburse directly for services provided to enrollees. For individuals dually enrolled in both Medicaid and Medicare Part C, providers bill Medicaid (as the secondary payer) for remaining financial obligations owed, such as coinsurance.

Medicare plans use Claim Adjustment Reason Codes (CARC) to communicate with providers as to why a claim was denied or paid differently than it was billed (e.g., CARC 2 = coinsurance amount). When providers bill Medicaid for Part C financial obligations, they are required to report CARCs as well as group codes (which, in general, assign responsibility for the adjustment amount, such as "patient responsibility") on their claims. The CARCs and group codes are essential for Medicaid to

determine whether a billed service should be paid as well as the correct payment amount.

eMedNY interprets and "maps" a claim's CARC and group codes to take certain actions (e.g., to pay or to not pay). Correct mapping of the codes is necessary to ensure the claims are paid appropriately. For example, a claim containing a CARC code that represents a duplicate service and a group code that designates the claim amount as the patient's financial obligation should not be mapped to pay the claim.

We identified 10 claims totaling overpayments of $72,555 involving two different CARC/group code combinations that were incorrectly mapped to pay the claims. Due to the high risk of overpayment on other claims that contained the identified code combinations, we immediately notified the Department of the two incorrect CARC/group code mappings. Department officials reviewed the mappings and corrected the eMedNY system in May 2013. In addition, Department officials stated they would identify all claims that were incorrectly paid as a result of the mapping errors and reprocess them.

At the time the audit fieldwork ended, the Department reprocessed and providers adjusted a total of 3,984 claims (including 9 of the original 10 claims we identified) associated with one of the two CARC/group code combinations, resulting in a total cost savings of $1,218,554. However, the Department had not yet reprocessed the inappropriately paid claims associated with the second CARC/group code combination, including 1 of the original 10 claims with an estimated overpayment of $1,828.

Recommendation

6. Identify all incorrectly paid claims containing the remaining CARC/group code combination and reprocess them to automatically correct and recover overpayments (including the claim with an overpayment of $1,828).

Duplicate Billings

Medicaid overpaid five providers a total of $488,837 on 136 claims (which originally paid $842,533) because the providers billed for certain services more than once. The duplicate payments occurred under several scenarios, as follows:

- One provider incorrectly billed two inpatient claims for the same patient. Both claims had the same admission and discharge dates but had different service spans, which allowed incorrect payments on both claims. The resulting overpayments totaled $257,228.
- Two providers repeatedly billed for Comprehensive Psychiatric Emergency Program (CPEP) evaluations multiple times during the same encounter, even though the evaluation is allowed only once per encounter. The resulting overpayments totaled $219,987 on 128 claims.
- One provider repeatedly billed the same physician-administered drug twice on the same claim. The resulting overpayments totaled $10,301 on five claims.

- One provider billed two anesthesia services on the same claim, resulting in an overpayment of $1,321.

The five providers acknowledged their errors and corrected the overpaid claims, saving Medicaid $488,837 ($257,228 + $219,987 + $10,301 + $1,321).

Recommendations

7. Implement controls to prevent duplicate payments of inpatient claims that have the same admission and discharge dates, but different service spans.

8. Implement controls to enforce the regulation that limits Medicaid payment of CPEP evaluations to once per encounter.

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

Dialysis Drugs

The dialysis drug Epogen is used to treat anemia caused by chronic kidney disease. To submit claims for this drug, providers should use the drug's Healthcare Common Procedure Coding System (HCPCS) code and should identify the number of HCPCS units provided. Providers are also required to report the drug's National Drug Code (NDC), NDC dispensing quantity and the NDC unit of measure.

We identified four providers who incorrectly billed excessive units of Epogen on their dialysis claims. We identified overpayments of $65,741 on 14 claims (which originally paid $93,250) in which the number of HCPCS units billed was excessive and did not match the NDC units reported as administered. Upon our inquiry, the providers discovered they billed the incorrect HCPCS code, which caused them to bill an incorrect number of HCPCS units. The providers told us the strength of the HCPCS code they billed was 10 times the actual amount administered to the patient.

