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

Division of State Government Accountability

Medicaid Claims Processing Activity October 1, 2014 Through March 31, 2015

Medicaid Program
Department of Health

Report 2014-S-53 December 2015

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 October 1, 2014 through March 31, 2015.

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 March 31, 2015, eMedNY processed about 264 million claims, resulting in payments to providers of about $28.5 billion. The claims are processed and paid in weekly cycles, which averaged about 10.1 million claims and $1.1 billion in payments to providers.

Key Findings

Auditors identified about $4.3 million in inappropriate Medicaid payments. The audit found:

- $1,956,679 in overpayments for newborn claims that were submitted with incorrect birth weights;
- $1,061,204 in overpayments for inpatient claims that were either billed at a higher level of care than what was actually provided or were billed with incorrect patient status codes;
- $590,405 in overpayments for claims billed with incorrect information pertaining to other health insurance coverage that recipients had;
- $476,888 in improper payments for pharmacy claims that were not in compliance with State Medicaid policies; and
- $167,101 for claims with improper payments for duplicate billings and for clinic and durable medical equipment services.

By the end of the audit fieldwork, about $3.7 million of the overpayments were recovered.

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 13 of the providers we identified, but the status of 16 other providers was still under review at the time our fieldwork was completed.

Key Recommendations

- We made 13 recommendations to the Department to recover the remaining inappropriate Medicaid payments and improve claim processing controls.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Claims Processing Activity April 1, 2014 Through September 30, 2014 (2014-S-15)

Department of Health: Medicaid Claims Processing Activity October 1, 2013 Through March 31, 2014 (2013-S-50)

State of New York
Office of the State Comptroller

Division of State Government Accountability

December 8, 2015

Howard A. Zucker, M.D., J.D.
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 October 1, 2014 Through March 31, 2015*. 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

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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 2014-15, the federal government funded about 52.4 percent of New York's Medicaid claim costs; the State funded about 30.2 percent; and the localities (the City of New York and counties) funded the remaining 17.4 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 March 31, 2015, eMedNY processed about 264 million claims, resulting in payments to providers of about $28.5 billion. The claims are processed and paid in weekly cycles, which averaged about 10.1 million claims and $1.1 billion 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 to 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 March 31, 2015, 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 about $4.3 million in improper payments pertaining to: claims with incorrect birth weights; claims with incorrect information pertaining to other insurance recipients had; pharmacy claims that were not in compliance with policies necessary for payment of the claims; duplicate billings; and improper hospital, clinic, and durable medical equipment claims.

At the time the audit fieldwork concluded, about $3.7 million of the improper payments had been recovered. Department officials need to take additional actions to review the remaining improper payments (totaling about $588,000), recover funds as warranted, and improve certain eMedNY claim processing controls.

Incorrect Birth Weights

Medicaid reimburses providers for newborn services using the fee-for-service and managed care payment methods. Under fee-for-service, Medicaid pays providers (such as hospitals) directly for Medicaid eligible services. Under managed care, Medicaid pays managed care organizations (MCOs) a fixed monthly capitation payment for each newborn enrolled in the MCO. The MCO, in turn, is responsible for the provision of covered health care services. MCOs have networks of participating providers that they reimburse directly for providing services. In addition to the monthly capitation payments, MCOs receive a Supplemental Low Birth Weight Newborn Capitation Payment (or “kick” payment) for each enrolled newborn weighing less than 1,200 grams (or approximately 2.64 pounds) at birth. The low birth weight kick payments are intended to cover the high cost of care these newborns require.

Medicaid reimbursement of inpatient services for newborns is highly dependent on the birth weight. Low birth weights often increase payment amounts. We determined Medicaid overpaid $1,956,679 for 28 incorrect claims that contained low birth weights. The overpayments generally occurred because hospitals reported inaccurate birth weight information to MCOs and Medicaid on their claims. All 28 of the claims have been voided or rebilled by the providers as a result of our review.

