



New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Medicaid Claims Processing Activity April 1, 2013 Through September 30, 2013

Medicaid Program Department of Health



Executive Summary

Purpose

To determine whether the Department of Health's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to the providers. The audit covered the period April 1, 2013 through September 30, 2013.

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 it generates payments to reimburse the providers for their claims. During the six-month period ended September 30, 2013, eMedNY processed about 188 million claims, resulting in payments to providers of about \$25 billion. The claims are processed and paid in weekly cycles, which averaged about 7.2 million claims and \$964 million in payments to providers.

Key Findings

Auditors identified over \$5.6 million in inappropriate or questionable Medicaid payments, including:

- \$1,822,467 in payments for pharmacy claims that posed patient safety concerns or were not in compliance with regulations and policies necessary for payment of the claims;
- \$1,826,725 in overpayments for inpatient claims that providers billed at higher levels of care than what was actually provided;
- \$1,005,176 in overpayments for claims billed with incorrect information pertaining to recipients' other health insurance coverage;
- \$666,992 in overpayments for claims involving other insurance adjustment amounts that eMedNY incorrectly processed; and
- Claims with improper payments for hospital services, duplicate billings, and physician-administered drugs.

By the end of the audit fieldwork, auditors recovered about \$2.3 million of the overpayments identified.

Auditors also identified providers in the Medicaid program who were charged with or found guilty of crimes that violate health care programs' laws or regulations. The Department terminated 18 of the providers we identified, but the status of six other providers was still under review.

Key Recommendations

- We made 15 recommendations to the Department to recover the remaining inappropriate Medicaid payments and improve claim processing and monitoring controls.

Other Related Audits/Reports of Interest

[Department of Health: Medicaid Claims Processing Activity April 1, 2012 Through September 30, 2012 \(2012-S-24\)](#)

[Department of Health: Medicaid Claims Processing Activity October 1, 2012 Through March 31, 2013 \(2012-S-131\)](#)

State of New York
Office of the State Comptroller

Division of State Government Accountability

February 5, 2015

Howard A. Zucker, M.D., J.D.
Acting Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Zucker:

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 Medicaid program entitled *Medicaid Claims Processing Activity April 1, 2013 Through September 30, 2013*. 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

Table of Contents

Background	6
Audit Findings and Recommendations	7
Improper Payments for Pharmacy Claims	7
Recommendations	9
Alternate Level of Care Claims	9
Recommendation	10
Other Insurance on Medicaid Claims	10
Recommendation	11
Incorrect eMedNY Claim Adjustment Reason Code Mapping	11
Recommendation	11
Inaccurate Patient Status Codes	11
Recommendation	12
Duplicate Billings	12
Recommendation	12
Physician-Administered Drugs	12
Recommendations	13
Other Improper Claim Payments	14

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Recommendations	16
Status of Providers Who Abuse the Program	16
Recommendations	16
Audit Scope and Methodology	17
Authority	17
Reporting Requirements	18
Contributors to This Report	19
Agency Comments	20

Background

The New York State Medicaid program is a federal, State, and locally funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. In State Fiscal Year 2013-14, the federal government funded about 49.25 percent of New York's Medicaid claim costs; the State funded about 33.25 percent; and the localities (the City of New York and counties) funded the remaining 17.5 percent.

The Department of Health's (Department) Office of Health Insurance Programs 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 September 30, 2013, eMedNY processed about 188 million claims, resulting in payments to providers of about \$25 billion. The claims are processed and paid in weekly cycles, which averaged about 7.2 million claims and \$964 million in payments to providers.

When Medicaid claims are processed by eMedNY, they are subject to various automated edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate. For example, some edits verify the eligibility of the Medicaid recipient, other edits verify the eligibility of the medical service, and other edits verify the appropriateness of the amount billed for the service. In addition, some edits compare the claim with other related claims to determine whether any of the claims duplicate one another.

The Office of the State Comptroller performs audit steps during each weekly cycle of eMedNY processing to determine whether eMedNY has reasonably ensured the Medicaid claims were processed in accordance with requirements, the providers submitting the claims were approved for participation in the Medicaid program, and the amounts paid to the providers were correct. As audit exceptions are identified during the weekly cycle, our auditors work with Department staff to resolve the exceptions in a timely manner so 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 the Comptroller's audit responsibilities. Such follow-up and analytical audit procedures are designed to meet the Comptroller's constitutional and statutory requirements to audit all State expenditures.