Specifically, when claimed under HCPCS code J0886, Epogen has a strength of 1,000 units. In contrast, when claimed under HCPCS code Q4081, Epogen's strength is only 100 units. In one instance, a provider administered 3,300 units of Epogen to a recipient, but billed Medicaid for 33,000 units because it used the wrong HCPCS code (J0886). As one might expect, the Medicaid payment rate ($9.82) for J0886 is about 10 times the rate ($0.98) for Q0841. Consequently, Medicaid significantly overpaid the 14 miscoded claims. In particular, Medicaid overpaid the aforementioned claim by $292. Further, the four providers in question acknowledged their billing errors and corrected the 14 overpaid claims, thus saving Medicaid $65,741.

We expanded the scope of our review of these providers and identified potential overpayments on 355 additional claims from these providers. The 355 claims paid $174,757 for nearly 17.8 million units of Epogen billed under HCPCS code J0886. For these claims, the number of units billed was 10 times stronger than the number of NDC units reported as administered. If the providers had

billed the 355 claims using HCPCS code Q4081, they would have only been paid $17,692 for about 1.8 million units of Epogen, thus saving Medicaid $157,065 ($174,757 - $17,692).

Recommendations

10. Review and recover the overpayments (totaling $157,065) on the 355 claims billed using code J0886 instead of Q4081.

11. Formally remind the providers in question how to properly bill for Epogen and monitor the providers' compliance with the proper billing protocol.

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 73 claim payments totaling $261,414, we identified overpayments totaling $84,847 made to 25 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 $8,349 to administer one drug to a recipient. Based on Medicaid's maximum allowable fees, eMedNY paid $3,216 on this claim. At our request, the provider reviewed invoices and reported that the actual acquisition cost for the drug totaled only $1,440. The provider corrected this claim, saving Medicaid $1,776 ($3,216 - $1,440).

At the time the audit fieldwork ended, providers corrected 60 of the 73 claims, saving Medicaid $66,909. In addition, we anticipate that the remaining 13 claims will be corrected, saving another $17,938. Also, we identified apparent overpayments on 15 other claims totaling $87,504. 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. One provider was already aware of the problems and had been working to correct the billing system. 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. This audit identified similar errors found in prior audits, involving some of the same providers who submitted excessive claims. (Of the 25 providers addressed in this report, we cited 7 of them for the same problem in prior reports.) 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

12. Follow up on and recover the $17,938 from the 13 claims which should be corrected. Resolve the potential overpayments on the other 15 claim payments (totaling $87,504) and recover funds where appropriate.

13. Ensure the seven previously cited providers have taken corrective actions to prevent overpayments on physician-administered drugs. Formally instruct the remaining 18 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 these providers' submissions of such claims.

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.

As a result of errors by Department staff and agency rate setters, 15 incorrect retroactive rate changes were made that affected six providers and resulted in overpayments totaling approximately $50,000. In one instance, a rate setter for the Office for People with Developmental Disabilities (OPWDD) mistakenly switched the rates of two providers with two other rate codes, causing four rate codes to be incorrect. Two months after our initial inquiry, the rate setter corrected the rates. However, by the time the corrections were made, eMedNY overpaid one of the two providers by about $50,000.

Further, Department staff and rate setters incorrectly processed 11 other rate code changes for four providers by entering incorrect rate amounts or incorrect effective dates. Upon our inquiry, four of the errors were promptly corrected. However, a rate setter for seven of the erroneous rate codes took more than two months to correct the errors because the rate setter did not know the correction procedure. While the providers did not use the rate codes in question and the errors did not result in overpayments, untimely corrections increase the risk of improper payments.

Recommendations

14. Formally develop and implement procedures to ensure the accuracy of rate code changes processed by Department and the other agency staff.

15. Advise rate setters of the procedure to process rate code corrections.

Other Improper Claim Payments

We identified $212,461 in improper payments resulting from excessive charges related to alternate levels of care, inaccurate patient status codes, overlapping claims during hospital admissions, inappropriate medical equipment claims, and errant dental claims. At the time our audit fieldwork concluded, $184,773 of the improper payments had been recovered. However, actions were still needed to address the balance of the improper payments totaling $27,688 ($212,461 - $184,773).

Excessive Claim for Alternate Level of Care

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. Nevertheless, eMedNY overpaid one particular inpatient claim by $77,173 because the hospital billed a more costly level of care than what was actually provided. For the inpatient admission in question, the hospital billed the entire length of the stay at a higher level of care, which cost Medicaid $123,201. However, at our request, the hospital reviewed their records and determined ALC was provided during most of the admission. The hospital corrected the claim, which should have cost Medicaid only $46,028. The correction saved Medicaid $77,173 ($123,201 - $46,028).

