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

Division of State Government Accountability

Medicaid Claims Processing Activity October 1, 2013 Through March 31, 2014

Medicaid Program
Department of Health

Report 2013-S-50 May 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, 2013 through March 31, 2014.

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, 2014, eMedNY processed about 112 million claims, resulting in payments to providers of about $25 billion. The claims are processed and paid in weekly cycles, which averaged about 4.3 million claims and $973 million in payments to providers.

Key Findings

Auditors identified about $3.3 million in inappropriate Medicaid payments, including:

- $1,335,151 in overpayments for hospital claims for which eMedNY did not properly factor Medicare coverage or a lower level of care into the payment;
- $682,022 in overpayments for pharmacy claims that were not in compliance with various regulations and policies;
- $416,314 in improper payments for claims that were not subjected to the appropriate claims processing logic in eMedNY;
- $360,117 in overpayments for claims with incorrect information pertaining to other health insurance coverage that recipients had;
- $112,981 in overpayments for nursing home claims for which eMedNY did not correctly deduct the recipients' Net Available Monthly Income (NAMI); and
- Claims with improper payments for duplicate billings and hospital, clinic, transportation, and eye care services.

By the end of the audit fieldwork, auditors recovered about $2 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 12 of the providers we identified, but the status of four other providers was still under review.

Key Recommendations

- We made 16 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 October 1, 2012 Through March 31, 2013 (2012-S-131)

Department of Health: Medicaid Claims Processing Activity April 1, 2013 Through September 30, 2013 (2013-S-12)

State of New York
Office of the State Comptroller

Division of State Government Accountability

May 21, 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, 2013 Through March 31, 2014.* 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 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 March 31, 2014, eMedNY processed about 112 million claims, resulting in payments to providers of about $25 billion. The claims are processed and paid in weekly cycles, which averaged about 4.3 million claims and $973 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 others 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 March 31, 2014, 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 $3.3 million in inappropriate payments related to: claims with incorrect information pertaining to other insurance that recipients had; claims for duplicate services; and inappropriate pharmacy, hospital, and other claims.

At the time the audit fieldwork concluded, about $2 million of the overpayments had been recovered. Department officials need to take additional actions to review the remaining inappropriate payments (totaling about $1.3 million), recover funds as warranted, and improve certain eMedNY claim processing controls.

Incorrect Payments for Hospital Inpatient Claims

The Department uses a reimbursement methodology known as All Patient Refined Diagnosis Related Groups (or APR-DRG) to pay most hospital inpatient claims. The eMedNY system uses the APR-DRG methodology along with provider-reported information, including the hospital admission date and beginning date of service, to process hospital inpatient claims. The Department requires hospitals to prepare their claims in accordance with Medicaid APR-DRG billing policies. Failure to follow these policies could cause eMedNY to pay claims incorrectly.

We determined Medicaid overpaid two hospitals $740,310 on 20 APR-DRG claims. In each case, we determined the hospitals reported on their claims that Medicare covered the inpatient services in full. Despite this, eMedNY ignored the Medicare payment information and paid each claim as a full APR-DRG payment because the hospitals reported incorrect beginning dates of service. For example, one hospital submitted a claim with a patient admission date of January 30, 2014 and a beginning date of service of January 29, 2014. This caused eMedNY to misinterpret other third-party insurance information reported on the claim, resulting in an overpayment of $194,170. We contacted the provider, who confirmed that the claim was paid incorrectly.

When eMedNY initially processed these claims, it was not programmed properly to identify APR-DRG claims with improbable service dates (i.e., services dates preceding admission dates). As a result of our audit work, 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 denied payment in the future.

We contacted the two hospitals, and as a result, the hospitals adjusted 18 of the 20 claims, saving Medicaid $712,282. However, the two remaining claims (overpaid by $28,028) had not been adjusted at the time we completed our fieldwork.

