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

Division of State Government Accountability

Inappropriate Payments Related to Procedure Modifiers

Medicaid Program
Department of Health

Report 2016-S-63 April 2018

Executive Summary

Purpose

To determine whether Medicaid made inappropriate payments to providers that failed to use modifier codes properly. The audit covered the period from January 1, 2012 to March 31, 2017.

Background

The Medicaid program is a federal, state, and locally funded program that provides a wide range of health care services to those who are economically disadvantaged and/or have special health care needs. The Department of Health (Department) administers the Medicaid program in New York State. Health care providers bill Medicaid for services provided to Medicaid recipients. Medicaid payments are based, in part, on procedure codes reported on claims that indicate the services provided. In certain instances, providers must include a modifier code on the claim to further describe the service(s) provided.

Medicaid payments for surgical procedures include the preoperative, intraoperative, and postoperative services normally performed by the provider. This is commonly known as the global surgery period. All routine services related to the surgery, such as evaluation and management (E/M) services, are included in Medicaid's payment for the procedure. E/M services that are unrelated to the original procedure may sometimes occur during the global surgery period. These circumstances may be reported, and reimbursed, by adding the appropriate modifier code to the E/M service.

Key Findings

Auditors identified about $2.6 million in inappropriate payments made to providers for E/M services from January 1, 2012 to March 31, 2017. Specifically, the audit found:

- Medicaid made 50,715 inappropriate payments totaling $2,093,285 for E/M services billed without a modifier code on the same day a surgical procedure was performed. The payments were inappropriate because the costs of the services were already included in Medicaid's payment for the surgical procedures.
- Medicaid also made 15,170 inappropriate payments totaling $517,492 for E/M services billed without a modifier code during the postoperative period of surgery. Similarly, the costs of these services were already included in Medicaid's payment for the surgical procedures.

Key Recommendations

- Review the $2.6 million in inappropriate payments made to providers for E/M services and recover overpayments, as appropriate.
- Formally advise providers that received inappropriate payments to report accurate claim information when billing Medicaid for E/M services during global surgery periods to ensure claims are paid appropriately.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Claims Processing Activity April 1, 2016 Through September 30, 2016 (2016-S-12)

Department of Health: Medicaid Claims Processing Activity October 1, 2016 Through March 31, 2017 (2016-S-66)

State of New York
Office of the State Comptroller

Division of State Government Accountability

April 17, 2018

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 *Inappropriate Payments Related to Procedure Modifiers*. This 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.

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

Table of Contents

State Government Accountability Contact Information:
Audit Director: Andrea Inman
Phone: (518) 474-3271
Email: StateGovernmentAccountability@osc.ny.us
Address:
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

This report is also available on our website at: www.osc.state.ny.us

Background

The Medicaid program is a federal, state, and locally funded program that provides a wide range of health care services to those who are economically disadvantaged and/or have special health care needs. The Department of Health (Department) administers the Medicaid program in New York State. For the State fiscal year ended March 31, 2017, New York's Medicaid program had approximately 7.4 million enrollees and Medicaid claim costs totaled about $58 billion. The federal government funded about 55.3 percent of New York's Medicaid claim costs; the State funded about 29 percent; and the localities (the City of New York and counties) funded the remaining 15.7 percent.

Health care providers bill Medicaid for services provided to Medicaid recipients. Medicaid payments are based, in part, on procedure codes reported on claims to indicate the medical services performed, such as surgical services or evaluation and management services (E/M). In certain instances, providers must include a modifier code on the claim to further describe the service(s) performed.

Medicaid payments for surgical procedures include the preoperative, intraoperative, and postoperative services normally performed by the provider. This is commonly known as the global surgery period. All routine services related to the surgery, such as E/M services, are included in Medicaid's payment for the procedure. E/M services that are unrelated to the original procedure may sometimes occur during the global surgery period. These circumstances may be reported, and reimbursed, by adding the appropriate modifier code to the E/M service.

Medicaid classifies surgeries into three separate "postoperative period" groups:

- 0-Day Postoperative Period (endoscopies and some minor procedures);
- 10-Day Postoperative Period (other minor procedures); and
- 90-Day Postoperative Period (major procedures).

The postoperative periods are programmed into eMedNY, the Department's claims processing and payment system, to properly process claims during global surgery periods.

Claims processed through eMedNY are subjected to various automated controls, or edits. The purpose of these edits is to determine whether the claims are eligible for reimbursement and whether 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 still others verify the appropriateness of the amount billed for the service. In October 2012, the Department established eMedNY edits to identify inappropriate E/M billings during global surgery periods.

