NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

November 13, 2017

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 Follow-Up Audit Report 2017-F-11 entitled, "Eye Care Provider and Family Inappropriately Enroll as Recipients and Overcharge for Vision Services." (Follow Up to Report 2013-S-1)

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
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Department of Health
Comments on the
Office of the State Comptroller's
Follow-Up Audit Report 2017-F-11 entitled,
Eye Care Provider and Family Inappropriately Enroll as Recipients and Overcharge for Vision Services (Follow Up to Report 2013-S-1)

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2017-F-11 entitled, "Eye Care Provider and Family Inappropriately Enroll as Recipients and Overcharge for Vision Services." (Follow Up to Report 2013-S-1)

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of 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 1,276,304 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,609 in 2016, consistent with levels from a decade ago.

Recommendation #1

Coordinate with HRA officials to investigate the five identified recipients who had not yet been investigated. Such coordination should include an assessment of the recipients' Medicaid eligibility, deactivation of the Medicaid identification numbers of those determined to be ineligible for benefits, and the recovery of any improper payments identified.

Status – Partially Implemented

Agency Action – The five recipients we identified had a business or personal connection to the Provider's family, and we believe these recipients submitted misleading information when applying for Medicaid benefits to gain Medicaid eligibility. In March 2016, OMIG opened an investigation that included a review of the Medicaid eligibility of these recipients and, according to OMIG officials, appropriate action will be taken pending the results of the investigation. Two of the five recipients continued to have active Medicaid eligibility at the time of our follow-up review.

Response #1

OMIG has completed its investigations with no findings. HRA has closed all of the questionable recipient cases noted in the audit findings.

Recommendation #2

Review and recover the improper Medicaid payments made to the Provider including 69 services totaling $2,050 in overpayments that the Provider did not void and $4,443 in Medicaid payments that did not have supporting documentation.

Status – Partially Implemented

Agency Action – Our initial audit identified overpayments of $17,785 for Medicare coinsurance charges for 244 eye care services that were not covered by Medicare. The Provider should have billed the standard Medicaid reimbursement fee for the services. These payments were overpaid because the amounts claimed exceeded Medicaid's fee. After our conversation with the Provider during the initial audit, the Provider voided 175 of the 244 services we identified. However, the remaining 69 services totaling $2,050 had not been voided at the conclusion of our audit. Additionally, during the initial audit, the Provider was unable to provide medical records to support another $4,443 in Medicaid payments.

According to OMIG officials, their investigation included a review of the overpaid claims our audit identified, and the appropriate action will be taken at the conclusion of the investigation.

Response #2

OMIG has completed its investigations. OMIG has placed the provider on pre-payment review, to prevent further inappropriate payments from being issued.

Recommendation #3

Review the remainder of the Provider's Medicaid claims (not tested as part of the audit) to determine the extent to which the Provider submitted other improper claims, and recover improper payments, as warranted.

Status – Partially Implemented

Agency Action – OMIG officials stated they are currently investigating this provider to determine if there are other improper claims, and appropriate actions will be taken at the conclusion of the investigation.

Response #3

OMIG has completed its investigations. OMIG has placed the provider on pre-payment review, to prevent further inappropriate payments from being issued.

Recommendation #4

Assess the appropriateness of the Provider's future participation in the Medicaid program, and take the necessary steps to remove the Provider from the program if warranted.

Status – Partially Implemented

Agency Action – OMIG officials stated they will take appropriate action regarding the Provider's future participation in the Medicaid program at the conclusion of their investigation. Of note, the spouse of the Provider's owner opened a new optical establishment in February 2016. OMIG's investigation should include an assessment of the new business's participation in Medicaid.

Response #4

OMIG referred this matter to the New York State Attorney General's Medicaid Fraud Control Unit (MFCU) based on the cited issues, which was subsequently rejected by MFCU. Two cited subjects from this referral were already under review by MFCU, and are still being reviewed, which does not allow OMIG to investigate further.

Recommendation #5

Assess whether the eMedNY system edit noted in this report should be set to deny inappropriate and/or excessive claims.

Status – Implemented

Agency Action – Prior to the issuance of our initial audit report, the Department implemented a payment control in the eMedNY system (an eMedNY edit) designed to detect the type of inappropriate claims for Medicare coinsurance that we identified. However, the edit was set to pend claims (temporarily suspend for further review) at the time our initial audit concluded. On January 28, 2016, the Department set the edit to deny. We note that, from January 28, 2016 through June 30, 2017, $146,710 in charges for 1,843 eye care claims were denied payment by the new edit.

Response #5

The Department confirms our agreement with this report.

Recommendation #6

Formally advise the providers noted in this report of the Department's requirements for updating changes to business ownership, address, and/or affiliations.

Status – Implemented

Agency Action – During our initial audit, we found the Provider's business was sold to a new owner, and the previous owner of the Provider opened a new office at a new location. The new owner told us they purchased the business in October 2012 and moved in during February 2013. We determined that neither party had contacted the Department to advise it of the changes.

Subsequent to our initial audit, the Department sent letters to both providers notifying them of the requirement to update information about their businesses, including business ownership and address information.

Response #6

The Department confirms our agreement with this report.

Recommendation #7

Deactivate the two ETINs that the owner of the billing company established.

Status – Not Implemented

Agency Action – Our initial audit found that the Provider used a non-Medicaid-enrolled billing service company to submit its claims, and the owner of the billing company was also the spouse of the owner of the Provider. In addition, the owner of the billing company inappropriately submitted applications for ETINs using the Medicaid IDs of two other physicians to gain unauthorized access to the eMedNY claims system and bill over $700,000 in Medicaid claims on behalf of 55 providers. We interviewed one of the physicians associated with one of the ETINs and provided him with a copy of an ETIN recertification form from eMedNY that contained his signature. According to the physician, the signature on the form was not his, and he was unaware the owner of the billing company was using his ETIN to bill on behalf of other Medicaid providers.

According to OMIG officials, the use of the two ETINs is part of their investigation. Department officials stated they will take action as recommended by OMIG once the investigation is complete. We note that, since our initial audit period, one of the ETIN was used to submit 27,052 additional Medicaid claims on behalf of 18 providers totaling over $1 million. Thus, the billing company has been using an improperly obtained ETIN, yet we found that the owner of the billing company obtained a Medicaid ID for the billing company and used it to establish a new ETIN. We determined no claims have been submitted to eMedNY using the new ETIN.

Response #7

OMIG has completed its investigations, and determined the ETINs are being utilized correctly by numerous other providers. OMIG has placed the providers identified as misusing the ETINs on pre-payment review, to prevent further inappropriate payments from being issued.

Recommendation #8

Using a risk-based approach, assess the propriety of claims billed through the two ETINs that the owner of the billing company established.

Status – Partially Implemented

Agency Action – As previously mentioned, our initial audit determined the two ETINs were used to bill over $700,000 in Medicaid claims on behalf of 55 providers. OMIG officials stated their investigation includes a review of these claims for appropriateness. We further determined that, since our initial audit, one of the ETINs was used to bill Medicaid for over $1 million. We encourage OMIG to also assess the propriety of the recently billed claims.

Response #8

OMIG investigated the providers utilizing the ETINs. OMIG has placed the providers on pre-payment review, to prevent further inappropriate payments from being issued.