Audit Findings and Recommendations

Based on the results of our audit work for the weekly cycles of Medicaid payments made during the six months ended September 30, 2013, we concluded eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to the providers. In addition, we identified the need for improvements in the processing of certain types of claims. We found over \$5.6 million in inappropriate or questionable Medicaid payments pertaining to: pharmacy claims that posed patient safety concerns or were not in compliance with policies necessary for payment of the claims; inpatient claims that were billed at a higher level of care than what was actually provided; claims involving other insurance information that was inaccurate and incorrectly processed by eMedNY; claims with improper charges for physician-administered drugs; and improper hospital and other claims.

At the time the audit fieldwork concluded, about \$2.3 million of the overpayments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments (totaling nearly \$3.4 million), recover funds as warranted, and improve certain eMedNY claim processing controls.

Improper Payments for Pharmacy Claims

Medicaid pays pharmacies for drugs that are dispensed and billed in compliance with various New York State laws, rules, regulations, and Medicaid policies, including but not limited to: Article 1 of the Public Health Law, Article 137 of the Education Law, Title 10 and Title 18 of the New York Codes, Rules and Regulations (NYCRR), and the NYS Medicaid Program Pharmacy Manual Policy Guidelines.

Medicaid paid 21 pharmacies \$1,822,467 on 49 pharmacy claims that, according to the billing records and other documentation, posed safety concerns to the patients or were not in compliance with the various regulations and policies that would allow payment of the claims. The following table summarizes the audit findings by category.

Patient Safety Concerns	Number of Claims	Medicaid Payment
Patient Is Allergic to Medication Dispensed – according to the pharmacy’s records, the patient is allergic to the drug	2	\$197,217
Dispensing Label Directions Conflict With Prescription Directions	7	\$167,386
Medication Therapy Is Contraindicated – the claim was for a drug that had adverse effects with another drug the patient was taking*	1	\$20,079
Subtotals	10	\$384,682
Non-Compliance With Laws, Rules, Regulations and Policies	Number of Claims	Medicaid Payment
Invalid Faxed Prescription – faxed prescription doesn’t contain the source fax number and/or is not on the Official NYS Prescription Form)**	28	\$1,040,104
Incorrect Quantity Billed and Pharmacy Could Not Provide Invoices Substantiating the Drugs Claimed***	4	\$166,454
Pharmacy Billed for Refills That Were Not Authorized by the Prescriber	2	\$113,268
Pharmacy Billed in Excess of Dispensed Quantity	3	\$81,249
Printed Name of Prescriber Missing on Prescription	2	\$36,710
Subtotals	39	\$1,437,785
Totals	49	\$1,822,467

The following illustrates some of the exceptions we identified in the table above:

*A claim payment of \$20,079 was for a drug that was contraindicated with another drug the patient was taking. Although the claim was originally denied because of the severe interaction, the pharmacy overrode the rejection and processed the claim. According to pharmacy officials, they contacted the prescriber’s office, which confirmed that it was proper to fill the prescription. However, when we inquired with the prescriber, she stated that she would have discontinued one of the conflicting medications if the pharmacy had asked her about the interaction.

**The Medicaid pharmacy policies state, “All orders received by the pharmacy as a fax must be on the Official New York State Prescription Form.” In addition, the policies state, “A faxed order must originate from a secure and unblocked fax number. The source fax number must be clearly visible on the fax that is received.” We identified 28 claims that paid \$1,040,104 where the prescription was faxed to the pharmacy but there was no source fax number. In addition, 18 of the 28 claims’ source documentation was not an Official New York State Prescription Form. Further, one of the claims reported a prescribing doctor’s name that did not match the prescriber’s name on the prescription provided to us as supporting documentation for the claim.

***Pharmacy officials acknowledged the quantities billed on the claims were incorrect; also, the pharmacy could only provide invoices to substantiate 62,961 of the 114,000 medication units billed on three of the claims.

