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

Division of State Government Accountability

Medicaid Claims Processing Activity April 1, 2011 Through September 30, 2011

Medicaid Program
Department of Health

Report 2011-S-9 January 2013

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 April 1, 2011 through September 30, 2011.

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 September 30, 2011, eMedNY processed approximately 178 million claims resulting in payments to providers of about $25 billion. The claims are processed and paid in weekly cycles which averaged about 6.8 million claims and $954 million in payments to providers.

Key Findings

- Auditors identified about $7.8 million in overpayments resulting from:
  - Claims billed with information from other health insurance plans that was inaccurate. About $6.4 million in overpayments were attributable to claims which had excessive amounts for coinsurance, copayments, or deductibles from other plans;
  - Duplicate claims for the same procedures;
  - Inpatient claims billed with incorrect patient status codes and with high (intensive) levels of care that should have been based on less costly "alternate" levels of care;
  - Claims for a recipient who did not live in New York State; and
  - Improper claims for certain clinic services, physician-administered drugs, and vision care.
- Auditors recouped about $7.5 million of these overpayments and took steps to prevent future overpayments.
- Auditors also found 21 providers in the Medicaid program who were charged with or found guilty of crimes that violate Medicaid program laws or regulations. The Department promptly terminated 20 of these providers, but the status of the remaining provider (whom Medicaid paid $5,164 after his sentencing) was still under review.

Key Recommendations

We made 20 recommendations to the Department to recover the inappropriate Medicaid payments and to improve claim processing controls.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Claims Processing Activity October 1, 2010 through March 31, 2011 (2010-S-65)

Department of Health: Medicaid Claims Processing Activity April 1, 2010 through September 30, 2010 (2010-S-15)

Department of Health: Medicaid Claims Processing Activity October 1, 2009 through March 31, 2010 (2009-S-71)

State of New York
Office of the State Comptroller

Division of State Government Accountability

January 10, 2013

Nirav Shah, M.D., M.P.H.
Commissioner
Department of Health
Corning Office Building
Empire State Plaza
Albany, New York 12237

Dear Dr. Shah:

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 April 1, 2011 through September 30, 2011. 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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This report is also available on our website at: www.osc.state.ny.us

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. The federal government funds about 49 percent of New York's Medicaid costs; the State funds about 34 percent; and the localities (the City of New York and counties) fund the remaining 17 percent.

The Department of Health's (Department's) 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 September 30, 2011, eMedNY processed approximately 178 million claims resulting in payments to providers of about $25 billion. The claims are processed and paid in weekly cycles which averaged about 6.8 million claims and $954 million in Medicaid payments to the providers.

When Medicaid claims are processed by eMedNY, they are subject to various automated edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate. For example, some edits verify the eligibility of the Medicaid recipient, other edits verify the eligibility of the medical service, and other edits verify the appropriateness of the amount billed for the service. In addition, some edits compare the claim to other related claims to determine whether any of the claims duplicate one another.

The Office of the State Comptroller performs audit steps during each weekly cycle of eMedNY processing to determine whether eMedNY has reasonably ensured the Medicaid claims were processed in accordance with requirements, the providers submitting the claims were approved for participation in the Medicaid program, and the amounts paid to the providers were correct. As audit exceptions are identified during the weekly cycle, our auditors work with Department staff to resolve the exceptions in a timely manner so payments can be made to providers. If necessary, payments to providers can be suspended until satisfactory resolution of the exceptions has been achieved.

In addition, the audit work performed during the weekly cycle may identify patterns and trends in claims and payment data that warrant follow-up and analysis as part of the Comptroller's audit responsibilities. Such follow-up and analytical audit procedures are designed to meet the Comptroller's constitutional and statutory requirements to audit all State expenditures.

Audit Findings and Recommendations

Based on the results of our audit work for the weekly cycles of Medicaid payments made during the six months ended September 30, 2011, 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. For example, we found overpayments pertaining to claims involving other insurance information that was inaccurate; hospital claims for services that should have been billed at lower reimbursing alternate levels of care; claims for overlapping clinic and inpatient services; claims with incorrect patient (discharge) status codes; and claims for a recipient who was no longer a resident of the State. In total, we identified actual and potential overpayments of approximately $7.8 million. At the time our audit fieldwork concluded, about $7.5 million of these overpayments had been recovered.