Low Birth Weight Kick Payments

Medicaid paid MCOs $1,376,454 for 14 low birth weight kick claims that contained inaccurate birth weights. We found that hospitals did not accurately report birth weights to the MCOs on 13 of the 14 claims. In turn, the MCOs reported the incorrect information to Medicaid. For example, one hospital’s billing system truncated a birth weight of 3,765 grams to 765 grams. This incorrect birth weight was submitted to the MCO. Consequently, the MCO then billed Medicaid for a low

birth weight kick claim since it appeared the newborn weighed less than 1,200 grams. Medicaid paid the MCO $99,246 for this claim. However, based on the correct birth weight, Medicaid should have only paid the MCO $3,789, resulting in an overpayment of $95,457 ($99,246 - $3,789) in this instance. Regarding the remaining claim, an MCO reported an incorrect birth weight to Medicaid. As a result of our review, the MCOs corrected the birth weights on all 14 claims, for a Medicaid savings of $1,352,740.

Graduate Medical Education Payments

Medicaid makes separate fee-for-service Graduate Medical Education (GME) payments to hospitals for care provided to recipients enrolled in MCOs to cover the cost of training residents. In addition to the incorrect low birth weight kick payments identified above, we found that Medicaid paid hospitals $150,929 for nine corresponding GME claims that also contained inaccurate birth weights. For example, the same hospital from the previous example also submitted a GME claim directly to Medicaid that contained the same incorrect birth weight of 765 grams. Medicaid paid the hospital $30,988 based on the incorrect birth weight. However, based on the correct birth weight (3,765 grams), Medicaid should have only paid the hospital $7,652. The hospitals corrected all nine GME claims, resulting in a Medicaid savings of $111,508.

Hospital Fee-for-Service Payments

We also found Medicaid paid hospitals $532,802 for five fee-for-service claims that either contained incorrect newborn birth weights or were duplicate payments. Specifically, the same hospital noted in the examples above reported incorrect low birth weights on four of the five claims. The hospital's billing system erroneously truncated the correct birth weights on the claims. The hospital was overpaid $423,931 for the four claims. The remaining claim was an instance where a duplicate payment was made to a hospital and the MCO. The overpayment of $68,500 occurred because the newborn was retroactively enrolled into an MCO, making the fee-for-service payment inappropriate. The hospitals corrected all five claims, resulting in a total Medicaid savings of $492,431.

Recommendations

1. Formally advise the hospitals and MCOs in question to report accurate birth weight information on claims.

2. Ensure that the hospital whose billing system caused incorrect birth weights to be reported on its claims has corrected its billing problem.

Overpayments for Inpatient Services

Incorrect Level of Care

When billing Medicaid for inpatient care, hospitals must indicate a patient's level of care to

ensure accurate claim processing and payment. Certain levels of care (such as acute care) are more intensive and, therefore, more expensive than others. When a patient is placed in a lower Alternate Level of Care (ALC) setting, hospitals should not bill Medicaid for more intensive acute levels of care. Rather, hospitals should bill less expensive ALC per diem rates.

Medicaid paid $1,580,350 for four inpatient claims in which hospitals billed for higher (and more costly) levels of care than what was actually provided to patients. For example, Medicaid paid a hospital $753,546 for 923 days of care at an acute psychiatric rate. We contacted the hospital to review the medical record and it was determined that the patient received only two days of acute psychiatric care. The remaining 921 days should have been billed at a lower ALC rate. If the hospital properly billed the entire stay reflecting the actual level of care provided, Medicaid would have only paid $211,864 to the hospital. At the time our fieldwork concluded, the hospitals adjusted all four claims, saving Medicaid $971,080.