In response to the audit findings, Department officials stated the Office of the Medicaid Inspector General (OMIG) would review the \$1.8 million in paid claims and recover any overpayments as appropriate. Also, at the time our fieldwork concluded, one claim (for which the dispensing label directions conflicted with the prescription directions) had been voided, saving Medicaid \$20,079; and two pharmacies (that billed quantities in excess of the amounts actually dispensed) adjusted two claims, saving Medicaid \$12,721. Thus, actions were still required to review and recover the remaining \$1,789,667 (\$1,822,467 - \$20,079 - \$12,721) in improper payments we identified.

Recommendations

1. Review the remaining \$1,789,667 in payments and recover any overpayments as appropriate.
2. Formally instruct the pharmacies in question to ensure Medicaid claims are accurately billed and dispensed in accordance with existing requirements.
3. With regard to the items detailed in the table, determine whether the identified providers should be referred to the State Education Department's Office of the Professions for a review of their professional conduct (or potential misconduct).

Alternate Level of Care Claims

According to the Department's Medicaid Inpatient Policy Guidelines, hospitals must report certain information on claims, which indicates the level of care, to ensure accurate processing and payment. Certain levels of care are more intensive (and therefore more costly) than others. Department guidelines prohibit hospitals from billing for intensive levels of care for days when patients are in an alternate (lower) level of care (ALC) setting. However, we identified \$1,826,725 in overpayments on claims for inpatient stays that Medicaid overpaid because providers billed at a higher level of care than what was actually provided.

Medicaid pays inpatient claims using two reimbursement methods: All Patient Refined-Diagnosis Related Groups (or APR-DRG, which covers all the care necessary for the conditions being treated during a patient's episode of care - for instance, from admission to discharge) and DRG-exempt per diem (daily) rates. When we analyzed APR-DRG claims, we identified \$292,146 in overpayments on two claims because providers failed to declare ALC days. For example, one claim paid \$282,214 for 305 days of acute psychiatric care. At our request, the provider reviewed and corrected the claim based on a physician's order for lower-cost ALC for the patient. This reduced the amount of acute psychiatric care claimed by 248 days (or to 57 days). The adjusted claim paid \$117,960, resulting in a savings to Medicaid of \$164,254. We asked the second provider to review the remaining APR-DRG claim, and the provider also identified ALC days which were not reported on the original claim. The claim was corrected, resulting in a savings of \$127,892.

We also tested payments based on DRG-exempt per diem (daily) rates and identified overpayments of \$1,534,579 on 101 claims. Although the providers indicated some of the days claimed were for ALC, the providers billed (and eMedNY paid) them at higher-paying acute care rates. Effective

March 2014, the Department implemented eMedNY controls to prevent payment of DRG-exempt per diem claims at excessive rates (for acute and other non-ALC care) when ALC is indicated on a claim. Prior to our audit, eMedNY did not recognize “provider indicated” ALC days on DRG-exempt per diem claims. We, therefore, expanded our review of such claims.

Our review identified claims with patient admission dates on or after January 1, 2008 that were billed to one of three acute care per diem rate codes: codes 2853 and 2948 (for rehabilitation care) and code 2852 (for psychiatric care). We then analyzed claims that had ALC indicators sometime during the dates of service. We identified and reviewed 101 claims that paid approximately \$4.58 million. We applied the correct reimbursement rates to the 101 claims’ ALC days and determined they were overpaid by \$1,534,579. At our request, one provider reviewed and corrected one claim, which saved Medicaid \$79,602. The remaining 100 claims, with estimated overpayments totaling \$1,454,977, had not been adjusted at the time our fieldwork concluded.

Recommendation

4. Recover the \$1,454,977 in overpayments from the DRG-exempt per diem claims.

Other Insurance on Medicaid Claims

Many Medicaid recipients also have other health insurance coverage (mostly Medicare). When submitting Medicaid claims, providers must verify that such recipients have other insurance coverage on the dates of the services in question. If the individual has other insurance coverage, that insurer becomes the primary insurer and must be billed first. Medicaid then becomes the secondary insurer and generally covers the patient’s normal financial obligation, including coinsurance, copayments, and deductibles. If the recipient or the medical service is not covered by any other insurer, Medicaid is the primary insurer and should be billed first.