Recommendation

1. Review and recover the remaining $28,028 in overpayments.

Improper Pharmacy Claims

Medicaid pays pharmacies for drugs 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 (Guidelines). However, Medicaid potentially overpaid eight pharmacies $682,022 on 17 claims that, according to the billing records and other documentation we examined, did not comply with the various applicable regulations and policies.

Pharmacies are allowed to receive prescriptions by fax. However, the prescriber as well as the pharmacy must comply with certain Medicaid requirements. For example, the Guidelines state that "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 Guidelines further state, "The source fax number must be clearly visible on the fax that is received." Also, under Medicaid, faxed pharmacy requests to a prescriber for refill authorizations (without an official New York State prescription) are not allowed. If these rules are not followed, the medications are not eligible for Medicaid reimbursement.

We identified 11 faxed prescriptions, which Medicaid reimbursed $449,861, that did not comply with New York's rules and regulations and the Department's Medicaid Guidelines. Specifically, all 11 prescriptions were faxed without a source fax number, and ten of them were not written on official New York State prescription forms. Moreover, eight were refill authorizations, which Medicaid does not allow.

We identified six additional prescriptions, which Medicaid reimbursed $232,161, that were billed under questionable circumstances, as follows:

- Three pharmacies billed claims totaling $130,794 in which the prescribers' identification number recorded on the claim differed from the prescribers' identification number on the prescription order;
- Two other pharmacies could not provide the source prescriptions for their claims totaling $59,754; and
- One additional pharmacy could not provide invoices to substantiate the quantity of medication dispensed totaling $41,613.

At the time our fieldwork concluded, none of the claims had been adjusted.

Recommendations

2. Review the $682,022 in pharmacy payments and recover overpayments as appropriate.

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

Incorrect Billing of Alternate Level of Care

According to the Department's Medicaid inpatient policies, hospitals must indicate a patient's "level of care" on claims to ensure accurate processing and payment. Certain levels of care are more intensive (and therefore more expensive) than others. When a hospital stay is composed of both acute care and lower levels of care, the Department requires hospitals to bill separate claims for days when patients are in an alternate (lower) level of care (ALC) setting.

We identified overpayments totaling $594,841 on 21 inpatient hospital claims. In each case, the hospital included ALC days within the acute inpatient stay claim instead of billing the ALC days separately. For example, Medicaid paid a provider $470,213 for an inpatient hospital claim that included a total of 518 days – 26 intensive level of care days and 492 ALC days. After we contacted the provider, they billed separate claims for each level of care. The new claims totaled $153,377 and resulted in a savings to Medicaid of $316,836. As a result of our audit work, on March 27, 2014, the Department implemented changes to eMedNY designed to deny inpatient hospital claims that combine acute and ALC days on the same claim.

During our audit, we contacted the providers who were overpaid. As a result of our inquiry, three providers adjusted seven claims, resulting in Medicaid recoveries totaling $534,389. At the time our fieldwork concluded, 14 claims that were overpaid by $60,452 had not been corrected.

Recommendation

4. Review and recover the remaining $60,452 in overpayments.

Incorrect eMedNY Claim Adjustment Reason Code Mapping

Insurance providers use claim adjustment codes to identify the reasons for differences between a provider's charge for a service and the payer's reimbursement. Insurance providers use combinations of adjustment codes, specifically Group Codes and Claim Adjustment Reason Codes (CARCs), to inform providers as well as other third-party payers (during the coordination of benefits) why a claim was either adjusted or denied payment.

The Group Code identifies who is financially responsible for the amount that the payer is not reimbursing the provider. For example, Group Code CO (Contractual Obligation) assigns financial responsibility to the provider and Group Code PR (Patient Responsibility) assigns financial responsibility to the patient. CARCs explain why the financial adjustment was made. For example,

CARC 1 indicates a deductible; CARC 2 indicates a coinsurance amount; and CARC 3 indicates a copayment. A combination of Group Code PR and CARC 2 would indicate the patient is responsible for paying a coinsurance amount.

