NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

January 16, 2014

Mr. Brian Mason
Acting Assistant Comptroller
New York State 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-39 entitled, "Medicaid Claims Processing Activity October 1, 2011 through March 31, 2012."

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-39 Entitled
Medicaid Claims Processing Activity
October 1, 2011 Through March 31, 2012

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2011-S-39 entitled, "Medicaid Claims Processing Activity October 1, 2011 Through March 31, 2012."

Recommendation #1:

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

Response #1

The Department will continue to monitor, track and establish rates of reimbursement and work on internal controls to reduce risk moving forward. The Department is also attempting to decrease retroactive rate adjustments in the Medicaid program. The goal is to effectuate rates on a prospective basis. Moreover, the enacted 2013-14 budget consolidated all Medicaid rate setting functions within the Department. This transition will centralize all Medicaid rate setting functions and will decrease incorrect rate changes moving forward.

Recommendation #2:

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

Response #2:

Four of eight claims have been voided resulting in recoveries of $277,596. Our recovery audit contractor (RAC) is continuing to pursue recoveries on the remaining four claims.

Recommendation #3:

Formally advise the hospitals in question to ensure that alternative (lower) level of care (ALC) days are accurately reported on claims.

Response #3:

The Department requested that Computer Sciences Corporation (CSC) provide training on the appropriate billing procedures of ALC days to the two hospitals in order to ensure that they indicate a patient's "level of care" on claims for accurate processing and payment moving forward. CSC in turn contacted the providers on July 23, 2013 and July 24, 2013.

In addition, the Department issued an update in the May 2013 issue of the New York State Medicaid Update to educate all providers on appropriate billing procedures of ALC days.

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

Recommendation #4:

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

Response #4:

The provider submitted payment for all overpayments via self-disclosure.

Recommendation #5:

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

Response #5:

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

Moreover, Medicaid claims processed through New York's current Medicaid Information System (MMIS), 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 2011-12 with major state law changes. As a result of this initiative, fee-for-service (FFS) spending will ultimately drop to only 15% 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.

Recommendation #6:

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

Response #6:

The OMIG will review these payments and initiate recovery as appropriate. Additionally, the Department issued an update in the August 2013 issue of the New York State Medicaid Update to educate providers to bill physician-administered drugs at their acquisition costs.

Recommendation #7:

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

Response #7:

The Department issued an update in the August 2013 issue of the New York State Medicaid Update advising providers of the OSC Audit findings and correct billing and claiming processes. Where feasible, the OMIG may monitor the submission of claims by these providers.

In addition, the Department recently requested an evolution project to require that J code drugs are issued at acquisition costs.

Recommendation #8:

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

Response #8:

The Department requested that CSC provide training on the appropriate billing procedures of Patient Status Codes to the two hospitals in question. CSC in turn contacted the providers on July 24, 2013 and July 30, 2013.

In addition, the Department issued an update in the May issue of the New York State Medicaid Update to educate all providers on correctly entering patient status codes on hospitals claims.

Recommendation #9:

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

Response #9:

The Department advises the provider on an ongoing basis to request prior approval from New York Medicaid unless the provider agrees to accept the New York State Medicaid reimbursement rate.

Recommendation #10:

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

Response #10:

The Department will research and evaluate the claims to determine if edits and/or a Medicaid Update article are appropriate.

Recommendation #11:

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

Response #11:

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

Recommendation # 12:

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

Response #12:

The Department requested that CSC provide training to the provider regarding the proper billing procedures for medical equipment. CSC in turn contacted the provider on July 30, 2013. Beginning April 1, 2012, the Department requires prior authorization to prevent any duplicate rental payments.

Recommendation #13:

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

Response #13:

The OMIG will review the overpayments and pursue recovery as appropriate.

Recommendation #14:

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

Response #14:

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

Recommendation #15:

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

Response #15:

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

The Department will also review the rate codes in question and make any necessary changes, including the establishment of billing guidelines and edit protocols, to prevent duplicate billings from both nursing homes and hospice providers.

Recommendation #16:

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

Response #16:

The OMIG has determined the status of the remaining 19 providers, and all appropriate exclusions have been processed. Five of the nineteen providers had their exclusions either stayed or reversed on appeal.

Recommendation #17:

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

Response #17:

The OMIG will investigate the propriety of the payments made to the six providers who violated Medicaid laws and or regulations, and will recover any improper payments.