Errors in the amounts claimed for coinsurance, copayments, deductibles, and/or designation of the primary payer will likely result in improper Medicaid payments. We identified such errors on 49 claims that resulted in improper payments totaling \$1,005,176. Specifically, we identified overpayments totaling \$286,315 on 34 claims (for which Medicaid paid \$298,547) that resulted from excessive charges for coinsurance and copayments for recipients covered by other insurance. We contacted the providers and as a result of our inquiry, they adjusted 24 of the 34 claims, saving Medicaid \$248,203. Six providers, however, still needed to adjust 10 claims that were overpaid by \$38,112.

We also identified 15 claims (totaling Medicaid payments of \$832,928) in which Medicaid was incorrectly designated as the primary payer, when the primary payer was actually another insurer. Generally, primary payers pay more than secondary payers. We contacted the providers and advised them that the recipients had other insurance coverage when the services were provided and, therefore, Medicaid was incorrectly designated as the primary payer. At the time our audit fieldwork concluded, providers adjusted nine of the 15 claims, saving Medicaid \$666,061. Five providers, however, still needed to adjust six claims that were overpaid by \$52,800.

Recommendation

5. Review and recover the unresolved overpayments totaling \$90,912 (\$38,112 + \$52,800) on the 16 incorrect claims.

Incorrect eMedNY Claim Adjustment Reason Code Mapping

Other insurance providers, such as Medicare, use Claim Adjustment Reason Codes (CARC) to inform providers why a claim was denied or paid differently than it was billed. (For example, CARC 209 means that per regulatory or other agreement, the provider cannot collect the amount in question from the patient.) When providers bill Medicaid for patients' remaining financial obligations, they are required to report CARCs as well as group codes (which further describe adjustment amounts) on their claims. The CARCs and group codes are essential for Medicaid to determine whether a billed service should be paid, as well as the correct payment amount on the claim.

eMedNY interprets and "maps" a claim's CARC and group codes to take certain actions (e.g., to pay or to not pay). Correct mapping of the codes is necessary to ensure the claims are paid appropriately. For example, a claim containing a CARC code of 209 and a group code that designates the claim amount as "OA - Other Adjustment" should not be mapped to pay the adjustment amount.

However, we identified 1,044 claims totaling overpayments of \$660,741 involving a CARC code of 209 and a group code of OA that were incorrectly mapped to pay the claims. Due to the high risk of overpayment on other claims that contained the identified code combinations, we immediately notified the Department of the incorrect CARC/group code mapping. Department officials reviewed the mappings and corrected the eMedNY system in January 2014. At the time our audit fieldwork ended, the Department reprocessed and providers adjusted 1,648 claims (including the claims we identified), resulting in recoveries totaling \$666,992.

Recommendation

6. Determine whether additional unresolved CARC-related overpayments exist. If so, reprocess and correct them, and recover any overpayments identified.

Inaccurate Patient Status Codes

When a hospital bills Medicaid, it must include a patient status code, which indicates whether the patient was discharged or transferred to another health care facility. The patient status code is important because the reimbursement method (and amount) depends on whether a patient is discharged or transferred. When a patient is discharged, institutional medical treatment is ostensibly complete. When a patient is transferred, medical treatment has not been completed. Hence, a transfer claim often pays less (and sometimes significantly less) than a discharge claim.

We identified three inpatient claims (totaling payments of \$230,890) that contained incorrect patient status codes. Although the hospitals transferred the recipients to other health care facilities, the hospitals applied a discharge code (instead of a transfer code) to the claim. At our request, the hospitals reviewed and corrected their claims, reducing their payments to \$104,012, which realized a Medicaid savings of \$126,878 (\$230,890 - \$104,012).

In May 2013, the Department issued guidance to hospitals on the importance of recording the appropriate billing patient status codes on inpatient claims.

Recommendation

7. Formally remind the providers in question to properly record patient status codes on their inpatient service claims.

Duplicate Billings

Medicaid overpaid nine providers a total of \$115,865 on 56 claims (which originally paid \$188,159) because the providers billed for certain services more than once. The duplicate payments occurred under several scenarios, as follows:

- Three providers billed for Comprehensive Psychiatric Emergency Program (CPEP) evaluations multiple times during the same encounter, even though the evaluation is allowed only once per encounter. The resulting overpayments totaled \$79,004 on 46 claims.
- Four providers billed the same physician-administered drug twice on the same claim. The resulting overpayments totaled \$25,826 on eight claims.
- Two providers billed twice for the same service on two claims, resulting in overpayments of \$11,035.

