



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

Division of State Government Accountability

Improper Payments for Ancillary Services Provided During Hospital Inpatient Admissions

Medicaid Program Department of Health



Report 2012-S-160

April 2014

Executive Summary

Purpose

To determine whether the Department of Health's eMedNY system processes Medicaid claims for ancillary services in accordance with Medicaid reimbursement policies. The audit covers the period April 1, 2012 through September 30, 2013.

Background

Ancillary services refer to health care services provided in the home, medical offices, clinics, and other freestanding sites. They can be classified into three general categories: diagnostic, therapeutic, and custodial. For example, laboratory, physical therapy, and home health care are typical ancillary services. Medicaid claims for ancillary services are processed by eMedNY, the Department's automated claims processing and management information system. Claims are subject to various edits - automated controls within eMedNY designed to pay Medicaid claims in accordance with the Department's Medicaid reimbursement policies. Some edits check various Department files to verify recipient eligibility, provider credentials, and medical necessity. Other edits compare claims to each other to detect improper claims, including duplicate claims for the same service. Improper Medicaid claims detected by eMedNY are either denied or paid and reported to Department officials for review.

Medicaid reimbursement rates for inpatient hospital claims include the costs of most medical care provided during a hospital admission. As such, claims for ancillary services provided during a hospital admission are generally not reimbursable. In 2007, the Department implemented several eMedNY edits to detect improper Medicaid claims for ancillary services for hospitalized recipients.

Key Findings

- eMedNY identified 9,821 improper ancillary service claims totaling about \$1 million that were paid and reported to Department officials. However, at the time of our audit fieldwork, Department officials had not taken actions to recover these improper payments.
- In addition, Medicaid paid \$368,000 for about 6,600 improper ancillary service claims for recipients who were also covered by Medicare.

Key Recommendations

- Recover the \$1 million in improper Medicaid payments for ancillary services that were detected by eMedNY and reported to the Department.
- Recover the \$368,000 in improper Medicaid payments for claims for ancillary services provided to recipients also covered by Medicare.
- Enhance existing eMedNY edits or implement new edits to detect any improper claim for ancillary services. Such edit enhancements should also provide for the prevention or recovery of related payments.

Other Related Audits/Reports of Interest

[Department of Health: Overpayments of Ambulatory Patient Group Claims \(2011-S-43\)](#)

[Department of Health: Medicaid Claims Processing Activity October 1, 2011 Through March 31, 2012 \(2011-S-39\)](#)

State of New York
Office of the State Comptroller

Division of State Government Accountability

April 3, 2014

Nirav R. 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 *Improper Payments for Ancillary Services Provided During Hospital Inpatient Admissions*. 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

Medicaid is a federal, State and local government program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. About six million people are enrolled in New York's Medicaid program. The federal government funds about 48.25 percent of New York's Medicaid costs; the State funds about 34.25 percent; and the localities (the City of New York and counties) fund the remaining 17.5 percent. For the fiscal year ended March 31, 2013, Medicaid spending totaled approximately \$51 billion.

The Department of Health administers the State's Medicaid program. Medicaid claims are processed by eMedNY, the Department's automated claims processing and management information system. Medicaid claims are subject to various edits - automated controls within eMedNY designed to pay Medicaid claims in accordance with the Department's Medicaid reimbursement policies. Some edits check various Department files to verify recipient eligibility, provider credentials, and medical necessity. Other edits compare claims to each other to detect inappropriate claims such as duplicate claims for the same services. Inappropriate Medicaid claims identified by eMedNY are either denied or paid and then reported to Department officials. The Department periodically updates eMedNY with new edits that enforce current Medicaid reimbursement policies.

Ancillary services refer to health care services provided in the home, medical offices, clinics, and other freestanding sites. They can be classified into three general categories: diagnostic, therapeutic, and custodial. For example, laboratory, physical therapy, and home health care are typical ancillary services. Medicaid reimbursement rates for inpatient hospital claims include the costs of most medical services provided during a hospital stay. As such, Medicaid generally should not pay claims for ancillary services billed by other providers when a hospital submits a claim for an inpatient admission covering the dates of the ancillary services.