Inaccurate Patient Status Code

When a hospital bills Medicaid, it must include a patient status code, which indicates whether the patient was discharged or transferred to another health care 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 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 eMedNY paid $78,314 on one inpatient claim that contained an incorrect patient status code. Although the hospital transferred the recipient to another health care facility, the hospital 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 $3,063 and saved Medicaid $75,251 ($78,314 - $3,063).

Overlapping Claims During Inpatient Hospital Admissions

The Department establishes all-inclusive hospital inpatient rates that generally cover the costs of all medical services provided during an admission. Under this arrangement, no additional payments should be made for services provided to recipients while they are hospitalized. Furthermore, if a Medicaid recipient receives services in a hospital's clinic and is then admitted as an inpatient, the hospital should not submit a separate claim for the clinic services. Also, when an admitting hospital sends a Medicaid inpatient to another hospital or clinic to obtain a diagnostic

or therapeutic service that is not available in the admitting hospital, the admitting hospital is responsible for reimbursing the other hospital or clinic that provided the services. Neither provider may bill separately for the services because the Medicaid payment to the admitting hospital includes all procedures and services, regardless of where they were performed.

We identified 10 claims that eMedNY overpaid by $29,739 due to overlapping medical services, which are detailed as follows:

- A hospital was overpaid $12,936 on a claim because it billed Medicaid for both clinic and inpatient services for the same recipient on the same day (the hospital determined the patient was never admitted as an inpatient);
- A hospital was overpaid $7,123 on a claim because it billed for an ambulatory surgery clinic claim when the recipient was subsequently admitted to the hospital as an inpatient;
- A hospital was overpaid $9,680 because it billed eight clinic radiation claims while the recipient was an inpatient at another hospital.

The hospitals in question reviewed and corrected their improper claims, saving Medicaid $29,739.

Incorrect Claims for Medical Equipment

Foster care agencies that receive Medicaid funding based on a pre-determined rate should directly pay for most health care costs (including those for durable medical equipment) for the children placed in their care. However, we identified overpayments of $18,499 on two claims for medical equipment because the providers billed Medicaid directly instead of the recipients' foster care agency. Department officials initiated an eMedNY project in December 2011 to prevent improper payments for services covered under a foster care agency's rate; however, the project was postponed due to other priorities. Department officials should review and recover the overpayments we identified totaling $18,499.

Incorrect Claims for Dental Services

Medicaid overpaid providers $11,799 on 11 claims for dental services. The overpayments occurred for several reasons, including $7,065 for five claims submitted after the time limit allowed by the Department. The providers submitted the late claims using delay reason codes that did not match the actual cause of the delay. Of the remaining six claims, Medicaid overpaid four by $2,842 because of improper charges for orthodontic treatments. For three of the (four) orthodontic claims, the provider stated the recipients were not seen on the dates of service. The provider voided the three claims, saving Medicaid $2,610. At the time our fieldwork concluded, adjustments were still needed for the remaining eight claims, with overpayments totaling $9,189.

Recommendations

16. Review and recover the unresolved overpayments totaling $27,688 ($18,499 in medical equipment + $9,189 in dental services).

17. Formally instruct the providers in question to ensure Medicaid claims are accurately billed.

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 on 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, perhaps placing recipients at risk of poor quality care while the provider receives Medicaid payments.

We identified 31 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. Of the 31 providers, 27 had an active status in the Medicaid program. The other four 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 the 31 providers and the Department terminated 19 of them from the Medicaid program. Prior to program termination, Medicaid paid two (of the 19) providers a total of $22,321. Also, the Department determined five of the 31 providers should not be terminated. At the time the audit fieldwork ended, the Department had not resolved the program status of the seven remaining providers.

Recommendations

18. Resolve the status of the seven remaining providers with respect to their future participation in the Medicaid program.

19. Investigate the propriety of the payments (totaling $22,321) made to the two 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, 2012 through March 31, 2013. 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 concurred with most of 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.

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.

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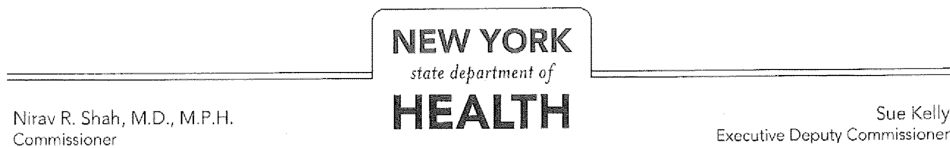
To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments



March 21, 2014

Mr. Brian Mason, Acting Assistant Comptroller
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 Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2012-S-131 entitled, "Medicaid Claims Processing Activity October 1, 2012 through March 31, 2013."