The nine providers acknowledged their errors and corrected the overpaid claims, saving Medicaid \$115,865 (\$79,004 + \$25,826 + \$11,035).

Recommendation

8. Formally instruct the nine providers how to properly bill the types of procedures in question.

Physician-Administered Drugs

Medicaid requires providers to bill physician-administered drugs at their acquisition costs, including any discounts given by the drugs' manufacturers. To pay a claim for a physician-administered drug, eMedNY compares the drug's acquisition cost (as indicated by the provider) with the maximum allowable Medicaid fee and pays the lesser of the two amounts. Typically, a provider's drug acquisition cost is less than the maximum allowable Medicaid fee. Thus, when a provider overstates the acquisition cost of a physician-administered drug, there is a considerable

risk that Medicaid will overpay the claim.

From 27 claim payments totaling \$164,083, we identified overpayments totaling \$43,048 made to 14 providers of physician-administered drugs. On these claims, the providers billed amounts well in excess of the drugs' actual acquisition costs, which also were generally less than the maximum Medicaid fee amounts. For example, one provider submitted a claim for \$13,305 to administer one drug to a recipient. Based on Medicaid's maximum allowable fees, eMedNY paid \$6,431 on this claim. At our request, the provider reviewed their invoices and reported that the actual acquisition cost for the drug totaled only \$2,841. The provider corrected this claim, saving Medicaid \$3,590 (\$6,431 - \$2,841).

At the time our audit fieldwork ended, providers corrected 11 of the 27 claims, saving Medicaid \$17,482. In addition, we anticipate that another seven claims will be corrected, saving another \$15,427. Also, we identified apparent overpayments on nine other claims totaling \$10,139. At the time our fieldwork concluded, provider actions (including the provision of supporting documentation) were still needed to resolve these questionable claims.

Most providers cited problems with their billing systems as the reason for the improper claims. One provider was already aware of the problems and had been working to correct its billing system. Other providers attributed overcharges to human errors. No matter the reason, overpayments occur when providers overstate their actual drug acquisition costs on claims for physician-administered drugs. We identified similar errors in prior audit reports. In fact, eight of the 14 providers cited in this report were cited for the same problem in prior reports.

In response to our findings, the Department now requires the top paid providers (including four with excessive claims noted in this report) of physician-administered (J-code) drug claims to submit their claims with invoices attached. Also, in July 2014 the Department strengthened eMedNY claim processing controls to deny claims with unreasonably high acquisition costs.

Recommendations

9. Follow up on and recover the \$15,427 from the seven claims which should be corrected. Resolve the potential overpayments on the other nine claim payments (totaling \$10,139) and recover funds where appropriate.
10. Ensure the eight previously cited providers take sufficient corrective actions to prevent excessive future claims for physician-administered drugs. Formally instruct the remaining six providers of the correct way to bill claims for physician-administered drugs and advise the providers to take corrective actions to prevent overpayments.
11. As resources and priorities permit, actively monitor claims for physician-administered drugs submitted by higher-risk providers.

Other Improper Claim Payments

We identified \$24,374 in improper payments resulting from excessive charges related to nursing home claims, dental claims, inpatient claims, vision care, and transportation claims. At the time our audit fieldwork concluded, \$14,400 of the improper payments had been recovered. However, actions were still needed to address the balance of the improper payments totaling \$9,974 (\$24,374 - \$14,400).

Nursing Home Services

Medicaid recipients with income from Social Security, pensions, or other sources are required to pay for some of the cost of their nursing home care. The amount they pay is net available monthly income, or NAMI. NAMI is deducted from the amount that Medicaid pays each month to nursing homes. Further, nursing home providers are required to accurately bill for days recipients are in their care.

Medicaid overpaid three providers a total of \$7,973 on four claims (for which Medicaid originally paid \$67,083) because the providers either failed to deduct the amount of the patient's NAMI liability from the claim or overbilled for days a recipient was not in their care. Of the four improper claims, three occurred because two providers underreported the amounts of recipients' NAMI liabilities for their care. As a result of the audit, both providers corrected the three claims, saving Medicaid \$5,463. The third provider overbilled for two days of care when the recipient was an inpatient at a hospital. The provider acknowledged the error and corrected the claim, saving Medicaid \$2,510.

