



# Department of Health

Medicaid Claims Processing Activity  
October 1, 2008 through March 31, 2009

Report 2008-S-155



Thomas P. DiNapoli



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# State of New York Office of the State Comptroller

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## Division of State Government Accountability

December 22, 2009

Richard F. Daines, M.D.  
Commissioner  
NYS Department of Health  
Corning Office Building  
Empire State Plaza  
Albany, New York 12237

Dear Dr. Daines:

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 Department of Health, entitled Medicaid Claims Processing Activity October 1, 2008 through March 31, 2009. 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*





# State of New York Office of the State Comptroller

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## EXECUTIVE SUMMARY

### **Audit Objective**

Our objective was to determine whether the Department of Health's eMedNY System reasonably assured that Medicaid claims were submitted from approved providers, were accurately processed and resulted in correct provider payments.

### **Audit Results - Summary**

The Department of Health'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 March 31, 2009, eMedNY processed approximately 171 million claims resulting in payments to providers of about \$22 billion. We performed audit work related to the systems and the payments as part of the Comptroller's constitutional and statutory requirements to audit all State expenditures. Based on the results of our audit work of the weekly cycles of Medicaid payments made during the six months ended March 31, 2009, we concluded that eMedNY reasonably assured that Medicaid claims were submitted from approved providers, were accurately processed and resulted in correct provider payments.

We identified five reportable conditions. When audit exceptions were identified, these were communicated to Department of Health (Department) officials who initiated appropriate actions to address them. The first reportable condition entailed the identification and prevention of a potential \$20.3 million overpayment resulting from a reimbursement rate that was incorrectly updated on a rate file loaded onto the eMedNY System. This incorrect rate was applied to 1,351 claims and an incorrect payment amount was computed. We brought this matter to the immediate attention of the Department of Health and other State officials and it was corrected before the claims were reimbursed. Officials are assessing adding an additional control to the process to help ensure this type of error does not occur again.

The remaining four reportable conditions resulted in overpayments of approximately \$1.2 million, as follows.

- \$771,347 in net overpayments resulting from 77 invalid neonatal inpatient claims that occurred due to incorrect claim information, such as newborn birth weights;

- \$357,267 in inappropriate payments for transportation services that were either not medically necessary, not rendered, not allowed by Medicaid, or were duplicate billings;
- \$35,306 in overpayments resulting from 394 claims for dialysis services in which the provider billed an incorrect reimbursement rate code; and
- \$16,823 in overpayments on three claims resulting from inaccurate reporting of coinsurance.

As a result of our audit, we made eight recommendations to the Department to recover Medicaid payments and improve the controls over payments in these areas. Detailed results of our audit were provided to Department of Health and Office of the Medicaid Inspector General officials. Department officials generally agreed with our recommendations and indicate actions planned or taken to implement them.

The Department agreed with all but one of our recommendations.

This report, dated December 22, 2009, can be found on our website at: <http://www.osc.state.ny.us>. Add or update your mailing list address by contacting us at: (518) 474-3271 or  
Office of the State Comptroller  
Division of State Government Accountability  
110 State Street, 11<sup>th</sup> Floor  
Albany, NY 12236



## Introduction

### 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 generates payments to reimburse the providers for their claims. During the six-month period ended March 31, 2009, eMedNY processed approximately 171 million claims resulting in payments to providers of about \$22 billion. The claims are processed and reimbursed in weekly cycles which averaged 6.6 million claims and \$862 million in Medicaid payments to providers.

The Office of the State Comptroller (OSC) performs audit steps during each weekly cycle of eMedNY processing to determine that eMedNY reasonably assures accurate Medicaid claims processing resulting in correct reimbursement payments to authorized providers. As audit exceptions are identified during the weekly cycle, OSC auditors work with Department staff to resolve them in a timely manner so that 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 an expanded OSC performance audit. These audit steps are designed to meet the Comptroller's constitutional and statutory requirements to audit all State expenditures.

### Audit Scope and Methodology

We audited selected Medicaid claims processed by the Department to determine whether the Department's eMedNY System reasonably assured that Medicaid claims were submitted from approved providers, were accurately processed and resulted in correct provider payments. The scope of our audit was from October 1, 2008 through March 31, 2009.

To accomplish our audit objective, 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 Mental Retardation and Developmental Disabilities. 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. Our audit steps were designed to reasonably

assure that Medicaid claims were submitted from approved providers, were accurately processed and resulted in correct provider 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 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 management 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**

A copy of this report, in draft, was provided to Department officials for their review and comment. Their comments were considered in preparing this draft report.

