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

Division of State Government Accountability

Improper Medicaid Payments for Childhood Vaccines

Medicaid Program
Department of Health

Report 2017-S-41 December 2018

Executive Summary

Purpose

To determine whether Medicaid made improper payments for free vaccines available through the Vaccines for Children Program. The audit covered the period January 1, 2012 to May 31, 2017.

Background

The Vaccines for Children Program (VFC Program) is a federally funded Medicaid benefit that provides free vaccines to eligible children younger than 19 years of age whose parents or guardians may not be able to afford them. The VFC Program helps ensure these children receive their recommended vaccines and are protected from a number of diseases. The Centers for Disease Control and Prevention (CDC) is responsible for implementation of the VFC Program. The CDC purchases vaccines from drug manufacturers at a discount and distributes the vaccines to state health departments and certain local and territorial public health agencies at no cost. These agencies then distribute the vaccines at no cost to physicians and public health clinics enrolled in the VFC Program. Because the federal government purchases the vaccines, providers are not reimbursed for the cost of the vaccines. Instead, they are paid a fee for administering the vaccines. For children enrolled in Medicaid, the Medicaid program pays the vaccine administration fee.

Key Findings

Auditors identified $32.7 million in improper Medicaid payments for costs related to administering VFC Program vaccines between January 1, 2012 and May 31, 2017. Medicaid payments were made for free vaccines, and payments of the fee to administer the vaccines were not always accurate. Specifically, the audit found:

- Managed care organizations (MCOs) made improper payments totaling $29.8 million to health care providers. The improper payments occurred because of control weaknesses in the MCOs' claims processing systems.
- Medicaid made improper fee-for-service payments totaling $2.9 million to health care providers. The improper payments occurred because providers did not bill claims according to Medicaid policies and eMedNY lacked controls to prevent overpayments.

Key Recommendations

- Review the improper MCO and fee-for-service payments we identified and ensure proper recoveries are made.
- Formally instruct MCOs on the proper payment of administered VFC Program vaccines.
- Formally advise providers to report accurate claim information when billing Medicaid for administered VFC Program vaccines.
- Ensure claims processing controls prevent improper MCO and fee-for-service VFC Program payments.

Other Related Audits/Reports of Interest

Department of Health: Maximizing Drug Rebates for Health and Recovery Plans (Report 2017-S-61)

Department of Health: Managed Care Premium Payments for Recipients With Comprehensive Third-Party Insurance (Report 2016-S-60)

State of New York
Office of the State Comptroller

Division of State Government Accountability

December 6, 2018

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 *Improper Medicaid Payments for Childhood Vaccines*. This 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.

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

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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. For the State fiscal year ended March 31, 2018, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $62.9 billion. The federal government funded about 55.7 percent of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 44.3 percent.

The New York State Medicaid program, administered by the Department of Health (Department), pays health care providers either directly through fee-for-service payments (for instance, the Department makes Medicaid payments directly to health care providers for services rendered to Medicaid recipients) or through monthly premium payments made to managed care organizations (MCOs). Under managed care, the Department pays each MCO a monthly premium for each Medicaid recipient enrolled in the MCO. The MCOs are then responsible for ensuring enrollees have access to a comprehensive range of health care services. The MCOs make payments to health care providers for the services provided to their enrollees, and are required to submit encounter claims to the Department's Medicaid claims processing system (eMedNY) to inform the Department about each medical service provided to recipients enrolled in managed care. In addition, MCOs report their medical costs and administrative costs annually to the Department on Medicaid Managed Care Operating Reports (MMCORs). The Department uses this information to establish the managed care premiums.