Other Insurance on Medicaid Claims

Many Medicaid recipients also have other health insurance coverage (mostly Medicare). When submitting Medicaid claims, providers must verify that such recipients have other insurance coverage on the dates of the services in question. If the individual has other insurance coverage, that insurer becomes the "primary insurer" and must be billed first. In this case, Medicaid (as the secondary insurer) 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 insurer, Medicaid is the primary insurer and should be billed first.

Errors in claims' designation of the primary payer and/or the amounts of charges for coinsurance, copayments, and deductibles will likely result in improper Medicaid payments. We identified $7.1 million in overpayments pertaining to 2,114 claims for Medicaid recipients with other health insurance coverage. At the time our fieldwork concluded, 2,106 (of the 2,114) claims were corrected, saving Medicaid $6,931,576. Adjustments were still needed for the remaining 8 claims, corresponding to overpayments of as much as $173,025.

Specifically, we identified overpayments totaling $6,405,583 on 14 claims that resulted from excessive charges for coinsurance and copayments for recipients with other insurance coverage. Most of this was attributable to an overcharge of $6,171,957, wherein a provider inadvertently posted a date into the field designated for the amount of a copayment. We contacted the providers and notified them of the incorrect information on these 14 claims. At the time of our review, the providers adjusted all 14 of the claims, saving Medicaid $6,405,583.

We also identified 53 claims totaling $861,752 with the wrong primary insurer. For 48 of these claims totaling $367,718, another insurer (usually Medicare) was designated as the primary insurer when it should have been Medicaid. In these cases, the recipients had Medicare coverage at one time, but their coverage ended before the provider's date of service. Nonetheless, providers submitted claims as though Medicare was the primary payer - and the amounts charged to Medicaid were greater than the amounts Medicaid would have normally paid as the primary

payer. We contacted the providers and notified them of the incorrect designations of Medicaid as the secondary payer. At the time of our review, the providers adjusted 42 of the 48 claims, saving Medicaid $262,956. Adjustments were still needed for the six other claims, corresponding to payments totaling $71,973.

For the remaining five (of the 53) claims totaling $494,034, 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 of our review, the providers adjusted 3 of the 5 claims, which saved Medicaid $245,038. At the time our fieldwork concluded, adjustments were still needed for the remaining two claims that were paid $152,132.

Additionally, we determined other improper payments were generated for claims submitted with Medicare Part A insurance information - when they should have had Part B information. These overpayments were caused by a flaw in the eMedNY claims processing. We notified the Department of this problem, and officials recovered overpayments of $18,000 made on 2,047 improper claims. The Department also initiated a system project to correct eMedNY processing of such claims in the future.

We also concluded that the Department could have prevented most of the overpayments we identified with better eMedNY controls. For example, many claims we reviewed were subjected to the eMedNY edit "Medicare/MCO Payer Amounts Not Reasonable." However, the edit was "set to pay" (as opposed to pend or deny) a questionable claim. If this edit was set to pend or deny payment, eMedNY could have prevented the aforementioned overpayment (totaling $6,171,957) when a date was entered into the field designated for a copayment. We have identified similar errors in prior audits. Thus, the Department needs to take prompt actions to ensure that eMedNY prevents overpayments of this magnitude in the future. In addition, the Department should improve eMedNY processing to prevent overpayments when inaccurate primary insurer information is submitted on a claim.

Recommendations

1. Review and recover overpayments on the eight incorrect claims (totaling payments of $224,105) cited in the report.

2. Formally assess the efficacy of changing the disposition on the eMedNY edit that tests the reasonableness of Medicare/MCO amounts to pend or deny claims with unreasonable amounts.

3. Develop and implement solutions to properly process payments when primary insurer information on a claim does not match related eMedNY data.

4. Implement a system change to correct eMedNY processing of claims submitted with an incorrect Medicare insurance designation.

Duplicate Hospital Clinic Billings

Medicaid overpaid 74 claims from three hospital clinics by $256,762 because the clinics billed for certain procedures more than once. For example, we determined that:

- A clinic billed for anesthesia services five times on a single claim when it can be billed only once per claim. Upon our notification, this provider identified 71 other similar claims that were incorrect. The overpayments for the 72 claims totaled $236,738;
- A clinic billed the same procedure on two claims with overlapping dates of service, although the procedure was only performed once on a single day. The overpayment on this claim totaled $16,800; and
- A clinic billed anesthesia services on four days when the service was provided only once on a single day. The overpayment of this claim totaled $3,224.

