



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Acting Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

January 16, 2015

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 Follow-Up Audit Report 2014-F-17 entitled, "Overpayments of Certain Medicare Crossover Claims" (Report 2011-S-28).

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in cursive script, reading "Sally Dreslin".

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
Follow-Up Audit Report 2014-F-17 Entitled,
Overpayments of Certain Medicare Crossover Claims**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2014-F-17 entitled, "Overpayments of Certain Medicare Crossover Claims" (Report 2011-S-28).

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

Status – Partially Implemented

Agency Action – Overpayments of \$6.9 million occurred because eMedNY incorrectly interpreted Medicare crossover claim information and, as a result, improperly paid for services that Medicare denied. The Office of the Medicaid Inspector General (OMIG) contracted with Health Management Systems (HMS) to review these claims and make recoveries. OMIG officials stated these overpayments should be recovered by May 2015. As of October 29, 2014, HMS has recovered \$52,856.

The remaining \$3.1 million in overpayments occurred because eMedNY did not properly apply New York State Medicaid reimbursement limits to electronic Medicare crossover claims for certain services. At the time of our follow-up, the OMIG was reviewing the claims and had recovered \$1,060 of overpayments.

Response #1

OSC determined that this recommendation was partially implemented. The OMIG will continue to review and recover 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.

Status - Partially Implemented

Agency Action – The Department developed eMedNY controls designed to limit payment of crossover claims submitted by group providers for professional services to 20 percent of the coinsurance charge. Department officials stated the controls are scheduled for implementation on December 18, 2014.

Response #2:

Evolution Project (EP) #1729 entitled, “Professional Claim Limitation on Medicare/Medicaid Crossovers,” was designed to limit the payment of crossover claims submitted by group providers for professional services to 20 percent of the coinsurance charge. This EP was implemented on December 18, 2014. This recommendation has now been fully implemented.

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.

Status – Partially Implemented

Agency Action – As of October 29, 2014, OMIG has recovered \$923,427. The OMIG will review the remaining potential overpayments identified and determine appropriate action.

Response #3

OSC determined that this recommendation was partially implemented. The OMIG will continue to review and recover 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.

Status – Implemented

Agency Action – Department officials have considered risks of providers submitting crossover claims directly to Medicaid. However, Department officials do not plan to automatically deny these claims because there are legitimate reasons for directly billing crossover claims to Medicaid. For example, according to the Department, Medicare and Medicaid do not always use the same procedure codes and providers would legitimately bill these services directly to Medicaid.

Alternatively, the Department has taken steps to prevent providers from billing crossover claims directly to the Medicaid program. The Department has implemented eMedNY system controls to identify potentially duplicate claims (wherein a claim is directly submitted to Medicaid by a provider and another claim, for the same service, is submitted to Medicaid through the Medicare crossover system) and pend those claims for manual review. Further, the OMIG has audit criteria in place to identify and recoup duplicate claims, as well as criteria to identify and recoup direct bill claims that should have been submitted to Medicare first, but were not. In addition, since 2011, the Department has sent letters to 5,538 providers notifying them their claims are being monitored.

Response #4:

The Department confirms our agreement with this report.

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.

Status – Partially Implemented

Agency Action – The Department has identified and followed-up with providers who repeatedly bill Medicaid directly (as noted in the agency actions regarding Recommendation #4). However, the Department had not followed-up with any billing service bureau, including the one we identified in the original report.

Response #5:

The Department followed-up with practitioners who provide services to dual eligible Medicare/Medicaid recipients in the April 2014 Medicaid Update. In addition to the publication of Medicaid Update articles on proper claim submission when Medicaid is secondary to Medicare, the Department and Computer Sciences Corporation continually engage with Medicaid providers and their billing agents (service bureaus) when inappropriate billing patterns are identified. Through the Provider on Review process (edit 01142), provider training, and both verbal and written communication, providers and their billers are educated on claims submission rules related to coding, third party billing, proper reporting of coinsurance, deductibles and payment reductions to ensure consistency with the primary payer's adjudication. Also, effective beginning December 8, 2014, the service bureau identified in this audit was excluded from the Medicaid Program by the OMIG, so no further follow-up is warranted. In light of these actions, this recommendation has now been fully implemented.