Many Medicaid recipients are also enrolled in Medicare. When individuals are dual-enrolled in Medicaid and Medicare, Medicare becomes the primary payer and Medicaid is responsible for paying remaining patient financial obligations, such as coinsurance. When eMedNY processes claims that involve Medicare, the system relies on Group Codes and CARCs to correctly process and pay patient responsibilities. eMedNY interprets a claim's Group Codes and CARCs and "maps," or directs, the claim's processing to take certain actions (e.g., to pay or to not pay). For example, if Medicare used the Group Code CO (i.e., the provider is responsible for the unpaid balance) to adjust a provider's claim, and the provider subsequently submitted the claim to Medicaid with the Group Code CO, eMedNY should not pay the claim. Correct mapping of adjustment codes is essential to ensure Medicaid claims are paid accurately.

We identified 7,837 claims that eMedNY incorrectly mapped, which resulted in overpayments totaling $416,314. The claims were initially processed, adjusted, and paid by Medicare. According to the claims' Group Code (CO), the providers were contractually obligated for any unpaid balance. However, the providers billed claims for the unpaid balance to Medicaid using CARCs of either 1, 2, or 3, indicating a Medicare deductible, coinsurance amount, or copayment was due. In these instances, eMedNY failed to account for the Group Code and overpaid each claim.

We contacted one provider who billed 4,522 claims that overpaid $239,803 and requested supporting documentation for ten claims that overpaid $1,123. The provider acknowledged that all ten were billed incorrectly. The provider also stated their in-house billing process contained flaws, and as a result of our audit, changes would be made to ensure Group Codes and CARCs are billed correctly.

At the time the audit fieldwork ended, two providers began making corrections to their claims, resulting in Medicaid recoveries of $12,264. However, the remaining claims, with overpayments totaling $404,050, had not been adjusted.

Recommendations

5. Review and recover, as warranted, the remaining $404,050 in overpayments.

6. Make the necessary changes to eMedNY to ensure the correct mapping of Group Code CO and CARCs of 1, 2, and 3.

7. Provide technical assistance to the provider with the flawed system who billed 4,522 incorrect claims that Medicaid overpaid by $239,803 to ensure future overpayments are prevented. Recover any additional overpayments that may have occurred.

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 that 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 becomes 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 25 claims that resulted in overpayments totaling $360,117. Specifically, we identified overpayments totaling $111,094 on 18 claims (for which Medicaid paid $112,886) 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 14 of the 18 claims, saving Medicaid $91,926. Four providers, however, still needed to adjust four claims that were overpaid by $19,168.

We also identified overpayments totaling $54,324 on five claims 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 all five claims, saving Medicaid $54,324.

We also identified a hospital claim that was overpaid by $141,705 because the hospital improperly billed Medicaid as the primary insurer for a portion of the inpatient stay. Generally, Medicare covers up to 90 days of inpatient hospital services in a benefit period and an additional 60 lifetime reserve (LTR) days – the remaining financial obligation is a daily coinsurance charge. In this case, the hospital did not apply the patient's Medicare LTR days and improperly billed Medicaid as the primary insurer for 60 days of inpatient care that should have been billed as Medicare coinsurance. Initially, Medicaid reimbursed the hospital $165,374. After we contacted the provider, the claim was resubmitted correctly and eMedNY paid $23,669 (thus saving Medicaid the $141,705).

We also determined that an additional hospital claim, which Medicaid reimbursed $117,567 for a recipient's coinsurance charges, was overpaid by $52,994. According to the claim's Explanation of Benefits, the hospital was contractually obligated to absorb certain claim adjustments and other "write-offs" totaling $52,994. We referred the overpayment to the Office of the Medicaid Inspector General's audit recovery contractor (Health Management Systems), who advised that the claim may have been overpaid by approximately $53,000, pending further review.

Recommendations

8. Review and recover, as warranted, the remaining $72,162 ($19,168 + $52,994) in overpayments.

9. Periodically remind providers of their responsibilities to verify other insurance eligibility and properly record coinsurance, deductible, and copayment information when submitting claims to eMedNY.

