



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

Division of State Government Accountability

Multiple Same-Day Procedures on Ambulatory Patient Groups Claims

**Medicaid Program
Department of Health**



Executive Summary

Purpose

To determine if Medicaid overpaid Ambulatory Patient Groups (APG) claims because of deficiencies in the claims processing and payment system. The audit covered the period December 1, 2008 through March 31, 2013.

Background

The Medicaid program reimburses outpatient services through the use of the Ambulatory Patient Groups (APG) payment methodology. The APG system was adopted by the Department of Health (Department) in an effort to more accurately pay providers for services rendered. Accordingly, 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 APG methodology was then implemented in diagnostic and treatment centers and freestanding ambulatory surgery centers on September 1, 2009.

Key Findings

- Medicaid made \$1,083,836 in actual and potential APG claim overpayments for unit-based procedures, including rehabilitation services. Of this amount, payments of \$614,260 were made for the same medical procedure billed multiple times on the same date of service, and \$469,576 was paid for rehabilitation services beyond the allowed limits.
- Medicaid made questionable APG claim payments totaling \$10,195,755 for dental clinic claims that were processed without sufficient scrutiny of the propriety or frequency of the services billed.
- We concluded the Department relies too heavily on providers to comply with APG billing rules and regulations instead of implementing 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.

Key Recommendations

- Strengthen controls over APG claim processing to address the weaknesses we identified. Where feasible, apply professional service limits to APG claims. Formally communicate any corresponding modifications to providers.
- Review inappropriate APG payments and make recoveries, as appropriate.

Other Related Audits/Reports of Interest

[Department of Health: Overpayments of Ambulatory Patient Group Claims \(2011-S-43\)](#)

[Department of Health: Medicaid Claims Processing Activity April 1, 2012 Through September 30, 2012 \(2012-S-24\)](#)

[Department of Health: Medicaid Payments for Excessive Dental Services \(2009-S-46\)](#)

State of New York
Office of the State Comptroller

Division of State Government Accountability

August 12, 2014

Howard Zucker, M.D.
Acting Commissioner
Department of Health
Corning Tower
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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 *Multiple Same-Day Procedures on Ambulatory Patient Groups Claims*. 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 year ended March 31, 2013, New York's Medicaid program had approximately 6 million enrollees and Medicaid claim costs totaled about \$51 billion. The federal government funded about 48.5 percent of New York's Medicaid claim costs, the State funded about 34 percent, and the localities (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 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.

In 2008, amendments to the State's Public Health Law required a new Medicaid outpatient payment methodology - known as Ambulatory Patient Groups (APG) - for clinic, ambulatory surgery, and hospital-based emergency room services. A range of health care needs are covered, from primary care (such as immunizations) to ambulatory procedures (such as colonoscopies). The new APG payment methodology became effective on December 1, 2008 for hospital outpatient departments and ambulatory surgery centers and on September 1, 2009 for diagnostic and treatment centers (e.g., clinics) 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 providers to report diagnosis and procedure codes, APG rate codes, and other billing information when submitting APG claims.

Audit Findings and Recommendations

Medicaid made \$1,083,836 in actual and potential APG claim overpayments to health care providers. Of this amount, \$614,260 involved claims where providers billed the same medical procedure multiple times on the same date of service. The remaining \$469,576 in overpayments occurred because Medicaid paid for excessive rehabilitation services beyond established limits. Furthermore, we question \$10,195,755 in payments for dental clinic claims that were processed, as designed by the Department, without sufficient scrutiny of the services billed. For example, we estimated \$749,066 (of the \$10,195,755) represented excessive payments because the Department did not apply frequency limits to non-site-specific dental procedures.

We concluded the Department relies too heavily on providers to comply with billing rules and regulations instead of designing and implementing 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, further eroding provider compliance. We made five recommendations to the Department to reassess its internal control system over APG claims and establish adequate controls to enforce Department policies and prevent future inappropriate Medicaid payments of such claims.

Ambulatory Patient Groups Unit-Based Claims

Medicaid made \$1,083,836 in actual and potential APG claim overpayments to health care providers for unit-based procedures, including rehabilitation services. Of this amount, \$614,260 involved claims wherein providers billed the same medical procedure multiple times on the same date of service. The remaining \$469,576 in overpayments occurred because Medicaid paid for excessive rehabilitation services beyond established limits of 20 visits per year.

Inappropriate Billing of Unit-Based Procedures

Generally, APG claims processing does not assess the number of times a particular procedure or service is provided to a recipient for payment control purposes. However, the Department has authorized payment of certain procedures on a unit basis in order to recognize the quantity of the service provided. Physical and occupational therapy, for example, are unit-based procedures, many of which are based on 15-minute intervals. Thus, a provider should claim three units of service for 45 minutes of therapy (15 minutes \times 3 units = 45 minutes).

