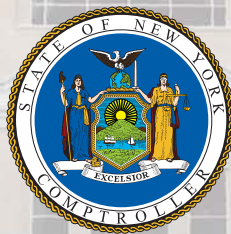




Department of Health

Inappropriate Payments for Vision Care Services Claimed by Dr. Horowitz

Report 2008-S-166



Thomas P. DiNapoli

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State of New York Office of the State Comptroller

Division of State Government Accountability

September 29, 2009

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

Dear Commissioner 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 entitled, Inappropriate Payments for Vision Care Services Claimed by Dr. Horowitz. 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

EXECUTIVE SUMMARY

Audit Objective

Our objective was to determine whether claims submitted by Dr. Kenneth Horowitz, an optometrist from Staten Island, were appropriate.

Audit Results - Summary

Dr. Horowitz received about \$370,000 from Medicaid during the five-year period ended September 30, 2008. From 2003 through 2008, Dr. Horowitz submitted claims for 221 to 777 Medicaid recipients annually. Most of Dr. Horowitz's patients were residents of the Staten Island Care Center (which includes a nursing home). Generally, Dr. Horowitz's patients were 65 years of age and older, and they were eligible for Medicare. We audited the Medicaid claims of Dr. Horowitz because of the unusually high amounts of certain eye care services he claimed and the questionable aspects of many of these services. Based on the results of our review, we determined that Dr. Horowitz was paid about \$239,500 by Medicaid for unsupported and inappropriate claims made during our audit period. Accordingly, we have referred these matters to the Office of the Medicaid Inspector General for further investigation.

According to the Department's Medicaid rules and regulations, the usual frequency for optometric eye examinations is once every 24 months. However, Dr. Horowitz routinely billed Medicaid for more frequent eye examinations for his patients. Certain patients received 10 or more eye examinations within a 24-month period. For one of his patients, Dr. Horowitz claimed seven examinations within one year. Moreover, the documentation available generally provided insufficient evidence that Dr. Horowitz's patients had conditions that required more frequent eye examinations than normally allowed by Medicaid.

We also concluded that Dr. Horowitz billed Medicaid for additional procedures that were not medically necessary and might not have been performed. For example, Dr. Horowitz generally billed Medicaid for an extended ophthalmoscopy (in addition to a basic eye examination). For Medicaid reimbursement, an extended ophthalmoscopy requires the diagnosis of a serious retinal condition and documentation of such in the form of a highly detailed drawing of the eye and a report of the optometrist's findings. The Department requires Medicaid providers to maintain these drawings and reports on file for six years. However, no records were available for 38 of the 69 Medicaid claims we selected at random for review. Moreover, only one of the 38 claims

with documentation had the appropriate level of documentation for an extended ophthalmoscopy procedure. In total, we identified probable overpayments of nearly \$125,000 for more than 4,000 extended ophthalmoscopies that were not adequately documented and medically necessary - and might not have been performed.

Medicare also provides for basic eye examinations, and Medicare enrollees are responsible for paying co-insurance for eye care services. When a patient is eligible for both Medicare and Medicaid, Medicaid will pay the provider the amount of the recipient's Medicare co-insurance. Thus, it is critical that Medicare insurance information be entered correctly on the Medicaid bill, otherwise overpayments can occur. However, in 1,098 instances, Dr. Horowitz submitted Medicaid claims with incorrect Medicare information, which resulted in overpayments totaling about \$112,000. In each instance, Dr. Horowitz billed Medicaid using his own fees (usually \$100 to \$110) instead of the correct Medicare rates (generally \$48 and \$74). Further, based on the correct Medicare rates, we determined that Medicaid should have paid co-insurance charges of only \$3 to \$5 for the individual services Dr. Horowitz billed to Medicare and Medicaid.

In addition, Dr. Horowitz inappropriately billed Medicaid for transportation costs when he traveled to the nursing home where most of his patients lived. Under New York's Medicaid program, health care professionals can be reimbursed fifty cents a mile for traveling to a nursing home. Each day Dr. Horowitz saw patients at the nursing home, he could claim reimbursement of \$5, for a round-trip totaling 10 miles. However, we determined Dr. Horowitz routinely claimed mileage reimbursement for each patient he served while at the nursing home. For example, if Dr. Horowitz provided services to five patients in one trip to the nursing home, he billed Medicaid five separate mileage claims and received reimbursement totaling \$25 (instead of the correct amount - \$5). Thus, we determined Dr. Horowitz over-charged Medicaid nearly \$2,500 for mileage during the period of our audit.