The Department generally agreed with all but one of the recommendations. They disagreed with our recommendation to recover over \$195,000 from a county for transportation services that were not medically necessary. Our rejoinders to the Department's response are included in State Comptroller's comments at the end of the report.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department 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 the Report**

Major contributors to this report include Andrea Inman, Amanda Strait, Mark Breunig, Earl Vincent, Christopher Morris, Wendy Matson, Tracy Samuel, Judith McEleney, Kate Merrill, Emily Wood, and Brian Mason.

## Audit Findings and Recommendations

### **Incorrect Reimbursement Rate Change**

The eMedNY System processes claims submitted by certain State agencies that operate programs eligible for Medicaid participation. According to Department officials, for the fiscal year ended March 31, 2009, Medicaid payments to the Office of Mental Retardation and Developmental Disabilities (OMRDD) and the Office of Mental Health (OMH) accounted for approximately \$5.6 billion. Medicaid payments to certain OMRDD providers for developmental disabilities services are based on daily reimbursement rates. When reimbursement rates are retroactively revised and entered into the eMedNY System, eMedNY will automatically re-price the providers' previously paid claims affected by the rate change.

During our audit, we identified one instance where an incorrect retroactive reimbursement rate was entered onto eMedNY that generated a potential overpayment of \$20.3 million. We noted that one OMRDD provider's reimbursement rate was changed from \$147.74 to \$15,151.28, instead of \$151.51. According to OMRDD officials, the incorrect reimbursement rate of \$15,151.28 was erroneously entered by an agency employee onto a file containing OMRDD reimbursement rates. The file of rates was then submitted and uploaded to eMedNY. The rate change was dated retroactively back to April 1, 2007 and affected 1,351 of the provider's claims. The Department agreed with our finding and OMRDD officials thanked the Comptroller's office for bringing this to their attention and indicated the correction was being processed to the Department of Health as a result. We coordinated with the Department and OMRDD officials to correct the error and within three days of our initial contact with OMRDD, the reimbursement rate was corrected and an overpayment of \$20.3 million was avoided.

In response to our report, Department and OMRDD officials indicated that they believe they would have identified the billing rate error before an actual payment was made. OMRDD officials stated that rates are reviewed for accuracy after they are entered onto the file for submission to eMedNY. However, in this instance, the incorrect rate change was missed by that review. Despite the oversight, OMRDD officials stated that they reconcile the claims processed by eMedNY to provider payments on OMRDD's internal tracking and billing system. Further, officials said that their internal billing system had the correct provider reimbursement rate, and the rate error occurred only on the file submitted to eMedNY. As a result, they believe the \$20.3 million claim payment error would have been caught by OMRDD before the final processing of their monthly reimbursement voucher. OMRDD officials stated that they will assess adding an additional control to their rate review process, such as checking that the rates on

eMedNY match those on their internal billing system, to ensure this type of error does not occur again.

### **Invalid Birth Weight Information on Neonatal Claims**

Under Medicaid, diagnosis related groups (DRG's) serve as a basis of payment for some inpatient stays, including those for neonatal (newborn) care. Neonatal claims are assigned one of several DRG codes based upon factors such as the newborn's birth weight, diagnosis, length of hospital stay, and type of discharge. Healthy newborns with normal birth weights are typically discharged after a two-day length of stay. Generally, DRG claim reimbursements for healthy newborns are less than the amounts paid for very low birth weight newborns, who often require longer periods of hospitalization and require more complex levels of care before discharge. As a result, providers must be careful when submitting claims for neonatal care because inaccurate birth weights may cause inappropriate payments.

During our weekly audit, we identified neonatal claims with low birth weights and unusually short lengths of stay that did not appear to be reasonable. Through our analysis of claims and review of medical records, we identified 19 neonatal claims that resulted in net overpayments of \$281,205. This occurred because the birth weights were incorrectly entered onto the claims by the hospitals. Of the 19 claims, 15 resulted in \$296,978 in overpayments to providers, and 4 resulted in underpayments of \$15,773. As a result of our audit, one provider took action and reduced their claim by \$123,870 (which we have excluded from amounts recommended for recovery).