Incorrect Patient Status Code

When a hospital bills Medicaid, it must include a patient status code on its claim to indicate 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. We determined Medicaid paid a hospital $136,238 for one claim that contained an incorrect patient status code. Although the hospital transferred the recipient to another health care facility, the hospital applied a discharge code instead of a transfer code to the claim. At our request, the hospital reviewed and corrected the claim, which reduced the payment to $46,114. The corrected claim resulted in a Medicaid savings of $90,124 ($136,238 - $46,114).

Recommendation

3. Formally advise the hospitals in question to accurately report ALC and patient status billing codes on Medicaid claims.

Other Insurance on Medicaid Claims

Many Medicaid recipients also have health insurance coverage provided by Medicare and/or other insurance carriers. When submitting Medicaid claims, providers must verify whether such recipients have other insurance coverage on the dates of service 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 insurance, Medicaid is the primary insurer and should be billed first.

Errors in the amounts claimed for coinsurance, copayments, or deductibles and/or in the designation of the primary payer will likely result in improper Medicaid payments. We identified

such errors on 34 claims that resulted in overpayments totaling $590,405. For example, we identified overpayments totaling $208,150 on 26 claims (for which Medicaid paid $215,987) 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 25 of the 26 claims, saving Medicaid $195,331. One provider, however, still needed to adjust the remaining claim that was overpaid by an estimated $12,819.

Further, we identified seven claims (for payments totaling $529,411) 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, the providers adjusted six of the claims, saving Medicaid $276,102. One provider, however, still needed to adjust the remaining claim that was overpaid by an estimated $19,752.

We also identified one claim where Medicaid made a full payment of $151,604 for an inpatient stay that was already partially paid by Medicare. According to Department officials, the eMedNY system incorrectly used the beginning date of service reported on the claim rather than the patient admission date in determining the Medicaid payment. We contacted the provider, who voided and then rebilled the claim, thereby saving Medicaid $86,401. Further, on November 6, 2014, the Department made changes to eMedNY designed to correct this system weakness. If the system changes function properly, such claims will be paid correctly in the future.

Recommendation

4. Review and recover the two unresolved overpayments totaling $32,571.

Improper Pharmacy Claims

Medicaid pays pharmacies for drugs dispensed and billed in compliance with State laws, rules, regulations, and Medicaid program policies. Pharmacies are allowed to receive prescriptions by fax. However, pharmacies must comply with certain Medicaid requirements. For example, according to the New York State Medicaid Program Pharmacy Manual, “All orders received by the pharmacy as a fax must be on the Official New York State Prescription Form.” In addition, “A faxed order must originate from a secure and unblocked fax number.” The manual further states, “The source fax number must be clearly visible on the fax that is received.” If these rules are not followed, the medications are not eligible for Medicaid reimbursement.

We identified 15 claims totaling $476,888 for prescriptions that were faxed to a pharmacy but were not written on the official New York State prescription form. In addition, the source fax numbers were not included on the “unofficial” form. At the end of our fieldwork, the pharmacy did not correct any of the claims. Thus, actions are still required to review and recover the $476,888 in improper payments we identified.

Recommendations

5. Review and recover the 15 unresolved overpayments totaling $476,888.

6. Formally advise the pharmacy of the Medicaid requirements for faxed orders.

Duplicate Billings

Medicaid overpaid ten providers a total of $144,377 on 21 claims (which originally paid $211,196) because the providers billed for certain services more than once. The duplicate payments occurred under the following scenarios:

- One provider billed for the same month of services on two separate inpatient claims, resulting in an overpayment of $88,210.
- Four providers billed for Comprehensive Psychiatric Emergency Program (CPEP) evaluations multiple times during the same encounter with a patient; however, these evaluations are allowed only once per an individual encounter (which might take place over multiple days). The resulting overpayments totaled $23,988.
- Three providers billed the same physician-administered drug twice on the same claim, resulting in overpayments totaling $23,113.
- One provider billed for the same services twice during a one-week span, resulting in an overpayment of $4,886.
- One provider billed for outpatient (clinic) services during inpatient stays, which resulted in an overpayment of $4,180.