10. Issue a provider update on proper claim submission when recipients have other forms of health insurance coverage.

Net Available Monthly Income

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 called net available monthly income, or NAMI, which is deducted from the amount that Medicaid pays each month to nursing homes.

Medicaid overpaid five providers a total of $112,981 on 57 claims. In each case, the providers failed to properly record NAMI on their claims to Medicaid. We contacted the providers and verified that they omitted the recipients' NAMI. As a result of our inquiry, the providers resubmitted most of their claims, resulting in Medicaid recoveries totaling $107,140. However, overpayments totaling $5,841 still need to be recovered.

Recommendation

11. Review and recover the remaining $5,841 in overpayments.

Other Improper Claim Payments

We identified $281,861 in improper payments resulting from excessive charges related to inpatient, clinic, transportation, and vision claims. We identified an additional $67,254 in duplicate billings. At the time our fieldwork concluded, $338,545 had been recovered. However, actions were still needed to address the balance of the improper payments totaling $10,570.

Newborn Inpatient Services

We identified two hospital inpatient claims for newborn services that Medicaid originally reimbursed $178,830 based on incorrect birth weights. Medicaid reimbursement of inpatient services for newborns is highly dependent on their birth weights, and low birth weights often increase the amounts of payments. We contacted the hospitals, and they resubmitted their claims with the newborns' correct weights. As a result, overpayments totaling $157,200 were recovered.

Patient Status (Discharge or Transfer) Codes

When providers bill Medicaid, they must include a patient status code on their claims that indicates whether the patient was discharged or transferred to another health care facility. The code is important because the reimbursement method (and amount) depends on whether a patient is discharged or transferred. A transfer claim often pays less (and sometimes significantly less) than a discharge claim.

We identified overpayments on two claims (totaling payments of $184,713) that contained incorrect patient status codes. Although the hospitals transferred the recipients to other health care facilities, the hospitals recorded a discharge code (instead of a transfer code) on the claims. At our request, the hospitals reviewed and corrected the claims, which reduced the total payments to $72,896, resulting in a Medicaid savings of $111,817 ($184,713 - $72,896).

Duplicate Claims and Payments

Medicaid overpaid nine providers a total of $67,254 on 26 claims because the providers billed services more than once. The duplicate payments occurred under different scenarios, as follows:

- Four providers billed the same physician-administered drug code twice within the same claim (the providers should have billed each drug code once and identified the units provided for each). The resulting overpayments totaled $53,647 on 20 claims; and
- Five providers billed the same service twice on six different claims, resulting in overpayments totaling $13,607.

Eight of the nine providers acknowledged their errors and corrected their overpaid claims, saving Medicaid $64,667. However, the remaining claim (overpaid by $2,587) still needed to be adjusted.

Clinic Service

A clinic claim overpaid $4,736 because the provider billed a $70 office visit as a surgical service for the insertion of a pacemaker. After contacting the provider, the claim was adjusted, saving Medicaid $4,736.

Transportation Services

Medicaid will pay the actual mileage to transport a recipient to and from the location where covered services are provided. The mileage fee is applied only to patient “loaded” miles – those miles during which the patient occupies the vehicle. One provider submitted two claims that paid $2,692 and $3,845, respectively. Both claims were for non-emergency taxi transportation and incorrectly included unloaded mileage (when the patients were not actually transported). The provider was overpaid a total of $4,590 ($1,890 for the first claim and $2,700 for the second claim). At the time the audit fieldwork concluded, the two claims had not been adjusted.

Vision Care

Medicaid pays for routine vision care (such as eyeglasses and routine eye exams), and Medicare generally does not. Consequently, when submitting claims for routine vision services provided to recipients who are enrolled in both Medicaid and Medicare, Medicaid requires providers to apply the Medicaid program's standard fee amounts. 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. Providers must adhere to all applicable Medicaid policies when billing Medicaid, and are required to keep detailed records of the services provided to Medicaid recipients.