The three providers acknowledged their errors and corrected the 74 overpaid claims, saving Medicaid $256,762.

Recommendation

5. Formally advise the three clinics in question to not submit claims with duplicative charges. On a risk basis, monitor the claims of the three clinics to ensure they do not include duplicate charges.

Alternate Level of Care

According to Department Medicaid guidelines, 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. Thus, hospitals should not bill for intensive levels of care for days when patients are in an alternate (lower) level of care (ALC) setting.

We identified overpayments totaling $161,521 on two inpatient hospital claims because the hospitals billed a more costly level of care than what was actually provided. On these claims, the hospitals indicated ALC days during some portion of the patients' admissions. However, the hospitals billed all of the days at higher levels of care. Although Medicaid paid $764,830 on the two claims, it should have paid only $603,309 (to properly account for the lower costing ALC days). We advised the hospitals of these billing errors, and hospital officials agreed to correct the claims - which should save Medicaid $161,521 ($764,830 - $603,309). At the time our fieldwork concluded, however, the hospitals had not adjusted the two claims through eMedNY.

Recommendation

6. Review and recover the unresolved overpayments (totaling $161,521) on the two claims with excessive charges for ALC days.

Inaccurate Patient Status Codes

When a hospital bills Medicaid, it must include a patient status code (code) which 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 transferred or discharged. When a patient is discharged, institutional medical treatment is ostensibly complete. When a patient is transferred, medical treatment has not been completed. Hence, a transfer claim often pays less (and sometimes significantly less) than a discharge claim.

We identified an inpatient claim that paid $237,103 because the hospital entered a discharge code when it should have applied a transfer code. On the day the patient left the hospital that submitted this claim, the patient was admitted to a different hospital. At our request, the hospital corrected the claim, reducing the payment to $88,860 and saving Medicaid $148,243 ($237,103 - $88,860).

Recommendation

7. Formally advise the hospital in question to ensure that the patient status codes on claims are correct.

Overlapping Clinic Services During Inpatient Stays

The Department establishes all-inclusive hospital inpatient rates that generally cover the costs of all medical services provided to Medicaid recipients during their admission. Under this type of arrangement, no additional payments should be made for services provided to recipients while they are hospitalized.

However, we identified 18 claims (totaling $46,564) for clinic (ambulatory) services when a recipient was already admitted, as an inpatient, to the clinic's affiliated hospital. Although eMedNY has an edit that denies clinic claims with dates of service that overlap inpatient stays, the edit did not apply to certain ambulatory surgery codes on the claims we identified. Upon notification, the clinic identified 12 more claims (totaling $29,275) that were also billed incorrectly.

As a result of our audit, the clinic voided 29 of the 30 claims realizing a Medicaid cost savings of $65,103. At the time our fieldwork concluded, the clinic was working to determine the outcome of the remaining claim.

Recommendations

8. Strengthen eMedNY controls to prevent payment of clinic claims that contain the hospital ambulatory surgery procedure codes we identified when they are billed on the same date of service as a hospital inpatient admission.

9. Instruct the identified provider how to correctly bill such claims and monitor for compliance.

10. Review and recover the unresolved overpayment on the remaining claim.

Physician-Administered Drugs

Medicaid requires providers to bill physician-administered drugs at their acquisition costs, including any discounts given by the drugs' manufacturers. To pay a claim for a physician-administered drug, eMedNY compares the drug's acquisition cost (as indicated by the provider) to the maximum allowable Medicaid fee - and pays the lesser of the two amounts. Typically, a provider's drug acquisition cost is less than the maximum allowable Medicaid fee. Thus, when a provider overstates the acquisition cost of a physician-administered drug, there is considerable risk that Medicaid will overpay the claim.