Our report includes three recommendations to the Department addressing the review and recovery of the inappropriate and undocumented claim payments detailed in this report and the possible decertification of Dr. Horowitz as a participating Medicaid provider. In response to our draft report, Department officials agreed to take action on our audit recommendations.

This report, dated September 29, 2009, is available 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, 11th Floor
Albany, NY 12236

Introduction

Background

An optometrist is a health care professional licensed by the State to provide primary eye care services. Optometrists are doctors of optometry (ODs) and are trained to examine, diagnose and treat certain disorders and diseases of the eye. For example, optometrists can diagnose eye diseases (such as glaucoma and cataracts) and treat vision conditions (such as nearsightedness and farsightedness). They also prescribe eyeglasses and medications to treat certain eye diseases. Under federal Medicaid requirements, optometrist services and eyeglasses are considered optional services which States may choose to provide. New York includes these services in its Medicaid program and pays about \$12 million annually for them.

The usual frequency for optometric eye examinations is one exam every two years. However, a patient's medical or visual condition may necessitate an optometric eye examination more frequently. For example, people 65 years-old and over may require an examination every one to two years. If an optometrist provides a Medicaid recipient with eye examinations more frequently than once in two years, the Department requires documentation of the particular eye condition(s) supporting the medical necessity of the additional examinations.

In order to be Medicaid reimbursable, optometric eye examinations must include a variety of tests and specific documentation. A proper optometric eye examination consist of a case history, reasons for the examination, prognosis, internal eye examination findings, external eye examination findings, recommendations, and various tests (including a routine ophthalmoscopy). Under Medicaid, an ophthalmoscopy is a standard part of a regular eye examination and, therefore, should not be billed separately. Routine ophthalmoscopy is performed to detect changes to the retina due to eye disease.

In addition to eye examinations that include routine ophthalmoscopy, Medicaid also provides for extended ophthalmoscopy. Extended ophthalmoscopy is a more detailed examination of the eye and is generally performed when a serious retinal condition exists. Generally, a claim for an extended ophthalmoscopy should correspond with a serious eye problem and be supported by a detailed retinal drawing and the optometrist's clearly written description of the patient's condition. For Medicaid purposes, optometrists are required to retain the detailed drawing and the description of the patient's condition on file for six years.

The Department of Health (Department) administers the Medicaid program in New York State. Each week, the Department's Medicaid claims processing system, eMedNY, uses various automated controls (edits) to detect inappropriate claims and prevent payment. For example, certain edits identify duplicate claims for the same service and other edits detect claims submitted for deceased Medicaid recipients. The Office of the State Comptroller performs continuous audits of Medicaid payments. These audits are designed to identify billing patterns that warrant further review. In some cases, detailed on-site reviews of a provider's medical records are necessary to ensure that the claims are valid and appropriate.

Kenneth Horowitz, OD, is an optometrist from Staten Island who received about \$370,000 from Medicaid during the five-year period ended September 30, 2008. From 2003 through 2008, Dr. Horowitz submitted claims for 221 to 777 Medicaid recipients annually. Most of Dr. Horowitz's patients were residents of the Staten Island Care Center (which includes a nursing home). Generally, Dr. Horowitz's patients were 65 years of age and older, and they were eligible for Medicare. In addition, Dr. Horowitz maintained the medical records for patients at the Staten Island Care Center. Dr. Horowitz also operated a professional office from his personal residence on Staten Island, about five miles from the nursing home.

Audit Scope and Methodology

Our objective was to determine whether claims submitted by Dr. Kenneth Horowitz, an optometrist from Staten Island, were appropriate. To accomplish our objective, we interviewed Department officials, reviewed applicable sections of Federal and State laws and regulations, and examined the Department's relevant policies and procedures. We analyzed and examined the Medicaid claims submitted by Dr. Horowitz for the five-year period ended September 30, 2008. We visited Dr. Horowitz's office and the Staten Island Care Center to review medical records supporting his claims. We tested a judgmental sample of 69 Medicaid claims totaling \$5,561. Our sample included 17 of Dr. Horowitz's patients who received frequent eye examinations on or after January 1, 2006. We also consulted with an independent vision care professional.

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.

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 the comments at the end of the report. Department officials generally agreed with our report's recommendations and indicated the steps that will be taken to implement them.

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 therefor.

**Contributors
to the Report**

Major contributors to this report include Warren Fitzgerald, Daniel Towle, Tracy Samuel, Frank Commisso, and Brian Mason.