The eMedNY system must distinguish between unit-based and non-unit-based procedures to correctly process and pay an APG claim. Consequently, the Department instructs providers to bill unit-based procedure codes on one claim line only and to enter the number of times (units) they provided that service on that line. Department policy specifically 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.

Medicaid made actual and potential overpayments totaling \$614,260 on 16,674 claim lines for

unit-based procedures. On 9,637 of these claim lines (totaling \$320,420), providers incorrectly billed such procedures multiple times on multiple claim lines for a single date of service. The improper payments occurred because eMedNY's APG claim payment process does not prevent payment of unit-based procedures billed on multiple claim lines, nor does it properly apply frequency limit controls to the procedures among all claim lines for the same date of service.

For example, Medicaid paid \$548 on an APG claim that included three different unit-based procedures on seven separate claim lines each (21 total claim lines), all with the same date of service. Each procedure was billed and paid seven times. However, the procedures billed had frequency limits of one, three, and three units, respectively. Medicaid paid all 21 procedures because the number of units on each individual claim line did not exceed the frequency limits. Medicaid would have paid only \$189 on the claim if it was billed according to Department policy - with each procedure code and the number of units of service provided on a single claim line (for a total of three claim lines, not 21). However, Medicaid overpaid this claim by \$359 (\$548 – \$189).

For the remaining 7,037 claim lines (totaling \$293,840), providers billed unit-based rehabilitation therapy procedures on multiple claim lines for a single date of service. Because rehabilitation procedure codes can be used to represent more than one type of rehabilitation service (physical therapy, occupational therapy and speech therapy), a modifier code is required to further describe the specific therapy performed. For example, the modifier code GP indicates physical therapy, while the code GO indicates occupational therapy. However, the 7,037 claim lines lacked a modifier code to distinguish the type of therapy provided. Therefore, these rehabilitation therapy procedures, billed on multiple claim lines on a single date of service, could represent either different types of therapy provided or one type of therapy provided multiple times. In the latter instance, Medicaid requires providers to bill on one claim line and include the number of times (units) the service was provided.

A review of medical records would be necessary to confirm the appropriateness of the 7,037 claim billings. We visited two providers (accounting for approximately 2 percent of the \$293,840) who perform a wide range of services processed as Medicaid APG claims. Our review included a sample of rehabilitation therapy claims that were billed without modifier codes. Our review of their records found that the providers provided different types of therapy for 12 out of the 13 claims reviewed. Therefore, while the 12 claims were not billed correctly (they should have contained modifier codes designating the different therapies), they were not overpaid. The remaining claim, however, was overpaid by \$51.

In addition to weak eMedNY controls, we attributed the improper claiming to provider confusion and weak guidance from the Department. Certain Department guidance was contradictory and untimely. Providers stated they were confused by Department APG billing guidance, including guidance regarding rehabilitation services. For instance, the Department publishes a monthly newsletter, called *Medicaid Update*, to communicate Medicaid policies, billing guidance, and other changes in the Medicaid program. In the August 2011 issue, the Department stated that, effective October 1, 2011, rehabilitation modifiers (GP, GO, and GN) must be included on claims for rehabilitation services to ensure correct counting for each therapy type claimed. However, two subsequent official APG policy guides ("APG Provider Manual" and "NYS APG Modifiers" -

each last updated about one year later) did not contain the new requirements. Consequently, clinic providers who relied on the APG policy guides would not have been in compliance with the requirement for modifiers on rehabilitation claims.

Inappropriate Payments for Excessive Rehabilitation Services

Effective October 1, 2011, Social Service Law amendments limited rehabilitation services (speech therapy, physical therapy and occupational therapy) to 20 visits per year. On February 23, 2012, the Department implemented controls to enforce the rehabilitation service limits by requiring prior authorization before services are provided. Nevertheless, from October 1, 2011 through March 31, 2013, Medicaid made overpayments totaling \$469,576 for excessive rehabilitation services.

The overpayments occurred mainly because of two problems. First, the prior authorization control did not apply to rehabilitation visits until February 2012, nearly five months after the limits on rehabilitation visits took effect. For example, one Medicaid recipient had 128 physical therapy visits from April 2011 through March 2012. Sixty-five of these visits were for rehabilitation services after October 1, 2011, but only three rehabilitation service visits were paid since February 23, 2012.

Second, we found eMedNY still allowed payments for excessive rehabilitation visits in spite of the prior authorization requirements. For example, we found one recipient who received 40 physical therapy rehabilitation service visits - all after February 23, 2012 - without prior authorization. A Department official confirmed that eMedNY still inappropriately pays clinic APG claims for rehabilitation services without prior authorization. The Department is assessing system processing to determine a solution.

