

**NEW YORK**  
*state department of*  
**HEALTH**

Nirav R. Shah, M.D., M.P.H.  
Commissioner

Sue Kelly  
Executive Deputy Commissioner

August 9, 2013

Mr. Brian Mason  
Audit Director  
NYS Office of the State Comptroller  
110 State Street, 10th Floor  
Albany, New York 12236

Dear Mr. Mason:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2011-S-28 entitled, "Overpayments for Certain Medicare Crossover Claims."

Please feel free to contact James Clancy, Assistant Commissioner, Office of Governmental and External Affairs at (518) 474-2011 with any questions.

Sincerely,



Nirav R. Shah, M.D., M.P.H.  
Commissioner of Health

Enclosure

**Department Of Health**  
**Comments on the**  
**Office of the State Comptroller's**  
**Final Audit Report 2011-S-28 Entitled**  
**Overpayments of Certain Medicare Crossover Claims**

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The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2011-S-28 entitled, "Overpayments of Certain Medicare Crossover Claims."

**Recommendation #1:**

Review and recover the \$10 million in actual overpayments attributable to the eMedNY control deficiencies we identified.

**Response #1:**

The overpayments identified by OSC fall into two categories. The Office of the Medicaid Inspector General (OMIG) has initiated a recovery of the claims identified as incorrect interpretations of claim adjustment reason codes. OSC classified the other overpayments as claims where reimbursement limits were not properly applied. For these claims, the OMIG is reviewing the data and making recoveries as appropriate.

**Recommendation #2:**

Design and implement eMedNY controls to properly process and pay Medicare crossover claims submitted by group providers. In particular, these controls should ensure that eMedNY properly limits crossover claims for professional services to 20 percent of the coinsurance charge.

**Response #2:**

An eMedNY systems change has been submitted to revise claims processing logic so that physician group practices that are reimbursed for services provided to Medicare/Medicaid dually eligible patients are subject to the same cost sharing limits, i.e., 20% of the Medicare Part B coinsurance amount, which individual physician claims are subjected to.

**Recommendation #3:**

Review the \$16.4 million in potential Medicaid overpayments attributable to providers directly billing crossover claims to Medicaid and recover overpayments, where appropriate.

**Response #3:**

The OMIG will follow-up with the providers identified to determine if there is documentation supporting the Medicaid billings and ultimate payments. The OMIG will recover overpayments as appropriate.

#### **Recommendation #4:**

Implement the controls necessary to prevent providers from billing crossover claims directly to the Medicaid program. Consider denying crossover claims providers submit directly to Medicaid.

#### **Response #4:**

The OSC did not correct its recommendation despite the Department's response to the draft report which highlighted the multiple valid reasons for providers to submit claims directly to Medicaid for dually eligible beneficiaries. Therefore, the recommendation to prevent direct crossover claim submission and/or to deny all such claims is not accepted by the Department because it is contrary to the policies and regulations of the New York State Medicaid program. For example, the Medicaid program reimburses for many services not covered by the Medicare program. In such cases, the provider may submit claims for services not covered by Medicare directly to Medicaid.

The Department will continue efforts to reduce risk in this area by identifying and preventing overpayment by Medicaid on claims for dual eligible beneficiaries. For example, these efforts included criteria based manual review of providers submitting potentially duplicate claims for dually eligible beneficiaries in 2010, resulting in denial of claims from numerous providers. Findings from this ongoing review were utilized in the design, development and implementation in 2012 of eMedNY system enhancements to more efficiently deny duplicate claims for dual eligible beneficiaries through automated system edits and manual review. The risk of overpayment will be further reduced by the movement of the dual eligible population to managed care over the next several years and resulting reduction of billing to the Medicaid program.

#### **Recommendation #5:**

Follow-up with providers and billing service bureaus (including the bureau identified in this report) who routinely submit claims for Medicare coinsurance charges for services provided to dual eligible persons directly to Medicaid.

#### **Response #5:**

The Department issued billing guidance in its June 2013 Medicaid Update provider publication reminding providers and billing service bureaus that, when appropriate, Medicare must be billed prior to billing Medicaid for services provided to dual eligibles. The Department will additionally contact the specific billing service bureau identified in this audit and direct it to correct the billing procedures identified by OSC as being inappropriate, and to also furnish documentation to the Department confirming the corrective actions taken.

In response to OSC's preliminary audit report which recommended an investigation of a specific service bureau, the OMIG did open an investigation but the initial assessment determined that investigators could not prove intent to defraud the Medicaid program based on the fact that eMedNY cannot require billing service bureaus to include their unique provider identification number on claims submitted for payment since the HIPAA-compliant claim layout does not include sufficient space for both the provider's ID and its billing service bureau's ID. Since the billing agent utilizes information submitted by providers for billing, it would be difficult to distinguish fraud from errors.