Re: MMIS Claims Processing Activity
Report 99-D-2

Dear Dr. Novello:

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 have reviewed the accuracy of claims processed by the Medicaid Management Information System for the twelve months ended March 31, 2000.

A. **Background**

The Department of Health (Department or Health) administers the State’s Medical Assistance program (Medicaid), which was established in accordance with Title XIX of the Federal Social Security Act to provide medical assistance to needy people. Health’s fiscal agent, Computer Sciences Corporation, uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims and pay providers for medical services rendered to eligible Medicaid recipients. In New York, the Federal, State and local governments jointly fund the Medicaid program. During the twelve months ended March 31, 2000, MMIS processed 167.5 million claims, including 59.2 million claims relating to retroactive adjustments. MMIS paid $25.4 billion to settle all the claims.

The Office of the State Comptroller (OSC) has on-site staff conducting continuous audits of MMIS. Each week, our on-site staff execute a series of computer programs to extract claims data from the newly adjudicated claims payment file. We designed the programs to extract those claims most likely to have been overpaid. We analyze the reports generated by these programs and select claims for in-depth review.

This report is a summary of our examination of Medicaid payments for the 12 month period ended March 31, 2000. We reported details concerning exceptions and related causes to Health
during the period of our review, so that recovery of overpayments could be initiated promptly.

B. Results of MMIS Claims Review

Based on available claims payment information, we determined that MMIS overpaid providers $32 million. In addition, we found another approximately $1.7 million that may have been overpaid.

1. Actual Inpatient Hospital Overpayments

We determined that inpatient provider errors caused MMIS to overpay 2,668 claims valued at $31,970,028. Of this amount, $8,750,056 pertains to 974 claims that had already been recovered from providers prior to the completion of our field work on June 9, 2000. For the remaining $23,219,972, which represents 1,694 claims, the Department needs to make recoveries from providers. In accordance with regulations, providers are expected to take reasonable action to maximize third-party insurance resources and record such revenues on the Medicaid claim. In many of the overpaid claims, such revenues had not been attained or the information on the claims was improperly recorded. The following paragraphs describe the error conditions we identified during our review and the amounts which need to be recovered.

We identified that MMIS overpaid 2,600 claims valued at $31,181,341. In these instances, we found that other insurers had already paid the claim, or providers had not taken or could not demonstrate reasonable actions to first bill other insurers as required by Department regulations. In some instances, we found that providers did not comply with insurers' requirements of prior notification and billing within their time-limit rules.

MMIS overpaid 68 claims by $788,687 due to other miscellaneous provider billing errors. For example, MMIS pays a higher reimbursement for newborns with low birth weights. We noted that providers incorrectly entered the birth weight of newborns on the Medicaid claim forms, resulting in overpayments.

2. Actual Skilled Nursing Facility Overpayments

Regarding payments to skilled nursing facilities, we noted that MMIS overpaid 558 claims totaling $592,437. In these claims, the providers billed MMIS using their per-diem rates when the claims should have reflected billing for Medicare coinsurance rates. Medicare coinsurance rates are generally lower than Medicaid per-diem rates. We provided detailed information concerning these claims to the skilled nursing facilities and requested that they submit adjustment claims to effect Medicaid recovery.

3. Actual Health Maintenance Organization Overpayments

Regarding managed care billings, we noted that MMIS overpaid $119,557 (representing 1,769 claims). For these health maintenance organizations (HMOs), Medicaid paid a higher paying rate code for health care services intended for recipients age zero to five months. Our analysis showed that in the claims in question, the recipients were in fact older than five
months. In addition, our analysis of the amount entered by the HMOs in the amount charge field of the claim form showed the amount that Medicaid should have paid. We provided detailed information concerning these claims to the HMOs and requested that they submit adjustment claims to effect Medicaid recovery.

4. **Potential Overpayments to Inpatient Hospitals**

We identified 68 claims totaling $1,725,749 that MMIS potentially overpaid. In these claims, we noted that insurers had determined that the recipients’ inpatient hospital stay was not medically necessary. Therefore, we question the appropriateness of these MMIS payments. We referred the claims in question to the Department for review by the Department’s peer review contractor.

C. **Medicaid Rate Revisions**

Health sets Medicaid hospital rates; payments to hospitals are based on such rates, which are calculated based on provider operating and peer-group costs. When Health revises Medicaid rates, the MMIS automatically re-prices the hospital’s previously paid claims affected by the rate change and generates a payment based on the rate revision. It is critical that the rates calculated by Health are accurately recorded on the MMIS rate master file.

In this regard, in cooperation with Health staff, we prevented the overpayment of $3,835,588 to a downstate hospital. In this instance, we found that Health updated the facility’s daily rehabilitation rate at $11,106. However, we confirmed with Health’s rate setters that the daily rate should have been $1,863. We also confirmed that the hospital’s rate was subsequently restored to the correct rate of $1,863.

D. **Provider-Owed Balances**

As part of routine MMIS claims processing, it is sometimes determined that providers owe money to Medicaid, either because previous claims were retroactively adjusted to a lower payment rate or because previous claims were incorrectly paid. In these cases, such adjustments result in provider-owed balances, which are normally collected from a provider’s future billings. However, these balances may remain uncollected for a long period of time if the provider stops billing MMIS. Working in conjunction with Health’s Division of Administration, we were able to effect the recoupment of $567,598 of provider-owed balances to the Medicaid program.

E. **Third Party Insurance Files**

The Federal Social Security Act requires that Medicaid be the payor of last resort. The MMIS meets this requirement using the MMIS third-party insurance master file. The insurance master file includes coverage dates, which MMIS uses to determine if insurance existed on the date of service. We reviewed the status of recipients’ insurer coverage dates as of December 31, 1999, to determine whether Health updated the MMIS master files to extend recipient’s coverage dates after December 31, 1999. Extending insurance coverage dates beyond December 31, 1999 was necessary in preparation for the year 2000.
We identified 546 active-enrolled recipients with commercial insurer coverage dates ending on December 31, 1999. It is possible that some of these recipients’ insurance may still have active insurance coverage. As a result, the likelihood exists that MMIS will pay claims that should have been paid by insurance carriers. We have referred these insurance cases to the Department for follow-up.

**Recommendations**

1. Recover Medicaid overpayments totaling $23,219,972 relating to 1,694 inpatient hospital claims.

2. Recover Medicaid overpayments totaling $119,557 relating to 1,769 managed care organization claims.

3. Recover Medicaid overpayments totaling $592,437 relating to 558 skilled nursing facility claims.

4. In conjunction with the Department’s peer review agent, assess the appropriateness of the 68 inpatient hospital claims totaling $1,725,749 relating to medical necessity and, as appropriate, recover any overpayments.

5. In conjunction with the local districts, evaluate whether the 546 recipients with end dated insurance coverage have active coverage and, as necessary, update the MMIS third-party insurance files to reflect active insurance status.

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We would appreciate receiving your response to the recommendations made in this report within 30 days, indicating any action planned or taken to implement the recommendations. We also wish to express our appreciation for the courtesies and cooperation extended to our auditors during their review.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Charles Conaway