New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Ambulatory Patient Groups Payments for Duplicate Claims and Services in Excess of Medicaid Service Limits

Medicaid Program
Department of Health

Report 2013-S-17 June 2015

Executive Summary

Purpose

To determine whether the Department of Health established adequate controls to prevent duplicate and excessive Medicaid payments to clinics and outpatient facilities reimbursed by the Ambulatory Patient Groups (APG) payment methodology. The audit covered the period from December 1, 2008 through May 29, 2013.

Background

The Medicaid program reimburses outpatient services using the APG payment methodology. The Department of Health (Department) adopted the APG methodology in an effort to pay providers more accurately for their services. APG claims are reimbursed based on patient condition and complexity of service. The Department phased in the APG methodology beginning with hospital outpatient departments and ambulatory surgery centers on December 1, 2008. The methodology was implemented in freestanding diagnostic and treatment centers and ambulatory surgery centers on September 1, 2009.

Key Findings

- Medicaid made $32.1 million in actual and potential overpayments to providers for services that exceeded Medicaid service limits. For example, Medicaid limits dental exams to two times per year, yet we found Medicaid reimbursed a clinic for 41 dental exams (totaling $2,771) for one patient over three years. We determined the clinic's records did not support any of the exam procedures, and in some instances the medical records did not indicate any service was provided. As a result, none of the 41 claims were eligible for reimbursement.
- Medicaid also overpaid $7.5 million for duplicate claims. In these cases, a clinic, for instance, and an individual practitioner (i.e., medical doctor) both billed Medicaid for the same service.
- APG claims processing does not have the controls necessary to detect and prevent the types of overpayments we identified.

Key Recommendations

- Review the overpayments we identified and make recoveries as appropriate.
- Strengthen controls over APG claims processing to address the weaknesses we identified.

Other Related Audits/Reports of Interest

Department of Health: Multiple Same-Day Procedures on Ambulatory Patient Groups Claims (2012-S-163)

Department of Health: Overpayments of Ambulatory Patient Group Claims (2011-S-43)

State of New York
Office of the State Comptroller

Division of State Government Accountability

June 29, 2015

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

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Ambulatory Patient Groups Payments for Duplicate Claims and Services in Excess of Medicaid Service Limits*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

Medicaid is a federal, state, and local government program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the fiscal year ended March 31, 2014, New York's Medicaid program had approximately 6.5 million enrollees and Medicaid claim costs totaled about $50.5 billion. The federal government funded about 49.25 percent of New York's Medicaid claim costs; the State funded about 33.25 percent; and the localities (the City of New York and counties) funded the remaining 17.5 percent.

The Department of Health (Department) administers the Medicaid program in New York State. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. When Medicaid claims are processed by eMedNY, they are subject to various automated edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate. For example, some edits compare claims to detect and prevent duplicate billings for the same service. Other edits track the number of services provided to a recipient in a certain period to ensure they don't exceed Medicaid service limits. In some cases, eMedNY edits flag claims for further scrutiny by the Department, which then makes a determination to approve or deny payment.

In 2008, amendments to the State's Public Health Law required a new Medicaid outpatient payment methodology called Ambulatory Patient Groups (APG) for clinic, ambulatory surgery, and hospital-based emergency room services. Such services cover a range of health care needs, from primary care (such as immunizations) to ambulatory procedures (such as colonoscopies). The APG payment methodology became effective on December 1, 2008 for hospital outpatient departments and ambulatory surgery centers and on January 1, 2009 for hospital emergency departments. The APG payment methodology became effective on September 1, 2009 for freestanding diagnostic and treatment centers and freestanding ambulatory surgery centers.

The APG payment methodology is designed to reimburse medical services requiring a higher level of professional care a higher amount than those requiring lower levels of care. To do this, it identifies clinical characteristics, such as the diagnosis, the procedures performed, as well as the amount and type of resources used, to compute the payment amount. The APG approach requires health care providers to report diagnosis and procedure codes, APG rate codes, and other billing information when submitting APG claims.