We identified $62,726 in overpayments Medicaid made on 49 claims submitted by 13 providers of physician-administered drugs. On these claims, the providers billed Medicaid amounts well in excess of the drugs' actual acquisition costs, which were generally less than the maximum Medicaid fee amounts. We estimate the actual acquisition costs for the drugs totaled only $238,220 - less than one-third the amount ($755,000) the providers claimed. For example, one provider submitted a claim for $35,608 for multiple physician-administered drugs. Pursuant to Medicaid's maximum allowable fees, eMedNY paid $9,768 on this claim. However, based on the provider's invoices, we determined the actual acquisition costs for the drugs totaled only $1,185. At our request, the provider corrected this claim, saving Medicaid $8,583 ($9,768 - $1,185).

At the time our fieldwork concluded, providers corrected certain claims (saving Medicaid $21,097), and corrections saving another $15,918 are expected. Further actions, including the presentation of supporting documentation, are still needed to resolve apparent overpayments on 18 claims totaling $25,711.

One provider attributed its overcharges to human error. Five others stated they were unaware of the excessive drug claims and noted limitations in their billing systems. Moreover, as a result of our audit, several providers are reviewing their systems for billing physician-administered drugs to help ensure that future claims for such drugs are prepared and submitted properly to eMedNY.

Recommendations

11. Review and recover the $15,918 in expected corrections and the unresolved overpayments (totaling $25,711) on the remaining 18 claims.

12. Formally instruct the 13 providers identified by our audit of the correct way to claim payments for physician-administered drugs. Actively monitor the submissions of such claims by these providers.

13. Through automated and/or manual processes, strengthen the controls over claims for physician-administered drugs when providers' stated acquisition costs exceed the maximum allowable Medicaid fee amount.

Recipient Residing in Pennsylvania

According to NYCRR Title 18, Section 360-3.2, a recipient's state of residence is responsible for providing public medical assistance. Hence, someone must be a resident of New York State to be eligible for New York Medicaid. Further, a recipient's New York eligibility should be terminated if another state has determined the person is a resident of that state for Medicaid purposes.

We identified recurring claims from out-of-state providers for a recipient who was no longer a resident of New York and, therefore, was not eligible for New York Medicaid benefits. The recipient resided in Pennsylvania and was enrolled in Pennsylvania's Medicaid program at the time the payments were made by New York. In fact, the recipient had been a resident of Pennsylvania and was eligible for Pennsylvania Medicaid since 2005. As a result, New York should not have paid 86 claims totaling $19,992 for services rendered between March 1, 2008 and September 27, 2011.

In New York State, local social service districts (including the New York City Human Resources Administration [or HRA]) are responsible for ensuring applicants meet eligibility requirements, enrolling them in Medicaid, and ensuring their enrollment information is current. Further, reports from the Federal government's Public Assistance Reporting Information System identify individuals who are enrolled in two or more states' Medicaid programs at the same time. Nevertheless, HRA officials did not identify the person in question and remove that person from New York's Medicaid Program. Consequently, eMedNY made the improper payments (totaling $19,992) we identified.

Recommendations

14. Recover the $19,992 in inappropriate payments for the person who resides in Pennsylvania and is enrolled in Pennsylvania's Medicaid program.

15. Ensure that the person in question, who resides in Pennsylvania, is disenrolled from New York's Medicaid program.

16. Formally remind HRA to keep recipients' enrollment information current and to remove recipients who establish residency in another state from New York's Medicaid program.

Inappropriate Eye Care Claims

Although Medicaid pays for routine vision care services (such as eyeglasses and routine eye exams), Medicare generally does not. Consequently, Medicaid requires providers to apply the Medicaid program's standard fee schedule amounts when submitting claims for routine vision care services provided to recipients who are enrolled in both Medicaid and Medicare.

We determined that 12 providers submitted 26 vision claims (totaling $6,853) that appeared excessive and were at high risk of overpayment. We contacted the 12 providers, and 10 of them responded to our inquiry. Each of the ten respondents acknowledged they either did not bill Medicare or that Medicare denied the services because they were not covered. In these instances,

the providers should submit Medicaid claims using the standard fee schedule amounts. Still, the providers billed Medicaid and wrongly indicated certain Medicare involvement - to obtain Medicaid payments they were not entitled to.