Dental Services

Medicaid overpaid providers \$7,910 on seven claims for dental services. The overpayments occurred under two different scenarios, as follows:

- Four providers were overpaid \$5,971 on four claims because they submitted them outside of the claim submission time period allowed by the Department. Each provider submitted the late claim using a delay reason code that did not match the actual cause of the delay. As a result, they do not appear to be valid for payment per Medicaid policy.
- Three providers were overpaid \$1,939 on three claims because they billed Medicaid for services that were not supported by patient records. When questioned, the providers stated they were billing errors. Two providers voided two of the claims, saving Medicaid \$1,466. The remaining provider acknowledged the error, but did not adjust the remaining claim that was overpaid by \$473.

At the time the audit fieldwork concluded, adjustments were needed for the remaining five claims, totaling overpayments of \$6,444 (\$5,971 + \$473).

Transfers Between Merged Facilities

Medicaid pays certain inpatient claims based on the APR-DRG reimbursement methodology. APR-DRG reimbursement covers all the care necessary for the condition(s) being treated during a patient's episode of care - for instance, from admission to discharge. According to regulations, patient transfers among certain hospitals or inpatient divisions that are part of a merged or consolidated entity shall be reimbursed as if the hospital that first admitted the patient had also discharged the patient. In other words, only one APR-DRG payment is made for the entire episode of care; separate payments shall not be made to the admitting facility and the subsequent treating facility because that can result in overpayments.

We identified two inpatient claims for a patient who had been transferred between two facilities that are within the same entity. Despite both providers having the same name and Medicaid entity number, each claim contained (1) a different physical location of where the services were provided and (2) a different Medicaid billing provider number. The patient's principal diagnosis was the same on each claim.

Each claim was paid a full APR-DRG for the patient's treatment. Based on the procedure and diagnosis codes, it appeared that the patient's condition worsened during the stay at the first facility, requiring transfer to another facility within the same entity. Hospital officials acknowledged that claims such as these are usually combined as one. The provider voided the first claim, resulting in a savings of \$4,730.

Vision Care

Although Medicaid pays for routine vision services (such as eyeglasses and routine eye exams), Medicare generally does not. Consequently, for recipients enrolled in both Medicaid and Medicare, providers should receive no more than the Medicaid program's standard fee amounts when submitting claims for routine vision services. If Medicare does cover a service, Medicaid is then the secondary insurer and will generally cover the recipient's normal financial obligation, including coinsurance, copayments, and deductibles. In all cases, providers must correctly report the recipient's financial obligation amount. Providers are also required to keep detailed records of the services provided to Medicaid recipients.

We identified overpayments totaling \$2,728 on 27 claims. The overpayments occurred under two different scenarios, as follows:

- Providers improperly reported recipients' financial obligation amounts on 12 claims, resulting in improper payments totaling \$1,669; and
- Providers did not supply supporting documentation of the services provided, resulting in potential overpayments totaling \$1,059 on 15 claims. For example, one provider did not respond to our written request for supporting records for a claim that paid \$284. Another provider did not supply records to support a claim for an exam of a "new" patient. The provider had previously billed for services provided to that patient.

At the time our audit fieldwork concluded, one provider corrected one claim (saving Medicaid \$231) and adjustments were still needed on the remaining 26 claims, with overpayments totaling \$2,497.

Transportation Services

Medicaid will pay the actual mileage to transport a recipient to and from the location where covered services are provided. One provider reported incorrect mileage on a claim that paid \$3,112 for a one-way emergency transport by helicopter. The mileage reported on the claim was 68 miles, yet the patient was only transported 41 miles. The provider was overpaid \$1,033 for the additional 27 miles that were billed to Medicaid. At the time our fieldwork concluded, the claim had not been adjusted.

Recommendations

12. Review and recover the unresolved overpayments totaling \$9,974 (\$6,444 in dental services + \$2,497 in vision services + \$1,033 in transportation services).
13. Formally instruct the providers in question to ensure Medicaid claims are accurately billed.

