NEW YORK
STATE OF
OPPORTUNITY.
Department
of Health

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HOWARD A. ZUCKER, M.D., J.D.
Commissioner

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Executive Deputy Commissioner

August 24, 2015

Ms. Andrea Inman
Audit Director
Division of State Government Accountability
NYS 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-50 entitled, "Medicaid Claims Processing Activity October 1, 2013 through March 31, 2014."

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 2013-S-50 entitled,
# Medicaid Claims Processing Activity
# October 1, 2013 Through March 31, 2014

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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-50 entitled, "Medicaid Claims Processing Activity October 1, 2013 Through March 31, 2014."

## Background:

New York State is a national leader in its oversight of the Medicaid Program. Through the efforts of the Department and the Office of the Medicaid Inspector General (OMIG), for 2009 through 2013, 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. For 2011 through 2013, the administration's Medicaid enforcement efforts 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 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 1,330,000 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 and recover the remaining $28,028 in overpayments.

**Response #1**

The $28,028 in overpayments has been recovered.

**Recommendation #2**

Review the $682,022 in pharmacy payments and recover overpayments as appropriate.

**Response #2**

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

**Recommendation #3**

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

**Response #3**

The Department educates pharmacies on potential patient safety issues through Prospective and Retrospective Drug Utilization Review (DUR). The DUR Program promotes safety through State administered utilization management tools and systems that interface with the Centers for Medicare and Medicaid Services' Medicaid Management Information Systems. Medicaid DUR is a two phase process that is conducted by the Medicaid State agencies. In the first phase (prospective DUR), the State's Medicaid agency's electronic monitoring system screens prescription drug claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy and clinical misuse or abuse. The second phase (retrospective DUR) involves ongoing and periodic examination of claims data to identify patterns of fraud, abuse, gross overuse, or medically unnecessary care and implements corrective action when needed.

42 CFR Subpart K – Drug Use Review (DUR) Program and Electronic Claims Management System for Outpatient Drug Claims, Section 456.700-456.725, provides the requirements for the DUR program.

The Department also educates pharmacies on various Medicaid requirements through the Medicaid Pharmacy Manual Policy Guidelines. Many of these guidelines are republished periodically in the Department's Medicaid Update:

(http://www.healthy.ny.gov/health_care/medicaid/program/update/main.htm)

Guidelines on faxed prescriptions were published in the May 2014 issue of the Medicaid Update and were updated as recently as in the May 2015 Medicaid Update as follows:

***"Origin Codes for New York State Fee-for-Service Medicaid Claims for Valid Prescriptions Dispensed When Not Written on Official NYS Prescription Forms***

*New York State allows e-prescribing, as well as written prescriptions when issued on an Official New York State Prescription form. Both formats must conform to all State Education Rules and Public Health Law requirements. When submitting claims for prescriptions written on an Official New York State Prescription form, the serialized number from the Official Prescription* ***MUST*** *be used.*

*In specific situations, State Education Law allows the dispensing of prescription drugs and/or supplies when not written on Official New York State Prescription Forms.*

*The table below lists some of the specific situations along with the applicable NYS Medicaid required codes 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** |
| *DDDDDDDD* | *Prescriptions dispensed as Medically Necessary during a Declared State of Emergency (excluding controlled substances)* |
| *EEEEEEEE* | *Prescriptions submitted electronically (computer to computer)*** |

| | |
|---|---|
| *NNNNNNNN* | *Prescriptions for nursing home patients (excluding controlled substances) in accordance with written procedures approved by the medical or other authorized board of the facility.* |
| *SSSSSSSS* | *Fiscal orders for supplies* |
| *TTTTTTTT* | *Transfer prescriptions (traditional, intra-chain, file buys)**** |
| *ZZZZZZZZ* | *Prescriptions written by out-of-state prescribers or by prescribers within a federal institution (e.g., US Department of Veterans Affairs) or Indian Reservation* |

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

*** Electronically submitted prescriptions that do not transmit properly or default to a facsimile must conform to the requirements of the New York State Education Law at: http://www.op.nysed.gov/prof/pharm/pharmelectrans.htm.*

**** Transfers are not allowed for controlled substances in New York State.*

*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."***

In addition, the OMIG educates providers during the audit process. Their audit protocols for Pharmacy can be found on their website at:

http://www.omig.ny.gov/audit/audit-protocols

And finally, the Department has provided Computer Sciences Corporation (CSC) Provider Services specific instructions as to the proper reporting of pharmacy claims. CSC has formally provided instruction to those pharmacies identified in this audit and has notified the Department of their outreach performed in Transmittal No. R-450-10024 dated June 5, 2015.

