Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2014-S-53 entitled,
"Medicaid Claims Processing Activity October 1, 2014 Through March 31, 2015"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2014-S-53 entitled, "Medicaid Claims Processing Activity October 1, 2014 Through March 31, 2015."

Background:

New York State is a national leader in its oversight of the Medicaid Program. With the transition to care management, the Office of the Medicaid Inspector General (OMIG) continues to improve upon our processes and direct our resources to match this changing direction in the Medicaid program. In conjunction with the Department, NYS will continue its focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse wherever it exists.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,405,500 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,868 in 2014, consistent with levels from a decade ago.

Recommendation #1:

Formally advise the hospitals and MCOs in question to report accurate birth weight information on claims.

Response #1:

Current billing documentation includes the requirement to report birth weight in grams. *Inpatient Hospital Billing Guidelines Manual, Rule 3 – Newborns*, specifies that All Patient Refined Diagnosis Related Group claims for newborns, 28 days or younger, must report the birth weight using Value Code 54 in the Value Information segment.

Providers were reminded of this billing rule in the following September 2015 Medicaid Update:

"Reporting of Newborn Birth Weight
Billing Reminder

Providers are reminded that pursuant to the inpatient billing procedures for All Patient Refined Diagnostic Related Groups (APR DRGs) documented in ***New York State UB-04 Billing Guidelines – Inpatient Hospital****, claims for newborns, 28 days or younger, must contain the newborn's birth weight in grams. The birth weight is reported using Value Code 54 in the Value Information segment.*

The billing guidelines regarding newborns are detailed under ***2.3.1.2, Rule 3 – Newborns*** *(https://www.emedny.org/ProviderManuals/Inpatient/PDFS/Inpatient_Billing_Guidelines.pdf).*

To ensure proper payment, providers should follow these guidelines when billing Medicaid fee-for-service (MFFS) as well as billing Medicaid Managed Care (MMC) plans.

For MFFS billing guideline questions, please contact the eMedNY Call Center at 1-800-343-9000. Questions regarding MMC billing and reimbursement requirements should be directed to the enrollee's MMC plan."

An email blast was sent on September 29, 2015 to all Managed Care Organizations reinforcing this information.

Additionally, the Department directed Computer Sciences Corporation (CSC) to notify and educate the specific hospitals and Managed Care Organizations identified in this audit on the proper billing of DRG claims for newborns.

Recommendation #2:

Ensure that the hospital whose billing system caused incorrect birth weights to be reported on its claims has corrected its billing problem.

Response #2:

The Department conducted an audit of sixteen (16) claims from Montefiore Hospital for the timeframe from June 24, 2014 through June 11, 2015. Claims selected represented birth weights throughout low, normal and high ranges. Birth records for the claims were requested from the hospital and compared to the birthweight submitted on the claim. No discrepancies between the birth records and the information submitted on the claims were found.

Recommendation #3:

Formally advise the hospitals in question to accurately report ALC and patient status billing codes on Medicaid claims.

Response #3:

The Department has instructed its fiscal agent, CSC, to educate the four providers identified in this audit report on the accurate reporting of Alternate Level of Care days; in addition CSC was instructed to educate a fifth provider concerning use of accurate Inpatient Status Codes. CSC has documented the provider instruction.

Recommendation #4:

Review and recover the two unresolved overpayments totaling $32,571.

Response #4:

OMIG's Third Party Liability contractor verified the findings and notified the providers. Both claims were voided, rebilled, and paid correctly. No further action is needed.

Recommendation #5:

Review and recover the 15 unresolved overpayments totaling $476,888.

Response #5:

OMIG is reviewing the documentation for the 15 claims, and will recover any inappropriate payments that are identified.

Recommendation #6:

Formally advise the pharmacy of the Medicaid requirements for faxed orders.

Response #6:

To ensure proper dispensing, the Department issued guidance in the August 2014 Medicaid Update and the November 2014 Medicaid Update to pharmacies about Medicaid requirements for the transmission of prescription orders. The revised November 2014 Medicaid Update is as follows:

"Pharmacy Update

Reminder - Transmission of the Official Prescription Serialized Number is required for All NYS Fee-for-Service Medicaid Claims
Re-issuance of August 2014 article

When submitting claims for prescriptions written in New York State on an Official New York State Prescription form, the serialized number from the Official Prescription MUST be used.
In specific situations, valid prescriptions for prescription drugs and/or supplies may still be dispensed when not written on Official New York State Prescription Forms.

The table below lists some of the specific situations when this is allowed and indicates the appropriate code to be entered in NCPDP field 454-EK in lieu of the Prescription Serial Number.

