NEW YORK STATE OF OPPORTUNITY. Department of Health

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Governor

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Commissioner

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Executive Deputy Commissioner

October 2, 2015

Mr. Brian Mason
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 2014-S-15 entitled, "Medicaid Claims Processing Activity April 1, 2014 Through September 30, 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 2014-S-15 entitled,
Medicaid Claims Processing Activity April 1, 2014 Through September 30, 2014

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2014-S-15 entitled, "Medicaid Claims Processing Activity April 1, 2014 Through September 30, 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:

Ensure that pricing methodology changes are appropriately tested prior to implementation. Such tests should include an examination of claims that contain service dates prior to the effective date of pricing methodology changes.

Response #1:

When the grouper/pricer was developed by 3M for the July 1, 2014 updates, an error occurred where a change that was to be effective July 1, 2014 forward was implemented retroactively. This resulted in the preparation of improper clinic payments; however, corrective actions were implemented and these payments were **never** released to the providers and the claims were then reprocessed for appropriate payment. The Department's fiscal agent, Computer Sciences Corporation (CSC), had been made aware of the payment error based on a report that is generated each week for the top fifty highest paid claims for each claim type. This report is reviewed by CSC's Quality Assurance group, as well as OSC. The week the error occurred, the Ambulatory Payment Group (APG) claims appeared in the report and were being investigated by CSC and corrective actions were being developed.

Standard process during the development of the software updates is to perform testing to review the programming changes. This testing includes developing test cases that are processed offline through the grouper/pricer to determine if the software is processing payments as required. The

testing that occurred produced accurate results for claims with effective dates July 1, 2014 forward. After the error occurred, the testing procedures for both 3M and the Department were reviewed to determine the cause of the pricing error and revised testing procedures have been implemented. It should be noted that the error that occurred with the July 1, 2014 grouper/pricer was the first time this error had occurred since the inception of APGs, which were effective beginning December 1, 2008.

In addition to reviewing the testing procedures and enhancing them to incorporate additional testing, the Department has also reviewed its process of providing APG updates to 3M and has revised its communication process between the policy bureau, the rate bureau and 3M. The revised communication process will provide changes in an updated structured manner to ensure that 3M has an appropriate time period to program the updates, and that both 3M and the Department have the appropriate time period to complete the testing process for the grouper/pricer updates. Working together with 3M we determined how the error occurred and by implementing a structured update format, this error should not occur in the future.

Recommendation #2:

Review and recover the unresolved overpayments (totaling at least $52,304) on the 10 claims with excessive charges for coinsurance and copayments.

Response #2

OMIG has recovered $4,406. OMIG's Recovery Audit Contractor is reviewing the remaining claims and will recover any payments determined to be inappropriate.

Recommendation #3:

Review the 13 claims totaling $555,103 and recover overpayments as appropriate.

Response #3

OMIG will review the claims and recover any payments determined to be inappropriate.

Recommendation #4:

Formally advise the pharmacy of the Medicaid requirements for faxed orders.

Response #4:

To ensure proper dispensing, the Department included an article in the August 2014 Medicaid Update and provided a revision in the November 2014 Medicaid Update that reminds/educates pharmacies about Medicaid requirements for the transmission of prescription orders. The revised November 2014 Medicaid Update is as follows:

"Pharmacy Update

Reminder - Transmission of the Official Prescription Serialized Number is required for All NYS Fee-for-Service Medicaid Claims

Re-issuance of August 2014 article

When submitting claims for prescriptions written in New York State on an Official New York State Prescription form, the serialized number from the Official Prescription MUST be used.

In specific situations, valid prescriptions for prescription drugs and/or supplies may still be dispensed when not written on Official New York State Prescription Forms.

The table below lists some of the specific situations when this is allowed and indicates the appropriate code 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 **
EEEEEEEE	** Prescriptions submitted electronically (computer to computer)***
NNNNNNNN	** Prescriptions for carve-out drugs for nursing home patients (excluding controlled substances)*
SSSSSSSS	** Fiscal orders for supplies*
ZZZZZZZZ	** Prescriptions written by out-of-state prescribers or by prescribers within the US Department of Veterans Affairs*

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

*** Prescriptions submitted electronically, that do not transmit properly or default to a facsimile, must conform to the requirements of the NYS Education Law at:*

http://www.op.nysed.gov/prof/pharm/pharmelectrans.htm.

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."

Finally, the Department has instructed CSC Provider Services to contact the pharmacy identified in this audit on May 5, 2015 in Transmittal #H-450-13210. CSC responded with documentation on June 5, 2015 in Transmittal #R-450-10024 that the Pharmacy identified in this audit report was properly instructed.

Recommendation #5:

Formally advise the providers in question how to correctly bill Medicaid to ensure Medicaid claims are accurately billed in accordance with existing requirements.