The Vaccines for Children Program (VFC Program) is a federally funded Medicaid benefit that provides free vaccines to eligible children younger than 19 years of age whose parents or guardians may not be able to afford them. The VFC Program helps ensure these children receive their recommended vaccines and are protected from a number of diseases. Funding for the VFC Program is allocated through the Centers for Medicare & Medicaid Services to the Centers for Disease Control and Prevention (CDC). The CDC is responsible for policy development and implementation of the VFC Program. The CDC purchases vaccines from drug manufacturers at a discount and distributes them to state health departments and certain local and territorial public health agencies at no cost. These agencies then distribute the vaccines at no cost to physicians and public health clinics enrolled in the VFC Program. Because the federal government purchases the vaccine, providers are not reimbursed for the cost of the vaccine. Instead, they are paid a fee for administering the vaccine. The Medicaid program pays this fee.

The Department administers the VFC Program in New York State. As the agency also responsible for administering the State Medicaid program, federal regulations require the Department to submit a Medicaid State Plan amendment that identifies the amount that the State will pay providers for the administration of a VFC Program vaccine to a Medicaid-eligible child. The regulations further state that this amount cannot exceed the State's regional maximum administration fee that is established by the Secretary of the Department of Health and Human Services. During the audit period of January 1, 2012 through May 31, 2017, the regional maximum administration fee for New York State was $25.10. Medicaid's VFC Program administration fee for all fee-for-service

claims was $17.85 and MCOs could pay providers up to $25.10.

During the audit period, from January 1, 2012 through May 31, 2017, MCOs reported $255 million in payments to providers that administered VFC Program vaccines. During that same period, Medicaid made $21 million in fee-for-service payments to providers that administered VFC Program vaccines.

Audit Findings and Recommendations

We identified $29.8 million in overpayments made by 26 MCOs to providers that administered VFC Program vaccines from January 1, 2012 through May 31, 2017. The MCOs made overpayments because of weaknesses in their claims processing controls. Furthermore, we found the Department did not monitor VFC Program vaccine encounter claims to ensure the MCOs made appropriate payments. We also found that Medicaid made $2.9 million in improper fee-for-service payments to providers that administered VFC Program vaccines. The improper payments occurred because providers did not properly bill Medicaid for the administration fee and the Department did not have adequate claims processing controls in place to prevent the improper payments.

Improper Payments Made by Managed Care Organizations

Each MCO establishes its own controls to process and pay VFC Program claims. MCOs can pay providers as much as $25.10 for administering these vaccines. We identified encounter claims where the MCOs' payments for an administered vaccine exceeded $25.10. We determined that MCOs' claims processing controls were not adequate when paying these administration fees. As a result, we found that 26 MCOs made $29.8 million in overpayments to providers that administered these vaccines.

To identify the causes of the overpayments, we sampled 105 encounter claims from four MCOs that reported paying vaccine administration fees in excess of $25.10. The four MCOs we sampled accounted for $20.6 million of the $29.8 million that we identified. Officials from the MCOs reviewed the payments and confirmed they made overpayments on 85 of the 105 encounter claims. The MCOs made the 85 overpayments because of control weaknesses related to the processing and payment of these claims. These weaknesses included not identifying children who were eligible for the VFC Program, paying administration fees for more vaccines than were actually administered, and establishing administration fee schedules in excess of $25.10. The MCOs stated 12 of the remaining 20 encounter claims were not overpaid; rather, the encounter claims were either reported in error to the Department or were subsequently adjusted. However, at the conclusion of our audit fieldwork, the 12 encounter claims were not adjusted or reported any differently to the Department in the Medicaid system (note: MCO claim payments are built into the monthly managed care premium rates). We determined that the remaining eight claims were appropriate and we removed these encounter claims and encounter claims with similar characteristics from our overpayment population.

We found that three MCOs overpaid providers because they established inadequate claims processing controls to identify the administration of VFC Program vaccines. For example, one MCO's claims processing system did not include the Human Papillomavirus vaccine as a VFC Program vaccine. We identified claims where the MCO paid as much as $316 when this vaccine was administered. Another MCO's claims processing system did not identify 18-year-old members as eligible for VFC Program vaccines. This caused the MCO's claims processing system to adjudicate the claims using different fee schedules. These amounts exceeded $25.10. Finally, one MCO's claims processing system paid amounts in excess of $25.10 when providers did not

use a required modifier code on claims. At the time our fieldwork concluded, the MCOs stated that they were in the process of updating their claims processing systems to properly identify and pay the administration of VFC Program vaccines.