Audit Findings and Recommendations

For the period December 1, 2008 through May 29, 2013, Medicaid made $39.6 million in actual and potential APG claim overpayments to clinics and outpatient facilities, including $32.1 million reimbursed for services that exceeded Medicaid's established service limits and $7.5 million for duplicate claims. Claims for excessive services were made because the Department did not adequately monitor and control claims processed through the APG system since its inception in 2008. We found claims were overpaid because eMedNY's automated edits that are regularly applied to non-APG (e.g., individual practitioners, non-clinic) claims were not configured and applied to APG claims to enforce APG policy and payment rules. Instead, the Department relies on providers to submit accurate APG claims that fully comply with the Department's APG billing rules and regulations. We also found the Department has provided weak guidance to clinic providers, resulting in confusion and misinterpretation of APG payment rules – a factor further contributing to improper duplicate claiming. We made several recommendations to the Department to strengthen their controls over APG claims and recover overpayments.

Excessive Services

We analyzed APG claims for services provided between December 1, 2008 and May 29, 2013, and identified actual and potential overpayments totaling $32.1 million to clinics and outpatient facilities for approximately 366,000 services billed in excess of Medicaid service limits. We determined that generally APG claims processing does not track the number of times a particular service rendered to a recipient is billed for payment control purposes. Instead, the Department mostly relies on providers to submit appropriate and accurate information on their Medicaid claims, which leaves substantial room for human error as well as possible willful misrepresentation.

Our analysis of the $32.1 million in APG claim payments identified $18.5 million in excessive services that eMedNY would have automatically denied had the system edit that is applied to non-APG claims (such as those from individual [or non-clinic] practitioners) been in place. According to Department officials, eMedNY does not currently have the capability to edit APG claims by service limit and such a change would require significant resources. Furthermore, although officials agree these services are likely inappropriate, they stated that recipients seen in a clinic, for example, typically have more severe health issues, and a review of each service may be necessary to determine if the same limits (those applied to non-APG claims) can be applied. The largest portions of the excessive APG payments were for dental services, which totaled $17.5 million and accounted for 174,631 of the 366,000 services.

For example, Medicaid limits dental cleaning and dental exam services to two times per year, yet we found Medicaid reimbursed a clinic for seven dental cleanings for one patient in a single year, and reimbursed another clinic for 41 dental exams (totaling $2,771) for one patient over three years. Claims such as these that exceed Medicaid's service limits would have been automatically denied if they were billed by a dentist instead of a clinic. Furthermore, in the latter case, the Department's Medicaid Dental Unit assisted us in reviewing the clinic's records supporting its 41 claims. The Dental Unit concluded the records didn't support any of the exam procedures, and in

some instances the progress notes did not indicate any billable service was provided. As a result, none of the 41 claims were eligible for reimbursement.

For some non-APG services, eMedNY suspends processing of claims when such services are billed in excess of specific limits or thresholds. The Department will then request additional documentation from the Medicaid provider supporting the medical necessity of the services exceeding the threshold. If providers do not supply the appropriate documentation, their claims are denied. We identified $13.6 million in APG claims (of the $32.1 million) that would have been suspended for review – and potentially denied – had the same system edit controls that are in place for non-APG claims been applied.

As an example, one clinic submitted claims for 46 sessions of power wheelchair fitting and training services over a 3½-year period, from September 17, 2009 through March 8, 2013, for one patient – a service that Medicaid limited to two sessions during a five-year period. (After October 1, 2011, Medicaid limited occupational therapy services, which includes power wheelchair fitting and training, to a total of 20 visits per year.) Processing of the provider's excessive service claims prior to October 1, 2011 should have been suspended, pending a review for medical necessity. We requested medical records and other documentation from the clinic to support the services. With the assistance of the Department, we determined that none of the claims were properly supported. As a result, Medicaid overpaid this clinic $5,054 for these services.

During the audit, we reviewed a judgmental sample of medical records from seven clinics and outpatient facilities with a high volume of claims for procedures that exceeded Medicaid service limits. We found significant issues at five of the seven providers in our sample. Of the 1,639 services reviewed for these five providers, 1,134 (69 percent) lacked sufficient supporting documentation. As a result, Medicaid overpaid these providers $138,408 (or 66 percent) of the total $210,342 we reviewed in detail.