We identified overpayments totaling $3,518 on 59 claims. The overpayments occurred under three different scenarios, as follows:

- Two providers did not supply sufficient documentation to support services billed to Medicaid, resulting in potential overpayments totaling $3,239.
- One provider incorrectly billed Medicare coinsurance when Medicare denied the claim, resulting in an overpayment of $154.
- Another provider erroneously billed for a service that was not provided. The provider voided the claim, saving Medicaid $125.

At the time the audit fieldwork concluded, a provider corrected one claim, saving Medicaid $125. However, adjustments were still needed on the remaining 58 claims, with overpayments totaling $3,393.

Recommendations

12. Review and recover the unresolved overpayments totaling $10,570 ($4,590 in transportation + $3,393 in vision care services + $2,587 in duplicative billings).

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

14. Formally instruct providers how to properly submit claims for physician-administered drugs provided in multiple units on the same date of service.

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 the provider receives Medicaid payments.

We identified 16 Medicaid providers who were charged with or found guilty of crimes that violated the laws or regulations of a health care program. Eleven of these providers had an active status in the Medicaid program and five 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 these providers, and the Department terminated 12 of them from the Medicaid program. Prior to program termination, Medicaid paid two (of the 12) providers a total of $16,659. At the time our audit fieldwork ended, the Department had not resolved the program status of the remaining four providers.

Recommendations

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

16. Investigate the propriety of the payments (totaling $16,659) 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 October 1, 2013 through March 31, 2014. 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 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

NEW YORK STATE OF OPPORTUNITY. | 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

April 29, 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 2013-S-50 entitled, "Medicaid Claims Processing Activity October 1, 2013 through March 31, 2014."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2013-S-50 entitled, "Medicaid Claims Processing Activity October 1, 2013 to March 31, 2014"

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-50 entitled, "Medicaid Claims Processing Activity October 1, 2013 to March 31, 2014."

Background:

New York State (NYS) 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, NYS 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 remaining $28,028 in overpayments.

Response #1:

The $28,028 in overpayments has been recovered.

Recommendation #2:

Review the $682,022 in pharmacy payments and recover overpayments, as appropriate.

Response #2:

The OMIG will review the overpayments identified and pursue recovery as appropriate.

Recommendation #3:

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

Response #3:

The Department educates pharmacies on potential patient safety issues through Prospective and Retrospective Drug Utilization Review (DUR). The DUR Program promotes safety through State administered utilization management tools and systems that interface with the Centers for Medicare and Medicaid Services' Medicaid Management Information Systems. Medicaid DUR is a two phase process that is conducted by the Medicaid State agencies. In the first phase (prospective DUR), the State's Medicaid agency's electronic monitoring system screens prescription drug claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy and clinical misuse or abuse. The second phase (retrospective DUR) involves ongoing and periodic examination of claims data to identify patterns of fraud, abuse, gross overuse, or medically unnecessary care and implements corrective action when needed.

42 CFR Subpart K – Drug Use Review (DUR) Program and Electronic Claims Management System for Outpatient Drug Claims, Section 456.700-456.725, provides the requirements for the DUR program.

The Department also educates pharmacies on various Medicaid requirements through the Medicaid Pharmacy Manual Policy Guidelines. Many of these guidelines are republished periodically in the Department's Medicaid Update:

(http://www.healthy.ny.gov/health_care/medicaid/program/update/main.htm)

As an example, guidelines on faxed prescriptions were published in the May, 2014 issue of the Medicaid Update.

In addition, the OMIG educates providers during the audit process. Their audit protocols for Pharmacy can be found on their website at:

http://www.omig.ny.gov/audit/audit-protocols

And finally, the Department has provided Computer Sciences Corporation (CSC) Provider Services specific instructions as to the proper reporting of pharmacy claims. CSC will formally provide instruction to those pharmacies identified in this audit report.

Recommendation #4:

Review and recover the remaining $60,452 in overpayments.