We contacted the providers and, as a result of our inquiry, they corrected 13 of the 21 claims, saving Medicaid $119,909. However, by the end of our fieldwork, providers had not corrected the eight remaining claims totaling $24,468.

Recommendations

7. Review and recover the eight unresolved overpayments totaling $24,468.

8. Formally instruct the providers in question not to bill multiple times for CPEP evaluations during a single patient encounter.

9. Formally instruct the provider in question not to bill Medicaid for outpatient services provided to recipients who are hospitalized.

Other Improper Claim Payments

We identified $22,724 in overpayments resulting from excessive charges related to clinic and durable medical equipment (DME) claims. At the time our audit fieldwork concluded, $14,024 of the overpayments had been recovered. However, actions are still required to address the balance of the overpayments totaling $8,700.

The overpayments occurred under the following scenarios:

- One provider billed an incorrect DME supply code on five claims that paid $111,106. Moreover, the prior approval submitted by the provider to the Department also contained the incorrect DME supply code. At the end of our fieldwork, the provider had not corrected the five claims with an estimated savings of $8,700.
- One provider inappropriately billed for a pacemaker as part of a routine office visit. The claim paid $7,233. At our request, the provider reviewed and subsequently adjusted the claim, saving Medicaid $6,943.
- One provider inappropriately billed a procedure that conflicted with the diagnosis on a claim that paid $4,532. At our request, the provider reviewed and subsequently adjusted the claim, saving Medicaid $3,590.
- One provider used an incorrect reimbursement rate code on a claim that paid $4,240. At our request, the provider reviewed and subsequently adjusted the claim, saving Medicaid $3,491.

Recommendations

10. Review and recover the five unresolved overpayments totaling $8,700.

11. Formally instruct the DME provider in question how to correctly bill Medicaid to ensure appropriate payment.

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 against 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 the Department does not identify a provider who should be excluded from the Medicaid program or fails to impose proper sanctions, the provider remains active to treat Medicaid patients, perhaps placing recipients at risk of poor-quality care while continuing to receive Medicaid payments.

We identified 31 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. In addition, we identified two providers who were involved in a civil settlement. Of the 33 providers, 27 had an active status in the Medicaid program. The remaining six 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 33 providers and the Department terminated 13 of them from the Medicaid program. Prior to program termination, Medicaid paid two of the 13 providers a total of $45,593 from the date they were charged with a crime to their termination date. Also, the Department determined four of the 33 providers should not be terminated. At the time our audit fieldwork ended, the Department had not resolved the program status of the 16 remaining providers.

Recommendations

12. Determine the status of the 16 remaining providers with respect to their future participation in the Medicaid program.

13. Determine the appropriateness of the $45,593 received by the two terminated providers and recover improper payments as warranted.

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 October 1, 2014 through March 31, 2015. 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. Our rejoinder to certain Department comments is included in the report's State Comptroller's Comment.

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

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

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

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

October 16, 2015

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th 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 Draft Audit Report 2014-S-53 entitled, "Medicaid Claims Processing Activity October 1, 2014 Through March 31, 2015."

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 2014-S-53 entitled,
Medicaid Claims Processing Activity
October 1, 2014 through March 31, 2015

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2014-S-53 entitled, "Medicaid Claims Processing Activity October 1, 2014 through March 31, 2015."

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), for 2009 through 2013, 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. For 2011 through 2013, the administration's Medicaid enforcement efforts 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 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 1,330,000 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

Formally advise the hospitals and MCOs in question to report accurate birth weight information on claims.

Response #1

Current billing documentation includes the requirement to report birth weight in grams. *Inpatient Hospital Billing Guidelines Manual, Rule 3 – Newborns* specifies that All Patient Refined Diagnosis Related Group claims for newborns, 28 days or younger, must report the birth weight using Value Code 54 in the Value Information segment.