Status of Providers Who Abuse the Program

If a Medicaid provider has violated statutory or regulatory requirements related to the Medicaid or Medicare programs (or has engaged in other unacceptable insurance practices), the Department can impose sanctions on the provider. These sanctions can range from excluding the provider from the Medicaid program to imposing participation requirements, such as requiring all claims to be reviewed manually before payment. If no action is taken, the provider remains active to treat Medicaid patients, perhaps placing recipients at risk of poor-quality care while the provider receives Medicaid payments.

We identified 29 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. Of the 29 providers, 25 had an active status in the Medicaid program. The other four providers had an inactive status (i.e., two or more years of no claims activity and, therefore, they would be required to seek re-instatement from Medicaid to submit new claims). We advised Department officials of the 29 providers and the Department terminated 18 of them from the Medicaid program. Prior to program termination, Medicaid paid two (of the 18) providers a total of \$75,576. Also, the Department determined five of the 29 providers should not be terminated. At the time our audit fieldwork ended, the Department had not resolved the program status of the six remaining providers.

Recommendations

14. Determine the status of the six remaining providers with respect to their future participation in the Medicaid program.

15. Investigate the propriety of the payments (totaling \$75,576) made to the two providers who violated Medicaid laws or regulations. Recover any improper payments, as appropriate.

Audit Scope and Methodology

We audited selected Medicaid claims processed by the Department to determine whether the Department's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to the providers. The scope of our audit was from April 1, 2013 through September 30, 2013. Additionally, claims and transactions outside of the audit scope period were examined in instances where we observed a pattern of problems and high risk of overpayment.

To accomplish our audit objectives and to determine whether internal controls were adequate and functioning as intended, 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 the Medicaid Inspector General. 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.

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.

Reporting Requirements

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 them in their entirety at the end of it. In their response, Department officials generally concurred with our recommendations and indicated that certain actions have been and will be taken to address 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 why.

Contributors to This Report

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

NEW YORK
state department of
HEALTH

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

December 18, 2014

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2013-S-12 entitled, "Medicaid Claims Processing Activity April 1, 2013 through September 30, 2013."

Thank you for the opportunity to comment.

Sincerely,



Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
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**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2013-S-12 entitled
Medicaid Claims Processing Activity April 1, 2013 Through
September 30, 2013**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2013-S-12 entitled, "Medicaid Claims Processing Activity April 1, 2013 Through September 30, 2013."

Background

New York State is a national leader in its oversight of the Medicaid Program. Through the efforts of the Department and the Office of the Medicaid Inspector General (OMIG), over the last five years, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. Over the last three calendar years, the administration's Medicaid enforcement efforts have recovered over \$1.73 billion, a 34 percent increase over the prior three-year period.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 840,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to \$7,929 in 2013, consistent with levels from a decade ago.

Recommendation #1

Review the remaining \$1,789,667 in payments and recover any overpayments as appropriate.

Response #1

The OMIG will review and recover the overpayments as appropriate.

Recommendation #2

Formally instruct the pharmacies in question to ensure Medicaid claims are accurately billed and dispensed in accordance with existing requirements.

Response #2

The Department agrees with the OSC recommendation and will provide Computer Sciences Corporation (CSC) Provider Services specific instructions as to the proper reporting of pharmacy claims. CSC will formally instruct those pharmacies identified in this audit report.

Recommendation #3

With regard to the items detailed in the table, determine whether the identified providers should be referred to the State Education Department's Office of the Professions for a review of their professional conduct (or potential misconduct).

Response #3

The OMIG agrees that the identified providers should be referred to the State Education Department's Office of the Professions for a review of their professional conduct (or potential misconduct).

Recommendation #4

Recover the \$1,454,977 in overpayments from the DRG-exempt per diem claims.

Response #4

The OMIG's Recovery Audit Contractor will review the overpayments identified and pursue recoveries as appropriate.

Recommendation #5

Review and recover the unresolved overpayments totaling \$90,912 (\$38,112+\$52,800) on the 16 incorrect claims.

Response #5

The OMIG's Third Party Contractor is reviewing the overpayments identified and pursuing recoveries as appropriate. To date, the OMIG's Third Party Contractor has recovered approximately \$18,000.

Recommendation #6

Determine whether additional unresolved CARC-related overpayments exist. If so, reprocess and correct them, and recover any overpayments identified.

