NEW YORK STATE OF OPPORTUNITY. Department of Health

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April 22, 2015

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 2013-S-12 entitled, "Medicaid Claims Processing Activity April 1, 2013 through September 30, 2013."

Please feel free to contact Amy Nickson, Office of Governmental and External Affairs at (518) 474-2011 with any questions.

Sincerely,

Howard Zucker M.D.

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

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2013-S-12 entitled,
Medicaid Claims Processing Activity April 1, 2013
through September 30, 2013

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2013-S-12 entitled, "Medicaid Claims Processing Activity April 1, 2013 through September 30, 2013."

Background:

New York State is a national leader in its oversight of the Medicaid Program. Through the efforts of the Department of Health (Department) and the Office of the Medicaid Inspector General (OMIG), over the last five years, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. Over the last three calendar years, the administration's Medicaid enforcement efforts have recovered over $1.73 billion, a 34 percent increase over the prior three-year period.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality 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 840,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,929 in 2013, consistent with levels from a decade ago.

Recommendation #1

Review the remaining $1,789,667 in payments and recover any overpayments as appropriate.

Response #1

The OMIG will review the prescription documentation for the remaining claims, and recover the overpayments as appropriate.

Recommendation #2

Formally instruct the pharmacies in question to ensure Medicaid claims are accurately billed and dispensed in accordance with existing requirements.

Response #2

The Department agrees with the Office of the State Comptroller's (OSC) recommendation and has notified Computer Sciences Corporation (CSC) Provider Services specific instructions as to the proper reporting of pharmacy claims. The notification of these pharmacy providers was addressed in Transmittal #H-450-12893 and forwarded to CSC on January 2, 2015 to engage in provider outreach. In their response on February 10, 2015 in Transmittal R-450-09884, CSC

indicated that they had reached out to those pharmacies identified in this audit report between January 8 and January 28, 2015.

Recommendation #3

With regard to the items detailed in the table, determine whether the identified providers should be referred to the State Education Department's Office of the Professions for a review of their professional conduct (or potential misconduct).

Response #3

The OMIG will review the prescription documentation in order to determine if the identified providers should be referred to the State Education Department's Office of the Professions for a review of their professional conduct (or potential misconduct).

Recommendation #4

Recover the $1,454,977 in overpayments from the DRG-exempt per diem claims.

Response #4

The OMIG's Recovery Audit Contractor is reviewing the overpayments identified and pursuing recoveries as appropriate. To date, the OMIG's Recovery Audit Contractor has recovered $353,000.

Recommendation #5

Review and recover the unresolved overpayments totaling $90,912 ($38,112 + $52,800) on the 16 incorrect claims.

Response #5

The OMIG's Third Party Contractor is reviewing the overpayments identified and pursuing recoveries as appropriate. To date, the OMIG's Third Party Contractor has recovered $18,000.

Recommendation #6

Determine whether additional unresolved CARC-related overpayments exist. If so, reprocess and correct them, and recover any overpayments identified.

Response #6

In April 2014, the Department created a committee designated to review all Claims Adjustment Reason Codes (CARC) for accuracy and its' progress to date is as follows:

- During January 2014, a request to review the existing CARC codes and their action code mapping came from the "provider issues meeting."

- An initial list of 170 CARCs were identified that were defaulted to action code 7, including 28 new codes that were added by the codes committee in 2013.

- These CARCs were reviewed and appropriate action codes were assigned to 168 CARCs. Two CARC codes were to be further reviewed for possible Evolution Projects (EP). System updates for these codes with the approved action codes were performed on April 10, 2014, July 10, 2014, August 11, 2014, September 19, 2014 and December 9, 2014.

- A secondary list of 180 CARC codes have been identified that were defaulted to action code 7 for group code Other Adjustment (OA) only. All other groups for these CARCs have appropriate action codes mapped.

- These CARCs were being reviewed for assigning appropriate action codes for Group OA alone. Currently more research is being done to understand the business scenarios that drive the providers/primary payers to use the OA group code so that a more appropriate action code can be assigned.

- Parallel to the second list (CARCs with OA 7), another list has been put together to identify the CARCs that have been previously assigned with an action code of 5 (zero-fill) and 6 (do-not map).

  Currently this list is being reviewed to identify any discrepancies in the mapping process. It is anticipated that the review of this list will be finished by the end of May 2015, however, there may still be a few pending action items/CARCs that may need some additional work.

- Apart from these, newer CARC codes that are released every three months by the codes committee are being reviewed and assigned with appropriate action codes as soon as they are added to the system.

It is important to note that CARC reviewing/updating will always remain an ongoing process.

Recommendation #7

Formally remind the providers in question to properly record patient status codes on their inpatient service claims.