Audit Findings and Recommendations

Inappropriate and Questionable Claims for Services

Dr. Horowitz submitted Medicaid claims for excessive amounts of eye care services, often under questionable circumstances. According to the Department's Medicaid rules and regulations, the usual frequency for optometric eye examinations is one every 24 months. However, Dr. Horowitz routinely billed Medicaid for multiple eye examinations for many of his patients during a 24-month period. Eight patients received ten or more examinations within 24 months. One of these patients received 14 examinations. Moreover, Dr. Horowitz's patients rarely received other eye care-related services (indicative of vision problems requiring treatment and increased monitoring). We questioned the need for the additional eye examinations for most of Dr. Horowitz's patients because generally there was little evidence that these patients had serious vision problems that required higher levels of treatment and monitoring.

In one case, for example, Dr. Horowitz submitted claims for seven eye examinations for a patient (who resided at the nursing home) within one year. The high frequency of the eye examinations indicates that this patient would have required, under normal circumstances, other services to treat vision problems. However, there were no claims for other vision-related services, such as new eye glass lenses or visits to an ophthalmologist, for this patient. Consequently, we question the medical necessity of seven eye examinations for this patient within one year. Moreover, based on our analysis of all Dr. Horowitz's claims for eye examinations, there was little or no evidence that patients required the additional examinations. Although some patients received new eye glasses, none required other procedures to treat serious eye conditions or diseases that required monitoring through more frequent eye examinations.

We also determined that Dr. Horowitz frequently added other procedures with claims for standard eye examinations. For example, on September 7, 2006, Dr. Horowitz was reimbursed \$2,209 by Medicaid for performing 47 different procedures on 20 Medicaid recipients residing at the nursing home. For 17 patients, Dr. Horowitz billed Medicaid for eye examinations and an extended ophthalmoscopy. Our analysis of all Medicaid payments made to Dr. Horowitz showed that he routinely added charges for an extended ophthalmoscopy whenever he billed Medicaid for an eye examination. This billing practice explains, at least in part, why Dr. Horowitz's average Medicaid claim reimbursement was nearly twice the average claim reimbursement for all Medicaid optometrists.

Based on our review of these claims and patient's medical files, we conclude that many of these additional procedures were not medically necessary, and there is considerable risk that some of them were not performed. Under New York's Medicaid program, a routine ophthalmoscopy is part of a basic eye examination performed to detect changes to the retina due to eye disease - and consequently, a routine ophthalmoscopy is not billed as a separate procedure. An optometrist can make an additional claim for an extended ophthalmoscopy, which is performed when a serious retinal condition is diagnosed. An extended ophthalmoscopy also requires the preparation of a highly detailed drawing of the eye and a detailed report of the patient's condition. The Department requires Medicaid providers to maintain medical records of these drawings and reports for six years.

However, when we requested the medical records for a randomly selected sample of 69 claims for an extended ophthalmoscopy, Dr. Horowitz informed us that records for 38 of these claims were missing. Consequently, medical records were available for only 31 of the 69 selected claims. We reviewed the files for the 31 claims and found that the required records (including the detailed retinal drawing and optometrist's report) for extended ophthalmoscopies were available for only one claim. Thus, Dr. Horowitz was unable to provide sufficient documentation for 68 of the 69 selected claims for extended ophthalmoscopies. In total, we identified potential overpayments of \$125,000 for more than 4,000 extended ophthalmoscopies that were not medically necessary and might not have been performed.

In addition, Dr. Horowitz often billed Medicaid for transportation expenses. Under New York's Medicaid program, health care professionals can be reimbursed 50 cents per mile to travel to and from a nursing home to provide services. As noted previously, the nursing home was five miles from Dr. Horowitz's residence. Consequently, each day that Dr. Horowitz went to the nursing home, he could claim reimbursement for a round-trip of 10 miles (or \$5 per day). However, we determined that Dr. Horowitz often claimed mileage reimbursement for every patient he saw on a given day at the nursing home. For example, on February 20, 2008, Dr. Horowitz saw eight patients at the nursing home and made eight separate mileage claims totaling \$40 (when he was only entitled to \$5). During our audit period, we determined that Dr. Horowitz over-charged Medicaid nearly \$2,500 for mileage reimbursements.

**Excessive
Medicare
Co-insurance
Charges**

Since most of Dr. Horowitz's patients were over 65 years old, they were also eligible for Medicare. Medicare provides for certain forms of eye care, including extended ophthalmoscopy. According to Medicare, an extended ophthalmoscopy requires a meticulous, comprehensive evaluation of the eye and detailed documentation of a severe ophthalmologic problem. In the absence of findings of a serious disease, the ophthalmoscopy is part of the

basic eye examination, and extended ophthalmoscopy should not be billed. Medicare regulations further state that repeated extended ophthalmoscopies, without changes in symptoms or condition, may be denied for lack of medical necessity. As noted previously in this report, there was virtually no documentation of the need for extended ophthalmoscopies in the files of the patients we selected for review.

