New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Medicaid Claims Processing Activity April 1, 2014 Through September 30, 2014

Medicaid Program
Department of Health

Report 2014-S-15 June 2015

Executive Summary

Purpose

To determine whether the Department of Health's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to the providers. The audit covered the period April 1, 2014 through September 30, 2014.

Background

The Department of Health (Department) administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients, and it generates payments to reimburse the providers for their claims. During the six-month period ended September 30, 2014, eMedNY processed about 164 million claims, resulting in payments to providers of about $25 billion. The claims are processed and paid in weekly cycles, which averaged about 6.3 million claims and $946 million in payments to providers.

Key Findings

Auditors identified about $33 million in actual and potential Medicaid overpayments. Auditors also identified claim processing control weaknesses that led to many of the problematic payments. Department officials took prompt actions to correct certain controls, including one which officials estimate will result in an annual savings to the Medicaid program of $2.4 million. The audit found:

- $31.4 million in potential overpayments for clinic claims that were processed using an incorrect pricing methodology;
- $402,927 in overpayments for claims billed with incorrect information pertaining to other health insurance coverage that recipients had. Further, certain improvements to eMedNY processing of claims involving Medicare Part A information will result in an additional annual savings of about $2.4 million;
- $555,103 in improper payments for pharmacy claims that were not in compliance with State Medicaid policies;
- $252,022 in overpayments for inpatient claims that were billed at a higher level of care than what was actually provided, were submitted with an inaccurate newborn birth weight, or contained an incorrect procedure code; and
- Claims with improper payments for HIV tests, duplicate billings, and clinic, practitioner, and health home services.

By the end of the audit fieldwork, about $32.1 million of the improper payments were avoided or recovered.

Auditors also identified providers in the Medicaid program who were charged with or found guilty of crimes that violate health care programs' laws or regulations. The Department terminated eight of the providers we identified, but the status of six other providers was still under review at the time our fieldwork was completed.

Key Recommendations

- We made 14 recommendations to the Department to recover the remaining inappropriate Medicaid payments and improve claim processing controls.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Claims Processing Activity October 1, 2012 Through March 31, 2013 (2012-S-131)

Department of Health: Medicaid Claims Processing Activity April 1, 2013 Through September 30, 2013 (2013-S-12)

State of New York
Office of the State Comptroller

Division of State Government Accountability

June 29, 2015

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Medicaid Claims Processing Activity April 1, 2014 Through September 30, 2014*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

Table of Contents

State Government Accountability Contact Information:
Audit Director: Andrea Inman
Phone: (518) 474-3271
Email: StateGovernmentAccountability@osc.state.ny.us
Address:
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

This report is also available on our website at: www.osc.state.ny.us

Background

The New York State Medicaid program is a federal, state, and locally funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. In State Fiscal Year 2013-14, the federal government funded about 49.25 percent of New York's Medicaid claim costs; the State funded about 33.25 percent; and the localities (the City of New York and counties) funded the remaining 17.5 percent.

The Department of Health's (Department) Office of Health Insurance Programs administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. During the six-month period ended September 30, 2014, eMedNY processed about 164 million claims, resulting in payments to providers of about $25 billion. The claims are processed and paid in weekly cycles, which averaged about 6.3 million claims and $946 million in payments to providers.

When Medicaid claims are processed by eMedNY, they are subject to various automated edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate. For example, some edits verify the eligibility of the Medicaid recipient, other edits verify the eligibility of the medical service, and other edits verify the appropriateness of the amount billed for the service. In addition, some edits compare the claim to other related claims to determine whether any of the claims duplicate one another.

The Office of the State Comptroller performs audit steps during each weekly cycle of eMedNY processing to determine whether eMedNY has reasonably ensured the Medicaid claims were processed in accordance with requirements, the providers submitting the claims were approved for participation in the Medicaid program, and the amounts paid to the providers were correct. As audit exceptions are identified during the weekly cycle, our auditors work with Department staff to resolve the exceptions in a timely manner so payments can be made to providers. If necessary, payments to providers can be suspended until satisfactory resolution of the exceptions has been achieved.