In 2007, the Department implemented several eMedNY edits to detect improper Medicaid claims for ancillary services for hospitalized Medicaid recipients. eMedNY has two edits to prevent reimbursement of certain ancillary service claims. Specifically, when eMedNY processes ancillary service claims, it checks a file of paid inpatient hospital claims. If a paid inpatient hospital claim is on file with service dates that span the date of the ancillary service, eMedNY edits deny payment of the ancillary service claim.

The eMedNY claims processing edits that deny ancillary service claims are:

- *Edit 760 "suspect duplicate, covered by an inpatient claim,"* which denies reimbursement of clinic services, nursing home care, home health care, referred ambulatory care, durable medical equipment, and lab services claimed during an inpatient hospital stay; and
- *Edit 2062 "transportation services performed during an inpatient stay,"* which denies reimbursement of transportation services claimed during an inpatient hospital stay.

Currently, about 75 percent of New York's Medicaid recipients are enrolled in managed care. The Department intends to have virtually all recipients enrolled in managed care by April 2018. This initiative, called *Care Management for All*, began in 2011 and required major State law changes. Because of this initiative, the Department estimates fee-for-service spending will drop substantially by 2018, and almost all Medicaid spending in the State will be paid to managed care organizations in the form of capitated rates (premiums). Consequently, the Department anticipates that the volume of Medicaid claims for ancillary services will likely decrease.

Audit Findings and Recommendations

We determined that eMedNY detected and denied most improper Medicaid claims for ancillary services. However, we also identified about \$1.4 million in improper claim payments that the Department should review and recover, as warranted. Specifically, we identified 9,821 improper claim payments totaling about \$1 million that eMedNY identified and reported to Department officials. Officials, however, had not taken actions to recover these overpayments at the time of our review. Further, Medicaid paid about 6,600 other improper claims for ancillary services, provided to recipients covered by Medicare, which eMedNY did not detect. These claims totaled about \$368,000 and should be resolved by the Department.

Improper Payments Detected and Reported by eMedNY

For the 18-month period ended September 30, 2013, eMedNY Edits 759 and 2063 identified 9,821 improper claims for ancillary services from 922 providers. These improper claims resulted in Medicaid overpayments totaling about \$1 million. Thirteen of the 922 providers received overpayments of more than \$10,000, and the overpayments to one provider totaled \$60,746. However, at the time of our audit fieldwork, Department officials had not taken actions to recover the overpayments. According to officials, they rely on post-payment reviews conducted by the Office of the Medicaid Inspector General (OMIG) to recover such overpayments. However, we determined that post-payment reviews of the overpayments in question might or might not occur depending upon priorities and available resources.

The following is an example of an improper claim payment that was not recovered. In May 2013, a recipient was admitted to a hospital for 16 days, and Medicaid paid \$22,959 for the related inpatient claim. During the admission period, the recipient also received three ancillary services, for which Medicaid paid \$11,310. However, the provider should not have submitted separate claims for the ancillary services because the recipient was already an inpatient at the time the ancillary services were provided, and the inpatient claim payment (of \$22,959) covered all services provided during that admission. eMedNY did not prevent the improper payment (of \$11,310) because the claims for the ancillary services were adjudicated before eMedNY processed the claim for the 16-day inpatient admission.

The Department's Medicaid policies require eMedNY to deny claims for ancillary services that coincide with the period of an inpatient admission and are submitted after the related inpatient claim is processed. However, eMedNY pays claims for coincidental inpatient and ancillary services if the claims for ancillary services are processed prior to the claim for the inpatient admission. We determined that two edits detect and report the inappropriate ancillary service claims to the Department, but do not deny Medicaid reimbursement. Often, ancillary service claims are submitted, processed, and paid before the matching hospital claim is billed. Under these circumstances, eMedNY pays the hospital claim and reports information about the ancillary service claim (which was already paid) to the Department.