**Recommendation #4**

Review and recover the remaining $60,452 in overpayments.

**Response #4**

The Department contacted the Island Peer Review Organization (IPRO), its contracted NYS Medicaid Review Agent, to review the remaining fourteen (14) claims through its multi-level, physician review process to determine if the appropriate "level of care" was billed throughout the patient stay. For claims identified with days that should have been paid at an alternate (lower)

level of care setting, IPRO will submit adjustments through the eMedNY system to deny days billed incorrectly and recoup the related overpayments.

IPRO has completed the reviews of all 14 claims identified in this audit. The results are as follows:

- Six (6) were approved for Length of Stay (LOS).
- Eight (8) were denied.

The providers have agreed with IPRO's denial of the eight (8) claims. IPRO has initiated the processing of the recoupment of overpayments through the eMedNY system.

**Recommendation #5**

Review and recover, as warranted, the remaining $404,050 in overpayments.

**Response #5**

At this time, OMIG's Recovery Audit Contractor has not been able to validate the potential overpayments on these claims. OMIG formally requests the methodology used by OSC to identify these overpayments. The data provided, as well as background of the audit, does not significantly prove an overpayment has occurred. Also, due to the age of these claims, providers would not be able to rebill these claims correctly if needed to show the actual overpayment of the original claim. This, along with the high number of claims and relatively low possible recovery amount, we feel would cause negative provider reaction if in fact the claims were paid correctly.

**Recommendation #6**

Make the necessary changes to eMedNY to ensure the correct mapping of Group Code CO and CARCs of 1, 2, and 3.

**Response #6**

EMedNY's Third Party Liability Unit is in the process of implementing systems changes that will correctly map Group Code CO and Claim Adjustment Reason Codes (CARCs) of 1, 2, and 3. The Department's Division of Systems updated CARCs 1, 2 and 3 action code mapping on April 23, 2015 and is currently in the process of reviewing claims preparatory to reprocessing.

**Recommendation #7**

Provide technical assistance to the provider with the flawed system who billed 4,522 incorrect claims that Medicaid overpaid by $239,803 to ensure future overpayments are prevented. Recover any additional overpayments that may have occurred.

**Response #7**

At this time, OMIG's Recovery Audit Contractor has not been able to validate the potential overpayments on these claims. OMIG formally requests the methodology used by OSC to identify these overpayments. The data provided, as well as background of the audit, does not significantly

prove an overpayment has occurred. Also, due to the age of these claims, providers would not be able to rebill these claims correctly if needed to show the actual overpayment of the original claim. This, along with the high number of claims and relatively low possible recovery amount, we feel would cause negative provider reaction if in fact the claims were paid correctly.

The Department had provided CSC Provider Services specific instructions as to the appropriate reporting of claims associated with CARCs 1, 2 and 3. CSC, in Transmittal No. R-450-10024 dated June 5, 2015 notified the Department that it has formally instructed the provider identified in this audit report.

**Recommendation #8**

Review and recover, as warranted, the remaining $72,162 ($19,168 + $52,994) in overpayments.

**Response #8**

The OMIG's Recovery Audit Contractor has verified the claims, and is currently making recoveries.

**Recommendation #9**

Periodically remind providers of their responsibilities to verify other insurance eligibility and properly record coinsurance, deductible, and copayment information when submitting claims to eMedNY.

**Recommendation #10**

Issue a provider update on proper claim submission when recipients have other forms of health insurance coverage.

**Response #9 and #10**

Providers are reminded of their responsibilities regarding the verification of other insurance eligibility and properly record coinsurance, deductible, and copay information. This was done in the February, 2014 Medicaid Update. A revised article was recently issued in the December 2014 Medicaid Update as follows:

***"Providers Urged to Submit Correct Coordination of Benefits (COB) Information to Medicaid for Medicare Advantage (Part C) Recipients***

*A recent review of claims has uncovered persistent misreporting of patient responsibility when the patient is enrolled in both the Medicare Advantage Plan (Part C) and Medicaid. The following practices were uncovered:*

- *A Medicare Advantage Plan made an adjustment to a claim after the claim was billed to Medicaid, and the billing provider did not make an adjustment to the Medicaid claim, resulting in an overpayment,*

- *Overpayments resulted because excessive Medicare Advantage Plan coinsurance, deductible and/or co-payments were reported on COB claims to Medicaid, and*

- *Reporting Cost Avoidance (formerly known as ZERO FILL) on a service that was in fact covered by a Medicare Advantage Plan*

