

Thomas P. DiNapoli
COMPTROLLER



110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

April 14, 2011

Nirav R. Shah, M.D., M.P.H.
Commissioner
NYS Department of Health
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Re: Report 2010-F-47

Dear Dr. Shah:

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, *Inappropriate Payments for Vision Care Services Claimed by Dr. Horowitz* (Report 2008-S-166).

Background, Scope and Objective

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.

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 \$16 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 consists 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 which is performed to detect changes to the retina due to eye disease. Under Medicaid, an ophthalmoscopy is a standard part of a regular eye examination and, therefore, should not be billed separately.

Medicaid also provides for extended ophthalmoscopy, which 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.

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 were also eligible for Medicare.

Our initial audit report, which was issued on September 29, 2009, examined whether Medicaid claims submitted by Dr. Horowitz were appropriate. We determined that Dr. Horowitz was paid about \$239,500 for unsupported and inappropriate claims made during our five year audit period ended September 30, 2008. The objective of our follow-up was to assess the extent of implementation, as of March 24, 2011, of the three recommendations included in our initial report.

Summary Conclusions and Status of Audit Recommendations

Department officials have made some progress in correcting the problems we identified in the initial report. However, improvements are still needed. All three of the prior audit recommendations have been partially implemented.

Follow-up Observations

Recommendation 1

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

Status - Partially Implemented

Agency Action - The Office of the Medicaid Inspector General (OMIG) investigates and recovers inappropriate Medicaid payments on behalf of the Department. As of January 2011, OMIG officials had identified \$147,756 of Dr. Horowitz's claims that should have been paid by Medicare and \$2,105 in inappropriate travel claims. However, officials have not completed their investigation of the potential improper payments identified in our audit that lacked documentation to support the services rendered. The officials plan to hire an optometrist consultant to review patient charts for such documentation. Furthermore, OMIG has not

recovered any inappropriate payments identified so far in its review. On May 27, 2009, the Department started withholding Dr. Horowitz's Medicaid payments, but stopped withholding his payments on September 13, 2010 due to New York State regulation requirements. During that time OMIG withheld a total of \$11,095, which was placed in escrow pending the completion of OMIG's investigation.

Recommendation 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.

Status - Partially Implemented

Agency Action - As indicated in Recommendation 1, OMIG has reviewed some of Dr. Horowitz's claims and plans to review others for the period from November 1, 2003, through May 27, 2009, the date when OMIG began withholding payments to Dr. Horowitz, which is eight months beyond the September 30, 2008 cut-off date of our original audit. However, OMIG has not reviewed any payments submitted by Dr. Horowitz after May 27, 2009, and has so far not recovered any inappropriate payments.

Recommendation 3

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

Status - Partially Implemented

Agency Action - Department officials state they have not completed their assessment of whether Dr. Horowitz should be decertified because they are still investigating the claims identified in our initial audit.

Major contributors to this report were Karen Bogucki and Donald Collins.

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 also thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this process.

Very truly yours,

Edward J. Durocher, CIA
Audit Manager

cc: Thomas Lukacs, Division of the Budget
Stephen Abbott, Department of Health
Stephen LaCasse, Department of Health