Response #7

The Department has instructed CSC Provider Services to reach out to the specific providers identified in this audit to remind them to properly record patient status codes on their inpatient claims. The notification of these providers was addressed in Transmittal #H-450-12893 and forwarded to CSC on January 2, 2015 to engage in provider outreach. In their response on February 10, 2015 in Transmittal R-450-09884, CSC indicated that they had reached out to those providers identified in this audit report between January 8 and January 28, 2015.

Recommendation #8

Formally instruct the nine providers how to properly bill the types of procedures in question.

Response #8

The Department and the Office of Mental Health (OMH) have been meeting to jointly resolve several outstanding issues, one of which is Comprehensive Psychiatric Emergency Program (CPEP) billing. Billing instructions to all providers for the CPEP program are currently being written and OMH expects to issue these instructions by April 2015. Additionally, an evolution project request to eMedNY will be initiated, the purpose of which is designed to prevent the ability of a provider to bill multiple times for a CPEP evaluation during a single patient encounter.

Recommendation #9

Follow up on and recover the $15,427 from the seven claims which should be corrected. Resolve the potential overpayments on the other nine claim payments (totaling $10,139) and recover funds where appropriate.

Response #9

The OMIG will review and recover overpayments as appropriate.

Recommendation #10

Ensure the eight previously cited providers take sufficient corrective actions to prevent excessive future claims for physician-administered drugs. Formally instruct the remaining six providers of the correct way to bill claims for physician-administered drugs and advise the providers to take corrective actions to prevent overpayments.

Response #10

The Department reminded providers that practitioner-administered drugs are to be billed to Medicaid at their acquisition cost by invoice in an August 2013 Medicaid Update.

To ensure that providers will be prevented from submitting excessive claims, the Department submitted Evolution Project (EP) #1861 on July 24, 2014. This EP will strengthen eMedNY controls through the use of a reasonability edit. Claims are being tracked by eMedNY that are currently set to pay and report. Once the data is collected and examined, the Department will review to ensure the edit is functioning as anticipated prior to fully implementing this edit.

The Department has reached out to CSC who will notify the remaining six providers identified in this audit of the correct way to bill claims for physician-administered drugs as well as advising them to take corrective actions to prevent overpayments.

Recommendation #11

As resources and priorities permit, actively monitor claims for physician-administered drugs submitted by higher-risk providers.

Response #11

The OMIG plans to conduct physician-administered (J-code) drug audits submitted by higher-risk providers, as part of its ongoing audit activities.

Recommendation #12

Review and recover the unresolved overpayments totaling $9,974 ($6,444 in dental services + $2,497 in vision services + $1,033 in transportation services).

Response #12

The OMIG will review and recover overpayments as appropriate.

Recommendation #13

Formally instruct the providers in question to ensure Medicaid claims are accurately billed.

Response #13:

The Department has instructed CSC Provider Services to reach out to providers identified in this report to provide appropriate instruction and training for the billing issues pertaining to Medicaid recipients in nursing homes and the deduction of the monthly net available monthly income liability from the monthly amount Medicaid pays to these providers. The notification of these providers was addressed in Transmittal #H-450-12893 and forwarded to CSC on January 2, 2015 to engage in provider outreach. In their response on February 10, 2015 in Transmittal R-450-09884, CSC indicated that they had reached out to those identified in this audit report between January 8 and January 28, 2015.

Concerning the "transfer between merged facilities" finding, it should be noted that during the scope of this audit, these were two separate facilities and were able to bill as such. Effective July 1, 2014, the Department combined the data of these two facilities, thus generating one merged reimbursement rate of payment. The facility was then notified, that from this point forward, they would be unable to bill for transfer payments between the two facility locations.

The Department will address those providers in the areas of Dental, Vision Care and Transportation Services in the following manner:

Dental Services – Dental providers' claims had shown either inappropriate use of delay reason codes or the providers had no documentation to support the claim. The providers are formally advised on a regular basis of the need for accurately billed Medicaid claims through enhanced instructions and Medicaid Updates.

Vision Care Services – The Department will not be providing instruction to the vision care providers as we have decided to take a stronger approach. These vision care providers have

been placed on report. As a result, all Medicare crossover claims will be pended for review prior to payment.

Transportation Services - The Department, in a letter dated November 14, 2014 to the transportation provider, advised that transportation vendors must submit claims based on actual mileage incurred pursuant to Title 18 NYCRR Section 505.10 (e)(5) which states that payment to vendors will be made only where a Medicaid enrollee is actually being transported in the vehicle.

Recommendation #14

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

Response #14

Five of the providers are still under investigation by MFCU, although one of those has had its enrollment terminated. One provider has been excluded.

Recommendation #15

Investigate the propriety of the payments (totaling $75,576) made to the two providers who violated Medicaid laws or regulations. Recover any improper payments, as appropriate.

Response #15

The two providers were enrolled and authorized to bill Medicaid for services at the time of billing. Therefore, there is not a violation since the billing was submitted prior to being excluded from the program.