The eMedNY claims processing edits that report (but do not adjust) improper ancillary claims are:

- *Edit 759 “duplicate inpatient/clinic, nursing home, home health, referred ambulatory, durable medical equipment, or laboratory claim,”* which pays the inpatient hospital claim and reports the previously paid ancillary service claim(s); and
- *Edit 2063 “transportation service paid during this inpatient admission period,”* which pays the inpatient hospital claim and reports the previously paid transportation service claim.

Regarding both edits, the recipients were hospitalized (as inpatients) on the days the ancillary services were claimed, and therefore, the ancillary service providers should not have submitted separate claims for such services. Reimbursements for ancillary services were already included in the payment(s) for the inpatient admission. To address this matter, the Department should consider programming eMedNY to adjust previously paid ancillary service claims to zero dollars when paying an inpatient claim that coincides with the dates of the related ancillary services. Similar Medicaid reimbursement policies are enforced by eMedNY *Edit 2169 “service conflicts with prior service, pay and adjust the history claim.”* In this case, the amounts allowed for prior services are generally eliminated or reduced, thus decreasing the amount of a subsequent Medicaid payment.

As noted previously, the OMIG conducts post-payment reviews of providers’ Medicaid claims. These reviews include computer matches to identify improper claims for ancillary services rendered during an inpatient hospital stay. As of September 30, 2013, the OMIG identified about \$2 million of improper Medicaid payments for ancillary service claims submitted during the four years ended December 31, 2011. However, we concluded that OMIG staff did not routinely use eMedNY’s automated listings of improper ancillary service claims for its reviews. Consequently, OMIG’s claims matches tended to duplicate eMedNY’s automated processes for identifying such improper claims and payments. Further, we concluded that pertinent OMIG personnel were generally unaware of eMedNY’s automated listings of improper ancillary service payments.

Moreover, eMedNY identifies improper ancillary service claims as they occur, whereas OMIG’s analysis and recoveries could take place several years after such improper claims have been paid. As noted previously, eMedNY identified 9,821 improper claim payments made during the 18-month period ending September 30, 2013 that were not reviewed and recovered. Until such time as eMedNY programming changes automatically adjust paid ancillary service claims to zero when duplicative inpatient claims are submitted after the related ancillary service claims are processed, the Department and OMIG should better coordinate efforts to identify and recover improper claim payments for ancillary services.

Recommendations

1. Recover the Medicaid overpayments totaling \$1 million identified by eMedNY Edits 759 and 2063 and reported to the Department. Focus efforts on those providers who received the largest amounts of improper payments for ancillary services.

2. Formally consider modifying eMedNY Edits 759 and 2063 or implement new edits to detect and recover improper claim payments for ancillary services. Provide particular attention to edits that deny payments for ancillary services when eMedNY processes and pays inpatient hospital claims that coincide with the ancillary services in question.
3. Improve the coordination of eMedNY's identification of improper ancillary claim payments with the corresponding data analysis and recovery efforts of the OMIG. Ensure overpayments identified by eMedNY for ancillary services are recovered in a timely manner.

Improper Payments Related to Medicare Crossover Claims

Crossover claims are Medicare-approved claims for Medicaid recipients who are also covered by Medicare. Such recipients are often referred to as "dual eligibles." Medicare is usually the primary payer of services provided to dual eligibles, and Medicaid pays recipients' coinsurance, copayments, and deductibles. Generally, providers submit claims for dual eligibles to Medicare, where they are processed and then "crossed over" to Medicaid. However, eMedNY does not match inpatient hospital claims that cross over from Medicare with ancillary service claims. Consequently, Medicaid paid about 6,600 improper claims totaling \$368,000 during our 18-month audit period. The top 20 payees received improper reimbursements ranging from \$2,894 to \$12,130.

For example, Medicaid overpaid a home care agency \$3,200 for services provided to a recipient who was hospitalized at the time the agency claimed to have provided service. In this case, the Department authorized 24 hours of daily personal care for the recipient. Since the recipient's hospital stay was covered by Medicare, the hospital claim crossed over to Medicaid for payment of the recipient's deductible. Based on the hospital admission and discharge dates from the recipient's Medicare claim, we determined the recipient's hospital stay lasted 10 days. During the period of the admission, the home care agency billed Medicaid for eight days of around-the-clock personal care at \$400 per day.