In addition, the audit work performed during the weekly cycle may identify patterns and trends in claims and payment data that warrant follow-up and analysis as part of the Comptroller's audit responsibilities. Such follow-up and analytical audit procedures are designed to meet the Comptroller's constitutional and statutory requirements to audit all State expenditures.

Audit Findings and Recommendations

Based on the results of our audit work for the weekly cycles of Medicaid payments made during the six months ended September 30, 2014, we concluded eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to the providers. In addition, we identified the need for improvements in the processing of certain types of claims. We found about $33 million in actual and potential overpayments pertaining to: claims that were not subjected to the appropriate pricing logic; claims with incorrect information pertaining to other insurance recipients had; pharmacy claims that were not in compliance with policies necessary for payment of the claims; and improper hospital and other claims. Also, as a result of our audit, the Department implemented an eMedNY edit that denies certain inpatient claims involving Medicare Part A coverage, which will result in an estimated $2.4 million in annual savings.

At the time the audit fieldwork concluded, about $32.1 million of the improper payments were avoided or recovered. Department officials need to take additional actions to review the remaining inappropriate payments (totaling about $871,000), recover funds as warranted, and improve certain eMedNY claim processing controls.

Incorrect Clinic Claim Pricing

On July 1, 2014 the Department implemented a new pricing methodology for certain procedures performed in a clinic setting, such as physician-administered drugs. However, upon implementation, we found the new methodology incorrectly priced claims for these procedures with dates of service prior to July 1, 2014, which caused the claims to be significantly overpriced. For example, we identified a clinic claim which included physician-administered drugs that were provided on June 19, 2014 (12 days before the implementation date), which would have paid $970,356 using the new pricing methodology. However, if the claim was processed using the appropriate pricing methodology, it would have only paid $3,988.

We promptly brought the issue to the attention of the Department's eMedNY contractor, CSC, who took immediate steps to request and review details of the problem we identified. The Department then took swift action to initiate a project to correct the problem. We worked with the Department and CSC to determine the reason for the overpriced claims. We found the Department's testing did not ensure claims with dates of service prior to July 1, 2014 would be processed using the former (and correct) pricing methodology for that period. To resolve the error, the Department voided the clinic claims with dates of service prior to July 1, 2014 and reprocessed them using the appropriate pricing methodology. In total, the Department voided 2,266 claims totaling $32,692,994 prior to payment. When the claims were reprocessed, they paid a total of $1,276,120, resulting in the avoidance of $31,416,874 in Medicaid overpayments.

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.

Other Insurance on Medicaid Claims

Many Medicaid recipients also have health insurance coverage provided by Medicare and/or other insurance carriers. When submitting Medicaid claims, providers must verify whether such recipients have other insurance coverage on the dates of service in question. If the individual has other insurance coverage, that insurer becomes the primary insurer, and must be billed first. Medicaid then becomes the secondary insurer and generally covers the patient's normal financial obligation, including coinsurance, copayments, and deductibles. If the recipient or the medical service is not covered by any other insurance, Medicaid is the primary insurer and should be billed first.

Errors in the amounts claimed for coinsurance, copayments, deductibles, and/or designation of the primary payer will likely result in improper Medicaid payments. We identified such errors on 45 claims that resulted in overpayments totaling $402,927. Also, as a result of our audit work, the Department implemented changes to the eMedNY system to correct weaknesses we identified. The Department estimates one of the corrections, which will deny claims containing certain incorrect Medicare Part A (hospital) payment information, will result in an annual savings of about $2.4 million.