Response #5:

In the area of incorrect Inpatient Claims, the Department has reached out to CSC Provider Services in transmittal #H-450-13117, dated March 27, 2015. The Department instructed CSC to reach out to the one provider identified in this audit that had one claim submitted with an incorrect birth weight and the one provider that incorrectly coded a temporary tracheostomy when the patient already had a tracheostomy that only needed a revision. CSC notified the Department, in transmittal #R-450-09992 dated May 7, 2015, that instruction was provided to ensure Medicaid claims are accurately billed by these providers.

Recommendation #6:

Review the 55 fee-for-service claims totaling $86,240 and recover any overpayments, as appropriate.

Response #6

OMIG's Recovery Audit Contractor is in the process of reviewing the claims and will recover the inappropriate payments.

Recommendation #7:

Review and recover the unresolved overpayments totaling $29,843.

Response #7

OMIG has reviewed the claims and is in the process of recovering any inappropriate payments.

Recommendation #8

Implement eMedNY edits to prevent more than one payment of the same physician-administered drug procedure code on the same day for the same patient.

Response #8:

Effective January 1, 2015, the Department implemented APG grouper/pricer logic for ambulatory care settings, including hospitals and freestanding facilities, that prevents more than one payment of the same physician-administered drug procedure code on the same day for the same patient. This includes a billing method that allows providers to bill for unused portions of drugs packaged in single use dosage forms since the unused portion cannot be safely administered to another patient. In such cases, the clinic must report the J code with a - JW modifier on a separate claim line, resulting in a payment of 100 percent to cover the cost of the amount of the drug administered as well as covering the portion identified as being unused. This supports Medicaid's policy to ensure adequate payment to providers when a single use dosage form contains medication that is greater than what is clinically required for a single patient.

Recommendation #9:

Formally remind providers not to bill Medicaid for outpatient services provided to recipients who are hospitalized.

Response #9:

The Department has been working extensively with CSC to establish edits that will prevent providers from billing and being paid for outpatient/Emergency Department (ED) visits provided concurrent to an inpatient stay. Recently, edits in Evolution Project (EP) #1941 were developed to implement Medicaid Redesign Team project #6022 that prevents a provider from billing and being paid for an ED visit that is provided on the same date of service as an inpatient discharge to the same patient. The Project Design Document for EP #1941 was approved February 10, 2015 and the edits were promoted March 27, 2015. With the implementation of EP #1941, the eMedNY billing system will no longer pay ambulatory care claims (e.g., clinic, ED, or surgery center) that originate during an inpatient hospitalization. The Department will be releasing a Medicaid Update to remind providers of this long-standing policy by October 2015.

Recommendation #10:

Formally instruct providers not to bill multiple times for CPEP evaluations during a single patient encounter.

Response #10:

The Department and the Office of Mental Health (OMH) have been meeting to strengthen Comprehensive Psychiatric Emergency Program (CPEP) billing. Medicaid Managed Care instructions have been drafted, but not yet implemented, and a rate code has been established for CPEP Extended Observation Beds. The Department continues its efforts in completing the billing instructions to all remaining FFS providers for the CPEP program and OMH expects to issue these instructions by September 2015.

Additionally, an EP request to eMedNY will be initiated, which is designed to prevent the ability of a provider to bill multiple times for a CPEP evaluation during a single patient encounter.

Recommendation #11:

Ensure OMIG reviews the 129 clinic claims (totaling $114,754) and make recoveries, as appropriate.

Response #11

OMIG will review the claims and recover any payments determined to be inappropriate

Recommendation #12:

Review and recover the unresolved overpayments totaling $32,732 ($25,440 in clinic services + $7,292 in practitioner services).

Response #12

OMIG has recovered the $32,732 in inappropriate payments.

Recommendation #13:

Formally instruct the providers in question how to correctly bill Medicaid to ensure appropriate payment.

Response #13:

Regarding the audit claims identified as those missing or having insufficient supporting documentation, the Department has reached out to CSC Provider Services in transmittal #H-450-13117, dated March 27, 2015. CSC has notified the Department in transmittal #R-450-09992, dated May 7, 2015, of its outreach to those providers identified in this audit and has provided instruction in the following manner:

Incorrect Clinic Claims – CSC Provider Services reached out to the provider identified in this audit that had one claim with multiple arthroscopy codes and has provided the necessary instruction to ensure Medicaid claims are accurately billed.

Incorrect Practitioner Claims – CSC Provider Services reached out to the two home care providers identified in this audit and has provided instruction to ensure Medicaid claims are accurately billed.

Incorrect Health Home Claims – The Department notified the Health Home Provider identified in this audit report, in a letter dated February 18, 2015, that claims were incorrectly billed for inpatient psychiatric services that occurred longer than six months after the recipient's inpatient admission, and that these claims were voided by the care management agency. The provider was directed to the link to the Health Home Policy Manual and the Health Home Provider Line telephone number to ensure that Medicaid claims are accurately billed in the future.

Recommendation #14:

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

Response #14

OMIG determined that:

- Two providers are under investigation
- Two providers were excluded
- One provider is deceased
- One provider pled guilty, and the OMIG is awaiting sentencing before reviewing for possible sanction.