Recommendations

4. Review and recover the Medicaid overpayments totaling \$368,000 for improper ancillary service claims for dual eligible recipients. Focus efforts on those providers who received the largest amounts of improper payments for ancillary services.
5. Formally consider modifying existing eMedNY edits or implement new ones that use information from Medicare crossover claims to detect improper ancillary service claims for dual eligible recipients.

Audit Scope and Methodology

The objective of our audit was to determine whether the eMedNY system processes Medicaid claims for ancillary services in accordance with the Department of Health's Medicaid

reimbursement policies. Our audit period was from April 1, 2012 through September 30, 2013.

To accomplish our audit objective, we interviewed officials from the Department of Health and the Office of the Medicaid Inspector General. We reviewed applicable sections of federal and State regulations, and examined the Department's relevant Medicaid policies and procedures. We also designed and executed computer programs to verify the accuracy of Medicaid payments for ancillary services.

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 at the end of it. In their response, Department officials indicated the actions that will be taken which address our recommendations. Also, our rejoinders to certain Department comments are included in the report's State Comptroller's Comments.

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

Brian Mason, Audit Director
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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



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

Sue Kelly
Executive Deputy Commissioner

February 26, 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-160 entitled, "Improper Payments for Ancillary Services Provided During Hospital Inpatient Admissions."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read "Sue Kelly".

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
Jason A. Helgerson
James C. Cox
Diane Christensen
Robert Loftus
Joan Kewley
Lori Conway
Ronald Farrell
Brian Kiernan
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**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2012-S-160 Entitled
Improper Payments for Ancillary Services
Provided During Hospital Inpatient Admissions**

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-160 entitled, "Improper Payments for Ancillary Services Provided During Hospital Inpatient Admissions."

Recommendation #1:

Recover the Medicaid overpayments totaling \$1 million identified by eMedNY Edits 759 and 2063 and reported to the Department. Focus efforts on those providers who received the largest amounts of improper payments for ancillary services.

Response #1:

The Office of the Medicaid Inspector General (OMIG) did not rely on edits 759 and 2063 to identify possible inappropriate claims, as these edits do not take into consideration all of the exceptions that would allow appropriate billing of these services. Instead, the OMIG performed data analysis to identify potentially inappropriate services (Ordered Ambulatory, Clinic/Emergency Room (ER) and Transportation) rendered during an inpatient stay. After reviewing OSC's findings, the OMIG identified several issues which conflict with Medicaid billing policy regarding services provided during an inpatient stay. As these are recurring audits, the OMIG is very familiar with the Office of Health Insurance Programs (OHIP) policy and Medicaid regulations pertaining to services rendered during an inpatient stay.

The OMIG routinely conducts audits on services (Ancillary, Clinic/ER and Transportation) provided during an inpatient stay. We are currently working on two audits which will recoup payments for these services rendered during an inpatient stay, both for Medicaid only and dual-eligible Medicaid recipients.

The following bullets outline some of the issues identified with the OSC analysis:

- Evaluation and Management services - These are allowed.
- The Office of Mental Health (OMH)/ The Office of Alcoholism and Substance Abuse Services (OASAS) services - Certain criteria applied to these types of services in which they may be allowed during an inpatient stay.
- Some services were actually outside of the inpatient time frame – These are allowed.
- Services rendered on the date of discharge – These may be allowed.
- Federally Qualified Health Center (FQHC) designated facilities - In certain situations, it is appropriate for FQHC to bill clinic service during inpatient stay.

<p>* Comment 1</p>

* See State Comptroller's Comments on Page 16.

- Critical Care Hospitals - In certain situations, they are allowed to bill ancillary services during inpatient stay.
- Home Health - Service occurred on admit or discharge date, the claim is allowed.
- Surgical procedures - These are allowed.
- Mutual Care Home Health cases - Which may be billable for the recipient not in the hospital.