We also identified other claims processing control weaknesses. We found that all four MCOs paid claims where the number of administered vaccines exceeded the number of vaccines reported on the claim. For example, one claim showed an MCO paid the administration fee 100 times for one VFC Program vaccine, which resulted in a $970.90 overpayment ($996.00 – $25.10). We also found that one MCO's administration fee schedule exceeded $25.10. The MCO paid providers as much as $33.61 for administering VFC Program vaccines, which resulted in an overpayment for every administered VFC Program vaccine. At the time our fieldwork concluded, the MCOs stated that they were addressing these billing issues.

The Department is responsible for ensuring MCOs comply with established Medicaid standards and the Department must assess the quality and appropriateness of care and services furnished. We interviewed Department officials and found that the Department does not monitor encounter claims to ensure MCOs are making appropriate payments for VFC Program vaccines. We encourage the Department to review the $29.8 million that we identified and work with the MCOs to ensure their payments for VFC Program administration fees comply with Medicaid standards.

Recommendations

1. Review the $29.8 million in improper MCO payments that we identified and instruct the MCOs to recover overpayments where appropriate. Ensure the MCOs recover the improper payments and account for the recoveries on their MMCORs.

2. Formally instruct MCOs on the proper payment of VFC Program claims in order to comply with Medicaid standards. This includes ensuring:

    - Administration fees do not exceed the regional maximum administration fee (and ensuring providers are instructed on the proper submission of claims with VFC Program modifiers);
    - Administered units do not exceed the number of vaccines reported;
    - VFC Program vaccine lists are complete and up-to-date; and
    - Claims for Medicaid recipients younger than 19 years old are processed using VFC Program payment rules.

3. Monitor encounter claims to ensure MCOs are not overpaying providers for VFC Program vaccines and administration fees.

Improper Fee-for-Service Payments

Medicaid's VFC Program administration fee for all fee-for-service claims was $17.85 during our audit period. Medicaid pays fee-for-service claims using different reimbursement methodologies. Medicaid reimburses outpatient services performed in certain settings, such as hospital outpatient

departments and diagnostic and treatment centers, through the Ambulatory Patient Groups (APG) payment methodology. The APG payment methodology examines all the procedure codes and any associated modifier codes reported on a claim to determine how the claim should be paid. Other (non-APG) claims, such as ordered ambulatory, practitioner claims, and certain pharmacy claims, are reimbursed from a set fee schedule, and the provider is paid the same fee for each procedure code regardless of the other services billed on the same claim.

We found that Medicaid made $2.9 million in improper payments on fee-for-service claims to providers that administered VFC Program vaccines. The improper payments occurred because providers did not properly bill Medicaid for the costs of administering the vaccines and eMedNY, the Department's claims processing and payment system, lacked controls to prevent overpayments.

APG Claims

The Department instructs providers using APGs to bill the vaccine procedure code and to use the "SL" modifier for VFC Program vaccines. Modifiers are added to procedure codes to provide additional information needed for eMedNY to properly process claims. The SL modifier indicates that a VFC Program vaccine was administered, and instructs eMedNY to pay the $17.85 administration fee.

We identified about $2.8 million in actual and potential overpayments on 62,847 APG claims. The improper payments occurred when providers billed for VFC Program vaccines without the SL modifier or when providers billed additional procedure codes for the cost of administering vaccines. When providers bill VFC Program vaccines without the SL modifier, eMedNY does not process the claim using VFC Program payment rules. Instead, eMedNY pays for the vaccine using a separate fee schedule. Generally, these fees are more than $17.85, which results in overpayments. For example, a provider billed Medicaid for administering the Human Papillomavirus vaccine without using the SL modifier. Instead of paying $17.85, eMedNY paid the provider $121.01, resulting in a $103.16 overpayment. The provider also billed an additional vaccine administration code on this claim. This caused eMedNY to overpay the provider an additional $15.18 for administering the vaccine.