Response #4:

The Department contacted the Island Peer Review Organization (IPRO), its' contracted NYS Medicaid Review Agent, to review the remaining fourteen (14) claims through its multi-level, physician review process to determine if the appropriate "level of care" was billed throughout the patient stay. For claims identified with days that should have been paid at an alternate (lower) level of care setting, IPRO will submit adjustments through the eMedNY system to deny days billed incorrectly and recoup the related overpayments.

IPRO has reviewed all 14 claims at the nurse level (first level of review) and/or the physician level (second level of review). The results are as follows:

- Six (6) were approved for Length of Stay (LOS).
- Eight (8) were denied at the physician level and the subject providers were notified.

In five (5) of the cases, the provider agreed with IPRO's findings. IPRO is awaiting provider responses in the remaining three (3) cases. Upon hearing from these three remaining providers, IPRO will submit its adjustments to eMedNY and recoup the remaining overpayments.

Recommendation #5:

Review and recover, as warranted, the remaining $404,050 in overpayments.

Response #5:

The OMIG's Recovery Audit Contractor (HMS) will review the overpayments, and recover as appropriate.

Recommendation #6:

Make the necessary changes to eMedNY to ensure the correct mapping of Group Code CO and CARCs of 1, 2, and 3.

Response #6:

EMedNY's Third Party Liability Unit is in the process of implementing systems changes that will correctly map Group Code CO and Claim Adjustment Reason Codes (CARCs) of 1, 2, and 3. Once this is completed, claims will be reviewed, reprocessed and monitored to correct payments.

Recommendation #7:

Provide technical assistance to the provider with the flawed system who billed 4,522 incorrect claims that Medicaid overpaid by $239,803 to ensure future overpayments are prevented. Recover any additional overpayments that may have occurred.

Response #7:

The Department has provided CSC Provider Services specific instructions as to the appropriate reporting of claims associated with CARCs 1, 2 and 3. CSC will formally instruct the provider identified in this audit report. The OMIG will recover overpayments as appropriate.

Recommendation #8:

Review and recover, as warranted, the remaining $72,162 ($19,168 + $52,994) in overpayments.

Response #8:

The OMIG's Recovery Audit Contractor (HMS) has verified that the claims have been adjusted, and are now paid correctly.

Recommendation #9:

Periodically remind providers of their responsibilities to verify other insurance eligibility and properly record coinsurance, deductible, and copayment information when submitting claims to eMedNY.

Recommendation #10:

Issue a provider update on proper claim submission when recipients have other forms of health insurance coverage.

Response #9 and #10:

Providers are reminded of their responsibilities regarding the verification of other insurance eligibility and properly record coinsurance, deductible, and copay information. This was done in the February, 2014 Medicaid Update. A revised article was recently issued in the December 2014 Medicaid Update as follows:

Providers Urged to Submit Correct Coordination of Benefits (COB) Information to Medicaid for Medicare Advantage (Part C) Recipients

A recent review of claims has uncovered persistent misreporting of patient responsibility when the patient is enrolled in both the Medicare Advantage Plan (Part C) and Medicaid. The following practices were uncovered:

- A Medicare Advantage Plan made an adjustment to a claim after the claim was billed to Medicaid, and the billing provider did not make an adjustment to the Medicaid claim, resulting in an overpayment,
- Overpayments resulted because excessive Medicare Advantage Plan coinsurance, deductible and/or co-payments were reported on COB claims to Medicaid, and
- Reporting Cost Avoidance (formerly known as ZERO FILL) on a service that was in fact covered by a Medicare Advantage Plan

Provider Responsibilities

It is the responsibility of a provider who renders services to a Medicaid recipient to verify their eligibility before treatment. All payers reported in the eligibility response must be accounted for in the COB reporting on the claim to Medicaid.

The misreporting of information on COB claims may at times result in inappropriate payments to a provider. Providers are reminded that both Federal and State laws specify that providers

participating in the Medicaid program must not retain any inappropriate payments. Knowingly retaining inappropriate payments violates the Fraud Enforcement and Recovery Act (FERA), which amended the Federal False Claims Act.