We further determined that some birth weight fields in eMedNY were truncated and caused incorrect payments. The Department's billing guidelines require all inpatient newborn claims to be submitted with a birth weight in grams. In processing claims, the eMedNY System automatically assigns a decimal point in the system's birth weight field. If a provider mistakenly inputs a second decimal point when entering the birth weight of a newborn on the electronic claim, the weight of the newborn will be processed incorrectly on the eMedNY System.

We identified one hospital that consistently input decimal points when entering the birth weights on claims, and consequently, these claims were not processed correctly. For example, for one newborn with a birth weight of 3401 grams, the hospital entered the weight as "3401.00" grams. However, in eMedNY, the newborn's birth weight was processed incorrectly as 340100.00 grams. To process and pay this type of claim, the eMedNY System reads only the first four digits to the left of the decimal point, and therefore, payment was based on a weight of 0100 grams (or 3301 grams less than the newborn's actual weight). Because of the frequency of this error, we expanded our analysis of this provider for the period from April 1, 2003 through March 31, 2008. As a result of our further audit work, we

identified 35 neonatal claims that resulted in net overpayments of \$174,616. Of the 35 claims, 32 resulted in \$226,343 in overpayments, and 3 resulted in underpayments of \$51,727 to the provider. The hospital has been contacted and instructed to correct the problem.

Lastly, we identified instances where there was a transfer between hospitals or two separate stays at the same hospital for neonatal claims and the birth weights decreased upon transfer or the re-admission. Due to the risk in this area, we expanded our analysis to April 1, 2003 through March 31, 2009. As a result, we identified 23 neonatal claims that resulted in net overpayments of \$315,526. Of the 23 claims, 20 resulted in \$350,919 in overpayments to providers, and 3 resulted in underpayments of \$35,393.

In total we identified 67 neonatal claims that resulted in \$874,240 in overpayments (and 10 claims resulting in \$102,893 in underpayments) because newborn information was incorrectly entered on the claims. These claims were processed because eMedNY lacks the controls necessary to identify unreasonable characteristics reported by providers on neonatal claims. We have reported this matter to Department officials in the past (through OSC audits 2008-S-70 and 2008-S-152), and Department officials should continue to take actions to address this longstanding issue.

**Recommendation**

1. Review the remaining \$750,370 related to the 66 overpaid claims we identified and recover overpayments as appropriate, and ensure correct payment of the 10 underpaid claims totaling \$102,893.

**Transportation Services**

We identified approximately \$357,000 in inappropriate payments for transportation services that were either not medically necessary, not rendered, not allowed by Medicaid, or were duplicate billings. As a result of our audit, some of the inappropriate payments have been recovered; however, further action is necessary to recover about \$256,000 in improper payments.

*Unnecessary and Costly Taxi Services*

According to Department Medicaid policies, reimbursement for transportation services should not be made when the associated medical service is not covered by Medicaid. Department policy further states that the Medicaid program intends to authorize transports using the least costly, most medically-appropriate mode of transportation.

Through our audit, we identified a Medicaid recipient who was receiving routine taxi service at a cost of approximately \$300 per day for five days per week without an associated medical service. Upon investigation, we found that transportation services were inappropriately authorized to allow for a

Medicaid recipient residing in Poughkeepsie, NY to visit her son in a long term care facility in Albany, NY. The transportation was authorized by the Dutchess County Local Department of Social Services (Dutchess County DSS) prior to December 2008 and thereafter by Dutchess County DSS's transportation contractor, responsible for managing transportation services for Medicaid recipients in that county, since December 2008.

Upon our request for details about the transports, the Dutchess County DSS and their contractor contacted the medical facility and determined that the transports were not medically necessary and, therefore, were not eligible for Medicaid reimbursement. The contractor cancelled the prior authorizations for the recipient's transportation, effective April 3, 2009. The Dutchess County DSS coordinated with New York State Child Protective Services to establish a more cost effective approach that will now be provided by Child Protective Services.

The Medicaid Program incurred inappropriate costs of \$195,958 for transportation services that were not medically necessary from July 28, 2006 through April 3, 2009.

#### *Services Not Rendered*

We identified transportation providers that submitted claims for transportation services before they were rendered. Three providers received prior authorization to render services on multiple days over a several month period. However, we found that the providers were billing for all prior authorized services at the beginning of the period. For example, one recipient was authorized to receive 182 trips between December 1, 2008 and July 13, 2009. The provider billed for all 182 trips, totaling \$16,380, for one day - December 1, 2008.

