NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

November 10, 2014

Ms. Andrea Inman
Audit Director
New York State Office of the State Comptroller
110 State Street, 11th Floor
Albany, New York 12236

Dear Ms. Inman:

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 2012-S-163 entitled, "Multiple Same-Day Procedures on Ambulatory Patient Groups Claims."

Please feel free to contact Amy Nickson, Office of Governmental and External Affairs at (518) 474-2011 with any questions.

Sincerely,

Howard Zucker M.D.

Howard A. Zucker
Acting Commissioner of Health

Enclosure

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2012-S-163 entitled,
"Multiple Same-Day Procedures on
Ambulatory Patient Groups Claims"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2012-S-163 entitled, "Multiple Same-Day Procedures on Ambulatory Patient Groups (APG) Claims."

Background:

New York State is a national leader in its oversight of the Medicaid Program. Through the efforts of the Department and the Office of the Medicaid Inspector General (OMIG), over the last five years, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. Over the last three calendar years, the administration's Medicaid enforcement efforts have recovered over $1.73 billion, a 34 percent increase over the prior three-year period.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality 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 840,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,929 in 2013, consistent with levels from a decade ago.

The audit period is December 2008 through March 2013. The OSC has cited $1,083,836 in actual overpayments and an additional $10,195,755 in questionable claim payments, or a total of $11,279,591 over the audit period. Annually, this represents .005% of the total $54 billion Medicaid program.

Recommendation #1

Ensure an adequate system of controls enforcing Department policy, especially over the types of APG claims identified in this report, are incorporated into the design of the replacement system. Where feasible, apply professional service limits to APG claims.

Response #1

The Department acknowledges the importance of incorporating professional service limits to APG claims and will explore the option of including these service limits into the development of the new Medicaid Administrative Services system. Furthermore, it should be noted that with the move towards Managed Care, the occurrences cited above will diminish.

Recommendation #2

Formally reassess how dental services performed in a clinic setting should be billed, including, but not limited to, a cost/benefit analysis of using the 837D health care claim transaction set.

Response #2

The Department has discussed with 3M the possibility of using the 837D dental practitioner claim form for clinic APG claims in lieu of the 837i Institutional claim form. We have been advised that the APG grouper/pricer is unable to accept and process certain 837D fields including anatomical location and tooth surface. Furthermore, it should be noted that the claims in question are from clinic institutional providers, not practitioners. The 837D claim form is formatted for practitioner claims, not institutional claims. It does not have the data fields necessary for the Medicaid Program to process an institutional claim. For example, a field is not available on the 837D for the clinic to report rate code. The clinic rate code is critical to deriving the provider payment and claims processing. Health Insurance Portability and Accountability Act compliant transactions, including the 837D claim form, are the sole acceptable format for claim submission. It cannot be altered to accommodate specific payer billing requirements, e.g., adding a field to capture rate code information. Given the above reasons, a cost/benefit analysis will not be performed.

As noted above, the claims in question are from institutional providers, not dental practitioners. The 837D claim form does not contain the data fields necessary for the Medicaid Program to recognize and process the claim as an institutional claim. OSC states in their comments that it is "worthy to note that Medicaid-participating dental clinics commonly use the 837D claim form to obtain reimbursement from other (non-Medicaid) health insurers." The OSC is aware that the Medicaid eMedNY claims processing system is significantly different than that used by commercial payers. Medicaid utilizes "rate codes" to differentiate rate based institutional providers from individual practitioners. The 837D claim form does not provide a data field for an institutional provider to report their Department assigned rate code. This is a nationally designated Health Insurance Portability and Accountability Act form that would have to be modified at the national level in order to accommodate New York State Medicaid billing procedures. If the claim form cannot be modified, the Medicaid Program would need to eliminate the rate code billing construct for institutional providers. This would be an extremely complex endeavor and require a significant re-design of the current claims processing system. It would also raise institutional rate methodology, regulatory, statutory, and federal state plan issues. As also indicated in our previous response, the eMedNY system does not have the capability to edit procedure codes at the claim level for frequency and units billed at this time. Again, making the necessary claims processing changes to do so would require a major and lengthy re-design of the institutional claims processing system. The Department is committed to exploring options for strengthening and/or restructuring APG claims processing and provider oversight, including working closely with the new fiscal contractor to incorporate procedure code unit and frequency editing into institutional claims processing where feasible and appropriate, and working with OMIG to identify areas of abusive billing.

It should also be noted, the APG rate is based on several procedures grouped into one grouping, that when combined, create an average price paid for each encounter. The provider's claim will list all of the services provided during this one encounter and get paid for the one encounter only.

Recommendation #3

Strengthen controls over APG claim processing and formally communicate to providers any modifications or clarifications to address:

- Frequency limits for unit-based procedures billed on multiple claim lines; and
- Excessive rehabilitation services billed since the October 1, 2011 effective date, as well as those without prior authorization.

Response #3

Neither the APG grouper/pricer, nor eMedNY, presently have the ability to edit frequency limits for unit-based procedures billed on multiple claim lines. This functionality will be explored with the new claims processing contractor when designing the eMedNY replacement system. With respect to rehabilitation services billed without prior authorization, the Department researched the claims in question and found that providers were indicating that the claims were "emergency," which then bypassed the need for a prior authorization number. An eMedNY systems change was implemented on January 23, 2014 (Evolution Project 1860) eliminating the "emergency" prior authorization bypass for rehabilitation services.

Recommendation #4

Review the apparent APG claim line overpayments identified in this report and make recoveries, as appropriate. The overpayments in question include: $614,260 in unit-based procedures; $749,066 in non-site-specific dental procedures; $469,576 in excessive rehabilitation services; and $1,406 in dental clinic billing errors.

Response #4

The OMIG will review the questionable claims and recover as appropriate.

Recommendation #5

Review the questionable APG claim line payments identified in this report and recover any overpayments as identified. The payments in question include $9,446,689 in dental claims with unreasonable, excessively billed procedures.

Response #5

The OMIG will review the questionable claims and recover as appropriate.