Department of Health

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Executive Deputy Commissioner

February 10, 2017

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 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 2016-F-17 entitled, "Multiple Same-Day Procedures on Ambulatory Patient Groups Claims." (2012-S-163)

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 2016-F-17 entitled,
Multiple Same-Day Procedures on Ambulatory Patient Groups Claims

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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 2016-F-17 entitled "Multiple Same-Day Procedures on Ambulatory Patient Groups Claims" (Follow Up to Report 2012-S-163).

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 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,305 in 2015, consistent with levels from a decade ago.

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.

Status – Partially Implemented

Agency Action – At the time of our follow-up review, the Department and Xerox State Healthcare, LLC (Xerox), the new fiscal agent, were working on the design and development of a new Medicaid claims processing system. Consequently, the Department was not yet able to fully implement the recommendation. The new system needs to include appropriate controls over the types of APG claims identified in the initial report. As such, officials indicated they would address the need to strengthen controls over APG claims processing during the development of the new system with Xerox. Examples of some planned efforts are detailed in the agency actions in response to subsequent recommendations.

Response #1

The Department confirms our agreement with this report.

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.

Status – Partially Implemented

Agency Action – In our initial audit, we determined improper payments for dental procedures occurred because: (1) the Department did not incorporate service limits in the processing of APG claims for dental services; and (2) the Department required dental clinics to bill Medicaid using the 837I (Institutional) claim transaction data set, which did not include site-specific information (such as tooth number and tooth surface) necessary to ensure the propriety of APG dental claims. In contrast, the claim transaction data set used for non-clinic (non-APG) dental claims (or 837D) included site-specific data, which helped to ensure the propriety of those claims. The Department's decisions surrounding dental clinic billing resulted in less assurance that APG dental clinic claims were processed and paid properly.

In our follow-up review, we determined Department officials did not formally reassess how dental services performed in a clinic setting should be billed, nor complete a cost/benefit analysis of using the 837D health care claim data transaction set. However, officials told us they discussed the possibility of using the 837D data format in the current claims processing system, and concluded it would be extremely complex and would require significant system redesign. Further, because the Department will replace the current claims processing system, Department officials plan to address strengthening controls over APG claims processing with Xerox during the new system's development, including an assessment of the feasibility of using the 837D format for clinic billings.

Response #2

The Department confirms our agreement with this report.

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.

Status – Partially Implemented

Agency Action – Providers are required to bill unit-based procedure codes (such as for rehabilitation services like physical therapy) on one claim line only and enter the number of units they provided on that line. Department policy prohibits providers from billing the same unit-based procedure code multiple times on multiple claim lines to indicate multiple units of a single procedure because it affects the claim's processing and payment amount. In our initial audit, we determined providers did not always bill unit-based procedure codes on one claim line with the number of units they provided on that line, which led to overpayments. Our follow-up review determined the Department had not strengthened controls over APG claims processing that pertain to frequency limits for unit-based procedures billed on multiple claim lines. Department officials plan to address those controls in the new Medicaid claims processing system.

The Department did strengthen eMedNY system controls over APG claims processing pertaining to excessive rehabilitative services and prior authorization requirements. The Department determined that claims with an emergency indicator were bypassing the prior authorization requirement for rehabilitation services and, as a result, payments could be made for rehabilitation

services that exceeded Medicaid's service limits. Changes to an eMedNY edit were implemented on January 23, 2014 to ensure that claims for rehabilitation services with an emergency indicator would no longer bypass the prior authorization requirement. Since January 23, 2014, the modified edit prevented approximately $4.7 million in improper claims. Additionally, the Department recommunicated the requirement for prior authorizations and other billing requirements pertaining to rehabilitation services in the September 2015 edition of the Medicaid Update (the Department's official publication for Medicaid providers).

Response #3

It is important to note that the great majority of claims identified by OSC over the four and one-half year audit period were billings for rehabilitation services. The Department has established procedure code modifiers to distinguish physical therapy and occupational therapy. This will enable the Department to more accurately identify and monitor inappropriately billed multiple rehabilitation services billed for a single date of service. The OSC fails to acknowledge this in their follow-up report.

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.

Status – Partially Implemented

Agency Action – The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. As of November 17, 2016, the OMIG recovered $61,331 of the $1,834,308 in total overpayments (detailed in the recommendation). Further, the OMIG conducted a limited review of the remaining claims totaling $1,772,977 ($1,834,308 - $61,331) and determined that additional medical documentation reviews would be required. The OMIG plans to refer these claims for additional review to the federal Unified Program Integrity Contractor, Safeguard Services.

Also, as of December 14, 2016, $439,014 of the $1,772,977 in overpayments not yet recovered may no longer be recoverable under regulatory look-back rules that prohibit the Department from recovering a payment more than six years after the date the corresponding claim was filed. To avoid further loss of recoverable overpayments, we strongly encourage the OMIG and Safeguard Services to place sufficient priority on the pursuit of the remaining overpayments that are still recoverable.

Response #4

OMIG's Unified Program Integrity Contractor (UPIC) 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 identified. The payments in question include $9,446,689 in dental clinic claims with unreasonable, excessively billed procedures.

Status – Partially Implemented

Agency Action – As of November 17, 2016, the OMIG recovered $46,057 of the $9,446,689 in questionable APG claim line payments identified in the initial audit. OMIG officials informed us they will continue to review the remaining questionable payments identified in the initial audit and make additional recoveries as time and resources permit.

The OMIG also referred four providers to the federal Medicaid Integrity Contractor auditor, Island Peer Review Organization, Inc. (IPRO). These providers made up $4,259,716 of the $9,446,689 in questionable payments. However, the time period covered by IPRO's audits included only $1,534,619 of the $4,259,716 in questionable payments. The IPRO audits of the four providers were engaged in November 2015, but according to OMIG officials, the Centers for Medicare and Medicaid Services subsequently placed all IPRO audits on hold. As a result, the audits have not been completed. OMIG officials stated the audits would be transferred to Safeguard Services, the aforementioned federal Unified Program Integrity Contractor, with a contract effective date of November 1, 2016.

Also, as of December 14, 2016, $2,442,870 of the $9,400,632 ($9,446,689 - $46,057) in questionable payments not yet recovered may no longer be recoverable under regulatory look-back rules that prohibit the Department from recovering a payment more than six years after the date the corresponding claim was filed. Again, to avoid further loss of recoverable overpayments, we strongly encourage the OMIG and Safeguard Services to place sufficient priority on the pursuit of the remaining overpayments that are still recoverable.

Response #5

OMIG's UPIC will review the questionable claims and recover as appropriate.