In addition, effective May 22, 2010, the Affordable Care Act (ACA) amended the Social Security Act (SSA) to include a variety of Medicare and Medicaid program integrity provisions. A new section under SSA, §1128J (d), requires providers of Medicare or Medicaid services or supplies to notify the program and return any inappropriate payments to the program(s) within sixty (60) days of identifying the overpayment.

It is imperative that COB claims submitted to Medicaid after Medicare or other Third Party adjudication contain all information as provided in the Remittance Advice, in accordance with Section 1.4.1.1 (COB Models) of the HIPAA 837 Claims Implementation Specifications or Technical Reports. The information is to include the Claim Adjustment Group Codes (CAGCs) and Claim Adjustment Reason Codes (CARCs) received from the previous payer(s).

Billing Remedies

Medicare Advantage Plan adjusts a previously adjudicated claim that has been billed to Medicaid:

The provider must send an adjusted claim with the corrected information - the Medicaid claim must be adjusted to accurately reflect Medicare's reprocessing of the claim.

Provider billed an incorrect coinsurance, deductible, or co-payment:

The Medicaid claim must be adjusted. In order to correctly bill the patient responsibility to Medicaid, the adjustments on the remit from Medicare Advantage Plan must be cross-walked, **without any modification**, to the Medicaid Claim.

Reporting Cost Avoidance on a claim covered by the Medicare Advantage Plan:

The Primary insurance, a Medicare Advantage Plan, must be billed. Upon receiving the Medicare Advantage Plan remit, the submitter must adjust the Medicaid claim. The adjusted claim must report all adjustments from the remit, without modification, in the Coordination of Benefits 837 claim to Medicaid.

Providers who may need technical assistance complying with COB claims submission requirements should contact **eMedNYHIPAASupport@csc.com**.

Recommendation #11:

Review and recover the remaining $5,841 in overpayments.

Response #11:

The OMIG will review the overpayments identified and pursue recovery as appropriate.

Recommendation #12:

Review and recover the unresolved overpayments totaling $10,570 ($4,590 in transportation + $3,393 in vision care services + $2,587 in duplicative billings).

Response #12:

The OMIG will review the overpayments identified and pursue recovery as appropriate.

Recommendation #13:

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

Response #13:

The Department agrees with the OSC's statement in audit Section Subtitle 3 regarding the payment by Medicaid for mileage to and from a location where services were provided and applying the reimbursement fee only to patient loaded miles, those miles during which the enrollee occupies the taxi. The Department, in a letter dated November 4, 2014, contacted Rude Dog Transportation Corporation to remind them that it is improper to bill Medicaid for unoccupied trip portions and to request that they review their paid claims and, where applicable, adjust the paid claims to reflect the actual number of miles where the enrollee was transported. The OMIG will review the claims and recover any overpayments.

The Department, as a result of the preliminary report of this audit, has also instructed CSC Provider Services (via transmittal H-450-12478 on November 6, 2014) to reach out to the inpatient and outpatient providers identified in Section 7 of this report, to provide appropriate instruction and training for the billing issues noted. CSC notified the Department on November 24, 2014 in Transmittal R-450-09798 that the appropriate instruction and training had been completed.

Recommendation #14:

Formally instruct providers how to properly submit claims for physician-administered drugs provided in multiple units on the same date of service.

Response #14:

A Medicaid Update article has been written that will notify providers how to properly submit claims for physician-administered drugs when provided in multiple units on the same date of service. It is expected to be published in the June 2015 Medicaid Update.

Recommendation #15:

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

Response #15:

Of the remaining four providers identified by OSC, one is pending verification of sentencing before the OMIG may take an action, two are under review, and one is under investigation.

Recommendation #16:

Investigate the propriety of the payments (totaling $16,659) made to the two providers who violated Medicaid laws or regulations. Recover any improper payments, as appropriate.

Response #16:

The OMIG is pending all potential actions against both providers because they are under criminal indictment.