NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

October 29, 2018

Mr. Kenneth Shulman
Assistant Comptroller
New York State Office of the State Comptroller
110 State Street, 10th Floor
Albany, New York 12236

Dear Mr. Shulman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2017-S-23 entitled, "Medicaid Claims Processing Activity April 1, 2017 through September 30, 2017."

Please feel free to contact Estibaliz Alonso, Assistant Commissioner, Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

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

Enclosure

cc: Estibaliz Alonso

Department of Health Comments on the Office of the State Comptroller's Final Audit Report 2017-S-23 entitled, Medicaid Claims Processing Activity April 1, 2017 Through September 30, 2017

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2017-S-23 entitled, "Medicaid Claims Processing Activity April 1, 2017 Through September 30, 2017."

Recommendation #1:

Review the $742,915 ($471,797 + $271,118) in overpayments and recover, as appropriate.

Response #1

OMIG's contractor will review the identified claims, and pursue recovery of any determined to be inappropriate.

Recommendation #2:

Routinely review high-risk claims with Medicare involvement that indicate no Medicare payment to determine if services were not medically necessary and, therefore, not reimbursable.

Response #2:

The Department and the OMIG will explore options regarding the review of claims with Medicare/Medicare Managed Care as primary for medical necessity.

Recommendation #3:

Review the $3,133,608 in overpayments and make recoveries, as appropriate.

Response #3

OMIG in conjunction with the Department, will review the identified overpayments, and determine an appropriate course of action.

Recommendation #4:

Evaluate eMedNY's current claims processing rules to ensure the Department's existing policy in regard to reimbursement of CARC 50 claims is followed.

Response #4:

The Department disagrees with the severity of the OSC audit findings/recommendation. OSC reviewed 79 claims and determined that all were for services not medically necessary. The Department reviewed the claims in question and determined that 14 were medically necessary since Medicare had made payment. It would therefore be inappropriate for OSC and the Department to assume that all claims with a CARC 50 are not medically necessary. However, despite this disagreement, the Department takes seriously its obligation to prevent inappropriate payments and is reviewing alternatives to strengthen existing requirements and procedures The Department will research the eMedNY claims system to determine if changes can be made to

more accurately identify services that may not be medically necessary. The Department will also issue billing instructions to providers.

Recommendation #5:

Review the one claim that overpaid $108,392 and make recoveries, as appropriate.

Response #5

OMIG will review the identified claim, and pursue recovery if determined to be inappropriate.

Recommendation #6:

Review the $428,000 ($70,508 + $357,492) in overpayments and make recoveries, as appropriate.

Response #6

OMIG will review the identified claims, and pursue recovery of any determined to be inappropriate.

Recommendation #7:

Review the $684,457 in overpayments and make recoveries, as appropriate

Response #7

OMIG's contractor will review the identified claims, and pursue recovery of any determined to be inappropriate.

Recommendation #8:

Ensure the planned eMedNY system change prevents multiple CPEP payments for an individual episode of care, and prevents CPEP claims from being paid for the same date of service as a psychiatric inpatient admission.

Response #8:

The Office of Mental Health (OMH) is currently in the process of reviewing and updating the regulations and billing practices for the Comprehensive Psychiatric Emergency Program (CPEP) with assistance from CPEP providers. One of the goals of these revisions is to clarify that one claim may be submitted per emergency visit, rather than per calendar day.

Additionally, OMH is working with the Department to ensure that the process for billing CPEP is updated to prevent multiple CPEP evaluation payments for an individual episode of care, and that CPEP claims are not paid for the same date of service as a psychiatric inpatient admission. A change will be submitted to update the rate type for rate codes 4007 and 4008 to a "monthly" rate type which will prevent the double payment issue. It is expected that the submission will occur by November 30, 2018.

Recommendation #9:

Review the $465,257 ($229,174 + $171,047 + $65,036) in improper payments made to CHHAs that we identified and recover overpayments, as appropriate.

Response #9

OMIG will extract its own data, perform analysis, and pursue recovery of any payment determined to be inappropriate.

Recommendation #10:

Review the $152,563 in overpayments and make recoveries, as appropriate.

Response #10

OMIG will review the overpayments, and pursue recovery of any payment determined to be inappropriate.

Recommendation #11:

Determine the status of the remaining six providers relating to their future participation in the Medicaid program.

Response #11

Of the remaining six providers, OMIG has determined the following:
Three providers have been excluded.
Three providers are still under review.

Recommendation #12:

Determine the appropriateness of the $292,681 received by the five terminated providers and recover improper payments, as warranted.

Response #12

OMIG's analysis of the OSC data determined the payments were appropriately paid by Medicaid. The dates of service were prior to the effective date of the exclusion from the Medicaid program, and the payments were not adjudicated until after the date of exclusion.

OSC Comment #1:

The Department's statement that some claims having a Medicare denial code of CARC 50 are for medically necessary services is misleading. A CARC 50 code indicates Medicare denied the payment because the service was deemed not medically necessary. Department policy

specifically states that Medicaid will not pay for claims that Medicare deems not medically necessary. Medicaid does not pay claims with a Medicare denial code of CARC 50 when claims are processed via the Department's automated Medicare/Medicaid claim crossover system. The claims identified in our report did not cross over from Medicare via the Department's automated crossover system. Instead, the providers reported a CARC 50 code on their claims and billed the claims in question directly to eMedNY. However, because of the current mapping rules, the claims were allowed to pay, contrary to existing policy. The Department should apply its policy consistently to both claims submitted via the crossover system and directly billed.

As noted on page 9 of our report, Department officials believe the providers who directly billed Medicaid may not have reported CARC 50 codes on their Medicaid claims correctly. As stated on pages 9 and 10, one provider accounted for $469,164 of the $687,469 in overpayments. The provider supplied us with supporting documentation for 20 claims, showing Medicare denied 16 of the claims for medical necessity, and for four claims, Medicare's explanation of benefits showed the provider subsequently received payment from Medicare after our fieldwork ended. This illustrates that a process exists for providers to appeal Medicare's decision of medical necessity and properly receive payment from Medicaid once the medical necessity has been determined.

Response #1:

OSC has commented that "CARC 50 code indicates Medicare denied the payment because the service was deemed not medically necessary." The Department disagrees with this comment. OSC provided the Department with the universe of claims they initially reviewed with a CARC Code 50. The Department reviewed the claims in question. 14 of the 79 claims the Department reviewed had a payment from Medicare or the Medicare Advantage Plan and were therefore medically necessary. This indicates that CARC Code 50 is not being accurately reported by payers and/or providers. Therefore, some claims with CARC Code 50 must be considered medically necessary. We advised OSC that to fully evaluate medical necessity, OSC would need to review medical records of the claims in question, however, they did not do so. Therefore, the Department does not agree with OSC's determinations that all claims did not meet the threshold of medical necessity and/or overpayment are substantiated.