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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

October 6, 2017

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

Re: Improper Medicaid Payments to Eye Care Providers
Report 2015-S-6

Dear Dr. Zucker:

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, we conducted an audit of the Department of Health (Department) to determine whether certain eye care providers who appeared to be affiliated complied with Medicaid provider enrollment rules and if Medicaid paid for improper claims billed by the eye care providers. This audit covered the period January 1, 2010 through December 31, 2015.

We identified six eye care professionals who jointly owned or operated 16 businesses located in Kings and Queens counties that did not fully comply with the Department's Medicaid policies for provider enrollment and revalidation. For example, certain disclosures about apparent affiliations were not made. As a result, they were able to obtain Medicaid provider eligibility under questionable circumstances. During the six-year period ended December 31, 2015, Medicaid reimbursed these providers about $13 million under 34 different Medicaid provider identification numbers. In addition to the enrollment issues, based on our review of selected samples of the providers' Medicaid claims, we identified 1,177 improperly billed eye care services totaling $34,625. The improper payments involved claims for excessive Medicare coinsurance and for services not supported by proper medical records. We made seven recommendations to the Department to review the appropriateness of the providers' enrollment, enhance controls over the Department's enrollment process, monitor the appropriateness of the providers' Medicaid claims, and recover improper payments.

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. For the fiscal year ended March 31, 2016, New York's Medicaid program had approximately 7.4 million enrollees and Medicaid claim costs totaled about $56 billion. The federal government funded about 53.2 percent of New York's Medicaid claim costs, the State funded about 30.6 percent, and the localities (the City of New York and counties) funded the remaining 16.2 percent. The Department administers the State's Medicaid program.

Many of the State's Medicaid recipients are also enrolled in Medicare, the federal health care program for people who are age 65 and older and people under 65 who have certain disabilities. Individuals enrolled in both Medicaid and Medicare are referred to as "dual eligibles." Generally, Medicare is the primary payer for medical services provided to dual-eligible individuals and Medicaid pays remaining balances, such as deductibles and coinsurance. To help ensure Medicaid claims for recipients' Medicare responsibilities are paid accurately, the Department implemented the Medicare/Medicaid crossover system in December 2009. Under that system, providers submit claims for dual-eligible individuals to Medicare, and after Medicare processes claims, they are electronically transferred to the Department's Medicaid claims processing system (eMedNY) for payment of deductibles and coinsurance. Prior to the crossover system, providers self-reported Medicare payments, deductibles, and coinsurance on their Medicaid claims.

Under federal and State regulations, providers, including optical establishments, optometrists, and opticians, must apply for enrollment into the Medicaid program and meet certain requirements in order to provide services to Medicaid recipients. In addition, Medicaid providers must revalidate their enrollment every five years. The enrollment and revalidating processes are intended to prevent improper payments for services rendered by providers who do not meet federal and State requirements for participation in the Medicaid program and to protect Medicaid recipients from receiving care or services from providers who are not qualified (e.g., individuals or entities who may be excluded from Medicare or Medicaid).

Provider enrollment and revalidation also serve as first-line defenses in the prevention of Medicaid fraud and abuse and are required in order to obtain a Medicaid provider identification number. Medicaid providers use these numbers to submit claims for services and receive reimbursement from the Medicaid program. Providers are prohibited from billing Medicaid for services rendered by other providers.

During the enrollment and revalidation processes, providers are obligated to disclose accurate and timely information about their practice, including information pertaining to other individuals or entities with a 5 percent or more ownership interest, agents, and managing employees. The Department uses this information to screen enrollment applications and revalidations, and ensure that only qualified providers participate in the Medicaid program. The Department coordinates with the Office of the Medicaid Inspector General (OMIG) to conduct site visits and additional screening steps, when necessary, before providers are enrolled or revalidated.

When the Department identifies aberrant provider billing practices or potentially inappropriate Medicaid claims, the Department may place the provider on prepayment review. Providers placed on prepayment review may be required to submit medical records or other documentation to support their claims before they are paid. Providers who commit fraud, waste, or abuse may face further sanctions, such as denied enrollment, suspension, or termination from the Medicaid program.