Response #6

The Department is currently reviewing all Claims Adjustment Reason Codes for accuracy. The Department will take appropriate actions after the review is complete. The expected completion date for this review is January 1, 2015.

Recommendation #7

Formally remind the providers in question to properly record patient status codes on their inpatient service claims.

Response #7

The Department will instruct CSC Provider Services to reach out to the specific providers identified in this audit to remind them to properly record patient status codes on their inpatient claims.

Recommendation #8

Formally instruct the nine providers how to properly bill the types of procedures in question.

Response #8

During the course of the OSC audit, the Office of Mental Health (OMH) provided instruction of proper billing procedures to the three Comprehensive Psychiatric Emergency Program (CPEP) providers identified in this audit. The Department will work with OMH on formally instructing these providers and will also follow up with its request to only pay one unit per claim instead of one unit per day in the setting of the CPEP rate codes to prevent the overbilling identified by OSC.

In response to the remaining six providers identified in this audit, the Department is currently researching system options to address potential duplications. Once the causes of the duplications are reviewed and identified, the Department will reach out to CSC to provide instruction to those providers that double billed.

Recommendation #9

Follow up on and recover the \$15,943 from the 10 claims which should be corrected. Resolve the potential overpayments on the six claim payments (totaling \$9,622) and recover funds where appropriate.

Response #9

The OMIG will review and recover overpayments as appropriate.

Recommendation #10

Ensure the eight previously cited providers take sufficient corrective actions to prevent excessive future claims for physician-administered drugs. Formally instruct the remaining six providers of the correct way to bill claims for physician-administered drugs and advise the providers to take corrective actions to prevent overpayments.

Response #10

The Department submitted Evolution Project #1861 on July 24, 2014 which strengthened eMedNY controls through the use of a reasonability edit. Claims are being tracked by eMedNY that are currently set to pay and report. Once the data is collected and examined, the Department will review to ensure the edit is functioning as anticipated prior to fully implementing this edit.

Recommendation #11

As resources and priorities permit, actively monitor claims for physician-administered drugs submitted by higher-risk providers.

Response #11

The OMIG plans to conduct physician-administered J-code drug audits submitted by higher-risk providers, as part of its ongoing audit activities.

Recommendation #12

Review and recover the unresolved overpayments totaling \$9,974 (\$6,444 in dental services + \$2,497 in vision services + \$1,033 in transportation services).

Response #12

The OMIG will review and recover overpayments as appropriate.

Recommendation #13

Formally instruct the providers in question to ensure Medicaid claims are accurately billed.

Response #13

The Department will instruct CSC Provider Services to reach out to providers identified in this report to provide appropriate instruction and training for the billing issues pertaining to Medicaid recipients in nursing homes and the deduction of the monthly net available monthly income liability from the monthly amount Medicaid pays to these providers and the two transfers between merged facilities.

The Department will address those providers in the areas of Dental, Vision Care and Transportation Services in the following manner:

Dental Services – Dental providers' claims had shown either inappropriate use of delay reason codes or the providers had no documentation to support the claim. The providers are formally advised on a regular basis of the need for accurately billed Medicaid claims through enhanced instructions and Medicaid Updates.

Vision Care Services – The Department will not be providing instruction to the vision care providers as we have decided to take a stronger approach. These vision care providers have been placed on report. As a result, all Medicare crossover claims will be pended for review prior to payment.

Transportation Services - The Department, in a letter dated November 14, 2014 to the transportation provider, advised that transportation vendors must submit claims based on actual mileage incurred pursuant to Title 18 NYCRR Section 505.10 (e)(5) which states that payment to vendors will be made only where a Medicaid enrollee is actually being transported in the vehicle.

Recommendation #14

Determine the status of the six remaining providers with respect to their future participation in the Medicaid program.

Response #14

Five of the providers are still under investigation by MFCU. One provider has been excluded.

Recommendation #15

Investigate the propriety of the payments (totaling \$75,576) made to the two providers who violated Medicaid laws or regulations. Recover any improper payments, as appropriate.

Response #15

The two providers were enrolled and authorized to bill Medicaid for services at the time of billing. Therefore, there is not a violation since the billing was submitted prior to being excluded from the program.