In total, the three transportation providers were paid a total of \$94,919 in inappropriate payments because they submitted claims before the services were actually rendered. We instructed the providers to void these claims and the Department informed the providers of the proper billing procedures. Department officials indicated that they are in the process of implementing an edit in eMedNY that will prevent a provider from billing more trips per day than the prior authorization allows.

We further identified one provider who billed for taxi services they did not provide. The transportation was for one recipient and was authorized to occur five days per week to a routine medical service during the period of December 2008 through July 2009. However, we determined that the recipient did not always attend the medical service and stopped going to the service in January 2009. The inappropriate billings occurred because the



provider did not account for trips that were canceled. There were a total of nine claims (for 56 dates of service) totaling \$6,160 in overpayments to this provider.

Department officials state there are on-going audits and reviews of transportation providers. These reviews include, but are not limited to, reviews of documentation for transportation services, including transportation services in which there was no corresponding medical service. We recommend the Department recover the remaining \$6,160 from the provider who did not void their inappropriate claims.

#### *Excessive Mileage*

According to Medicaid policy, only loaded mileage (i.e., the mileage incurred when actually transporting the recipient) is reimbursable. It is inappropriate to bill for unloaded mileage, such as that incurred by an ambulette when driving from the company's facility to the recipient's residence prior to transport for medical service.

As a result of our audit, we identified one provider that was billing Medicaid for unloaded mileage. The excessive mileage was billed on 604 claims from December 28, 2005 through January 30, 2009 and totaled \$36,210 in overpayments to this provider. Moreover, through August 24, 2009, this provider continued to bill Medicaid in this manner. We recommend the Department recover the inappropriate payments for unloaded mileage claimed by this provider and ensure the provider discontinues this billing practice.

We also identified two other transportation service providers who billed for inappropriate mileage amounts. A contractor, who is responsible for managing transportation services of Medicaid recipients in Orange County, issued multiple prior authorizations to providers for overlapping dates of transportation service. Consequently, the providers billed Medicaid for overlapping dates of service and, therefore, excess amounts of mileage. We identified 18 claims that resulted in \$24,020 in overpayments to these two providers. We instructed both providers to void these inappropriate claims, but only one complied (returning \$5,929 to the Department). Therefore, we recommend that the Department recover the remaining \$18,091 from the other provider.

At the time of these claims, the limits in the eMedNY System for taxi mileage were not set low enough to prevent these claims with excessive mileage from paying. However, the issue of placing limits on mileage (procedure codes) and preventing overlapping prior authorizations were previously addressed in OSC Audit 2008-S-70. As a result of that audit, the Department has

since strengthened eMedNY System edits to lower the amount of mileage a provider can bill per trip.

- Recommendations**
2. Recover the appropriate State and Federal share of the \$195,958 in improper transportation costs approved by Dutchess County. Also, recover the \$60,461 from the providers who did not void their inappropriate claims.
  3. Complete implementation of the eMedNY edit that will prevent providers from billing more trips per day than the prior authorization was intended to allow.
  4. Issue guidance, that addresses the audit findings discussed in this audit report, to remind providers on the correct way to bill for transportation services.
  5. Continue to perform reviews of providers to ensure that only transportation for services covered by Medicaid are reimbursed; that recipients use the least costly, most medically-appropriate mode of transport; and that providers only bill for services rendered and adjust claims for cancelled trips.
  6. Instruct and ensure that the provider who is billing for unloaded mileage discontinues this billing practice.

**Incorrect Rates  
for Dialysis  
Billings**

We found one provider who billed for facility hemodialysis services, when in fact the provider was actually providing home dialysis services. Facility hemodialysis is reimbursed at a rate of \$156.81, while home dialysis is reimbursed at a rate of \$67.20. The inappropriate billing affected 394 claims for one recipient during the period June 21, 2007 through September 30, 2008 and resulted in a \$35,306 overpayment to the provider. The provider is now billing correctly and, upon our request, all 394 claims were adjusted by the provider.

**Inappropriate  
Medicare  
Coinsurance  
Billings**

Many of the State's Medicaid recipients are also eligible for Medicare. Such recipients are referred to as dual eligible recipients. Medicaid is the payor of last resort for medical claims, paying for unpaid balances after all other insurance, such as Medicare, settles. Medicaid will pay for Medicare co-pays, deductibles and coinsurance costs. In regard to coinsurance costs, Medicaid will typically pay an amount based upon the portion of the bill not covered by Medicare. When Medicare pays nothing on behalf of a dual eligible recipient (non-covered service), such claims should be paid by Medicaid at the equivalent Medicaid rate for that service, rather than at the provider's submitted charges.



