

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

January 21, 2014

Mr. Brian Mason
Acting Assistant Comptroller
New York State 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 2012-S-24 entitled, "Medicaid Claims Processing Activity April 1, 2012 through September 30, 2012."

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 2012-S-24 Entitled
Medicaid Claims Processing Activity
April 1, 2012 through September 30, 2012**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2012-S-24 entitled, "Medicaid Claims Processing Activity April 1, 2012 through September 30, 2012."

Recommendation #1:

Review and recover the unresolved overpayments (totaling at least \$36,692) on the 12 claims with excessive charges for coinsurance and copayments.

Response #1

The Office of the Medicaid Inspector General's (OMIG's) recovery audit contractor (RAC) has identified recoveries amounting to \$8,463. The OMIG will send out collection notices for the remaining \$28,229.

Recommendation #2:

Formally advise the providers identified in our audit how to verify current Medicare and other insurance eligibility and how to accurately bill recipients' financial obligations. As resources and priorities permit, monitor the submissions of such claims by these providers.

Response #2:

Computer Science Corporation (CSC) was notified on December 19, 2013 to contact the six providers identified in the Office of the State Comptroller (OSC) audit that failed to verify Medicare eligibility and instruct them on how to access the eMedNY System to confirm patients' Medicare status once the list of providers has been obtained from the OSC. Where feasible, the OMIG may monitor the submission of claims by these providers.

Recommendation #3:

Formally advise the hospitals in question to ensure that alternate (lower) level of care (ALC) days are accurately reported on claims.

Response #3:

The OSC states in their audit finding that the providers corrected their ALC days on the claim. In addition, the Department issued a Medicaid Update article in May 2013.

Recommendation #4:

Review and recover the overpayments totaling \$338,950 on the 2,411 dental claims.

Response #4:

OSC provided OMIG with a file of claims to support OSC's findings. Analysis of this file by the OMIG resulted in total recovery of \$423,497.

Recommendation #5:

Assess eMedNY functionality that precludes line by line manual pricing adjustments for errant dental claims. Correct the eMedNY system as necessary to permit such adjustments.

Response #5:

The Department evaluated the current eMedNY functionality. It was determined that the eMedNY edit system allows for procedure codes to pend for manual review. This provides for a review of each line of the claim for which pricing is required. The reviewer is able to allow and price (pay) or deny these specific lines. The system does not allow for the adjustment of auto adjudicated lines however. For these claims where the reviewer determines an auto adjudicated line determination is appropriate, the entire claim is denied. This results in communication between the dental office and the Department who then provides guidance for the accurate submission of the claim in question.

The Department has also recently appointed a supervisor to the Pended Claims Unit who is providing direct oversight to the review staff and is currently assessing and adding new edits.

Due to other Department priorities (Medicaid Redesign Team (MRT) projects, Federal mandates and the need for extensive systems modifications and enhancements to accommodate interface with the New York Health Exchange), a potential solution will be addressed upon the procurement of the new Medicaid fiscal agent and claims processing system. At this time, the feasibility of manually reviewing/adjusting auto adjudicated claim lines, rather than the entire claim, will be re-evaluated.

Recommendation #6:

Follow-up with this provider to ensure it completes its proposed update of internal procedures for assigning patient status codes.

Response #6:

Social Services Law 363-d and Social Service regulation Part 521 requires Medicaid providers to adopt and implement effective compliance programs when a substantial portion of their business operation is Medicaid. A provider's compliance plan must include a system for identification of compliance risk and self-evaluation of potential risk areas. This includes internal and external audits and evaluation of actual non-compliance as a result of such self-evaluations and audits. The compliance program must also include a system for taking corrective action. We will follow up with the provider to ensure they have taken corrective action.

Recommendation #7:

Formally advise the four providers in question to ensure the diagnosis and procedure codes applied to their claims are correct.

Response #7:

The OSC identified four providers who entered incorrect procedure and diagnosis codes on their Medicaid claim which resulted in an overpayment. The OSC states in their audit finding that all of the overpayments were recovered.