Specifically, we identified overpayments totaling $123,783 on 39 claims (for which Medicaid paid $141,382) that resulted from excessive charges for coinsurance and copayments for recipients covered by other insurance. We contacted the providers and as a result of our inquiry, they adjusted 29 of the 39 claims, saving Medicaid $71,479. Eight providers, however, still needed to adjust 10 claims that were overpaid by an estimated $52,304.

We also identified four claims (for payments totaling $10,746) in which Medicaid was incorrectly designated as the primary payer, when the primary payer was actually another insurer. Generally, primary payers pay more than secondary payers. We contacted the providers and advised them that the recipients had other insurance coverage when the services were provided and, therefore, Medicaid was incorrectly designated as the primary payer. At the time our audit fieldwork concluded, the providers adjusted all four claims, saving Medicaid $10,674.

We further identified one inpatient claim in which Medicaid paid $162,635 for the entire admission, although Medicare had already paid for a significant portion of it. When Medicare covers an inpatient stay that is reimbursed on a per diem (daily rate) basis, the Medicaid payment is based on the number of days Medicare covered. Providers are required to enter the number of Medicare-covered days on the claim. The eMedNY system then subtracts those days from the total days of the inpatient stay and pays the Medicaid-only days. According to the Department,

the provider incorrectly entered a zero in the Medicare-covered days field on the claim, which the eMedNY system interpreted as an indication there was no Medicare payment, even though the provider did report a Medicare payment amount on the claim. The provider subsequently corrected the claim, resulting in a savings of $153,358. Also, based on our review of this claim, the Department initiated a project to develop an edit that would deny inpatient claims having a Medicare Part A payment amount reported on the claim and Medicare Part A days reported as zero. The Department estimates annual savings of about $2.4 million as a result of this project, which was implemented January 22, 2015.

We identified one other claim where Medicaid made a full payment of $115,112 for an inpatient stay that was previously paid in full by Medicare. According to Department officials, the eMedNY system incorrectly used the beginning date of service reported on the claim rather than the patient admission date in determining the Medicaid payment. We contacted the provider, who voided the claim, thereby saving Medicaid $115,112. Further, on November 6, 2014, the Department made changes to eMedNY designed to correct this system weakness. If the system changes function properly, such claims will be denied payment 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.

Improper Pharmacy Claims

Medicaid pays pharmacies for drugs dispensed and billed in compliance with New York State laws, rules, regulations, and Medicaid program policies. According to the New York State Medicaid Program Pharmacy Manual, all orders received by a pharmacy as a fax must be on the official New York State prescription form and the source fax number must be clearly visible on the fax that is received.

We identified 13 claims totaling $555,103 for prescriptions that were faxed to a pharmacy that were not written on the official New York State prescription form. In addition, for 12 of these claims, the source fax numbers were not included. At the end of our fieldwork, the pharmacy did not correct any of the claims. Thus, actions are still required to review and recover the $555,103 in improper payments we identified.

Recommendations

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

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

Overpayments for Inpatient Services

Medicaid overpaid three providers $252,022 on three claims for services provided in an inpatient setting. The overpayments occurred under the following scenarios:

- Medicaid overpaid an inpatient claim because a hospital billed a more costly level of care than what was actually provided. The hospital failed to report alternate (lower) level of care (ALC) days on the claim. Instead, the hospital billed the entire length of the stay at a higher level of care. Medicaid initially paid $636,690 for the inpatient claim. At our request, the provider reviewed and corrected the claim, resulting in a savings of $104,414.
- One provider incorrectly reported the birth weight of a newborn on a claim that paid $93,282. Because Medicaid reimbursement of inpatient services for newborns is highly dependent on the birth weight (and low birth weights often increase the amounts of payments), the incorrect birth weight led to an overpayment on the claim. The provider was contacted and subsequently corrected the birth weight, resulting in a savings of $85,387 to Medicaid.
- One provider submitted a claim to Medicaid with an incorrect code for a tracheotomy procedure. The claim initially paid $128,539. The provider confirmed the claim was incorrectly coded, and corrected the claim and billed for the correct tracheotomy procedure. This resulted in a savings of $62,221.