Results of Audit

We identified vulnerabilities in the Department's provider enrollment and revalidating processes and procedures that undermine the Department's ability to ensure that only qualified providers participate in the Medicaid program and prevent improper payments to providers who do not meet federal and State requirements. As a result of these weaknesses, six eye care professionals who did not comply with the Department's Medicaid policies for enrollment and revalidation were able to obtain Medicaid eligibility under 34 provider identification numbers without disclosing all of their apparent affiliations (hereafter referred to as Providers). We also determined the Providers improperly reported, and the Department paid, $16,542 in excessive Medicare coinsurance claims[1] and an additional $18,083 in improper claims for services not supported by proper medical records.[2]

Provider Enrollment – Application/Revalidation Review Procedures

We identified weaknesses in the Department's Medicaid provider application and revalidation review procedures that allowed the Providers to obtain Medicaid provider eligibility under questionable circumstances, as follows:

- The Department did not ensure optical establishments listed the names of individuals with an ownership or control interest. Therefore, the Department had no knowledge of who controlled or was liable for the establishment's conduct or whether these individuals were excluded or sanctioned by Medicaid or other health insurance programs such as Medicare. Nine of the 16 optical establishments we reviewed did not list an individual as an owner. For example, one optical establishment was allowed to enroll without identifying any owners or parties with controlling interest. This establishment only listed two compliance officers.
- The Optical Establishment Enrollment Application and Revalidation form does not capture all required information and inappropriately limits certain entries. For example, the form does not ask applicants to identify the officers of a corporation or the partners of a partnership.
- The Department did not verify the accuracy and completeness of information providers reported on applications. For example, a revalidation form of an eye care professional disclosed one affiliated optical establishment; however, two other optical establishments listed him as an owner or board of directors member.
- The Department did not elevate the enrollment risk for providers it had placed on

[1] For the period April 1, 2012 through December 31, 2014.

[2] For the period January 11, 2011 through December 24, 2014.

prepayment review. Even if the Department did elevate providers' risk, however, it does not have a step in its enrollment review process to implement higher review standards for them. For example, three providers previously placed on prepayment review were approved for revalidation without additional scrutiny.

- The Department does not have effective tools to search providers' phone numbers, addresses, and email addresses to find overlapping information and identify potential undisclosed affiliations. For example, the Department's eMedNY address searches will only return exact matches, meaning addresses must be spelled and abbreviated exactly the same way, or it will not recognize both addresses as matches.
- The Department did not have provider enrollment staff investigate suspicious provider responses on applications. Questionable applications are referred to the OMIG's Enrollment and Reinstatement Unit for further action. However, according to OMIG officials, they consider eye care providers to be a low risk, and the fact that optical establishments have certain commonalities, such as addresses and phone numbers, is not sufficient to justify expending limited resources on further investigation.

Incomplete ownership data and weak enrollment processes make it difficult for the Department to ascertain which providers are affiliated, resulting in the following improprieties and questionable situations to occur without the Department's knowledge:

- One of the Providers was notified by the Department in April 2015 that it would be involuntarily terminated from the Medicaid program. In July 2015, a key employee of that provider was able to enroll as a new optical establishment, under a new business name, at the same address, and obtain a new Medicaid identification number, effectively circumventing termination from the Medicaid program.
- Three Provider establishments at different locations each registered the same "Pay To" (Medicaid payment) address, which was already used by four other Provider optical establishments that operated from that address, indicating the possibility that the "Pay To" address was a nucleus of these affiliations. However, none of the three disclosed any affiliations to the other Provider optical establishments that operated from that address.
- As stated previously, three of the Providers previously identified by the Department to have billed improper claims and who had been placed on prepayment review had their revalidations approved without heightened scrutiny – and despite the Providers' failure to affirm that they were already on prepayment review.
- At least one of the Providers billed for services under another Provider's Medicaid identification number.
- Two of the Providers paired up, with each owning an optical establishment at the same two locations (total of four businesses at two addresses). At both locations, the two establishments shared the same business phone number and shared an optometrist as a common employee. However, no disclosure of any affiliations was made on their applications.
- Notably, as a group providing services in Kings and Queens counties – among 1,987 other Medicaid eye care providers – the Providers accounted for 12 percent of all eye care services billed to Medicaid, but billed certain services significantly higher than other providers. For example, the Providers accounted for more than twice the number of external eye

photography services billed to Medicaid than the other Medicaid providers combined. Our analysis showed the Providers billed one external eye photography procedure in 60 percent of their patients' visits, compared with 2 percent collectively for their peers.