Ambulatory Patient Groups Dental Claims

Medicaid made APG payments totaling \$10,195,755 for dental clinic claims that were processed without sufficient scrutiny of the propriety or frequency of the services billed. This included \$749,066 in likely overpayments for non-site-specific dental procedures and \$9,446,689 in questionable payments for site-specific services.

Inappropriate Payments for Non-Site-Specific Dental Procedures

Non-site-specific dental procedures (such as periodic cleanings and general examinations) apply to the whole mouth. In contrast, site-specific procedures (such as fillings and bitewing x-rays) pertain to a specific tooth or quadrant of the mouth. According to Department officials, in many instances, non-site-specific dental procedures should not be billed more than once on a single date of service. However, for the four-year period ending December 2012, we identified payments totaling \$749,066 for the same non-site-specific dental procedure code on multiple lines with the same date of service within a single claim.

On one particular APG claim, for example, a clinic billed a dental cleaning for a recipient nine times in a single day. Based on the Medicaid Dental Fee Schedule, the service limit for this dental procedure is two times per year. Medicaid would deny eight of the nine cleanings on a single date of service if the claim was billed by a traditional, non-clinic dental practitioner. However, Medicaid paid the dental clinic \$247 for all nine cleanings under the APG payment methodology. Because Medicaid should have paid only \$57 for one cleaning, the provider was overpaid \$190 (\$247 – \$57) for the eight improper charges.

The improper payments occurred because the Department has not incorporated service limits when processing APG claims for dental services. Dental providers (including dental clinics and dental schools) reimbursed through the APG process must follow the provisions of the Department's Medicaid Dental Policy and Procedure Code Manual. According to this Manual, dental care and services are restricted to the procedures and service limits presented in the Dental Fee Schedule. Although the Department applies these limits to non-clinic (non-APG) dental practitioner claims through eMedNY edits, it does not apply these limits to dental clinics' APG claims, thus increasing the risk of overpayments. Had the Department applied controls over the \$749,066 in non-site-specific dental procedures billed more than once on the same date of service, it could have prevented significant overpayments.

Questionable Payments for Site-Specific Dental Procedures

The Department requires dental clinic providers to bill Medicaid using the 837I (Institutional) health care claim transaction set, which does not include site-specific information (such as tooth number and tooth surface) necessary to ensure the propriety of APG dental claims. In contrast, the transaction set used for non-clinic dental claims (837D) includes site-specific data. The Department's decision to require dental clinics to bill using rate codes for APG claim processing - which are not compatible with the 837D transaction set - has resulted in less assurance that APG dental clinic claims are processed and paid properly.

We question payments totaling \$9,446,689 (from 159,342 claim lines) wherein dental procedures were billed multiple times on the same date of service; however, the procedures could not be subjected to service limits because the claims lacked site-specific information. For example:

- A dental clinic was paid \$1,810 for five claims (representing five dates of service) that billed a total of 50 extractions over a span of 38 days for one recipient. A normal adult mouth has 32 teeth; therefore, it appears the claims were inappropriately billed and overpaid. If these services were billed by non-clinic dental providers (who are required to use the 837D transaction that contains details such as tooth number), Medicaid would deny any duplicated teeth for this procedure. Assuming all 32 teeth were extracted, the minimum overpayment would be about \$612.
- Another dental clinic claim paid \$644 for a dental restoration procedure that was billed 49 times on a single day of service for one recipient. The professional service limit for this procedure is twice every two years per tooth. According to the Department's Dental Unit, the claim was likely improperly billed and, therefore, overpaid. If these services were billed by non-clinic dental providers (who must use the 837D transaction that details

tooth number and tooth surface), Medicaid would deny duplicate charges for the same tooth for this procedure. We estimated the overpayment on this claim to be about \$313.

In addition to the limitations of using the 837I claim for dental clinic claim processing, the APG system does not properly control for services billed over allowed limits, in part because the Department has not incorporated service limits when processing APG claims for dental services. As mentioned previously, such controls exist in eMedNY and are regularly applied to non-APG claims.

Department officials state they do not apply frequency or service-limit controls to dental clinic claims because dental clinics undergo more scrutiny than individual dental practitioners, as they are subject to Department surveillance audits and certification reviews and are required to have quality assurance programs to ensure patient safety and quality of care. However, we determined the Department's certification and surveillance programs do not require a review of dental clinic billing practices, nor have any dental clinics been the subject of a utilization review since 2008. Furthermore, these Department reviews apply clinic quality assurance program regulations¹ that have no specific requirement to review or verify billing practices. As a result, the Department has less assurance that dental clinics adequately "police themselves" to comply with Medicaid dental procedure billing rules and guidelines.