The Department expressed a concern that some of the $2.8 million in overpayments may be overstated. The Department stated that when providers improperly bill an additional administration code on an APG claim, those codes can impact the payment of other services on the claim, such as any evaluation and management service, which can result in a net underpayment on the claim. We reviewed the overpayments we identified and found 12,900 of the 62,847 claims where this issue may exist. Medicaid improperly paid providers $597,402 for the VFC Program portion of these claims. While improper billings may have caused other portions of the APG claims to be underpaid, the Department should review all the improperly billed claims to ensure that all providers are paid appropriately. The Department should also advise providers on the proper billing of APG claims submitted for VFC Program vaccines. Officials agreed that claims were billed incorrectly and they plan to instruct the providers to rebill the claims we identified.

In addition to weak eMedNY controls, we attributed the improper claiming to contradictory

guidance from the Department. For instance, the Department publishes a monthly newsletter, called Medicaid Update, to communicate Medicaid policies, billing guidance, and other changes in the Medicaid program. In the September 2012 issue, the Department stated that, effective October 1, 2011, the SL modifier was added to APG claims processing and that the modifier must be used with VFC Program procedure codes to ensure correct payment of any administration fees. Also, the Medicaid Update instructed providers not to bill an additional administration procedure code on their APG claims. However, the official APG policy guide (APG Provider Manual), which was last revised in August 2012, instructs providers to bill VFC Program vaccines as ordered ambulatory claims (i.e., non-APG claims). The APG Provider Manual instructs providers to bill a vaccine administration procedure code, along with the specific vaccine procedure code on ordered ambulatory claims. This is contrary to the instructions in the Medicaid Update.

Ordered Ambulatory and Pharmacy Claims

The Department instructs providers that bill VFC Program vaccines as ordered ambulatory claims or pharmacy claims to bill the vaccine procedure code and to use the SL modifier. Providers are also instructed to bill procedure code 90460 for the $17.85 vaccine administration fee. We identified $78,064 in overpayments on 1,719 ordered ambulatory and pharmacy claims when providers did not bill claims according to Department policies. The providers billed Medicaid for VFC Program vaccines without the SL modifier or billed codes other than 90460 for the vaccine administration fee. For example, a provider submitted an ordered ambulatory claim for five VFC Program vaccines. The provider billed the correct administration code and was properly paid the correct administration fee of $89.25 ($17.85 x 5). However, the provider did not use the SL modifier with the vaccine procedure codes. This caused eMedNY to use different rules to pay the claim. As a result, eMedNY improperly paid the provider an additional $273.40 for the five vaccines.

While the $2.9 million in total improper fee-for-service payments resulted from providers incorrectly submitting VFC Program claims to Medicaid, eMedNY also lacked adequate controls to prevent these improper payments. The Department uses an edit that denies payment of practitioner claims when VFC Program vaccines are billed without the SL modifier. We found this edit was working as intended for practitioner claims. However, the Department should consider using this or a similar edit for all claims where VFC Program vaccines are billed.

Recommendations

4. Review the $2.9 million in improper fee-for-service payments that we identified and recover overpayments where appropriate.

5. Design and implement eMedNY edits to prevent improper payments of VFC Program vaccines and administration fees on APG, ordered ambulatory, and pharmacy claims.

6. Ensure all VFC Program policies and guidance are up-to-date and formally advise providers on how to properly bill Medicaid for VFC Program vaccines and administration fees.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether Medicaid made improper payments for free vaccines available through the VFC Program. The audit covered the period January 1, 2012 to May 31, 2017.

To accomplish our audit objective and assess relevant internal controls, we interviewed officials from the Department and examined the Department's relevant Medicaid policies and procedures as well as applicable federal and State laws, rules, and regulations.

We used the Medicaid Data Warehouse to identify fee-for-service and encounter payments related to VFC Program vaccines that were not paid in accordance with Department policies. In order to calculate fee-for-service overpayments, we compared the amount paid for each VFC Program vaccine to the Medicaid fee of $17.85 plus any payment incentives. In order to calculate encounter overpayments, we compared the amount paid for each VFC Program vaccine to the regional maximum administration fee of $25.10.