As a result of our audit fieldwork, Department officials took immediate action to ensure that, going forward, applicants name at least one individual as an owner or board of director member of an optical establishment, and that one of those individuals signs the application. We commend the Department for taking this swift action to improve the process.

Providers' Medicaid Claims

The Providers received $34,625 in improper Medicaid payments for claims with inappropriate Medicare coinsurance charges totaling $16,542 and for services not supported by proper medical records totaling $18,083.

We analyzed the Providers' claims for Medicare coinsurance billed during the period from April 1, 2012 through December 31, 2014 and determined that Medicaid overpaid 474 procedures by $16,542. In each case, according to the Providers' claims, Medicare did not cover the service. When submitting claims to Medicaid for services not covered by Medicare, providers should bill the standard Medicaid reimbursement fee for the service. However, the Providers inappropriately billed Medicaid claims that contained inflated Medicare coinsurance charges.

For example, the Medicaid fee for an ophthalmic ultrasound is $58.25. However, the Providers billed Medicaid for Medicare coinsurance of $158.80, causing Medicaid to overpay $100.55 ($158.80 - $58.25). During our audit scope, Medicaid reimbursed health care providers the coinsurance amount they self-reported on claims. However, effective July 1, 2015, the Department implemented policies to limit Medicaid reimbursement for Medicare coinsurance up to the Medicaid fee for the procedure.

We also selected a judgmental sample of 1,481 procedures (for which Medicaid paid $40,436) billed by the Providers during the period from January 11, 2011 to December 24, 2014. Selection criteria included claims for the same procedure performed on the same recipient by different Providers within a short period (i.e., 45 days or less), and claims for multiple procedures performed on the same recipient on the same day at different Provider locations. We identified improper payments totaling $18,083 for 703 procedures:

- $12,932 for 585 procedures with missing or inadequate documentation (e.g., no eyeglass measurements).
- $3,035 for 55 procedures involving suspicious or altered documentation (e.g., files resubmitted to us for review had been supplemented with additional documents not in the original; data fields had been whited out and data re-entered). We did not accept these records as reliable supporting documents.
- $2,116 for 63 procedures billed by one optical establishment for services that, according to supporting documents, were provided by a different optical establishment at the same address.

Recommendations

1. Review the Providers' applications/revalidations to determine if their ownership and control interest disclosures were complete and accurate, and in compliance with regulations. Where necessary, consider remedial actions to ensure compliance, impose sanctions, or remove Providers from the Medicaid program.

2. Revise the Optical Establishment Enrollment Application and Revalidation form to capture all required affiliation data, and establish procedures to verify the accuracy and completeness of ownership, control interest, and affiliation data.

3. Consider using other technical tools and resources to verify information reported by providers on applications and revalidations.

4. Coordinate operational procedures between the Department's provider enrollment staff and the OMIG to ensure identification of providers with elevated enrollment or revalidation risk and to conduct additional integrity steps as appropriate.

5. Review the Medicaid overpayments totaling $34,625 for the 1,177 improper procedures and recover payments as appropriate.

6. Instruct the Providers that, in submitting claims, they must use the Medicaid identification number of the entity that rendered the services.

7. Monitor the Providers' claims to prevent improper payments, including excessive coinsurance payments.

Audit Scope, Objectives, and Methodology

The objectives of our audit were to determine whether certain eye care providers who appeared to be affiliated complied with Medicaid provider enrollment rules and if Medicaid paid for improper claims billed by the eye care providers. The scope of our audit was January 1, 2010 through December 31, 2015. (Note: During the course of this audit, our fieldwork was temporarily suspended to avoid interfering with reviews conducted by other public oversight authorities of the matters addressed in this report.)

To accomplish our audit objectives and assess related internal controls, we interviewed officials from the Department and the OMIG and two Provider optical establishment owners. We reviewed applicable federal and State regulations and examined the Department's relevant Medicaid policies and procedures. We also reviewed the Department's Medicaid provider enrollment and revalidation applications and related correspondence between the Department and the Providers.