Providers were reminded of this billing rule in the following September 2015 Medicaid Update:

"Reporting of Newborn Birth Weight
Billing Reminder

Providers are reminded that pursuant to the inpatient billing procedures for All Patient Refined Diagnostic Related Groups (APR DRGs) documented in ***New York State UB-04 Billing Guidelines – Inpatient Hospital****, claims for newborns, 28 days or younger, must contain the newborn's birth weight in grams. The birth weight is reported using Value Code 54 in the Value Information segment.*

The billing guidelines regarding newborns are detailed under ***2.3.1.2, Rule 3 – Newborns*** *(https://www.emedny.org/ProviderManuals/Inpatient/PDFS/Inpatient_Billing_Guidelines.pdf).*

To ensure proper payment, providers should follow these guidelines when billing Medicaid fee-for-service (MFFS) as well as billing Medicaid Managed Care (MMC) plans.

For MFFS billing guideline questions, please contact the eMedNY Call Center at 1-800-343-9000. Questions regarding MMC billing and reimbursement requirements should be directed to the enrollee's MMC plan."

An email blast was sent on September 29, 2015 to all Managed Care Organizations reinforcing this information.

Additionally, the Department has directed Computer Sciences Corporation (CSC) to notify and educate the specific hospitals and Managed Care Organizations identified in this audit on the proper billing of DRG claims for newborns.

Recommendation #2

Ensure that the hospital whose billing system caused incorrect birth weights to be reported on its claims has corrected its billing problem.

Response #2

The Office of Health Insurance Programs conducted an audit of sixteen claims from Montefiore Hospital for the timeframe June 24, 2014 through June 11, 2015. Claims selected represented birth weights throughout low, normal and high ranges. Birth records for the claims were requested from the hospital and compared to the birthweight submitted on the claim. No discrepancies between the birth records and the information submitted on the claims were found.

Recommendation #3

Formally advise the hospitals in question to accurately report ALC and patient status billing codes on Medicaid claims.

Response #3

The Department has instructed its fiscal agent, CSC, to educate the four providers identified in this audit report on the accurate reporting of Alternate Level of Care days; in addition CSC was instructed to educate a fifth provider concerning use of accurate Inpatient Status Codes.

Recommendation #4

Review and recover the two unresolved overpayments totaling $32,571.

Response #4

OMIG's Third Party Liability contractor verified the findings and notified the providers. Both claims were voided, rebilled, and paid correctly.

Recommendation #5

Review and recover the 15 unresolved overpayments totaling $476,888.

Response #5

OMIG will review the claims, and recover any inappropriate payments.

Recommendation #6

Formally advise the pharmacy of the Medicaid requirements for faxed orders.

Response #6

To ensure proper dispensing, the Department issued guidance in the August 2014 Medicaid Update and the November 2014 Medicaid Update to pharmacies about Medicaid requirements for the transmission of prescription orders. The revised November 2014 Medicaid Update is as follows:

"Pharmacy Update

Reminder - Transmission of the Official Prescription Serialized Number is required for All NYS Fee-for-Service Medicaid Claims
Re-issuance of August 2014 article

When submitting claims for prescriptions written in New York State on an Official New York State Prescription form, the serialized number from the Official Prescription MUST be used.
In specific situations, valid prescriptions for prescription drugs and/or supplies may still be dispensed when not written on Official New York State Prescription Forms.

The table below lists some of the specific situations when this is allowed and indicates the appropriate code to be entered in NCPDP field 454-EK in lieu of the Prescription Serial Number.

Code	***Value***
99999999	** Oral prescriptions and products dispensed pursuant to a non-patient specific order **
EEEEEEEE	** Prescriptions submitted electronically (computer to computer)***
NNNNNNNN	** Prescriptions for carve-out drugs for nursing home patients (excluding controlled substances)*
SSSSSSSS	** Fiscal orders for supplies*
ZZZZZZZZ	** Prescriptions written by out-of-state prescribers or by prescribers within the US Department of Veterans Affairs*

** Products dispensed pursuant to a non-specific patient order may include, but are not limited to, emergency contraceptives (e.g., Plan B) or pharmacist administered vaccines.*

*** Prescriptions submitted electronically, that do not transmit properly or default to a facsimile, must conform to the requirements of the NYS Education Law at:*

http://www.op.nysed.gov/prof/pharm/pharmelectrans.htm.

