



## Department of Health

**ANDREW M. CUOMO**  
Governor

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

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

January 26, 2016

Ms. Andrea Inman, Audit Director  
Office of the State Comptroller  
Division of State Government Accountability  
110 State Street – 11<sup>th</sup> Floor  
Albany, New York 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 2015-F-20 entitled, "Medicaid Program: Overpayments of Ambulatory Patient Group Claims" (Follow Up to Report 2011-S-43).

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sally Dreslin".

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

Enclosure

cc: Michael J. Nazarko  
Robert W. LoCicero, Esq.  
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**Department of Health  
Comments on the  
Office of the State Comptroller's  
Follow-Up Audit Report 2015-F-20 entitled, Overpayments of  
Ambulatory Patient Group Claims  
(Report 2011-S-43).**

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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) Follow-Up Audit Report 2015-F-20 entitled, "Overpayments of Ambulatory Patient Group Claims" (Report 2011-S-43).

**Background**

New York State is a national leader in its oversight of the Medicaid Program. With the transition to care management, the Office of the Medicaid Inspector General (OMIG) continues to improve upon our processes and direct our resources to match this changing direction in the Medicaid program. In conjunction with the Department, NYS will continue its focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse wherever it exists.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of 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 1,405,500 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to \$7,868 in 2014, consistent with levels from a decade ago.

**Recommendation #1**

Review the 6,615 instances of improper payments (totaling \$1,204,186) and make recoveries, as appropriate.

Status - Partially Implemented

Agency Action -The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. After our initial audit, the OMIG identified additional instances of improper payments, for a total of 7,197 such instances. As of November 30, 2015, the OMIG recovered \$17,881 on 366 of the improper payments. Also, by January 2016, the OMIG will initiate recoupments from 20 Medicaid providers who account for 74 percent of the problematic claims. The OMIG will instruct the providers to take certain corrective steps, including voiding and adjusting the problematic claims. Once the corrective steps are taken, the OMIG will determine the net overpayment on the instances of improper payments identified. OMIG officials informed us they will continue to review the improper payments identified in the initial audit report and make additional recoveries.

**Response #1**

OMIG has prepared an audit to recoup overpayments related to these inappropriate same day APG rate combinations, which consists of 7,197 instances. The draft audit letters were mailed on 12/21/15 to 30 providers, representing 75% of the total claims in the entire project. Of the remaining 25%, 7% could not be pursued, due to an ongoing investigation by the New York State

Attorney General's Office. The remaining 18% is spread across 146 providers, and would not be cost effective to pursue. This audit will require the provider to void one claim and adjust the other claim, using the "Ninety-Day Two-Year Code of 11", to include the procedure codes listed on the voided claim. The claim will then have to be re-priced through the APG Grouper Process. Once the provider voids and adjusts the claims, OMIG will track the void/adjustment, and determine the overpayment by adding the original two claims and subtracting the amount of the reprocessed claim.

OMIG will monitor compliance, via the Medicaid Data Warehouse (MDW) analysis, to ensure that one of the claims for each pair has been voided. The actual recoupment amount cannot be determined until all claims have been reprocessed.

### **Recommendation #2**

Design and implement eMedNY system edits which prevent the improper payments we identified.

Status –Implemented

Agency Action - In January 2014, the Department implemented eMedNY edits designed to prevent the improper payments that were identified during the initial audit. The initial audit found that providers billed prohibited combinations of APG reimbursement codes, which led to improper Medicaid payments. In certain instances, the eMedNY system erroneously paid the improper claims because of the order in which providers billed the improper rate code combinations. The new edits for the APG reimbursement system are programmed to deny payment for claims containing the prohibited rate code combinations, regardless of the order in which the rate codes are billed.

### **Response #2**

The Department confirms our agreement with this report.

### **Recommendation #3**

Review the 8,819 duplicate payments (totaling \$933,399) and make recoveries, as appropriate.

Status - Implemented

Agency Action - The Department reviewed the 8,819 duplicate payments and recovered \$879,825. In the initial audit, it was determined that providers received duplicate payments because providers were able to bill both the pre-existing non-APG rate codes as well as the new APG rate codes for the same service to the same recipient on the same date. In response to our audit, the Department reviewed the duplicate payments we identified and, by December 2013, set the non-APG rate codes billed on the claims to pay zero dollars on a retroactive basis. By doing so, the Department recovered \$879,825. Also, we determined that most of the remaining payments (totaling \$53,574) related to third party co-insurance and co-payments and, for various reasons, might not be recoverable.

**Response #3:**

The Department confirms our agreement with this report.

**Recommendation #4**

Complete the deactivation of pre-APG rate codes providers use to submit claims.

Status - Implemented

Agency Action - During December 2013, the Department completed the deactivation of the pre-APG rate codes that providers used to submit claims. The deactivation of pre-APG rate codes prevents Medicaid from making inappropriate duplicate payments to providers who submit claims under both the pre-APG and APG reimbursement methodologies.

**Response #4**

The Department confirms our agreement with this report.

**Recommendation #5**

Using the APG methodology, promptly reprocess the 56,241 claims that were processed using pre-APG rate codes.

Status - Implemented

Agency Action - To mitigate the risk of duplicate Medicaid payments, the Department completed the deactivation of pre-APG rate codes (as noted in the agency's action to Recommendation No. 4). Further, as part of this process, the Department reprocessed the 56,241 claims in question.

**Response #5**

The Department confirms our agreement with this report.