In addition, Medicare enrollees are responsible for paying co-insurance for eye care services. When a patient is eligible for both Medicare and Medicaid, Medicaid will pay the provider the recipient's Medicare co-insurance. Consequently, it is critical that Medicare insurance information be entered correctly on a Medicaid claim; otherwise, Medicaid overpayments can occur. However, during our audit period, Dr. Horowitz reported the wrong Medicare insurance information to Medicaid 1,098 times, resulting in overpayments from Medicaid totaling about \$112,000. For these claims, Dr. Horowitz used his personal fee rates (ranging from \$100 to \$110) for services instead of the correct Medicare rates (generally \$48 and \$74) for the same services. Using the correct Medicare rates, we determined that Medicaid should have paid Dr. Horowitz co-insurance charges of only \$3 to \$5 for most of the individual services he provided.

We attributed the improper claims to an errant understanding of Medicaid billing protocols by Dr. Horowitz's billing staff (which included the Doctor's wife and son). They told us that they do not record pertinent Medicare payment information when submitting Medicaid claims that corresponded to Medicare payments. They further believed that providers were allowed to bill Medicaid their customary fee (in this case \$100 or \$110) when Medicare denied payment of a claim for any reason. Consequently, Dr. Horowitz routinely submitted excessive Medicaid claims, particularly for extended ophthalmoscopies, for patients that were also eligible for Medicare.

At the conclusion of our audit fieldwork, we presented our findings to staff from the Office of the Medicaid Inspector General (OMIG). OMIG staff indicated that they would look further into Dr. Horowitz's Medicaid claims and work with Medicare to determine if any inappropriate payments were made. Furthermore, since many of the claims that we examined had no medical records supporting them, the Department should consider investigation of claims paid subsequent to the period of our audit (September 30, 2008). Moreover, based on the results of our audit and the Department's review of Dr. Horowitz's Medicaid record, we believe that Department officials should formally assess whether or not Dr. Horowitz should be decertified as a participating provider in the Medicaid program.

- Recommendations**
1. Investigate the \$239,500 in potential Medicaid overpayments we identified during this audit and recover any unsupported or otherwise inappropriate payments.
 2. Review Medicaid payments made to Dr. Horowitz subsequent to September 30, 2008 and determine if any were improper. Recover payments for improper claims, as appropriate.
 3. Formally assess whether Dr. Horowitz should be decertified from the Medicaid program.

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

August 25, 2009

Mr. Brian E. Mason, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th 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-166 on "Inappropriate Payments for Vision Care Services Claimed by Dr. Horowitz."

Thank you for the opportunity to comment.

Sincerely,

James W. Clyne, Jr.
Executive Deputy Commissioner

Enclosure

cc: James Sheehan
Robert W. Reed
Deborah Bachrach
Nicholas Meister
Steve Abbott
Irene Myron
Gail Kerker
Ron Farrell
Mary Elwell

**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2008-S-166 on
“Inappropriate Payments for Vision Care Services
Claimed by Dr. Horowitz”**

The following are the New York State Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2008-S-166 on "Inappropriate Payments for Vision Care Services Claimed by Dr. Horowitz."

Recommendation #1:

Investigate the \$239,500 in potential Medicaid overpayments we identified during this audit and recover any unsupported or otherwise inappropriate payments.

Response #1:

The Office of the Medicaid Inspector General (OMIG) will review the potential overpayments identified by OSC and pursue appropriate recoveries.

Recommendation #2:

Review Medicaid payments made to Dr. Horowitz prior to October 1, 2003, and subsequent to September 30, 2008, and determine if any were improper. Recover payments for improper claims, as appropriate.

Response #2:

The OMIG will review the payments subsequent to September 30, 2008, and pursue appropriate recoveries. However, payments prior to October 1, 2003, exceed the statute of limitations.

Recommendation #3:

Formally assess whether Dr. Horowitz should be decertified from the Medicaid program.

Response #3:

The OMIG will consider all appropriate provider sanctions following completion of its review activities relative to the above recommendations.

*
Comment

*** State Comptroller's Comment:**

We amended recommendation no. 2 by deleting reference to the review and recovery of payments made to Dr. Horowitz prior to October 1, 2003.