We determined overpayments totaled $4,680 for the 12 providers. For example, we reviewed supporting documentation for one claim billed for three different services that paid a total of $214. Documentation showed one service was not provided; one service was not billed to Medicare (but was billed to Medicaid as if it was billed to and denied by Medicare); and one service was billed and denied by Medicare as a non-covered service. This resulted in a total overpayment of $136 on this claim. At the time our fieldwork concluded, three providers corrected four claims, saving Medicaid $573. Thus, overpayments of 22 claims (totaling $4,107) had not been resolved.

Recommendations

17. Review and recover the unresolved overpayments on the 22 claims (with overpayments totaling $4,107).

18. Instruct identified providers how to correctly bill claims and monitor for compliance.

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 no action is taken, the provider remains active to treat Medicaid patients (either as a direct medical provider or as a Medicaid managed care plan provider), ultimately placing recipients at risk of poor quality care and obtaining Medicaid payments.

We identified 21 Medicaid providers who were charged with or found guilty of crimes that violate Medicaid program laws or regulations. Sixteen 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). One particular provider received $5,164 in Medicaid payments since his sentencing date, May 26, 2011, and he was also identified as a referring or ordering provider on other Medicaid claims totaling $1,632. We advised Department officials of these providers, and the Department promptly assessed the providers' respective cases - which resulted in the termination of 20 of them from the Medicaid program. At the end of our audit fieldwork, the Department was determining the status of the remaining provider.

Recommendations

19. Determine the status of the remaining problem provider relating to future participation (or non-participation) in the Medicaid program.

20. Investigate the propriety of payments (totaling $5,164) made to the provider in question and recover any overpayments, 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 April 1, 2011 through September 30, 2011. Additionally, claims and transactions outside of the audit scope period are examined in instances where we observe a pattern of problems and high risk of overpayment.

To accomplish our audit objectives, 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 (OMIG). We reviewed applicable sections of federal and State laws and regulations, examined the Department's Medicaid payment policies and procedures, and tested medical records supporting provider claims for reimbursement. Our audit steps reflect a risk-based approach taking into consideration the time constraints of the weekly cycle and the materiality of payments.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials generally concurred with our recommendations and indicated that certain actions have been and will be taken to address them. Also, certain other matters were considered to be of lesser significance and these were provided to the Department in a separate letter for further action.

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.

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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 department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

December 21, 2012

Mr. Brian E. Mason, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street - 11th Floor
Albany, New York 12236-0001

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2011-S-9 on "Medicaid Claims Processing Activity April 1, 2011 through September 30, 2011.

Thank you for the opportunity to comment.

Sincerely,

Sue E. Kelly
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
James C. Cox
Jason A. Helgerson
Diane Christensen
Stephen Abbott
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2011-S-9 on
Medicaid Claims Processing Activity
April 1, 2011 through September 30, 2011

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2011-S-9 on "Medicaid Claims Processing Activity April 1, 2011 through September 30, 2011."

Recommendation #1:

Review and recover overpayments on the eight incorrect claims (totaling payments of $224,105) cited in the report.

Response #1:

The Office of Medicaid Inspector General (OMIG) has referred these claims to a recovery audit contractor (RAC) for review and pursuit of recoveries as appropriate.

Recommendation #2:

Formally assess the efficacy of changing the disposition on the eMedNY edit that tests the reasonableness of Medicare/MCO amounts to pend or deny claims with unreasonable amounts.

Response #2:

With implementation of eMedNY Evolution Project 1312, effective April 1, 2012, all claims must be submitted in the format which allows pre-adjudication edits to reject those which do not balance, eliminating the need for the recommended reasonableness edits.

Recommendation #3:

Develop and implement solutions to properly process payments when primary insurer information on a claim does not match related eMedNY data.

Response #3:

On January 27, 2012, eMedNY Evolution Project 1615A was implemented, aligning Medicare Part B clinic coinsurance with Medicaid coverage and rates. Under this new methodology, eMedNY compares the Medicare payment to the hospital's outpatient diagnostic and treatment center to the amount which Medicaid reimburses for the service for a Medicaid-only recipient to determine the final Medicaid payment amount.

Recommendation #4:

Implement a system change to correct eMedNY processing of claims submitted with an incorrect Medicare insurance designation.

Response #4:

On September 9, 2012, the Department implemented a system change that is designed to identify and correct professional claims submitted with an incorrect Medicare insurance designation.