*
Comment
1

Recommendation #2:

Formally consider modifying eMedNY edits 759 and 2063 or implement new edits to detect and recover improper claim payments for ancillary services. Provide particular attention to edits that deny payments for ancillary services when eMedNY processes and pays inpatient hospital claims that coincide with the ancillary services in question.

Response #2 and # 5, same response for both recommendations:

The Department acknowledges OSC's findings that eMedNY edits detected and denied most of the improper ancillary service claims inappropriately billed by Medicaid providers. This is evidenced by the fact that for the one year period ending March 31, 2013, in which \$3,194,736,748 was paid for inpatient claims, OSC identified only less than 1% (\$1,368,000) in potential overpayments. However, the Department acknowledges that improvements to eMedNY should be ongoing and prioritized based on the overall impact to the Medicaid program. Therefore, the Department will review edits 759 and 2063 to assess their ability to detect and deny inappropriate ancillary payments for Medicaid-only claims as well as Medicare/Medicaid crossover claims. A systems project will be initiated and prioritized, if the edits are failing to deny ancillary services provided to Medicaid patients in the hospital. If determined to be warranted, cost effective, and feasible, the Department anticipates submission of an eMedNY Project request to strengthen payment edits to reduce the risk of payment for ancillary services provided to hospital inpatients by May 1, 2014. Moreover, Medicaid claims processed through New York's current Medicaid Management Information System eMedNY 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 11-12 with major State law changes. As a result of this initiative, fee-for-service 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, however, it is anticipated that this transition will dramatically decrease the impact of eMedNY edit issues moving forward.

*
Comment
2

Recommendation #3:

Improve the coordination of eMedNY's identification of improper ancillary claim payments with the corresponding data analysis and recovery efforts of the OMIG. Ensure overpayments identified by eMedNY for ancillary services are recovered in a timely manner.

Response #3:

OMIG's Business Intelligence Group performs a routine match that identifies potential overlapping services during an inpatient hospital stay. Questionable services are identified and

recovered unless the provider can justify the services. The OMIG will ensure the improper ancillary claim overpayments are recouped in a timely manner. The OMIG routinely conducts audits on services (Ancillary, Clinic ER and Transportation) provided during an inpatient stay. The OMIG is currently working on two audits which will recoup payments for these services rendered during an inpatient stay, both for Medicaid only and dual-eligible Medicaid recipients.

Recommendation #4:

Review and recover the Medicaid overpayments totaling \$368,000 for improper ancillary service claims for dual eligible recipients. Focus efforts on those providers who received the largest amounts of improper payments for ancillary services.

Response #4:

The OMIG performed data analysis to identify potentially inappropriate services (Ordered Ambulatory, Clinic/ER and Transportation) rendered during an inpatient stay. After reviewing OSC's findings, the OMIG identified several issues which conflict with Medicaid billing policy regarding services provided during an inpatient stay. As these are recurring audits, the OMIG is very familiar with OHIP's policy and Medicaid regulations pertaining to services rendered during an inpatient stay.

The OMIG routinely conducts audits on services provided during an inpatient stay. The OMIG is currently working on an audit which will recoup overpayments for these services for both Medicaid-only and dual-eligible Medicaid recipients.

Recommendation #5:

Formally consider modifying existing eMedNY edits or implement new ones that use information from Medicare crossover claims to detect improper ancillary service claims for dual eligible recipients.

Response #5 - See # 2 above, Response to # 2 and # 5 combined

State Comptroller's Comments

1. The exceptions cited by the Department accounted only for about \$13,400 of the \$1 million in potential overpayments identified by edits 759 and 2063. Consequently, we maintain that actions should be taken to recover overpayments indicated by those edits. Such actions could be taken during OMIG's recurring audits.
2. We acknowledge that the \$1,368,000 in potential overpayments we identified in this audit represented a comparatively small portion of total annual Medicaid payments. Nonetheless, we consider the amount in question material and would note that other audits performed by the State Comptroller have identified many millions of dollars of overpayments and/or opportunities for cost savings. Moreover, we are pleased the Department recognizes the significance of the inappropriate payments and is considering enhancing eMedNY edits to prevent them from recurring.