Code	***Value***
99999999	** Oral prescriptions and products dispensed pursuant to a non-patient specific order **
EEEEEEEE	** Prescriptions submitted electronically (computer to computer)***
NNNNNNNN	** Prescriptions for carve-out drugs for nursing home patients (excluding controlled substances)*
SSSSSSSS	** Fiscal orders for supplies*
ZZZZZZZZ	** Prescriptions written by out-of-state prescribers or by prescribers within the US Department of Veterans Affairs*

** Products dispensed pursuant to a non-specific patient order may include, but are not limited to, emergency contraceptives (e.g., Plan B) or pharmacist administered vaccines.*

*** Prescriptions submitted electronically, that do not transmit properly or default to a facsimile, must conform to the requirements of the NYS Education Law at:*

http://www.op.nysed.gov/prof/pharm/pharmelectrans.htm.

Prescriptions received by the pharmacy as a facsimile must be an original hard copy on the Official New York State Prescription Form that is manually signed by the prescriber, and that serial number must be used. Prescriptions for controlled substances that are submitted electronically but fail transmission MAY NOT default to facsimile.

For questions on this billing requirement providers may contact the eMedNY Call Center at (800) 343-9000."

The Department has directed CSC to contact the pharmacy identified in this audit. CSC has documented the provider instruction.

Recommendation #7:

Review and recover the eight unresolved overpayments totaling $24,468.

Response #7:

OMIG reviewed and will recover five inappropriate duplicate J-Code claims. OMIG will request and review the medical documentation for the remaining three CPEP claims, and recover any inappropriate payments.

Recommendation #8:

Formally instruct the providers in question not to bill multiple times for CPEP evaluations during a single patient encounter.

Response #8:

The Department and the Office of Mental Health (OMH) have developed Psychiatric Emergency Program (CPEP) billing guidance and established a rate code for CPEP Extended Observation Beds. This guidance was sent to all providers on September 29, 2015.

Additionally, systems modifications are being implemented to prevent the ability of a provider to bill multiple times for a CPEP evaluation during a single patient encounter.

Recommendation #9:

Formally instruct the provider in question not to bill Medicaid for outpatient services provided to recipients who are hospitalized.

Response #9:

Evolution Project #1941 was implemented on March 26, 2015 ensuring that claims for an Emergency Department visit provided on the same date of service as an inpatient discharge will

be denied. The October 2015 Medicaid Update article reminding providers that it is inappropriate to bill for certain services when a patient is hospitalized is as follows:

"Medicaid Disallows Payment for Outpatient and Inpatient on Same Date of Service

<<<REMINDER>>>

Medicaid utilizes a Diagnosis Related Group (DRG) payment methodology for services provided on an inpatient basis (rendered to a patient between the date of admission and date of discharge). The DRG facility payment is all inclusive and includes all services provided the patient during the inpatient stay. To enforce the policy, New York State Medicaid recently implemented a payment edit to reinforce billing policy that disallows payment for an outpatient visit concurrent with an inpatient stay.

The only exception to this policy is for emergency service procedures done in an Emergency Department. When emergency services are provided on the same date as the date of discharge and the primary diagnosis is different, the Emergency Department visit is Medicaid reimbursable.

Policy questions on this matter may be directed to the Division of Program Development and Management at 518-473-2160."

Recommendation #10:

Review and recover the five unresolved overpayments totaling $8,700.

Recommendation #11:

Formally instruct the DME provider in question how to correctly bill Medicaid to ensure appropriate payment.

Response #10 and #11:

A review of the prior approval request found a vendor error in coding, resulting in the overpayment of $8,700. The provider was notified of the coding error with instructions on the correct coding for the items being dispensed. The provider voided the overpayment claims and resubmitted corrected claims using the appropriate coding. The Department Prior Approval staff was also instructed on the correct coding for these items for future approvals.

Recommendation #12:

Determine the status of the 16 remaining providers with respect to their future participation in the Medicaid program.

Response #12:

Of the 16 providers:

13 have no basis for exclusion.
2 have been excluded.

1 is still under investigation.

Recommendation #13:

Determine the appropriateness of the $45,593 received by the two terminated providers and recover improper payments as warranted.

Response #13:

The two providers are currently under investigation.

State Comptroller's Comment:

We maintain that the three CPEP claim payments in question are problematic. As stated on page 11 of our report, CPEP evaluations are allowed once per patient encounter, and a single encounter can take place over multiple service dates. For the three payments cited, providers billed CPEP evaluations multiple times during the same encounter, and the assertion that the claims were paid appropriately because the services took place on separate dates is incorrect. Further, we identified this billing error in previous audits (2013-S-12 and 2014-S-15). In responding to these audits, the Department acknowledged that other CPEP claims with similar characteristics were overbilled. In addition, Department officials stated they would: work with the Office of Mental Health (OMH) to formally instruct providers how to properly bill CPEP claims; and follow up with OMH regarding their request to "only pay one unit per claim instead of one unit per day [in the CPEP setting] … to prevent the overbilling identified by OSC."

Response to Comment:

The Department and the OMH issued billing guidance to all providers on September 29, 2015 for CPEP and CPEP Extended Observation Beds. In addition, OMIG will request and review the medical documentation for the three CPEP claims, and recover any inappropriate payments.