NEW YORK STATE OF OPPORTUNITY. Department of Health

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February 15, 2017

Ms. Andrea Inman
Audit Director
New York State Office of the State Comptroller
110 State Street, 11th Floor
Albany, New York 12236

Dear Ms. Inman:

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 2015-S-74 entitled, "Medicaid Claims Processing Activity October 1, 2015 through March 31, 2016."

Please feel free to contact Amy Nickson, Assistant Commissioner, Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

Howard Zucker M.D.

Howard A. Zucker, M.D., J.D.
Commissioner of Health

Enclosure

cc: Ms. Nickson

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2015-S-74 entitled, Medicaid Claims Processing Activity October 1, 2015 through March 31, 2016

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2015-S-74 entitled, "Medicaid Claims Processing Activity October 1, 2015 through March 31, 2016."

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

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 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,305 in 2015, consistent with levels from a decade ago.

Recommendation #1:

Review the $3,516,162 in improper fee-for-service claim payments we identified and recover overpayments as appropriate.

Response #1

OMIG analyzed the improper fee-for-service claims, and is working with the Department to pursue recovery of any inappropriate payment.

Recommendation #2:

Review and recover the unresolved overpayments totaling $163,515 ($83,052 + $56,256 + $6,043 + $18,164).

Response #2

OMIG's Recovery Audit Contractor has reviewed the unresolved overpayments, recovered $1,295, and is continuing to make recoveries, where appropriate.

Recommendation #3:

Determine how providers who submit paper claim forms can accurately bill Medicaid for patient responsibility amounts when recipients also have Medicare managed care coverage; take any necessary corrective actions, including updating the eMedNY billing guidelines accordingly; and formally notify providers of the changes.

Response #3:

The Department is working to determine the best method for updating eMedNY billing guidelines to inform providers how to accurately bill Medicaid for Medicare managed care patient responsibility amounts using paper forms. An Evolution Project has been submitted that will require providers to submit claims electronically, except for in a few special circumstances (sterilizations/hysterectomies). The Department anticipates establishing and publishing billing guidelines by February 2017.

Recommendation #4:

Review the five unresolved overpayments totaling $322,163 ($310,967 + $11,196) and recover as appropriate.

Response #4

OMIG performed analysis on the five unresolved overpayments:

4 claims have been recovered for $306,857.
1 claim is under review.

Recommendation #5:

Review and recover the 28 unresolved overpayments totaling $60,316 ($19,117 + $26,331 + $14,618 + $250).

Response #5:

External Ambulatory Infusion Pumps (E0784) used for the administration of insulin are covered for Diabetes Mellitus as medically necessary when ordered by an endocrinologist and when specific clinical criteria are met. This item is approved by the Dispensing Validation System, which requires the provider to maintain all supporting documentation. In two instances, the pumps were ordered by appropriate staff in the endocrinologist's office. The referring providers were Physician Assistants who were affiliated with endocrinologists, meeting the intent of the policy. The provider, Shelbourne Pharmacists, was placed on pre-payment review to monitor all future insulin pumps claims. The Department also clarified the ordering provider policy by issuing an eMedNY Provider Communication on September 15, 2016.

Although the providers identified in this audit billed more than the allowable fee for speech generating devices, claims payment was made at the Medicaid Reimbursement Amount (MRA) so no overpayment was made. In these cases, it would not be appropriate to apply the "cost plus 50%" policy as this policy only applies when the item does not have an MRA. As speech generating devices have an MRA, they are not subject to this calculation and were appropriately paid at the MRA.

OMIG will review the 28 unresolved overpayments, and recover any inappropriate payments.

Recommendation #6:

Review and recover the unresolved overpayments from the 2011 and 2014 PERM reviews

totaling $333,504.

Response #6:

The Centers for Medicare and Medicaid Services (CMS) identified a total of $333,504 ($202,169 + $131,335) in overpayments for review years 2011 and 2014, respectively.

The Department's current protocol is to adjust the CMS-64 by the amount of the Federal Share of the overpayment amount. The Department has viewed the Payment Error Recovery Measurement (PERM) review as a tool to help educate providers on the proper claims submission process so that medical record and systems errors are submitted correctly. The Department concluded that the recovery of the full overpayment from providers would cause financial hardship. For 2011, the Department repaid the Federal Share by adjusting the CMS-64 in the amount of $169,254.

The Department's policy is to continue to review the PERM overpayments recovery protocol and will amend it to include additional edits as needed to reduce potential errors. If deemed appropriate, actions will be taken to recover the overpayments to further strengthen the PERM process.