Recommendation #5:

Formally advise the three clinics in question to not submit claims with duplicative charges. On a risk basis, monitor the claims of the three clinics to ensure they do not include duplicate charges.

Response #5:

The Department will advise the three clinics to not submit claims with duplicative charges, and the OMIG will monitor these clinics' claims to ensure they do not include duplicate charges.

Recommendation #6:

Review and recover the unresolved overpayments (totaling $161,521) on the two claims with excessive charges for alternate level of care (ALC) days.

Response #6:

The OMIG will review the unresolved overpayments identified as excessive charges for ALC days and pursue recoveries as appropriate.

Recommendation #7:

Formally advise the hospital in question to ensure that the patient status codes on claims are correct.

Response #7:

The Department will advise the hospital to ensure that the patient status codes on claims billed to Medicaid are correct.

Recommendation #8:

Strengthen eMedNY controls to prevent payment of clinic claims that contain the hospital ambulatory surgery procedure codes we identified when they are billed on the same date of service as a hospital inpatient admission.

Response #8:

The Department will review the payment edits for ambulatory surgery as well as for inpatient admissions and strengthen where appropriate and feasible.

Recommendation #9:

Instruct the identified provider how to correctly bill such claims and monitor for compliance.

Response #9:

The Department will provide guidance to the identified provider, and the OMIG will monitor for compliance.

Recommendation #10:

Review and recover the unresolved overpayment on the remaining claim.

Response #10:

The OMIG will review the unresolved overpayment and pursue recovery as appropriate.

Recommendation #11:

Review and recover the $15,918 in expected corrections and the unresolved overpayments (totaling $25,711) on the remaining 18 claims.

Response #11:

The OMIG will review these unresolved overpayments and pursue recoveries as appropriate.

Recommendation #12:

Formally instruct the 13 providers identified by our audit of the correct way to claim payments for physician-administered drugs. Actively monitor the submissions of such claims by these providers.

Response #12:

The Department will provide billing guidance to the providers, and the OMIG will monitor their claims submissions.

Recommendation #13:

Through automated and/or manual processes, strengthen the controls over claims for physician-administered drugs when providers' stated acquisition costs exceed the maximum allowable Medicaid fee payment.

Response #13:

Reimbursements for physician-administered drugs are limited to the federally designated Actual Sales Price (ASP), so claims submitted that exceed the ASP price on file are only reimbursed at ASP. The Department will explore the feasibility of strengthening this existing automated control to insure that reimbursements are limited to the provider's acquisition cost.

Recommendation #14:

Recover the $19,992 in inappropriate payments for the person who resides in Pennsylvania and is enrolled in Pennsylvania's Medicaid program.

Response #14:

The OMIG will review these payments and initiate recovery as appropriate.

Recommendation #15:

Ensure that the person in question, who resides in Pennsylvania, is disenrolled from New York's Medicaid program.

Response #15:

This individual was disenrolled in August 2012.

Recommendation #16:

Formally remind the New York City Human Resources Administration (HRA) to keep recipients' enrollment information current and to remove recipients who establish residency in another state from New York's Medicaid program.

Response #16:

The Department will review with HRA the details of the case behind this OSC recommendation as well as program policy and procedures relative to individuals who move out of state.

Recommendation #17:

Review and recover the unresolved overpayments on the 22 claims (with overpayments totaling $4,107).

Response #17:

The OMIG will review these claims and pursue recoveries as appropriate.

Recommendation #18:

Instruct identified providers how to correctly bill claims and monitor for compliance.

Response #18:

The Department will provide billing guidance to the providers in question, and the OMIG will monitor for compliance.

Recommendation #19:

Determine the status of the remaining problem provider relating to future participation (or non-participation) in the Medicaid program.

Response #19:

This provider's status is currently inactive, and it hasn't billed or ordered Medicaid services since 2009. OMIG has made numerous attempts to obtain court documents from the New Jersey Assistant Attorney General but has not been successful. As such, under the regulations, it is not possible to issue an immediate exclusion at this time. However, a note which OMIG has placed in eMedNY will alert the Department in the event of an attempt by the provider to renew enrollment.

Recommendation #20:

Investigate the propriety of payments (totaling $5,164) made to the provider in question and recover any overpayments, as appropriate.

Response #20:

The OMIG will analyze the propriety of the payments and pursue recoveries as appropriate.