NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

July 8, 2013

Mr. Brian Mason
Audit Director
NYS Office of the State Comptroller
110 State Street, 10th Floor
Albany, New York 12236

Dear Mr. Mason:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2011-S-29 entitled, "Medicaid Claims Submitted by Accordis, Inc. on Behalf of the New York City Health and Hospitals Corporation."

Please feel free to contact James Clancy, Assistant Commissioner, Office of Governmental and External Affairs at (518) 474-2011 with any questions.

Sincerely,

Nirav R. Shah

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

Enclosure

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

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

Recommendation #1:

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

Response #1:

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

Regarding the OSC's comment that "...to implement such a link, the Department could consider an approach similar to the one eMedNY uses for adjusted claims. When an adjusted claim is submitted, a suffix is added to the claim's original identification number," is not feasible and does not alter our original response. Adjustments are linked to the original claim, as stated in the OSC comment. When the provider submits an adjustment, it includes the ID number of the original claim; thus the two claims are already linked. This is not the case with denied claims. When a provider resubmits a claim that was previously denied, that resubmission includes no ID number or any other linkage to the claim originally denied; moreover, any number of data elements on the resubmitted claim might have been changed from the original submission, as noted in our original response.

Concerning the OSC comment that "the Department could request Federal authorities to approve a change to claims data (to link denied and corresponding paid claims) that would strengthen control over Medicaid payments," this change would require the support of a majority of payers (states, Blue Cross, etc.), and years of effort to bring about. At that point, a large systems change (evolution) project would be required within eMedNY (or a successor system), and given the history of systems evolution resource constraints, would take months or years to implement after that, if its priority was high enough to warrant the effort (which is questionable, given the $533 total overpayments cited by the audit). The Department does not believe this would be a cost-effective exercise.

Recommendation #2:

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

Response #2:

The Department included an article in its June 2013 Medicaid Update publication reminding all providers, including HHC and service bureaus, of the requirement for providers to review all service bureau claims prior to submission. This gives providers the opportunity to correct any inaccurate claims, delete improper claims, or otherwise revise the intended submission to ensure that claims submitted for reimbursement are for care, services and supplies actually delivered.

Recommendation #3:

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

Response #3:

The OMIG will review the six associated claims and recover overpayments as appropriate.