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.

HIV Laboratory Tests

Effective April 1, 2014, Medicaid Managed Care Plans (MMCP) began covering certain HIV resistance laboratory tests prescribed by physicians. As such, if a Medicaid recipient is enrolled in a MMCP, the MMCP is responsible for reimbursing the laboratory provider for these tests and the Medicaid program should not directly reimburse the provider under the fee-for-service method. The Department periodically updates its eMedNY files to reflect changes to the list of procedures that are covered by a MMCP.

Our audit identified 55 claims totaling $86,240 for which Medicaid inappropriately paid providers on a fee-for-service basis for tests that should have been covered by the recipients' MMCP. Medicaid inappropriately made the fee-for-service payments because the Department did not properly update the eMedNY files to ensure this test could not be paid in this manner.

During our audit, the Department updated the eMedNY file to prevent further inappropriate payments. However, at the conclusion of our audit fieldwork, the Department had not yet recovered any of the $86,240 in inappropriate payments.

Recommendation

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

Duplicate Billings

Medicaid overpaid 13 providers a total of $80,716 on 29 claims (which originally paid $144,017) because the providers billed for certain services more than once. The duplicate payments occurred under the following scenarios:

- Eight providers billed the same physician-administered drug twice on the same claim, resulting in overpayments totaling $60,181;
- One provider billed for the same services as another provider on two occasions, resulting in overpayments of $3,203;
- Two providers billed for Comprehensive Psychiatric Emergency Program (CPEP) evaluations multiple times during the same encounter with a patient; however, these evaluations are allowed only once per encounter. The resulting overpayments totaled $10,600; and
- Two providers billed for outpatient (clinic) services during inpatient stays, which resulted in overpayments of $6,732.

We contacted the providers and as a result of our inquiry, they corrected 21 of the 29 claims, saving Medicaid $50,873. However, at the end of our fieldwork, providers had not corrected the eight remaining claims totaling $29,843.

Recommendations

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

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.

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

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

Other Improper Claim Payments

We identified $83,099 in overpayments resulting from excessive charges related to clinic, practitioner, and health home claims. An additional $114,754 in potential overpayments resulting from a provider's lack of supporting documentation was also identified. At the time our audit fieldwork concluded, $50,367 of the overpayments had been recovered. However, actions were still needed to address the balance of the actual and potential overpayments totaling $147,486.

Claims With Missing or Insufficient Supporting Documentation

According to the General Policy manual for Medicaid, providers must maintain financial records and health records to disclose the extent of the services, care, and supplies provided to Medicaid enrollees. During our audit, we identified a provider that appeared to bill an excessive amount for certain clinic procedures. To determine if the claims were appropriate, we selected a judgmental sample of five claims totaling $16,468. We found the provider did not have documentation for two of the claims and the documentation for the other three claims didn't sufficiently support the amounts billed. For example, the provider billed 60 units of a dialysis drug, resulting in a payment of $5,892. However, the medical records showed only six units of the drug were ordered for the patient. As a result, this claim overpaid $5,303 as Medicaid should have only paid $589 for the six units that were actually ordered. Further, we also noted the order was not signed by a doctor and the provider's name on the medical record (supporting the dialysis treatment) was different from the provider's name on the claim to Medicaid.

Based on the results of our review, the Department requested that the Office of the Medicaid Inspector General (OMIG) review the initial five claims totaling $16,468 and an additional 124 similar claims totaling $98,286 (or 129 claims totaling $114,754 overall). At the end of our fieldwork, OMIG was investigating and reviewing these claims. In addition, the Department initiated a process to monitor future claims submitted by the provider.