Recommendation #8:

Follow-up and recover the \$102,835 from the 174 claims which should be corrected. Resolve the potential overpayments on the other seven claim payments (totaling \$28,291) and recover funds where appropriate.

Response #8:

One hundred sixty six claims from two providers were already self-disclosed to the OMIG. These providers are currently on abeyance which will affect review and recovery of overpayments.

Recommendation #9:

Confirm that the four providers have taken corrective actions to prevent overpayments on physician-administered drugs. Formally remind the remaining 16 providers of the correct way to bill claims for physician-administered drugs and advise the providers to take corrective actions to prevent overpayments. As resources and priorities permit, monitor the submissions of such claims by these providers.

Response #9:

All of the providers identified in the OSC audit were notified by the OSC of the potential overpayments. According to the OSC audit, each of the providers acknowledged the billing problems and indicated they were taking corrective action to prevent future overpayments.

In addition, a Medicaid Update article was published in June 2013 reminding providers that they are required to bill acquisition costs by invoice for physician administered drugs. Where feasible, the OMIG may monitor the submission of claims by the providers.

Recommendation #10:

Formally remind the six providers how to properly bill the procedures in question.

Response #10:

The OSC identified six different providers who provided incorrect procedure code information on their clinic ambulatory patient group (APG) claim. In each instance, the OSC notified the provider of the incorrect billing and the provider took corrective action by correcting the errors and submitting claim adjustments. The corrective action taken by each of the providers indicates that the providers are aware of the billing errors they previously committed and are now cognizant of the correct way to bill for the services in question. No additional billing instructions are indicated at this time.

Recommendation #11:

Review and recover the overpayments totaling \$1,594 resulting from the three improper claims for private duty nursing service.

Response #11

The OMIG will review these payments and initiate recovery as appropriate.

Recommendation #12:

Formally remind the providers in question how to correctly bill Medicaid when there are overlapping services for the same recipient on the same day.

Response #12:

Since the list of providers was obtained from the OSC, CSC was contacted on December 19, 2013 and asked to contact the three hospital providers noted in the report to provide appropriate reminders, notifications, education and/or instructions on the billing matters specified for each of the related finding areas.

The private duty nursing service was notified in a July 29, 2013 letter how to correctly bill Medicaid when there are overlapping services for the same recipient on the same day.

Recommendation #13:

Review and recover the unresolved overpayments totaling \$17,440 on the 28 transportation claims we identified.

Response #13:

The OMIG is currently working on implementing a process to collect and or void claims for repayment.

Recommendation #14:

Review and recover the unresolved overpayments totaling \$8,209 on the 56 eye care claims.

Response #14:

The OMIG will review these payments and initiate recovery as appropriate.

Recommendation #15:

Formally instruct the 20 providers how to properly bill claims for eye care services they provide to recipients who also have Medicare coverage. Also, advise the five providers who use billing agents that providers are responsible for the accuracy of claims submitted on their behalf to Medicaid.

Response #15:

All Medicare/Medicaid crossover claims submitted by the eye care providers identified in the OSC audit report are now on pre-payment review to insure the accuracy of their claims.

Recommendation #16:

Review and recover the unresolved overpayment of \$1,333.

Response # 16

The OMIG has referred the claim to the RAC for recovery. However, the provider has remained unresponsive. The OMIG will send a collection notice to the provider.

Recommendation #17:

Formally remind the providers in question of the requirements to correctly report recipient liabilities and to verify Medicare eligibility prior to billing Medicaid.

Response #17:

After the list of providers was obtained from the OSC, the Department notified CSC on December 19, 2013 and asked them to contact the nursing homes identified in the OSC audit that failed to verify Medicare eligibility and instruct them on how to access eMedNY to confirm patients' Medicare status.

Recommendation #18:

Review and recover the \$4,610 in Medicaid payments for the person who resides in Massachusetts.

Response #18:

Since the individual was enrolled in New York State Medicaid at the time of service, no recoveries can be made.

Recommendation #19:

For the person in question, contact Human Resources Administration officials and resolve the recipient's Medicaid eligibility status, as appropriate.

Response #19:

The Department verified the consumer has an out of state address. The Medicaid case was closed on April 26, 2013.