Prescriptions received by the pharmacy as a facsimile must be an original hard copy on the Official New York State Prescription Form that is manually signed by the prescriber, and that serial number must be used. Prescriptions for controlled substances that are submitted electronically but fail transmission MAY NOT default to facsimile.

For questions on this billing requirement providers may contact the eMedNY Call Center at (800) 343-9000."

The Department directed CSC to contact the pharmacy identified in this audit. CSC has documented the provider instruction.

Recommendation #7

Review and recover the eight unresolved overpayments totaling $24,468.

Response #7

OMIG reviewed and will recover five inappropriate duplicate J-Code claims payments. OMIG reviewed and will not recover payments for the remaining three Comprehensive Psychiatric Emergency Program (CPEP) claims because the services took place on separate service dates.

* Comment 1

Recommendation #8

Formally instruct the providers in question not to bill multiple times for CPEP evaluations during a single patient encounter.

Response #8

The Department and the Office of Mental Health (OMH) have developed CPEP billing guidance and established a rate code for CPEP Extended Observation Beds. This guidance was sent to all providers on September 29, 2015.

Additionally, systems modifications are being implemented to prevent the ability of a provider to bill multiple times for a CPEP evaluation during a single patient encounter.

Recommendation #9

Formally instruct the provider in question not to bill Medicaid for outpatient services provided to recipients who are hospitalized.

Response #9

The Department is establishing system edits that will reject claims for outpatient/Emergency Department (ED) visits provided concurrent to an inpatient stay. Recently, edits were

*See State Comptroller's Comment on Page 22.

implemented to reject claims for an Emergency Department visit provided on the same date of service as an inpatient discharge. The Department will be releasing a Medicaid Update to reinforce this long-standing policy in October 2015.

Recommendation #10

Review and recover the five unresolved overpayments totaling $8,700.

Response #10

OMIG will review the claims and recover any inappropriate payments.

Recommendation #11

Formally instruct the DME provider in question how to correctly bill Medicaid to ensure appropriate payment.

Response #11

A review of the prior approval request found a vendor error in coding, resulting in the overpayment of $8,700. The provider was notified of the coding error with instructions on the correct coding for the items being dispensed. The provider voided the overpayment claims and resubmitted corrected claims using the appropriate coding. The Department Prior Approval staff were also instructed on the correct coding for these items for future approvals.

Recommendation #12

Determine the status of the 16 remaining providers with respect to their future participation in the Medicaid program.

Response #12

Of the 16 providers:

15 are under review for possible immediate sanction or under investigation.
1 has been excluded.

Recommendation #13

Determine the appropriateness of the $45,593 received by the two terminated providers and recover improper payments as warranted.

Response #13

The two providers are currently under investigation.

State Comptroller's Comment

1. We maintain that the three CPEP claim payments in question are problematic. As stated on page 11 of our report, CPEP evaluations are allowed once per patient encounter, and a single encounter can take place over multiple service dates. For the three payments cited, providers billed CPEP evaluations multiple times during the same encounter, and the assertion that the claims were paid appropriately because the services took place on separate dates is incorrect. Further, we identified this billing error in previous audits (2013-S-12 and 2014-S-15). In responding to these audits, the Department acknowledged that other CPEP claims with similar characteristics were overbilled. In addition, Department officials stated they would: work with the Office of Mental Health (OMH) to formally instruct providers how to properly bill CPEP claims; and follow up with OMH regarding their request to "only pay one unit per claim instead of one unit per day [in the CPEP setting] … to prevent the overbilling identified by OSC."