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OFFICE OF THE STATE COMPTROLLER

October 12, 2017

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Eye Care Provider and Family
Inappropriately Enroll as Recipients and
Overcharge for Vision Services
Report 2017-F-11

Dear Dr. Zucker:

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 to implement the recommendations contained in our audit report, *Eye Care Provider and Family Inappropriately Enroll as Recipients and Overcharge for Vision Services* (Report 2013-S-1).

Background, Scope, and Objective

The Department of Health (Department) administers the Medicaid program in New York State. Medicaid provides a wide range of medical services, including vision care, to individuals who are economically disadvantaged and/or have special health care needs. Medicaid eligibility is based on several factors including household size and income. Since January 2014, many individuals enroll for Medicaid through the New York State of Health (NYSOH), the State's online marketplace for obtaining health insurance. Some individuals also coordinate with their respective local district social services office (local district) to receive Medicaid benefits. New York has 58 local districts, each representing a county in all areas of the State except New York City. The five boroughs of New York City comprise one local district, which is overseen by the New York City Human Resources Administration (HRA).

According to Department policy, vision care providers are required to maintain patient records for a minimum of six years. These records should include examination findings; visual field charts; eyeglass or contact lens prescriptions; and lens and frame specifications. Also, providers are responsible for notifying Medicaid of any changes in pertinent provider information, including

change of business address and changes in business ownership, within 15 days of the change to ensure provider information is up-to-date.

Medicaid allows health care providers to use billing companies, or service bureaus, to submit claims on their behalf. According to State Medicaid regulations, persons submitting claims on behalf of a provider must enroll in Medicaid as a service bureau and comply with all applicable regulations and policies. Enrolled service bureaus can submit claims electronically, and must apply to the Department for a unique Electronic Transmitter Identification Number (ETIN), which will allow them access to eMedNY, the Medicaid claims processing and payment system. Providers must certify each ETIN that can submit claims on their behalf and must recertify them each year.

We issued our initial audit report on March 21, 2016. The audit objectives were to determine whether the owner of a Medicaid eye care provider (Provider) and the owner's family members and associates inappropriately enrolled as Medicaid recipients and to determine whether the Provider inappropriately billed Medicaid for vision services. The scope of the audit was from January 1, 2008 through September 30, 2013. Our audit found numerous violations and questionable practices, including:

- The owner and family members submitted false income information to obtain Medicaid benefits. We found they engaged in transactions that were not indicative of a person living at the income levels that qualify a person for Medicaid. For instance, we identified over $400,000 in deposits made to the Provider's family's personal bank accounts. Also, the owner and the owner's spouse paid $105,000 toward the purchase of a condominium for one of their family members. The State paid $68,483 in medical benefits on behalf of the owner and the owner's spouse and three other family members during the enrollment periods.
- We identified five additional Medicaid recipients who had a business or personal connection to a member of the Provider's family and, we believe, submitted misleading information on their Medicaid applications to gain eligibility.
- We provided the ten recipients' information to HRA. HRA officials investigated five of the ten recipients and determined they were ineligible for the Medicaid benefits they received. The recipients were disenrolled from the Medicaid program and ordered to repay $40,100 in restitution. Of the five recipients HRA had not investigated, two remained enrolled in the Medicaid program as of December 2015.
- The Provider received over $22,000 in improper Medicaid payments for claims with inappropriate coinsurance charges and for services not supported by medical records.
- The Provider allowed non-Medicaid-enrolled providers to render services, and on its claims to Medicaid identified a different, authorized, provider as the service renderer.
- The Provider used a non-Medicaid-enrolled billing service company to submit its claims. The owner of the Provider and the owner of the billing service company were married.
- The owner of the billing company submitted applications for ETINs using two other providers' Medicaid identification numbers (IDs) to gain unauthorized access to the eMedNY claims system and bill over $700,000 in Medicaid claims on behalf of 55 providers.

We recommended that the Department: assess the eligibility of the identified Medicaid recipients, deactivate ineligible Medicaid recipients and providers, conduct an expanded review of improper Medicaid claims, recover improper State payments, and improve claims processing controls.

The objective of our follow-up was to assess the extent of implementation, as of August 24, 2017, of the eight recommendations included in our audit report.

Summary Conclusions and Status of Audit Recommendations

In March 2016, the Office of the Medicaid Inspector General (OMIG) commenced an investigation of the Provider, the Provider's billing company, and the recipients identified in the original audit. At the time of our follow-up review, the investigation was ongoing and OMIG officials stated that recoveries of Medicaid overpayments and corrective actions would occur, if warranted, when the investigation was complete. Of the initial report's eight audit recommendations, two were implemented, five were partially implemented, and one has not yet been implemented.

Follow-Up Observations

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.

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.

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.

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.

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.

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.

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 ETINs

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.

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.

Major contributors to this report were Sal D'Amato, Mostafa Kamal, and Misty Daiyan.

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 thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Christopher Morris
Audit Manager

cc: Ms. Diane Christensen, Department of Health
Mr. Dennis Rosen, Medicaid Inspector General