The Department does not have eMedNY system controls to prevent reimbursement of excessive services, and instead relies on clinics and other outpatient facilities to police themselves through their own compliance programs and to provide accurate billing information when submitting claims. This results in significant risk of human error as well as possible willful misrepresentation. However, the Department intends to replace the current eMedNY system, and has agreed to consider incorporating service limits on APG claims into the design of the replacement system. Until such changes are made, the Department will continue to pay for APG claims for services that exceed Medicaid limits.

Recommendations

1. Review the actual and potential overpayments we identified, particularly for the five providers identified in this report and for the services that otherwise would be denied if provided outside a clinic or outpatient facility, and make recoveries, as appropriate.

2. Strengthen controls over APG claims processing to prevent improper payments for excessive services.

Duplicate Payments

Medicaid overpaid more than $7.5 million in duplicate claims to 2,244 doctors and other medical professionals who separately billed Medicaid for 224,673 services that were also included on APG claims that clinics and other outpatient facilities submitted to Medicaid. In each case, one payment was made to the practitioner (e.g., a dentist or physician) for the service provided in a clinic/outpatient facility, and a second APG payment was made to the clinic/outpatient facility for the same service.

The APG payment methodology covers most medical outpatient services; however, some services are "carved out" of the APG payment and may be billed as a separate Medicaid claim. We found the Department did not establish adequate controls to identify cases of double-billing and enforce APG billing rules, resulting in Medicaid's payment of duplicate claims submitted by both the practitioner and the clinic/outpatient facility for the same service. The following table provides a breakdown of the overpayments by type of service.

Type of Service	Overpayment	Claims
Non-Physician*	$3,442,290	127,312
Dental	1,563,351	43,800
Laboratory and Radiology	1,161,802	14,483
Physician	947,918	25,580
Vision Care	177,913	5,799
Physician-Administered Drugs	168,104	2,111
Referred Ambulatory	88,132	5,588
Totals	**$7,549,510**	**224,673**

*Includes nurse practitioner, physician assistant, and midwife services.

For example, a clinic received a $133 payment for an evaluation and management procedure. A second Medicaid claim for $29 was paid to a nurse practitioner for the same service to the same recipient on the same date. We reviewed medical records from both providers, and determined the nurse practitioner worked at the clinic and the claims were for the same patient encounter. According to Department policy, nurse practitioner services are included in the APG payment and may not be billed separately; therefore, we concluded the $29 claim is a Medicaid overpayment.

We judgmentally selected five practitioners identified as billing for services that were also included in a separate APG claim. The five providers were selected because they were identified as having high overpayments in one of the "Type of Service" categories listed in the table above. When we followed up with them, two explained that they either misunderstood the APG payment rules or were not aware of the rules altogether. A third provider had already identified and repaid overpayments related to this issue prior to our review. However, we determined that issues with these providers' claims continued, and additional overpayments exist.

For the remaining two providers, the Department granted temporary exemptions from APG billing rules to allow them time to revise their processes for compliance with the new payment

system. One provider received $1.4 million in overpayments for 39,452 dental services. According to Medicaid policy, as of February 1, 2010, a dentist's professional services are included in the APG payment to clinics and other outpatient facilities. Previously, these services were carved out of the APG payment, and therefore dental providers could bill Medicaid separately for them. In May 2010, the Department granted this provider permission to continue the practice of billing Medicaid for professional services provided in a clinic, allowing an exemption through August 31, 2010.

We question the propriety of the Department's exemption of this provider from the official Medicaid policy through August 31, 2010. The Department's approval was purportedly based on a 1992 letter in which the Department confirmed that dental practitioner services were not included in the clinic's payments, and therefore the dental services could be claimed separately. However, this rationale is irrelevant, as the circumstances for the provider in question were the same for other providers who separately billed for their services prior to the APG changes and who were subject to the APG payment method effective February 2010. Regardless of the previously prescribed method, the APG policy applied to all similar providers. Further, in the Department's May 2010 letter to the provider (to grant the exemption), the Department also indicated that the policy outlined in the 1992 letter "no longer makes sense," and the Department "specifically designed the new APG dental payments to be sufficient to cover all facility and professional expense." Moreover, the Department indicated that the new APG "dental fee schedule has been designed to cover all office-based expense for dental services and has not been designed to pay separately for the professional component of providing dentistry in a clinic setting."