Clinic Services

Medicaid overpaid two providers $71,155 on 27 claims for services provided in a clinic setting. The overpayments occurred under the following scenarios:

- One provider used incorrect reimbursement rate codes on 26 claims totaling $68,900. At our request, the provider reviewed the claims and voided 16 of them, saving Medicaid $43,460. At the time our audit fieldwork concluded, adjustments were still needed on the remaining 10 claims, with estimated overpayments totaling $25,440.
- One provider inappropriately included multiple arthroscopy codes on a clinic claim which initially paid $4,729. At our request, the provider reviewed and corrected the claim, saving Medicaid $2,255.

Practitioner Services

Medicaid overpaid two practitioners $9,183 on 15 claims. The overpayments occurred under the following scenarios:

- One provider incorrectly billed 14 claims that initially paid $80,192. The provider billed for more hours than the prior authorization for the services allowed (providers are required to request approval of certain types or amounts of services from the Department before services are provided). According to the provider, the error was caused by a new billing system that led to the excessive charges. At the time our audit fieldwork concluded,

adjustments had not been made on the 14 claims, which we estimated were overpaid by $7,292.

- One provider incorrectly submitted a claim that paid $16,074 due to miscommunication between the provider and their billing service. At our request, the billing service reviewed and corrected the claim, saving Medicaid $1,891.

Health Home Services

Health home services are care management services that coordinate recipients' care to ensure the individuals receive all of the services they need. According to the Medicaid Health Home policy manual, recipients admitted for treatment to an inpatient facility may continue to receive health home care management services if discharge is anticipated within 180 days. We determined Medicaid overpaid one provider $2,761 on 10 claims for health home services for a recipient receiving inpatient psychiatric services. The dates of the health home services occurred more than six months after the recipient's inpatient admission, and the claims were therefore ineligible. We contacted the provider, who acknowledged the error and voided the claims, saving Medicaid $2,761.

Recommendations

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

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

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

Status of Providers Who Abuse the Program

If a Medicaid provider has violated statutory or regulatory requirements related to the Medicaid or Medicare programs (or has engaged in other unacceptable insurance practices), the Department can impose sanctions against the provider. These sanctions can range from excluding the provider from the Medicaid program to imposing participation requirements, such as requiring all claims to be reviewed manually before payment. If the Department does not identify a provider who should be excluded from the Medicaid program or fails to impose proper sanctions, the provider remains active to treat Medicaid patients, perhaps placing recipients at risk of poor-quality care while the provider receives Medicaid payments.

We identified 19 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. Of the 19 providers, 18 had an active status in the Medicaid program. The remaining provider had an inactive status (i.e., two or more years of no claims activity and, therefore, the provider would be required to seek re-instatement

from Medicaid to submit new claims). We advised Department officials of the 19 providers and the Department terminated eight of them from the Medicaid program. Also, the Department determined five of the 19 providers should not be terminated. At the time our audit fieldwork ended, the Department had not resolved the program status of the six remaining providers.

Recommendation

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

Audit Scope and Methodology

We audited selected Medicaid claims processed by the Department to determine whether the Department's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to the providers. The scope of our audit was from April 1, 2014 through September 30, 2014. Additionally, claims and transactions outside of the audit scope period were examined in instances where we observed a pattern of problems and high risk of overpayment.

To accomplish our audit objectives and to determine whether internal controls were adequate and functioning as intended, we performed various analyses of claims from Medicaid payment files, verified the accuracy of certain payments, and tested the operation of certain system controls. We interviewed officials from the Department, Computer Sciences Corporation (the Department's Medicaid fiscal agent), and the Office of the Medicaid Inspector General. We reviewed applicable sections of federal and State laws and regulations, examined the Department's Medicaid payment policies and procedures, and tested medical records supporting provider claims for reimbursement. Our audit steps reflect a risk-based approach taking into consideration the time constraints of the weekly cycle and the materiality of payments.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions, and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials generally concurred with our recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinder to certain Department comments is included in the report's State Comptroller's Comment.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Contributors to This Report

