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January 12, 2017

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

Re: Multiple Same-Day Procedures on
Ambulatory Patient Groups Claims
Report 2016-F-17

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*, Multiple Same-Day Procedures on Ambulatory Patient Groups Claims* (Report 2012-S-163).

Background, Scope, and Objective

The Department of Health (Department) administers the State's Medicaid program, which provides a wide range of health care services to individuals who are economically disadvantaged and/or have special health care needs. The Medicaid program reimburses outpatient services based on the Ambulatory Patient Groups (APG) payment methodology. The APG system pays providers 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 APG methodology was then implemented in diagnostic and treatment centers and freestanding ambulatory surgery centers on September 1, 2009.

Medicaid claims from health care providers are processed and paid by an automated system called eMedNY. When eMedNY processes claims, they are subject to various automated controls, or edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and if the amounts claimed for reimbursement are appropriate. For example, some edits verify the eligibility of the Medicaid recipient, others verify the eligibility of the medical service, and some verify the appropriateness of the amount billed for the service.

We issued our initial audit report on August 12, 2014. The audit objective was to determine if the Medicaid program overpaid APG claims because of deficiencies in the claims processing and payment system. The audit covered the period December 1, 2008 through March 31, 2013. Our initial audit determined the Department did not implement adequate controls to enforce APG policy and payment rules. As a result, Medicaid made $1,083,836 in actual and potential APG claim overpayments for unit-based procedures ($614,260 for the same medical procedure billed multiple times on the same date of service and $469,576 for rehabilitation services billed beyond the allowed limits).

The audit also determined the Department did not incorporate service limits when processing APG claims for dental services or require certain site-specific information (such as tooth number). As a result, the audit identified questionable APG claim payments totaling $10,195,755 for procedures that were billed multiple times on the same date of service. This included $749,066 in likely overpayments for non-site-specific dental procedures (such as one clinic that billed nine dental cleanings in a single day for one recipient) and $9,446,689 in questionable payments for site-specific services (such as one clinic that billed 50 tooth extractions for one recipient, when a normal adult mouth has 32 teeth).

The audit concluded the Department relied too heavily on providers to comply with APG billing rules and regulations instead of implementing automated controls to enforce APG policy and payment rules. In addition, the Department did not effectively communicate certain changes in APG policies and procedures to the provider community. We recommended that the Department: strengthen controls over APG claims processing to address the weaknesses we identified and, where feasible, apply professional service limits to APG claims; formally communicate any corresponding modifications to providers; and review and recover inappropriate APG payments.

The objective of our follow-up was to assess the extent of implementation, as of November 17, 2016, of the five recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made some progress in addressing the problems we identified in the initial audit report. Nevertheless, significant further actions are still needed. The Department strengthened payment controls over the APG claims processing of excessive rehabilitation services. However, the Department planned to address the remaining APG claims processing control weaknesses that were identified in the initial audit report during the design and development of the new Medicaid claims processing and payment system.

Additionally, although over two years had passed since our initial report was issued, the Office of the Medicaid Inspector General, which investigates and recovers improper Medicaid payments on behalf of the Department, had only recovered $107,388 of the $11,280,997 in improper and questionable APG payments identified by our initial report. Further, if significant recovery efforts are not undertaken soon, many of the improper payments identified by the audit could become too old for recovery.

The initial report's five audit recommendations were partially implemented. In certain instances, the actions taken were relatively limited, and consequently more purposeful and definitive actions are needed.

Follow-Up Observations

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.

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.

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).

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.

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.

Major contributors to this report were Mark Breunig, Theresa Podagrosi, and Andrea LaBarge.

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,

Warren Fitzgerald
Audit Manager

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