We judgmentally selected four MCOs to examine their policies and procedures related to processing and paying VFC Program claims. The MCOs were selected based on the highest total potential overpayment or highest average overpayment per encounter claim. We then tested each MCO's claims processing controls to determine the cause of any overpayments by judgmentally selecting a sample of 105 encounter claims at risk of being overpaid. We removed encounter claims from our overpayment population that we determined were appropriate.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

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 to certain boards, commissions, and public authorities, some of whom have minority voting rights. 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 the report. In their response, Department officials generally concurred with the audit recommendations and indicated that certain actions will be taken to address them. Our responses to certain Department comments are embedded within the Department's response.

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

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Division of State Government Accountability

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Vision

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

Agency Comments and State Comptroller's 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

October 26, 2018

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 2017-S-41 entitled, "Improper Medicaid Payments for Childhood Vaccines."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2017-S-41 entitled,
Improper Medicaid Payments for Childhood Vaccines

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2017-S-41 entitled, "Improper Medicaid Payments for Childhood Vaccines."

Recommendation #1

Review the $29.8 million in improper MCO payments that we identified and instruct the MCOs to recover overpayments where appropriate. Ensure the MCOs recover the improper payments and account for the recoveries on their MMCORs.

Response #1

Detail of the $29.8 million in potential overpayments was received by the Department on September 12, 2018.

State Comptroller's Comment - The Department is misrepresenting the audit work. We shared detail of the $29.8 million in actual overpayments with OMIG, which investigates and recovers improper Medicaid payments on behalf of the Department, on August 10, 2018. OMIG confirmed receipt on August 14, 2018. Nevertheless, we are pleased the Department is collaborating with OMIG to review and recover the overpayments.

The Department will collaborate with the Office of the Medicaid Inspector General (OMIG) to review these encounters and identify where overpayment has occurred. Findings will be distributed to the MCOs with instructions to review, recover and properly report any recoveries. However, the Department is concerned that OSC does not differentiate between potential overpayments and actual overpayments and characterizes both as improper payments.

State Comptroller's Comment - The Department's assertions are misleading. Our methodology was straightforward, based on facts, and agreed to by OMIG. We used payment information reported by MCOs to the Department on encounter claims to identify actual overpayments made. Specifically, we compared the amount an MCO paid to a provider to the amount that should have been paid using the Department's and federal government's payment policies related to VFC Program vaccines. As such, we are concerned as to why Department officials believe claims that reimbursed providers an amount higher than allowed under the Medicaid State Plan may in fact be appropriate. We also note that we used a conservative approach to identify the $29.8 million in actual overpayments. Specifically, we used the maximum allowable

administration fee of $25.10 to calculate the overpayments. As the Department is aware, MCOs can pay providers up to $25.10, but can also pay lower amounts – in which case, the actual overpayments would be higher than $29.8 million. Nonetheless, officials agreed to review the $29.8 million in overpaid claims and ensure recoveries are made.

In addition, OSC's $29.8 million in potential overpayments consists of institutional and professional encounters. The statement on page 7 of the report "…encounter claims, and the payments reported on them are built into the monthly managed care premium rates" is not accurate because the Department does not use encounter data to develop the non-pharmacy portion of the base medical component of the monthly capitation rate. That portion of the base medical component relies on data from the Medicaid Managed Care Operating Reports (MMCORs).

State Comptroller's Comment - We are aware of the Department's methodology for setting managed care premium rates. The MCOs report their medical costs on their MMCORs. The medical costs are derived from the MCOs' claim payments to providers, which are represented on the encounter claims submitted to the Department. Regardless, we modified the language on page 7 of the report to clarify the statement.