We identified two medical providers that were paid inappropriate coinsurance amounts on behalf of dual eligible recipients, who were also enrolled in a Medicare HMO (Health Maintenance Organization). For one of the providers, we identified two claims that were inappropriately paid. The services billed by the provider were not covered, or paid for by the Medicare HMO. According to a Department official, when Medicare pays nothing, the claim should be paid at the established Medicaid rate. However, the claims in question were paid according to the amounts of the provider's submitted charges and not the corresponding Medicaid rate. As a result, these claims produced an overpayment of \$12,251 to the provider.

The other provider submitted an incorrect (excessive) Medicare allowed amount on a coinsurance claim, and as a result, was overpaid \$4,572. The claim should have been for \$46.18 (for laboratory tests), but instead paid \$4,618. When advised of the error, the provider adjusted the claim to the appropriate amount.

As previously stated, the three overpaid claims we identified involved dual eligible recipients enrolled in a Medicare HMO. Department officials have an evolution project underway to address and correct overpayment issues involving Medicare claims for dual eligible recipients. The project, however, does not address claims of dual eligible recipients enrolled in Medicare HMOs; it will only address claims of recipients not enrolled in a Medicare HMO.

- Recommendations**
7. Develop an edit that will appropriately pay Medicare coinsurance claims for recipients enrolled in a Medicare HMO.
  8. Recover the remaining \$12,251 in overpayments.



## Agency Comments



## STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.  
*Commissioner*

James W. Clyne, Jr.  
*Executive Deputy Commissioner*

December 3, 2009

Brian E. Mason, Audit Manager  
Office of the State Comptroller  
Division of State Government Accountability  
110 State Street – 11<sup>th</sup> Floor  
Albany, New York 12236

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's draft audit report 2008-S-155 on "Medicaid Claims Processing Activity October 1, 2008 through March 31, 2009."

Thank you for the opportunity to comment.

Sincerely,

James W. Clyne, Jr.  
Executive Deputy Commissioner

Enclosure

Cc: James Sheehan  
Robert W. Reed  
Deborah Bachrach  
Diana Jones Ritter  
Nicholas Meister  
Stephen Abbott  
Vincent Sleasman  
Ron Farrell  
Mary Elwell  
Irene Myron  
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**Department of Health  
Comments on the  
Office of the State Comptroller's  
Draft Audit Report 2008-S-155 on  
“Medicaid Claims Processing Activity  
October 1, 2008 through March 31, 2009”**

The following are the Department of Health’s (Department) comments in response to the Office of the State Comptroller’s (OSC) draft audit report 2008-S-155 on “Medicaid Claims Processing Activity October 1, 2008 , through March 31, 2009” including a general comment, followed by responses to the specific recommendations contained in the report.

**General Comment:**

The report identifies a situation entailing OSC’s identification and prevention of a potential \$20.3 million overpayment resulting from a reimbursement rate being incorrectly updated by the Office of Mental Retardation and Developmental Disabilities (OMRDD) on a rate file loaded into eMedNY. While the Department and OMRDD agree with the finding, they believe existing procedures would have corrected the error prior to the payment being processed had OSC not discovered it first. OMRDD’s procedures require a reconciliation of its billing records (containing the appropriate rate) and relevant eMedNY system data prior to the reimbursement being released. This internal control would have identified the error, especially given a reconciliation item of this magnitude. OMRDD is nonetheless proactively assessing its existing review procedures to help ensure that the data entered into eMedNY is consistently accurate.

\*  
Comment  
1

**Recommendation #1:**

Review the remaining \$750,370 related to the 66 overpaid claims we identified and recover overpayments as appropriate, and ensure correct payment of the 10 underpaid claims totaling \$102,893.

**Response #1:**

The Department has instructed its utilization review contractor, Island Peer Review Organization (IPRO), to review the birth weights associated with the DRG claims that may have been paid incorrectly due to provider billing errors. Implementation of Evolution Project 1358 in April 2009 provided IPRO with eMedNY functionality to adjust DRG birth weight claims. IPRO’s analysis will be used to determine if claims were correctly reimbursed. Overpayments will be recovered from hospitals, underpayments will be refunded to the providers and eMedNY’s history files will be adjusted accordingly. Additionally, the Department will determine the feasibility of developing an edit to deny claims with birth weight reporting errors at the time the claim is processed.