As noted previously, the Department granted the exemption to give the provider additional time to revise its billing processes to the APG method. However, we do not believe this justified allowing the provider to retain the duplicate payments. Although the Department informed the provider that payments for dental claims were included in clinic APG payments, it did not establish a repayment agreement to recover the duplicate claims. Given the circumstances as detailed, we question why the Department did not establish a repayment schedule. During the seven months of the exemption, the provider received $1.3 million in duplicative payments.

The Department also granted the remaining provider a temporary exemption to continue billing Medicaid separately for physician services rendered in a clinic. According to Medicaid policy, all physician professional services are included in the APG payment made to diagnostic and treatment centers (D&TCs, also referred to as clinics).[1] This provider, however, formally requested an exemption from the Department through December 31, 2010, stating that officials were unclear how the various pieces of the APG reform applied to their operation. Provider officials acknowledged that they were unaware of the Department's March 2010 Medicaid update which stated that "the practitioner professional component for all D&TCs is currently included in the clinic threshold rate and will be included in the APG payment to the clinic upon implementation of APGs."

Despite the official APG policy, on November 2, 2010, the Department approved the provider's request, also without a repayment plan. We question the propriety of this provider's exemption

[1] Exceptions to this policy include freestanding D&TC dialysis clinics and ambulatory surgery centers.

(without a repayment plan) because of its unawareness of or confusion about the APG reform. From September 2009 through December 2010, this provider received $342,209 in duplicate Medicaid payments.

After our fieldwork concluded, the Department implemented an eMedNY system edit to address most of the duplicate Medicaid payments we identified and prevent future overpayments.

Recommendations

3. Review the duplicate Medicaid payments we identified and recover, as appropriate.

4. When granting exemptions from official State Medicaid policies, ensure such exemptions are based on appropriate rationales, which are properly documented.

5. To encourage compliance with prescribed payment policies, establish formal repayment plans for recipients of exemptions, when warranted.

6. Ensure the recently implemented eMedNY system controls prevent overpayments for the types of professional claims identified in this audit.

Audit Scope and Methodology

The objective of our audit was to determine whether the Department established adequate controls to prevent duplicate and excessive Medicaid payments to clinics and outpatient facilities reimbursed by the APG payment methodology. Our audit period was from December 1, 2008 through May 29, 2013.

To accomplish our objective and assess internal controls, we interviewed officials from the Department and the Office of the Medicaid Inspector General. We reviewed applicable sections of federal and State regulations, and examined the Department's relevant Medicaid policies and procedures. We contacted 12 providers and reviewed supporting documentation for claims billed.

We analyzed APG claims from the Medicaid Data Warehouse for service dates from December 1, 2008 through May 29, 2013. We analyzed procedure codes listed on these APG claims to determine the number of each service that a recipient received. We compared the result to the number allowed by eMedNY system edits when the services are billed as a professional, non-APG claim. Additionally, we analyzed professional claims from the Medicaid Data Warehouse for six claim types (practitioner, dental, referred ambulatory, eye care, laboratory, and durable medical equipment) for service dates from December 1, 2008 through May 29, 2013. We compared the professional claims with APG claims to determine if the same procedure, recipient, and service date were present on both. We excluded certain claims based on the Department's publications of ancillary and other carved-out procedures.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions, and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed 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.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials concurred with most of our recommendations and indicated that certain actions have been and will be taken to address them. In particular, officials indicated that the Department will design Medicaid's new billing system to enforce frequency edits for services rendered in a clinic setting. Our rejoinders to certain Department comments are included in the report's State Comptroller's Comments.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Contributors to This Report

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Vision

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To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Acting Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

May 1, 2015

Ms. Andrea Inman, Audit Director
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110 State Street – 11th Floor
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Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2013-S-17 entitled, "Ambulatory Patient Groups Payments for Duplicate Claims and Services in Excess of Medicaid Service Limits."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2013-S-17 entitled,
Ambulatory Patient Groups Payments for Duplicate Claims and Services in Excess of Medicaid Service Limits

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2013-S-17 entitled, "Ambulatory Patient Groups Payments for Duplicate Claims and Services in Excess of Medicaid Service Limits."