We analyzed $655,724 in Medicaid payments for Medicare coinsurance billed by the Providers during the period from April 1, 2012 through December 31, 2014 to identify excessive

charges for coinsurance. We also reviewed supporting documentation for a judgmental sample of 1,481 eye care procedures billed from January 11, 2011 through December 24, 2014 totaling $40,436 in payments. We selected our judgmental sample based on date-of-service conditions, such as recipients billed by more than one of the Providers on the same service date. We also performed site visits at four Provider optical establishments located at three addresses in Brooklyn, New York.

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 to certain boards, commissions, and public authorities, some of whom have minority voting rights. 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.

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 concurred with most of the audit 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.

Major contributors to this report were Warren Fitzgerald, Gail Gorski, Wendy Matson, and Mary McCoy.

We would like to thank Department of Health management and staff for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Andrea Inman
Audit Director

cc: Ms. Diane Christensen, Department of Health
Mr. Dennis Rosen, Medicaid Inspector General

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

September 13, 2017

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 2015-S-6 entitled, "Improper Medicaid Payments to Eye Care Providers."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
Jason A. Helgerson
Dennis Rosen
Erin Ives
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2015-S-6 entitled,
Improper Medicaid Payments to Eye Care Providers

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2015-S-6 entitled, "Improper Medicaid Payments to Eye Care Providers"

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

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 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,305 in 2015, consistent with levels from a decade ago.

Recommendation #1

Review the Providers' applications/revalidations to determine if their ownership and control interest disclosures were complete and accurate, and in compliance with regulations. Where necessary, consider remedial actions to ensure compliance, impose sanctions, or remove Providers from the Medicaid program.

Response #1

The Department reviews provider enrollment applications for compliance with regulations found at 18 NYCRR *§ 504.2 – Application for participation*, which require providers to furnish information relevant to the provider's ability to provide high-quality care, services, and supplies, and to be financially responsible. The Department will utilize the optical provider information provided by OSC to evaluate whether enrollment applications submitted by optical providers are complete and accurate. If information is found to be missing, the enrollment application will be returned and pended until the required information is received. The Department will consider potential remedial actions to ensure compliance, impose sanctions, or remove providers from the Medicaid program. Additionally, if warranted, OMIG will review for appropriate actions.

Recommendation #2

Revise the Optical Establishment Enrollment Application and Revalidation form to capture all required affiliation data, and establish procedures to verify the accuracy and completeness of ownership, control interest, and affiliation data.

Response #2

The Department respectfully disagrees that the enrollment form needs to be updated. The Business Provider Enrollment Form requires the optical establishment to report data required by 42 CFR § 455.104(b), including: name, address, date of birth and social security number of any person with an ownership or control interest; other tax identification number (TIN) with an ownership or control interest; and information about family relationships, five percent ownership in the company and managing employees. In addition, the application requires the establishment to:

* Comment 1

- Complete an OMIG Provider Compliance Certification;
- Provide an employee list;
- Submit an IRS Assignment letter that contains federal employer identification number and an Application Name (Form SS-4);
- Submit Disclosure of ownership and control information which includes:
    - Name and Federal Identification Number of entity
    - Ownership in Applicants, including relationship to another person with an ownership or control interest in the business, and
    - Other business addresses of corporations
    - Ownership or control interest of other disclosing Entities
    - When the owner has ownership or controls interest of 5% or more in a Subcontractor
    - When a family member (parent, child, sibling, spouse) has a relationship in its subcontractors
    - Those agents, management employees and those with a control interest (ex: facility administrator, all members of the board of directors, managing employees, compliance officer, or laboratory director.) This also requires the owner to provider the family relationship and type of association to the business.

The Department's staff reviews all documentation for completeness. If any information is missing, a follow-up email or letter is sent, requesting the missing information to be furnished within three weeks. If the information is not sent within the timeframe, the provider's application is withdrawn.

To verify the accuracy of the application, all persons and entities disclosed in the above required documents are checked at intake against the following databases:

- Social Security Administration Death Master File
- System for Award Management and OMIG list of Restricted and Excluded Providers
- eMedNY sanction File and the National Provider Index National Plan Enumeration.
- Disciplinary Hits (Excluded Parties List System) - food stamp violations and exclusion in federal programs

For optical providers, the Department will now review them against the list of providers found in this audit report.

*See State Comptroller's Comment, page 15.

Recommendation #3

Consider using other technical tools and resources to verify information reported by providers on applications and revalidations.

Response #3

The Department will consider using additional technical tools to verify that the information reported by providers is complete, as required.