### *1.1.1 Provider Responsibilities*

*It is the responsibility of a provider who renders services to a Medicaid recipient to verify their eligibility before treatment. All payers reported in the eligibility response must be accounted for in the COB reporting on the claim to Medicaid.*

*The misreporting of information on COB claims may at times result in inappropriate payments to a provider. Providers are reminded that both Federal and State laws specify that providers participating in the Medicaid program must not retain any inappropriate payments. Knowingly retaining inappropriate payments violates the Fraud Enforcement and Recovery Act (FERA), which amended the Federal False Claims Act.*

*In addition, effective May 22, 2010, the Affordable Care Act (ACA) amended the Social Security Act (SSA) to include a variety of Medicare and Medicaid program integrity provisions. A new section under SSA, §1128J (d), requires providers of Medicare or Medicaid services or supplies to notify the program and return any inappropriate payments to the program(s) within sixty (60) days of identifying the overpayment.*

*It is imperative that COB claims submitted to Medicaid after Medicare or other Third Party adjudication contain all information as provided in the Remittance Advice, in accordance with Section 1.4.1.1 (COB Models) of the HIPAA 837 Claims Implementation Specifications or Technical Reports. The information is to include the Claim Adjustment Group Codes (CAGCs) and Claim Adjustment Reason Codes (CARCs) received from the previous payer(s).*

### *1.1.2 Billing Remedies*

***Medicare Advantage Plan adjusts a previously adjudicated claim that has been billed to Medicaid:***

*The provider must send an adjusted claim with the corrected information - the Medicaid claim must be adjusted to accurately reflect Medicare's reprocessing of the claim.*

***Provider billed an incorrect coinsurance, deductible, or co-payment:***

*The Medicaid claim must be adjusted. In order to correctly bill the patient responsibility to Medicaid, the adjustments on the remit from Medicare Advantage Plan must be cross-walked,* ***without any modification****, to the Medicaid Claim.*

***Reporting Cost Avoidance on a claim covered by the Medicare Advantage Plan:***

*The Primary insurance, a Medicare Advantage Plan, must be billed. Upon receiving the Medicare Advantage Plan remit, the submitter must adjust the Medicaid claim. The adjusted claim must*

*report all adjustments from the remit, without modification, in the Coordination of Benefits 837 claim to Medicaid.*

*Providers who may need technical assistance complying with COB claims submission requirements should contact eMedNYHIPAASupport@csc.com."*

**Recommendation #11**

Review and recover the remaining $5,841 in overpayments.

**Response #11**

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

**Recommendation #12**

Review and recover the unresolved overpayments totaling $10,570 ($4,590 in transportation + $3,393 in vision care services + $2,587 in duplicative billings).

**Response #12**

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

**Recommendation #13**

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

**Response #13**

The Department agrees with the OSC's statement in audit (on page 13 under Transportation Services) regarding the payment by Medicaid for mileage to and from a location where services were provided and applying the reimbursement fee only to patient loaded miles, those miles during which the enrollee occupies the taxi. The Department, in a letter dated November 4, 2014, contacted Rude Dog Transportation Corporation to remind them that it is improper to bill Medicaid for unoccupied trip portions and to request that they review their paid claims and, where applicable, adjust the paid claims to reflect the actual number of miles where the enrollee was transported. The OMIG will review the claims and recover as appropriate.

The Department, as a result of the preliminary report of this audit, has also instructed CSC Provider Services (via transmittal #H-450-12478 on November 6, 2014) to reach out to the inpatient and outpatient providers (referenced on pages 12 through 13) of this report, to provide appropriate instruction and training for the billing issues noted. CSC notified the Department on November 24, 2014 in Transmittal #R-450-09798 that the appropriate instruction and training had been completed.

**Recommendation #14**

Formally instruct providers how to properly submit claims for physician-administered drugs provided in multiple units on the same date of service.

**Response #14**

A Medicaid Update article has been written that will notify providers how to properly submit claims for physician-administered drugs when provided in multiple units on the same date of service. It is expected to be published in a Medicaid Update prior to August 31, 2015.

**Recommendation #15**

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

**Response #15**

Of the remaining four providers identified by OSC, one has been excluded, two are under review, and one is under investigation.

**Recommendation #16**

Investigate the propriety of the payments (totaling $16,659) made to the two providers who violated Medicaid laws or regulations. Recover any improper payments, as appropriate.

**Response #16**

One pharmacy owner has been convicted and must pay restitution to both Centers for Medicare and Medicaid Services and Health Research Inc. Improper payment issue has been addressed through this court case. The other pharmacy is currently under criminal indictment. Once the criminal charges have been adjudicated, OMIG will review the case to determine if the subject funds should be recouped.