Andrea Inman, Audit Director
Dennis P. Buckley, CFS, Audit Manager
Brian Krawiecki, Audit Supervisor
Daniel Towle, Audit Supervisor
Arnold Blanck, Examiner-in-Charge
Kate Merrill, Examiner-in-Charge
Theresa Podagrosi, CGAP, Examiner-in-Charge
Emily Proulx, Examiner-in-Charge
Rebecca Tuczynski, Examiner-in-Charge
Earl D. Vincent, Examiner-in-Charge
Judith McEleney, Supervising Medical Care Representative
Benjamin Babendreier, Staff Examiner
Lauren Bizzarro, Staff Examiner
Yanfei Chen, Staff Examiner
Rachelle Goodine, Staff Examiner
Francesca Kent, Staff Examiner
Suzette Millard, Staff Examiner
Joe Paduano, Staff Examiner
Marsha Paretzky, Staff Examiner
Connie Walker, Staff Examiner
Shannon Younkin, Staff Examiner
Suzanne Loudis, Medical Care Representative
Roman Karpishka, Program Research Specialist

Division of State Government Accountability

Andrew A. SanFilippo, Executive Deputy Comptroller
518-474-4593, asanfilippo@osc.state.ny.us

Tina Kim, Deputy Comptroller
518-473-3596, tkim@osc.state.ny.us

Brian Mason, Assistant Comptroller
518-473-0334, bmason@osc.state.ny.us

Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

May 27, 2015

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2014-S-15 entitled, "Medicaid Claims Processing Activity April 1, 2014 through September 30, 2014."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
Robert W. LoCicero, Esq.
Jason A. Helgerson
Dennis Rosen
Thomas Meyer
Robert Loftus
James Cataldo
Ronald Farrell
Brian Kiernan
Elizabeth Misa
Ralph Bielefeldt
Diane Christensen
Lori Conway
OHIP Audit SM

Department of Health
Comments on the
Office of the State Comptroller's
Draft 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) Draft 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 test 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 retroactive. 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.

* Comment 1

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.

*See State Comptroller's Comment, Page 24.

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 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

The OMIG has recovered the overpayments identified.

Recommendation #3

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

Response #3

The OMIG will review the paid claims and recover overpayments as appropriate.

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 provided CSC Provider Services specific instructions as to the proper reporting requirements of pharmacy claims. CSC will formally provide instruction to the pharmacy identified in this audit report.

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

The OMIG's Recovery Audit Contractor is in the process of recovering these overpayments, as appropriate.

Recommendation #7

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

Response #7

The OMIG will review the claims, and recover as appropriate.

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 eMedNY edits to prevent 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 concurrent to an inpatient stay. Recently an edit, in Evolution Project (EP) #1941, was developed to implement MRT project #6022 that will prevent a provider from billing and being paid for an ED

visit provided on the same date of service as an inpatient discharge to the same patient. The Project Design Document was approved on February 10, 2015 and EP #1941 was promoted in the eMedNY billing system on March 26, 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.

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 jointly resolve several outstanding issues, one of which is 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 July 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

The OMIG will review the claims identified and make recoveries as appropriate.

Recommendation #12

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

Response #12

The OMIG's Recovery Audit Contractor is in the process of recovering these overpayments, as appropriate.

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, in a letter dated February 18, 2015 to the Health Home Provider identified in this audit report acknowledged 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

The OMIG determined that:
Two providers are under investigation
One provider was excluded
One provider is under review for possible sanction
One provider is deceased
One provider pled guilty, and the OMIG is awaiting sentencing before reviewing for possible sanction.

State Comptroller's Comment

1. We revised the final report as appropriate to clarify that the excessive amounts in question (about $31.4 million) were not paid to providers. Due to the prompt actions taken by auditors, Department officials, and the Department's Medicaid fiscal agent, the potential overpayments were avoided.