We visited two dental clinics to determine how they use their own compliance programs to ensure claims are prepared properly. The first dental clinic used a third-party compliance monitor. The second clinic's compliance program was incorporated into its parent hospital's compliance program. Officials at this clinic told us they monitor claim billing, but not on a regular basis. At these two clinics, we reviewed the medical records supporting Medicaid payments for 11 recipients to assess the effectiveness of the clinic's billing compliance programs. In total, we tested 122 claim lines related to payments of \$9,804. The following table summarizes the results of our review.

Dental Clinic	Number of Claim Lines	Number of Errors	Error Rate	Error Descriptions	Over-payment
1	54	11	20%	Duplicate billings; Incorrect coding; Policy does not allow	\$381
2	68	10	15%	Duplicate billings; Incorrect coding; Missing x-ray	\$1,025
Total	122	21	17%		\$1,406

Although both clinics had compliance programs, 17 percent of the procedures tested were billed incorrectly, resulting in overpayments totaling \$1,406 (about 14 percent of the \$9,804 paid). Further, for each of the 11 recipients in our sample, there was at least one billing error. Most of the errors were attributable to duplicate billing (the same service on multiple claim lines) and coding errors. Consequently, the Department has only limited assurance that dental clinics comply with Medicaid billing rules and regulations.

¹ 10 NYCRR Part 751

The Department's decision to use the 837I transaction set (instead of the 837D set) was based on retaining a rate-based payment methodology for dental clinics. However, as previously indicated, this methodology does not use certain site-specific data, and consequently, is prone to overpayments. Until the Department takes the necessary actions, overpayments will continue to occur because the Department cannot effectively enforce service limits in APG dental claim processing.

However, according to Department officials, it would be cost prohibitive to modify eMedNY so that frequency limits are applied to dental clinic APG claims. Because the Department intends to replace the current eMedNY system, officials are reluctant to invest resources to address this problem through eMedNY redesign projects. Department officials said they will consider a policy change to subject dental clinic claims to service limits when the replacement system is implemented.

Given the magnitude of the payments in question (\$9,446,689) and the risk of material overpayments, we believe the Department should take the appropriate steps now to ensure APG dental clinic claims are processed and paid properly.

Recommendations

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.
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.
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.
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.
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.

Audit Scope and Methodology

The objective of our audit was to determine if Medicaid overpaid APG claims because of deficiencies in the Medicaid processing system. Our audit period was from December 1, 2008 through March 31, 2013.

To accomplish our objective, 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 performed various analyses of claims data from Medicaid payment files. We visited two hospitals that perform a wide range of services processed as Medicaid APG claims. We compared samples of their records to Medicaid claims to determine risks of improper billing. We also visited two dental clinics to review their quality assurance processes and compared a sample of their Medicaid claims to their records to determine billing compliance. We also verified the accuracy of certain payments and tested the operation of certain system controls.

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 objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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. Our rejoinder to certain Department comments is included in the report's State

Comptroller's Comment.

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

A team of accountability experts respected for providing information that decision makers value.

Mission

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

Agency Comments

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

NEW YORK
state department of
HEALTH

Sue Kelly
Executive Deputy Commissioner

July 7, 2014

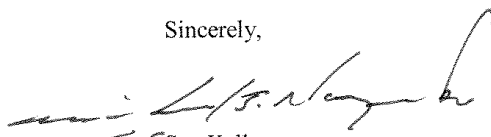
Ms. Andrea Inman, Audit Director
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Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2012-S-163 entitled, "Multiple Same-Day Procedures on Ambulatory Patient Groups Claims."

Thank you for the opportunity to comment.

Sincerely,


Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
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**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2012-S-163 Entitled
Multiple Same-Day Procedures on
Ambulatory Patient Group Claims**

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

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 of Health (the Department), where feasible, will consider incorporating professional service limits to Ambulatory Patient Group (APG) claims into the design of the eMedNY replacement system. As discussions with the new contractor evolve, professional service limits to the APG claims will be discussed.

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. The Department will assess opportunities to strengthen claims processing with the new eMedNY replacement contractor.

*
Comment
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* See State Comptroller's Comment on Page 17.

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 take action 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 take action as appropriate.

State Comptroller's Comment

1. As detailed in our report, there are material problems with the current APG rate-based payment methodology for dental clinics. Given the magnitude of the payments in question and the potential for millions of dollars of Medicaid cost savings, we reiterate that Department officials should formally assess options for processing dental clinic claims, including consideration of non-rate-based payment methodologies. 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.

Also, the Department intends to assess opportunities to strengthen claims processing with the new eMedNY replacement contractor. However, at this time, there is no approved contract with a replacement system vendor. Thus, there is significant risk that many of the weaknesses we identified (such as those pertaining to overpayments of non-site-specific dental procedures) might not be adequately addressed for many months or potentially years. Until a contract is in place and the replacement system addresses these issues, the Department will need to develop alternative controls to detect and recover overpayments of dental clinic APG claims, such as those identified in our report.