Recommendation #2

Formally instruct MCOs on the proper payment of VFC Program claims in order to comply with Medicaid standards. This includes ensuring:

- Administration fees do not exceed the regional maximum administration fee (and ensuring providers are instructed on the proper submission of claims with VFC Program modifiers);
- Administered units do not exceed the number of vaccines reported;
- VFC Program vaccine lists are complete and up-to-date; and
- Claims for Medicaid recipients younger than 19 years old are processed using VFC Program payment rules.

Response #2

The Department will issue plan guidance to instruct the MCOs on the proper payment of Program vaccine administration fees for all eligible members. Instructions will provide guidance and recommendations for MCOs to implement front end measures on their claim payment systems to ensure payments for vaccine administrations do not exceed the regional maximum fee; MCOs are not paying for the cost of Program vaccines; and administration units do not exceed the number of vaccines administered.

Recommendation #3

Monitor encounter claims to ensure MCOs are not overpaying providers for VFC Program vaccines and administration fees.

Response #3

The Department and OMIG will work collaboratively to monitor the issue and ensure MCOs are

properly paying providers for Program vaccines. The Department will require MCOs to develop and implement appropriate claims processing edits to prevent overpayment of claims.

Recommendation #4

Review the $2.9 million in improper fee-for-service payments that we identified and recover overpayments where appropriate.

Response #4

Fee-for-Service Payments: Ambulatory Patient Group (APG)

The Department has concerns with OSC's methodology of the calculation and the amount of the overpayment identified for APG clinic claims. However, despite these concerns, the Department takes seriously its obligation to prevent inappropriate payments and is reviewing ways to strengthen existing requirements and procedures.

In this particular finding, OSC's calculation of the potential overpayment assumes that all immunization claims reimbursed above $17.85 for vaccine administration billed with a vaccine administration procedure code are overpaid claims. The Department has advised OSC that the universe of claims must be re-run through the APG grouper/pricer to determine whether the claim is overpaid. To calculate the actual amount that Medicaid would have paid for the claim if billed correctly, the adjusted claims must include the immunization procedure code appended with only an "-SL" modifier and no vaccine administration code. The calculated amount then needs to be compared to the actual amount that was paid for the claim in question.

OSC acknowledged that it is necessary to re-run the claims through the APG grouper/pricer to determine whether a claim payment is improper, however, OSC is not able to re-run the claims and therefore has identified the payments as "potential" overpayments. The Department therefore questions the extent of the overpayment, if any.

State Comptroller's Comment - We acknowledged the Department's concern with our calculation on page 9 of this report. We reviewed the 62,847 improperly billed claims and found 12,900 (about 20 percent) of the claims where the Department's concern existed. We remind Department officials that, while each corrected overall claim payment amount is unknown without running the claims through the APG grouper/pricer, the individual line item(s) of each claim we identified was inaccurate and overpaid. The Department acknowledged that the claims would need to be billed correctly in order for the proper payment to be made. As we reported, the 62,847 claims were not billed correctly (i.e., in accordance with Department policy) and resulted in improper payments.

Fee-for-Service Payments: Non-APG

The Department is in the process of reviewing the claims to verify the overpayment amount. Once the overpayment amount is confirmed, the Department will defer to the OMIG for any potential recoveries.

Recommendation #5

Design and implement eMedNY edits to prevent improper payments of VFC Program vaccines and administration fees on APG, ordered ambulatory, and pharmacy claims.

Response #5

The Department will evaluate the need for system changes for APG claims.

State Comptroller's Comment - The Department's response does not address preventing improper payments on ordered ambulatory and pharmacy claims.

Recommendation #6

Ensure all VFC Program policies and guidance are up-to-date and formally advise providers on how to properly bill Medicaid for VFC Program vaccines and administration fees.

Response #6

The Department will re-issue billing guidance for vaccines. Provider billing guidance for VFC Program vaccines will be contained in a Medicaid Update. Pharmacy billing guidance for VFC Program vaccines will be contained in a Medicaid Update article and an email notification to billing providers.

State Comptroller's Comment - In addition to re-issuing billing guidance in a Medicaid Update, the Department should update its APG Provider Manual to reflect the instructions in the Medicaid Update.