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September 23, 2013

Nirav R. Shah, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower Building
Empire State Plaza
Albany, NY 12237

Re: Overpayments of Claims for
Selected Professional Services
Report 2013-F-14

Dear Dr. Shah:

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 officials of the Department of Health (Department) to implement the recommendations contained in our audit report, *Overpayments of Claims for Selected Professional Services* (Report 2010-S-73).

Background, Scope and Objective

Many Medicaid recipients are also eligible for Medicare. Such recipients are commonly referred to as "dual eligibles." For health care services provided to dual eligibles, Medicare is generally the primary payer, and Medicaid usually pays deductibles and coinsurance. On December 3, 2009, the Department implemented an automated Medicare/Medicaid crossover system. The crossover system was designed to reduce processing and payment problems, related to claims for dual eligibles, which have historically caused significant Medicaid overpayments.

Prior to the crossover system, Medicaid relied on providers to accurately self-report Medicare payments and the amounts Medicaid owed for deductibles and coinsurance to eMedNY (Medicaid's automated claims processing and payment system). Under the crossover system, providers do not submit separate claims to Medicare and Medicaid for services to dual eligibles.

Rather, providers submit claims directly to Medicare, which pays its portion of the claims. Thereafter, the provider's Medicare claim information is automatically forwarded (crossed over) to eMedNY for Medicaid's payment of any deductible and coinsurance.

Our initial report was issued on April 20, 2012. Our objective was to determine whether inappropriate Medicaid payments were made for selected providers who also received payments from Medicare. The audit primarily covered the period January 2010 through December 2011. We also reviewed certain claim payments and records for the period January 2006 through December 2009. Although the Department implemented the crossover system to prevent Medicaid overpayments of claims for dual eligibles, overpayments of certain claims persisted. As a result, we identified potential and actual overpayments of $100,387 for 12,715 duplicate claims for selected professional services (including podiatry, physical therapy, and occupational therapy) during 2010 and 2011.

In each case, both the provider and the provider's affiliated medical group received Medicaid payments for the same service. This occurred when one party billed Medicare and received a payment through the crossover system, and an affiliated party billed Medicaid directly and received a second payment. We determined the Department needed to fix a gap in eMedNY that allowed certain crossover claims to be paid twice. Automated eMedNY controls or "edits" prevent a duplicate claim payment when a service is billed through the crossover system and to Medicaid directly under the same provider identification number. However, the edits did not prevent the duplicate payments we identified because the related claims had different provider identification numbers.

The objective of our follow-up was to assess the extent of implementation, as of July 1, 2013, of the four recommendations included in our initial report.

Summary Conclusions and Status of Audit Recommendations

Department officials made significant progress in addressing the problems we identified in the initial audit. This included the recovery of overpayments totaling about $55,000. Of the four prior audit recommendations, three were implemented and one was partially implemented.

Follow-up Observations

Recommendation 1

Correct the flaw in the eMedNY claims processing system that allows duplicate payments of Medicare/Medicaid crossover claims submitted by medical groups and their individual providers.

Status - Partially Implemented

Agency Action - The Department improved eMedNY system edits to detect duplicate crossover claims submitted by medical groups and their individual providers. The improved edits would have prevented most of the overpayments identified in our initial audit. Currently, eMedNY edits deny a Medicaid payment if an individual provider's claim includes the identification number of an affiliated group which has submitted a claim for the same service. The edits compare the group identification numbers, identify the duplicate service claims, and deny payment of such claims. However, the edits will not identify duplicate claims if an individual provider's claim does not include the identification number of the affiliated medical group.

Recommendation 2

Review the $93,593 in potential duplicate payments we identified and recover where appropriate.

Status - Implemented

Agency Action - As part of its routine audits of Medicare crossover duplicate claims, the OMIG recovered $48,133 of the $93,593 identified in the initial audit. Further, according to OMIG officials, the remaining duplicate payments were not recovered because: the payments were to providers subject to formal investigations; or the dollar amounts in question were below OMIG's recovery threshold ($2,500) for an individual provider or group practice.

Recommendation 3

Recover the $6,794 in duplicate payments from the podiatrist. Review all claims for the podiatrist where there was no supporting documentation and recover payments, as appropriate.

Status - Implemented

Agency Action - The OMIG recovered the $6,794 in duplicate payments to the podiatrist. Further, OMIG officials did not review all claims lacking supporting documentation because the dollar amounts in question were below OMIG's recovery threshold for an individual provider.

Recommendation 4

Remind providers they should not rely on nursing homes to maintain their medical records and other documentation to support their Medicaid claims.

Status - Implemented

Agency Action - In its June 2012 Medicaid Update newsletter, the Department reminded providers to maintain their own medical records and other documentation required to support their Medicaid claims.

Major contributors to this report were Salvatore D'Amato, Mark Breunig and Zubair Rahman.

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

Very truly yours,

Dennis Buckley
Audit Manager

cc: Mr. James Cox, Medicaid Inspector General
Ms. Diane Christensen, Department of Health
Mr. Thomas Lukacs, Division of the Budget