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-9 entitled, "Medicaid Claims Processing Activity April 1, 2011 through September 20, 2011".

Please feel free to contact James Clancy, Assistant Commissioner, Office of Governmental and External Affairs at (518) 473-1124 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-9 entitled
Medicaid Claims Processing Activity
April 1, 2011 through September 30, 2011

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-9 entitled, "Medicaid Claims Processing Activity April 1, 2011 through September 30, 2011."

Recommendation #1:

Review and recover overpayments on the eight incorrect claims (totaling payments of $224,105) cited in the report.

Response #1:

As of March 2013, providers have voided two of the eight claims resulting in recoveries totaling $157,571. The remaining six claims were attributable to one provider who agrees with the findings and is summiting a check for the amount owed.

Recommendation #2:

Formally assess the efficacy of changing the disposition on the eMedNY edit that tests the reasonableness of Medicare/MCO amounts to pend or deny claims with unreasonable amounts.

Response #2:

The Department implemented Evolution Project 1685 on July 26, 2012. This project tests the reasonableness of Medicare/MCO amounts and pends claims for further review.

Recommendation #3:

Develop and implement solutions to properly process payments when primary insurer information on a claim does not match related eMedNY data.

Response #3:

The Department instituted eMedNY Evolution Project 1615A on January 27, 2012. EP 1615A – Medicare Part B Cost Sharing Limit (MRT-164) aligns Medicare part B Clinic Coinsurance with Medicaid coverage and rates. Under the new payment methodology, eMedNY compares the Medicare payment to the hospital's outpatient diagnostic and treatment center to the amount that

Medicaid reimburses for the service to a Medicaid-only recipient to determine the final Medicaid payment amount.

Recommendation #4:

Implement a system change to correct eMedNY processing of claims submitted with an incorrect Medicare insurance designation.

Response #4:

The Department implemented Evolution Project 1377B on May 23, 2013. This project identifies claims submitted with incorrect Medicare insurance designation.

Recommendation #5:

Formally advise the three clinics in question to not submit claims with duplicative charges. On a risk basis, monitor the claims of the three clinics to ensure they do not include duplicate charges.

Response #5:

The OSC identified three different providers who submitted clinic claims with duplicate charges. In each instance, the OSC notified the provider of the incorrect billing and the provider took corrective action by correcting the errors and submitting claim adjustments. The corrective action taken by the each of the providers indicates the providers are aware of the billing errors they previously committed and are now cognizant of the correct way to bill for the services in question. No additional billing instructions are indicated at this time. The OMIG will monitor the claims of the three clinics to ensure they do not include duplicate charges.

Recommendation #6:

Review and recover the unresolved overpayments (totaling $161,521) on the two claims with excessive charges for alternate level of care (ALC) days.

Response #6:

The Department included an article in the May 2013 Medicaid Update which explained the proper methodology for billing claims of this nature, referencing the appropriate section of the Provider Manual billing guidelines. The OMIG will review the unresolved overpayments identified as excessive charges for ALC days and pursue recoveries as appropriate.

Recommendation #7:

Formally advise the hospital in question to ensure that the patient status codes on claims are correct.

Response #7:

Computer Science Corporation (CSC) formerly advised the provider on October 23, 2012 of the proper patient status codes to use on claims billed to Medicaid.

Recommendation #8:

Strengthen eMedNY controls to prevent payment of clinic claims that contain the hospital ambulatory surgery procedure codes we identified when they are billed on the same date of service as a hospital inpatient admission.

Response #8:

We do not agree with the OSC's recommendation. The Department has not issued policy prohibiting providers from billing an ambulatory surgical procedure when the patient is subsequently admitted to the hospital as inpatient. It is therefore appropriate at this time for a facility to bill for the ambulatory surgery as well as the inpatient claim. The Department acknowledges that a review of current payment policy is warranted. We will review policy and determine the need to strengthen payment edits if appropriate. If a change in payment policy is indicated, providers will be notified through a Medicaid Update.

Recommendation #9:

Instruct the identified provider how to correctly bill such claims and monitor for compliance.

Response #9:

Billing policy will be communicated to providers if it is determined that a change in payment policy is warranted. The OMIG will monitor the provider for billing compliance.

Recommendation #10:

Review and recover the unresolved overpayment on the remaining claim.

Response #10:

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

Recommendation #11:

Review and recover the $15,918 in expected corrections and the unresolved overpayments (totaling $ 25,711) on the remaining 18 claims.

Response #11

The OMIG will review and recover the $15,918 of expected corrections, and unresolved overpayments on the remaining 18 claims (totaling $25,711).

Recommendation #12:

Formally instruct the 13 providers identified by our audit of the correct way to claim payments for physician-administered drugs. Actively monitor the submissions of such claims by these providers.

Response #12:

As part of the audit process, the OSC notified the providers that they had overbilled Medicaid for certain J code physician administered drugs. The providers corrected the errors and submitted claim adjustments. The corrective action taken by the each of the providers indicates the providers are aware of the billing errors they previously committed and are now cognizant of the correct way to bill for the services in question. No additional billing instructions to the providers are indicated at this time.

Recommendation #13:

Through automated and/or manual processes, strengthen the controls over claims for physician-administered drugs when providers' stated acquisition costs exceed the maximum allowable Medicaid fee amount.

Response #13:

The Department will request the OMIG identify outlier providers who may be billing Medicaid incorrectly for J code physician administered drugs and will put these providers on pre-payment claim review to insure that providers are paid no more than acquisition cost.

Recommendation #14:

Recover the $19,992 in inappropriate payments for the person who resides in Pennsylvania and is enrolled in Pennsylvania's Medicaid program.

Response #14:

The OMIG will review these payments and initiate recovery as appropriate.

Recommendation #15:

Ensure that the person in question, who resides in Pennsylvania, is disenrolled from New York's Medicaid program.

Response #15:

The individual in question was disenrolled from NYS Medicaid effective August 2012.

Recommendation #16:

Formally remind the New York City Human Resources Administration (HRA) to keep recipients' enrollment information current and to remove recipients who establish residency in another state from New York's Medicaid program.

Response #16:
The Department will review with HRA the details of the case behind this OSC recommendation, as well as program policy and procedures relative to individuals who move out of state.

Recommendation #17:

Review and recover the unresolved overpayments on the 22 claims (with overpayments totaling $4,107).

Response #17:

CSC will be instructed to contact the 12 vision providers identified in the OSC audit that overbilled Medicaid for services provided to Medicare/Medicaid dually eligible recipients. The providers will be advised that they are to report Medicare approved amounts on their Medicaid claim only when Medicare has approved payment for the service. If Medicare has not approved payment, then the provider is to enter $0 in the Medicare approved/paid fields.
The OMIG will review these claims and pursue recoveries as appropriate.

Recommendation #18:

Instruct identified providers how to correctly bill claims and monitor for compliance.

Response #18:

The OMIG will monitor providers for billing compliance.

Recommendation #19:

Determine the status of the remaining problem provider relating to future participation (or non-participation) in the Medicaid program.

Response #19

The provider's status is currently inactive, and it hasn't billed or ordered Medicaid services since 2009. The OMIG has made numerous attempts to obtain court documents from the New Jersey Assistant Attorney General but has not been successful. As such, under the regulation, it is not

possible to issue an immediate exclusion at this time. However, a note which the OMIG has placed in eMedNY will alert the Department in the event of an attempt by the provider to renew enrollment.

Recommendation #20:

Investigate the propriety of payments (totaling $5,164) made to the provider in question and recover any overpayments, as appropriate.

Response #20:

The OMIG will analyze the propriety of the payments and pursue recoveries as appropriate