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.

Recommendation #1

Review the actual and potential overpayments we identified, particularly for the five providers identified in this report and for the services that otherwise would be denied if provided outside a clinic or outpatient facility, and make recoveries, as appropriate.

Response #1

The OMIG, and the Recovery Audit Contractor, will recover as appropriate.

Recommendation #2

Strengthen controls over APG claims processing to prevent improper payments for excessive services.

Response #2

It is erroneous for OSC to assume that all Ambulatory Patient Group (APG) clinic claims where frequency limits were exceeded are not medically necessary. OSC would need to review medical records for the claims in question (or a statistically valid sample of medical records) to draw a conclusion that there had been $32,700,000 in questionable payments for clinic services which exceeded Medicaid's established professional frequency limits. It should be noted that as the

* Comment 1

*See State Comptroller's Comments, Page 16

Department continues to promote managed care coverage for all Medicaid recipients, there will be significantly less fee-for-service (FFS) payments and the billing issues identified in this audit will be minimized. Additionally, to minimize future potential inappropriate billings that may exceed established frequency limits, the Department will be designing the new Medicaid billing system to enforce frequency edits for services rendered in a clinic setting.

With respect to utilization of "wheelchair fitting and training services" referenced in the audit report, there are two levels of wheelchair management reimbursed by Medicaid - Comprehensive Wheelchair Management (CWM) and Wheelchair Management Evaluation (WME). CWM is billed using Rate Code 1228. This service consists of a comprehensive assessment to completely describe and analyze the patient's functional status with respect to his/her personal mobility/wheelchair device needs. It may be conducted over more than one day, but is only billed once on the last day of a face-to-face service/encounter. This service has a service limit of twice in a five year period. WME, Current Procedural Terminology (CPT) Code 97542 differs from CWM in that it is a time based Occupational Therapy (OT) service separate and distinct from the rate based CWM. It includes analysis of the patient's functional status, needs assessment, device modification and/or adjustment, and therapy related to use of the wheelchair. WME is a lower level service and is billed by clinics as a routine OT service based on 15 minute units for up to two hours per visit and is not subject to the twice in five year service limit. Since CWM Rate Code 1228 and WME CPT Code 97542 are two different services, it is inappropriate to ascribe the same frequency limits to both. It should be noted that the Medicaid Program does employ service limits to reduce over-utilization for WME. The program enforces frequency edits for OT, Physical Therapy and Speech Therapy, Enhanced Ambulatory Patient Groups 270, 271 and 272, limiting rehabilitation services to 20 visits per therapy type per benefit year. The frequency edit is enforced for APG claims and is applicable to WME billed under CPT code 97542.

The Department and the OMIG will continue to review these claims and collaborate where necessary.

Recommendation #3

Review the duplicate Medicaid payments we identified and recover, as appropriate.

Response #3

The OMIG, and the Recovery Audit Contractor, will recover as appropriate.

Recommendation #4

When granting exemptions from official State Medicaid policies, ensure such exemptions are based on appropriate rationales, which are properly documented.

Response #4

Upon implementation of APGs, the Department advised diagnostic and treatment centers (D&TCs) that all professional services were included in the APG payment to the clinic. A professional claim should not be billed to Medicaid in addition to the APG clinic claim. The Department was subsequently approached by one D&TC that indicated their clinic threshold rate did not include the professional component. This was supported by a 1992 letter from the Department that approved payment to the facility for professional services based on their rate

* Comment 2

* Comment 3

* Comment 4

composition. The clinic requested that the Department permit them to continue to bill separately for the professional component in addition to the APG claim. Due to the phased-in implementation approach of APGs (blended payment of both the legacy rate and the APG rate), it was decided by the Department to permit this provider to continue to bill for the professional services outside of the APG payment for a very limited time period.