\* See State Comptroller’s Comments, page 23.

**Recommendation #2:**

Recover the appropriate State and Federal share of the \$195,958 in improper transportation costs approved by Dutchess County. Also, recover the \$60,461 from the providers who did not void their inappropriate claims.

**Response #2:**

The Department disagrees with the recommendation to recover \$195,958 in transportation costs, but agrees with the recommendation to recover \$60,461 from the providers who did not void their inappropriate claims. The Office of the Medicaid Inspector General (OMIG) will review the payments associated with the \$60,461 and pursue appropriate recoveries.

Regarding the \$195,958 in transportation costs, St. Mary's Rehabilitation Center for Children, the discharging facility, sent a letter in 2004 to St. Margaret's Center, the admitting facility, stressing the importance of the mother's involvement in the child's care. Based on this opinion, the Dutchess County Department of Social Services approved the mother's transportation between Poughkeepsie and Albany in order for her to continue to participate in ongoing training/education specific to the child's care. In response to questions raised by OSC's audit, in 2009, St. Mary's reversed its position and concluded that the mother's trips were not "medically necessary." After OSC relayed this information to Dutchess County, Medicaid-funded transportation of the mother to St. Mary's was immediately discontinued.

\*  
Comment  
2

Considering these details, including the fact that the county acted expeditiously following the OSC contact, the Department does not agree that the county should be held liable for these payments; nor should the transportation provider be held liable as the trips were authorized and furnished. Furthermore, it is the Department's contention that St. Mary's reference to "medically necessary" is open to interpretation and has no bearing on whether the mother was inappropriately transported.

**Recommendation #3:**

Complete implementation of the eMedNY edit that will prevent providers from billing more trips per day than the prior authorization was intended to allow.

**Response #3:**

The Department recently implemented Edit #00700 which rejects claims containing more units per day than permitted by the prior authorization. In addition, Edit #00180 has been applied to transportation services since 2008, denying claims when the procedure code unit maximum is exceeded.

**Recommendation #4:**

Issue guidance, that addresses the audit findings discussed in this audit report, to remind providers on the correct way to bill for transportation services.

\* See State Comptroller's Comments, page 23.

**Response #4:**

The Department will evaluate whether the issuance of additional guidance is needed, considering that providers already have access to policy manuals and past Medicaid Update articles providing guidance on appropriate billing practices.

**Recommendation #5:**

Continue to perform reviews of providers to ensure that only transportation for services covered by Medicaid are reimbursed; that recipients use the least costly, most medically-appropriate mode of transport; and that providers only bill for services rendered and adjust claims for cancelled trips.

**Response #5:**

The OMIG will continue to perform reviews of transportation claims.

**Recommendation #6:**

Instruct and ensure that the provider who is billing for unloaded mileage discontinues this billing practice.

**Response #6:**

The Department sent a letter in July 2009 instructing the provider on the correct billing practice along with the related policy. The OMIG will follow-up to ensure compliance.

**Recommendation #7:**

Develop an edit that will appropriately pay Medicare coinsurance claims for recipients enrolled in a Medicare HMO.

**Response #7:**

Effective February 2010, the Department expects to implement a new data source for identifying Medicare managed care plans and updating the information in eMedNY. The billing guidelines will be published in the November 2009 edition of "Medicaid Update" which will be released in late November.

**Recommendation #8:**

Recover the remaining \$12,251 in overpayments.

**Response #8:**

The OMIG will review the overpayments identified and pursue appropriate recoveries.

## State Comptroller's Comments

1. We acknowledge that OMRDD officials maintain that procedures requiring reconciliation of billing records prior to release of reimbursement are intended to and would likely have identified an error of this magnitude prior to payment. However, as our report points out, OMRDD's established controls also should have detected this error after the rates were loaded to eMedNY. Nevertheless, the detection control missed this error raising some concerns about how effectively OMRDD controls have been working.
2. We disagree with the Department's conclusion that it should not be required to recover the \$195,958 from the county in question. The original determination was not appropriate and should have been reviewed periodically by the county for appropriateness. Further, we contacted the long term care facility officials and they state that throughout the child's stay, it has not been their position that the parent's visits have been medically necessary. The county's quick reaction to our inquiry does not avert the error.