Thank you for the opportunity to comment.

Sincerely,

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
Jason A. Helgerson
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Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2012-S-131 entitled Medicaid Claims Processing Activity October 1, 2012 through March 31, 2013

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-131 entitled, "Medicaid Claims Processing Activity October 1, 2012 through March 31, 2013."

Recommendation #1:

Review eMedNY claim type assignment logic over all claim types and, where necessary, develop and implement corrective action.

Recommendation #2:

Reprocess the 129,386 identified claims (totaling $6,329,458), as well as all other claims incorrectly processed under an improper claim type, and recover any overpayments identified.

Response #1 and #2:

The Department has performed an initial evaluation of the identified claims. The vast majority of these claims were submitted by free standing clinics (Article 28 facilities). Medicare does not recognize these facilities as clinics and requires they submit professional claims. Medicare payment for professional services is always less than the Ambulatory Payment Group claim payment. Since the Medicare approved/paid amount is less than what Medicaid would have paid, Medicaid is required to pick up the full Medicare Part B coinsurance amount. Although the claim type assignment may be incorrect, it is not resulting in overpayments to the providers. The Department will further evaluate these claims with an expected completion date of July 1, 2014.

Recommendation #3:

Review the potential overpayments totaling $2,689,352 to determine whether the claims are valid and appropriate for payment. Recover improper payments as warranted.

Response #3:

The Office of the Medicaid Inspector General (OMIG) is actively reviewing recovery options for these potential overpayments.

Recommendation #4:

Recover the unresolved overpayments (totaling $3,399) on the two correct claims.

Response #4:

The OMIG's Recovery Audit Contractor (RAC) will review the overpayments and pursue appropriate recoveries.

Recommendation #5:

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

Response #5

The Department directed Computer Sciences Corporations' (CSC) Provider Services to contact the providers in question and provide the necessary instruction in how to verify insurance coverage. CSC contacted the providers in July of 2013, as instructed. Where feasible, the OMIG may monitor the submission of claims by these providers.

Recommendation #6:

Identify all incorrectly paid claims containing the remaining Claim Adjustment Reason Codes (CARC)/group code combination and reprocess them to automatically correct and recover overpayments (including the claim with an overpayment of $1,828).

Response #6:

The Department started the process of reviewing Claim Adjustment Reason Codes to ensure that claims are paid appropriately with an anticipated completion by September 2014.

Recommendation #7:

Implement controls to prevent duplicate payments of inpatient claims that have the same admission and discharge dates, but different service spans.

Response #7:

The implementation of controls to prevent duplicate payments of inpatient claims that have the same admission and discharge dates, but different service spans will be addressed in Evolution Project (EP) 1672, "Inpatient Pricing and Editing Modifications." EP1672 is scheduled for implementation on March 27, 2014.

Recommendation #8:

Implement controls to enforce the regulation that limits Medicaid payment of Comprehensive Psychiatric Emergency Program (CPEP) evaluations to once per encounter.

Response #8:

The Office of Mental Health and the Department worked jointly on assessing the need for controls for CPEP billing; edit 00715 was developed and implemented in July 2013.

Recommendation #9:

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

Response #9:

The Department directed CSC Provider Services to contact the providers in question and provide the necessary instruction in how to verify insurance coverage. CSC contacted the providers in July of 2013 as instructed.

Recommendation #10:

Review and recover the overpayments (totaling $157,065) on the 355 claims billed using code J0886 instead of Q4081.

Response #10:

The OMIG will review the 355 claims billed for code J0886. The OMIG will review the 14 "corrected" claims for adjustment accuracy. Payment is made on the number of Healthcare Common Procedure Coding System (HCPC) units billed; the associated National Drug Code (NDC) dispensing quantity entered on the claims is for rebate purposes and is a different unit of measure. Both HCPC units and NDC dispensing quantity require conversions for the ordered quantity. Therefore OMIG will need to also review the orders supporting these claims in order to determine which amount on the claims, if any, was correct. The OMIG will recover overpayments found on the 355 claims. The OMIG will recover overpayments, if appropriate, from the 14 "corrected" claims.

Recommendation #11:

Formally remind the providers in question how to properly bill for Epogen and monitor the providers' compliance with the proper billing protocol.