Recommendation #4

Coordinate operational procedures between the Department's provider enrollment staff and the OMIG to ensure identification of providers with elevated enrollment or revalidation risk and to conduct additional integrity steps as appropriate.

Response #4

The Department will continue with its operational procedures to ensure identification of providers with elevated enrollment or revalidation risk and to conduct additional integrity steps, as appropriate. As part of ongoing program integrity efforts, provider enrollment and policy staff will evaluate appropriate measures to address optical provider issues. If issues are identified, OMIG will review and make recommendations back to the Department.

Recommendation #5

Review the Medicaid overpayments totaling $34,625 for the 1,177 improper procedures and recover payments as appropriate

Response #5

OMIG will review the claims, and determine an appropriate course of action if necessary.

Recommendation #6

Instruct the Providers that, in submitting claims, they must use the Medicaid identification number of the entity that rendered the services.

Response #6

The Department has forwarded the following email blast to CSRA that will go out on its Listserv reminding all optical providers of the importance of always utilizing the appropriate Provider ID when rendering services:

"BILLING REMINDER
Optical Establishments

Optical Establishments must bill with the Medicaid Provider ID Number (MMIS/NPI) of the entity where the services were rendered. They also need to include on the claim the

Medicaid Provider ID # (MMIS/NPI) of the salaried optician or salaried optometrist who performed the service as the rendering/servicing provider.

Billing instructions-

Paper:

The billing provider for paper is reported in field 25A.
The rendering/servicing provider for paper NPI is reported in field 22C and their name is reported in field 22A.

Electronic:

The billing provider for 837P is reported in Ref: Loop 2010AA NM109 or Loop 2310B NM109.
The rendering/servicing provider is reported in 837P Ref: Loop 2310B NM1, and the name is reported in 837P Ref: Loop 2310B NM1.

The billing instructions for vision care specifically state that rendering provider's information MUST be completed ONLY by Optical Establishment providers enrolled with category of service 0401, 0402 or 0423 that employ either or both licensed ophthalmic dispensers (opticians) and/or licensed optometrists. Rendering provider fields SHOULD NOT be completed by categories of service 0404 (self-employed optician), 0405 (eye prostheses supplier) and 0422 (self-employed optometrists) who are the billing providers. If rendering provider and billing provider are the same, the rendering provider field is left blank.

If the rendering or servicing salaried optician or salaried optometrist is not enrolled in NYS Medicaid they must enroll at https://www.emedny.org/info/ProviderEnrollment/index.aspx On this page providers can choose a link to their provider type. Complete the enrollment form, follow all instructions and provide required documentation. Providers can call CSRA at 800-343-9000 for assistance.

NYS Medicaid requires physicians and other healthcare professionals to be enrolled either in fee for service Medicaid as billing provider or as an ordering/prescribing/referring/attending (OPRA) provider

If the professional is not enrolled in FFS Medicaid (billing or as an OPRA provider), under federal law Medicaid must deny the FFS claim for the ordered service. Consequently, the billing entity must include the respective professional's Medicaid ID or NPI on all claims. If the required Medicaid ID/NPI is not provided, the claim is subject to denial or recoupment if paid in error. More information is provided in the December 2013 Medicaid Update (Special Edition Vol. 29, Number 13).
http://www.health.ny.gov/health_care/medicaid/program/update/2013/dec13_muspec.pdf"

Additionally, the Department has individually notified by mail, all of the optical providers identified in this audit report as to the proper use of the Provider ID when rendering services.

Recommendation #7

Monitor the Providers' claims to prevent improper payments, including excessive coinsurance payments.

Response #7

Information specific to the providers and procedure codes identified in this audit, necessary to monitor provider claims, was provided to the Department's Bureau of Medical Review and Evaluation's Pended Claims Unit. Criteria was developed and instituted to pend future claims of these providers for review prior to payment.

State Comptroller's Comment

1. During the course of our audit, the Department revised the enrollment form a number of times, including a revision that coincided with the issuance of our draft audit report. We are pleased the current enrollment form complies with federal regulations and addresses our recommendation. However, to avoid provider confusion, the Department should update its "Instructions for Completing the NY Medicaid Enrollment Form for Optical Establishment" under Association Types to include Officers (for Corporations) and Partners (for Partnerships).