Recommendation #7:

Formally advise the two hospitals to accurately report alternate levels of patient care when billing Medicaid.

Response #7:

Computer Sciences Corporation (CSC) Provider Services formally advised the two hospitals identified in this audit on how to accurately report alternate levels of patient care.

Recommendation #8:

Review and recover the unresolved overpayments totaling $37,555.

Response #8:

The Department notified the OSC in the Preliminary report that the dental office identified in this audit was contacted regarding the overpayment of dentures in the amount of $2,240. The dental office refunded this amount in a check to CSC on January 5, 2016.

During the Prior Approval process, the Department's Bureau of Medical Review (BMR) staff made an error when checking the member's eligibility. As a Principal Provider was indicated, that Principal Provider is responsible for paying the Medicaid vendor for the equipment. BMR staff approved the equipment request and the vendor was paid in error under Fee-for-Service (FFS). BME staff will be reminded to check for a Principal Provider during a Prior Approval review and inactivate the request in eMedNY (to prevent FFS payment) and remind the vendor to seek payment from the principle care provider.

OMIG will review the unresolved overpayments, and recover any inappropriate payments.

Recommendation #9:

Determine the status of the remaining provider regarding its future participation in the Medicaid program.

Response #9

OMIG has excluded the remaining provider.

State Comptroller's Comments:

OSC Comment #1:

Based on the Department's response, we concur that two claims for External Ambulatory Infusion Pumps ordered by physician assistants were appropriate. Consequently, we amended page 12 of our report to reduce the overpayments pertaining to the DME claims by $10,257 (from $36,588 to $26,331). In addition, we encourage the Department to review the propriety of the remaining five claims for External Ambulatory Infusion Pumps identified in our report.

Response to Comment #1:

As indicated above, OMIG will review and recover as appropriate.

OSC Comment #2:

We determined Medicaid overpaid three claims because the provider was reimbursed in excess of "cost plus 50 percent" for the item. Each claim was for a speech generating device accessory that did not have a Medicaid Reimbursement Amount on file, and consequently, the claims were subject to the "cost plus 50 percent" limit. Therefore, we maintain that the claims in question were overpaid.

Response to Comment #2:

The Department is in agreement that two of the three prior approvals used for reimbursement of the speech generating device accessories (code E2599) were priced incorrectly. Additional information was submitted with the prior approvals showing a discounted invoice for the item and should have been used to establish a reimbursement for each instance. The providers were paid based on the incorrect staff pricing and the Department defers to the OMIG to recoup the overpayment. However, the Department still disputes the third claim. Each prior approval is priced independently based on information received for that specific review. Invoices showing a lower or discounted price were not received in the prior approval documentation and therefore, pricing was established based on the non-discounted invoice. The Department is reinforcing manual pricing methodology with staff to insure consistency and avoid these errors in the future.

OSC Comment #3:

If Department officials determine that recovering the full amounts of overpayments from certain providers, as identified by the PERM review, would cause financial hardships, then officials should explore other recovery and repayment options, such as a payback schedule, to avoid causing providers undue financial harm.

Response to Comment #3:

The Department has reviewed the errors identified in the PERM review and has determined that the errors fell into two primary categories: data processing errors and findings of Medical Record errors that are subsequently determined to have been inaccurately flagged as errors. Those identified as Medical Record errors were a result of the purported error not being disputed in a timely fashion during the CMS dispute resolution period for PERM, which resulted in these transactions appearing on the Corrective Action Plan (CAP) report. The services related to these transactions were provided, the claims processed correctly and appropriately paid; had they been identified during the resolution period, they would not have appeared on the CAP report. While it was belatedly determined that these were not actual errors applicable to the PERM review, the Department was still responsible for the reimbursement of the Federal Share related to the findings based on a PERM error rate calculation that included these transactions. The majority of the remaining errors were correctly identified Data Processing errors; a mechanism was not in place at the time to reject the error, which would have required the rejected claim to be corrected by the provider and then re-billed. As a result, the provider was able to bill and receive payment for a service that was correctly provided but contained coding errors that were undetected at the time.

As previously indicated, the Department approaches the PERM review as an informational and iterative process review designed to strengthen claims processing through the identification of potential errors and the remediation of risk through proactive systemic enhancements that would prevent similar errors occurring in future PERM cycles. We further reiterate that the intent of PERM reviews was not established to retroactively recover funds from providers, but to identify potential issues that could be resolved prospectively for future claims cycles. We continue to welcome CMS and OSC identification of issues and suggested corrective actions to reduce potential claims errors and further enhance the integrity of the NYS claims processing system.