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November 29, 2021

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

Re: Overpayments for Therapy Services and Prescription Drugs Covered by Medicare
Report 2020-F-29

Dear Dr. Zucker,

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, we have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report, *Overpayments for Therapy Services and Prescription Drugs Covered by Medicare* (Report 2016-S-73).

Background, Scope, and Objective

The New York State Medicaid program provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. Many of the State's Medicaid recipients are also enrolled in Medicare. Such individuals are referred to as "dual-eligibles." The Medicare program covers physical, occupational, and speech therapy services as well as prescription drugs. When these services are rendered to dual-eligible recipients, health care providers are required to bill Medicare, which is generally the primary payer, before billing Medicaid.

Medicaid claims from health care providers are processed and paid by an automated system called eMedNY. When eMedNY processes claims, they are subject to various automated controls, or edits. Some of these edits verify whether Medicaid recipients have additional third-party health insurance that should be billed before Medicaid.

We issued our initial report on October 30, 2019. The audit objective was to determine if the Department of Health (Department) overpaid health care providers' Medicaid claims for therapy services and prescription drugs that are covered by Medicare. The audit covered the period January 1, 2012 to December 31, 2016 for prescription drugs and January 1, 2012 to December 31, 2017 for therapy services. The audit concluded that the State's Medicaid program paid $20.1 million for services that, according to the claims data, were Medicare-covered services that should have been paid by Medicare. The payments included $18.6 million for physical, occupational, and speech therapy services and $1.5 million for prescription drugs.

Auditors found many providers were generally unaware that Medicare covers therapy services, particularly maintenance therapy provided by licensed therapists. As a result, the providers often did not bill Medicare for the services or incorrectly reported a “GY” modifier, which caused Medicare to automatically deny the claims. Also, over half of the prescription drug claims were paid for recipients whose Medicare Part D coverage was retroactively updated; therefore, the recipients’ Medicare coverage information was not available to providers on the service dates.

The objective of our follow-up was to assess the extent of implementation, as of May 11, 2021, of the three recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made some progress in addressing the problems identified in the initial audit report; however, additional action is needed. For instance, since the initial audit, we identified another $17.7 million in payments that should have been paid by Medicare. Of the three recommendations, two were partially implemented and one was not implemented.

Follow-Up Observations

Recommendation 1

Using a risk-based approach, assess the $20.1 million in claims paid to providers for Medicare-covered services to dual-eligibles and recover overpayments, as appropriate. Ensure prompt attention is paid to those providers who received the largest dollar amounts of payments, and recover the $3,584 in overpayments we identified from our sample of therapy services.

Status – Partially Implemented

Agency Action – The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. As of November 2020, only 237 claims totaling $30,779 had been recovered as part of OSC’s audit findings. OMIG did not recover any overpayments from the sampled therapy claims totaling $3,584. OMIG did perform an analysis of providers who received the largest dollar amounts of payments in our findings, identifying $8 million in questionable payments. In February 2021, OMIG initiated audits with 17 of those providers whose identified claims totaled about $5 million.

In response to the initial audit, OMIG officials stated that $7.9 million of the improper payments made on 2012 and 2013 claims was no longer recoverable due to federal look-back provisions. However, by initiating audits at the time of our follow-up review rather than when the audit report was issued in October 2019, we estimate that OMIG lost an opportunity to collect an additional $3.8 million pertaining to 2014 claims in our findings. We encourage OMIG to take more prompt action on our audit findings in the future to avoid similar loss of recoveries.

Recommendation 2

Formally remind providers to comply with all Medicaid and Medicare billing rules, including:

- *Recording the NPI of the clinician who rendered services as the attending provider on Medicaid claims;*
- *Properly using the "GY" modifier code; and*
- *Billing Medicare prior to Medicaid for services on behalf of dual-eligibles.*

Status – Partially Implemented

Agency Action – Our original audit found that Medicare did not make payments for certain services because providers improperly reported a "GY" modifier on claims for services that were covered by Medicare. Providers are to use a modifier code of "GY" when billing for a service that is not covered by Medicare. By submitting a claim to Medicare with this modifier code, the provider is determining, in advance, that the procedure is not covered. We also noted two providers (of six sampled providers) who did not correctly report the National Provider Identifier (NPI) of the clinician who rendered services as the attending provider on their Medicaid claims.

Department officials informed us that a Medicaid Update had been drafted and was awaiting final approval before being published. A copy of the draft was sent to OSC on December 30, 2020. While the draft included most of the action items in our recommendation, it did not include language to remind providers to record the NPI of the clinician who rendered the service as the attending provider.

We note that Department officials sent a reminder to Children and Family Treatment and Support Services (CFTSS) and Home and Community Based Services (HCBS) providers on March 8, 2019 to report the appropriate NPI in the attending provider field of a claim. However, this reminder was not sent to all providers that made up OSC's findings. In fact, only three of the 20 top providers from the audit's therapy-related findings were associated with either CFTSS or HCBS.

Recommendation 3

Develop and implement controls to identify and prevent Medicaid overpayments on behalf of dual-eligibles for the types of therapy services and prescription drug claims included in the audit.

Status – Not Implemented

Agency Action – Department officials informed us that eMedNY edit enhancements within Evolution Project 6195 should address the types of claims contained in the audit findings. However, we determined that the proposed modifications would not address the specific causes for the overpayments identified in the audit report.

To further determine if the Department took action to prevent the types of overpayments found in the initial audit, we analyzed claims for physical, speech, and occupational therapy services from January 1, 2018 through November 30, 2020 and prescription drug claims from January 1, 2017 through December 31, 2020. The following table shows that issues identified in the audit report still existed each year for both therapy and prescription drug claims. We identified 86,635 members for whom Medicaid paid

approximately $9.1 million for therapy services even though the annual Medicare payment cap amount for therapy claims was not met. We also identified an additional 59,147 pharmacy claims totaling $6.9 million that should have been paid by Medicare.

Therapy and Prescription Drug Findings By Year

	Therapy		Pharmacy	
Year	**Recipients**	**Amount**	**Claim Count**	**Amount**
2017	–	–	18,562	$1,854,157
2018	30,976	$3,193,181	16,459	1,872,605
2019	32,834	3,358,366	14,845	1,890,070
2020	22,825	2,540,083	9,281	1,269,982
Totals	**86,635**	**$9,091,630**	**59,147**	**$6,886,814**

In addition to the $9.1 million in therapy claims, we identified other improper payments. During the initial audit period, there were annual payment caps on the amount of therapy services Medicare would pay. Once Medicare payments reached those annual caps, Medicaid would generally become the primary payer for these services. Since 2018, providers can bill Medicare $3,000 annually (and in certain cases more), as long as the therapy services were claimed to be medically necessary. For calendar years 2018 through 2020, we identified an additional $1.7 million of therapy claims paid by Medicaid when Medicare's annual payments were below $3,000.

Major contributors to this report were Salvatore D'Amato, Samuel Carnicelli, and Misty Daiyan.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

David Schaeffer
Audit Manager

cc: Mr. Robert Schmidt, Department of Health
Mr. Frank T. Walsh, Jr., Acting Medicaid Inspector General