* Comment 5

A second D&TC provider also contacted the Department early during APG implementation and indicated that they were unable to comply with the APG billing requirements for professional claims in a timely manner due to the complexities of implementing APGs. In order to minimize the fiscal impact on this provider, and due to the phased-in implementation approach of APGs (blended payment of both the legacy rate and the APG rate), the Department agreed to permit this provider to also continue to bill the physician component for a short period of time.

In both situations, due consideration was given to the phased-in implementation of APGS in which both the legacy rate as well as the APG payment logic was used to derive the provider payment as well as the extent to which professional services were included in the legacy rate.

Recommendation #5

To encourage compliance with prescribed payment policies, establish formal repayment plans for recipients of exemptions, when warranted.

Response #5

* Comment 5

As noted in the response to recommendation #4, a provider recoupment was not warranted since the provider payment included both the legacy payment as well as the APG base rate component.

Recommendation #6

Ensure the recently implemented eMedNY system controls prevent overpayments for the types of professional claims identified in this audit.

Response #6

The Department's Office of Health Insurance Programs, Division of Systems received a new release of 3M APG software from the 3M Company to replace the flawed version installed earlier. The new release that would prevent the overpayment of these types of professional claims was successfully tested and implemented on December 30, 2014.

Furthermore, the Department has submitted an Evolution Project to establish Edit 2240 which will deny duplicate professional claims that are inappropriately billed outside of the APG rate. Presently, the edit is set to pay and report so that we can test the impacts of the edit to determine whether revisions are needed before we implement in September 2015.

State Comptroller's Comments

1. The Department misrepresents our findings and conclusions. We did not state or otherwise imply that all Ambulatory Patient Groups (APG) clinic claims that exceeded frequency limits were not medically necessary. Rather, our report clearly states that the amounts in question pertained to "actual and potential" overpayments. Further, with regard to the $32.1 million in payments for excessive clinic services, we based and formulated our conclusions on the Department's Medicaid reimbursement policies for the same services when provided in a non-clinic setting. As stated on page 5 of our report, Medicaid would have denied $18.5 million of these payments if the services were provided in a non-clinic setting. Moreover, during the course of the audit, Department officials agreed that these payments were likely inappropriate.

   In addition, as stated on page 6 of our report, Medicaid would have suspended the remaining $13.6 million in claims, requiring Department review for medical necessity prior to payment. As stated on page 6, we requested several Medicaid clinics to provide us with the medical records for a sample of 1,639 services, and we found that 1,134 (69 percent) of the services totaling $138,408 (66 percent of the amount paid) were not supported. Consequently, the claims for the 1,134 unsupported services would have been denied. Moreover, there is high risk that Medicaid should have denied a very large portion of the $13.6 million in claim payments in question.
2. We commend the Department for taking steps to ensure the new Medicaid billing system will have the necessary controls to enforce frequency limits for services rendered in a clinic setting.
3. Medicaid claims for comprehensive wheelchair management (rate code 1228) were not included in the scope of our audit.
4. As stated in our report and State Comptroller's Comment 1, we formulated our findings by applying the Medicaid frequency limits for professional (non-APG clinic) claims to APG claims. Regarding claims for wheelchair management evaluation (CPT Code 97542), eMedNY limits this service when provided in a professional (non-clinic) setting to twice per five years. Claims for services above this frequency limit are suspended for review of medical necessity. Per the Department's response, wheelchair management evaluation (code 97542) is an occupational therapy service, and as of October 1, 2011, Medicaid limited occupational therapy to 20 visits per benefit year. Consequently, for the final report, we reduced the actual/potential overpayments we identified by $566,332 ($357,346 for claims with code 97542 and $208,986 for claims with other therapy codes subject to the 20 visits per year limit). Further, this adjustment represented only 1.76 percent of the actual/potential overpayments in question.
5. As stated in the report, the circumstances (including the "blended" payment) for the two providers were the same for all providers who separately billed for their services prior to the APG changes and then became subject to the APG payment methodology. Thus, the Department was inconsistent in its treatment of affected Medicaid providers during the transition to the APG methodology. Those providers who converted to the APG methodology timely did not receive the same benefits (totaling about $1.6 million) as

the two providers in question. Because State officials should ensure that limited taxpayer dollars are spent properly, we maintain that our conclusions are correct and Department officials should take the corrective actions we recommended.