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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

October 10, 2007

Richard F. Daines, M.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Report 2007-F-21

Dear Dr. Daines:

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 followed up on the actions taken by the Department of Health officials to implement the recommendations contained in our audit report, *Duplicate Medicaid Payments to Clinics* (Report 2006-S-35).

Background, Scope and Objective

The New York State (State) Department of Health (Department) administers the State's medical assistance program (Medicaid), which was established under Title XIX of the Federal Social Security Act to provide needy people with medical services. In this State, Medicaid is funded jointly by the federal, State, and local governments. Its management information and claims processing functions are handled through the State's eMedNY system, which the Department implemented on March 24, 2005.

Clinics are independent facilities that provide preventive, diagnostic, therapeutic, or rehabilitative services to recipients on an outpatient basis. For many of the services performed by clinics, Medicaid pays a per visit all-inclusive rate. When billing Medicaid, clinics are required to complete a claim using the Medicaid all-inclusive rate code and the appropriate medical procedure code for the services provided to the recipients. According to the Department's billing guidelines, clinics are allowed to bill only one claim for each Medicaid recipient per day. During claims processing, eMedNY checks for duplicate claims by comparing several claim fields on the current claim to the same claim fields on previously paid claims.

Our initial audit report, which was issued on September 7, 2006, determined if clinics billed for services according to the billing policy set forth in the Department's guidelines. We identified six clinics that submitted duplicate Medicaid claims resulting in inappropriate duplicate payments of nearly $336,000. We determined the first claim submitted by the providers complied with the Department's billing guidelines and the claims paid properly. In these claims, the provider completed the claim with the required billing rate code and the medical procedure code. However, eMedNY paid the second claims inappropriately because the providers neglected to include the procedure code on the Medicaid claim. Without the required procedure coding information, eMedNY could not detect the services submitted on the first clinic claim were identical to the services on the second claim resulting in a duplicate payment. The eMedNY system lacked the necessary edit controls to detect duplicate clinic payments when providers neglected to provide all the required claim information.

The objective of our follow-up, which was conducted in accordance with generally accepted government auditing standards, was to assess as of October 1, 2007, the extent of implementation of the two recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

We determined Department officials have made progress in correcting problems we identified. However, additional action is necessary. Of the two prior audit recommendations, one recommendation was fully implemented and one has been partially implemented.

Follow-up Observations

Recommendation 1

Recover the $336,000 duplicate payments identified.

Status - Partially Implemented

Agency Action - The Department, through the Office of the Medicaid Inspector General (Office), is presently conducting a case record review of two providers that represented 99 percent of the overpayments identified in our audit. The Office will seek restitution from the remaining four providers if the Office's initial review of the two largest providers confirms overpayments were in fact made.

Recommendation 2

Design and implement eMedNY controls to prevent this type of duplicate payment from occurring.

Status - Implemented

Agency Action - The Department designed two edits for its eMedNY claims processing system to detect the type of duplicate clinic payments we identified. We tested the edits and found they were working properly. Since the implementation of the edits on July 9, 2007, 834 claims totaling approximately $96,680 have been denied.

Major contributors to this report were Andrea Inman, Daniel Towle and Wendy Matson.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We wish to thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this process.

Very truly yours,

Sheila Emminger
Audit Manager

cc: Lisa Ng, Division of the Budget
Stephen Abbott, Department of Health
Steven Sossei, OSC State Government Accountability