Response #11:

The OSC identified four providers who had billed Medicaid for Epogen using an incorrect Current Procedural Terminology (CPT) code of J0886 instead of Healthcare Common Procedure Coding System (HCPCS) code Q4081. According to the OSC audit, the providers in question have already adjusted previously paid claims to insure correct payment. The CPT, or J-code J0886, which was incorrectly billed, was eliminated from the payment side of the Ambulatory Patient Group (APG) rate and placed on the Never Pay Procedure list effective October 1, 2013. This list has been posted on the Department's APG public website. This will eliminate the problem entirely and will ensure that it does not continue to happen. Providers are now correctly billing the HCPCS code of Q4081.

Recommendation #12:

Follow up on and recover the $17,938 from the 13 claims which should be corrected. Resolve the potential overpayments on the other 15 claim payments (totaling $87,504) and recover funds where appropriate.

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Response #12:

The OMIG will review invoice data to determine the physician-administered drug actual acquisition cost on 73 claims. The OMIG will review the 60 adjusted claims for adjustment accuracy, and pursue appropriate recoveries. The OMIG will review the OSC identified potential overpayment of $17,939 from 13 claims that had not yet been adjusted and pursue appropriate recoveries.

Recommendation #13:

Ensure the seven previously cited providers have taken corrective actions to prevent overpayments on physician-administered drugs. Formally instruct the remaining 18 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 these providers' submissions of such claims.

Response #13:

Twenty five providers were identified by the OSC who had billed incorrectly for J-code drugs which resulted in provider overpayments. Two Medicaid Update articles have been published (May 2013 and August 2013) formally notifying providers of the correct way to bill claims for physician-administered drugs. Additionally, EP1861 was also submitted and will implement reasonability edits for J-code drugs. At this time, EP1861 is in the Planning Phase; the Assessment has been completed and approved by the Department with an anticipated release date of July 24, 2014. Where feasible, the OMIG may monitor the submission of claims by these providers.

Recommendation #14:

Formally develop and implement procedures to ensure the accuracy of rate code changes processed by Department and the other agency staff.

Recommendation #15:

Advise rate setters of the procedure to process rate code corrections.

Response #14 and #15:

The established process for preparing rates for loading into the eMedNY system is as follows:

Transmittal documents with tracking numbers are prepared with information pertaining to the rates being transmitted and forwarded to the Division of OHIP (Office of Health Insurance Programs) Operations.

- Statewide rate files to be electronically transmitted are prepared electronically versus manually assisting with the elimination of manual input errors.
- Manual input sheets are prepared by staff for individual facility rate changes and reviewed by supervisory staff prior to submission.

* Comment 1

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* See State Comptroller's Comment, page 26.

If an error occurs on a rate load, the process is as follows:

- The transmittal document tracking number is updated with a C on the end to note that a rate correction to the original transmittal is being transmitted.
- The corrected transmittal document and rate to be transmitted is reviewed by supervisory staff.
- The corrected rate is electronically submitted to eMedNY and paperwork transmitted to OHIP.

Staff has been advised of the above procedures.

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Comment
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Recommendation #16:

Review and recover the unresolved overpayments totaling $27,688 ($18,499 in medical equipment + $9,189 in dental services).

Response #16:

The OMIG will review the medical equipment and dental services overpayments identified and pursue appropriate recoveries.

Recommendation #17:

Formally instruct the providers in question to ensure Medicaid claims are accurately billed.

Response #17:

The Department directed CSC Provider Services to contact the providers in question and provide the necessary instruction in how to verify insurance coverage. CSC contacted the providers in July of 2013 as instructed.

Recommendation #18:

Resolve the status of the seven remaining providers with respect to their future participation in the Medicaid program.

Response #18:

Six of the seven remaining providers have been excluded. Pending the sentencing of the seventh provider, the OMIG will review and take appropriate action.

Recommendation #19:

Investigate the propriety of the payments (totaling $22,321) made to the two providers who violated Medicaid laws or regulations. Recover any improper payments, as appropriate.

Response #19:

The OMIG will review the overpayments identified and pursue appropriate recoveries.

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State Comptroller's Comment

1. We acknowledge the Department's procedures for preparing rates for loading into eMedNY and correcting rate errors. However, Department officials did not detail the procedures in place to verify rates (and identify errors) after loading into eMedNY. We encourage Department officials to address this when implementing our recommendations.