Audit Findings and Recommendations

For the period January 1, 2012 to March 31, 2017, we identified $2.6 million in inappropriate Medicaid payments for E/M services that were not billed with modifier codes indicating separately reimbursable services during global surgery periods. Accordingly, the costs of these services were already included in Medicaid's payment for the surgical procedures. During the audit period, the Department implemented controls to prevent payment for claims like the ones we identified; however, no action was taken to recover the inappropriate claims we found during our review.

Inappropriate Payments for Evaluation and Management Services Billed Without Modifier Codes

E/M Services Performed the Same Day as Surgical Procedures

An E/M service may be claimed on the same day as a surgical procedure when a patient's condition requires a significant, separately identifiable E/M service beyond the usual care or when the decision to perform a major surgical procedure is made the same day as the surgery. In these instances, providers must append an appropriate modifier code on the E/M claim.

When an E/M service unrelated to the surgery occurs on the day of the procedure, providers are instructed to append modifier "25" to the E/M claim to indicate that it was a significant, separately identifiable service. When the decision to perform a major surgical procedure is made on the same day as the surgery, providers are instructed to append modifier "57" to the E/M claim. However, according to Department guidelines, these occurrences should not be routine practice.

For the period from January 1, 2012 to March 31, 2017, we identified 50,715 payments totaling $2,093,285 for E/M services billed without a modifier code and provided on the same day a surgical procedure was performed. Without the addition of modifier "25" or "57" to the E/M claims, the billings do not indicate that a significant, separately identifiable E/M service was performed or that the decision to perform a major procedure was made. The payments for the E/M services we identified do not comply with Medicaid policy and, therefore, are inappropriate.

For example, Medicaid paid a provider $112 for a bone marrow biopsy, which is considered a minor surgical service with a global surgery period of 0 days. Medicaid also paid the provider $108 for a new patient office visit, which is considered an E/M service. The provider did not append modifier "25" to the E/M claim to indicate that a significant, separately identifiable service was performed. As a result, Medicaid inappropriately paid the provider $108 for this claim.

E/M Services Performed During Postoperative Periods

When an unrelated E/M service by the same physician occurs during the postoperative period (after the surgery is performed), providers are instructed to append modifier "24" to the E/M claim

to indicate that the E/M service billed is not part of the global surgery package and, therefore, is separately reimbursable. For the period from January 1, 2012 to March 31, 2017, we identified 15,170 payments totaling $517,492 for E/M services billed without a modifier code and provided during the postoperative period. Without the addition of modifier "24" to the E/M claims, the billings do not indicate that the E/M service was unrelated to the surgery. The payments for the E/M services we identified do not comply with Medicaid policy and, therefore, are inappropriate.

For example, Medicaid paid a provider $385 for an appendectomy, which is considered a major procedure with a global surgery period of 90 days. Medicaid also paid the provider $104 for subsequent hospital inpatient care, which is considered an E/M service. The provider did not append modifier "24" to the E/M claim to indicate that the service billed was not part of the global surgery package and, therefore, was separately reimbursable. As a result, Medicaid inappropriately paid the provider $104 for this claim.

eMedNY Edits to Prevent Inappropriate Payments

The $2.6 million ($2,093,285 + $517,492) in inappropriate payments occurred because providers submitted claims for E/M services during global surgery periods without an appropriate modifier; and eMedNY lacked claims processing controls to prevent the inappropriate payments. In October 2012, the Department established eMedNY edits to identify inappropriate E/M billings during global surgery periods. However, the edits were initially set to "pay." It was not until November 2016, during our fieldwork, that the Department changed the disposition of the edits to "deny." If the edits were set to "deny" during our audit period, eMedNY would have prevented Medicaid from making the $2.6 million in inappropriate payments.

Recommendations

1. Review the $2.6 million in inappropriate payments made to providers for E/M services and recover overpayments, as appropriate.

2. Formally advise providers that received inappropriate payments to report accurate claim information when billing Medicaid for E/M services during global surgery periods to ensure claims are paid appropriately.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether Medicaid made inappropriate payments to providers that failed to use modifier codes properly. The audit covered the period from January 1, 2012 to March 31, 2017.

To accomplish our audit objective and assess relevant internal controls, we interviewed officials from the Department, examined the Department's relevant Medicaid policies and procedures, and reviewed applicable federal and State laws, rules, and regulations. We used the Medicaid Data Warehouse and the eMedNY claims processing system to identify payments for E/M services

that were not billed in accordance with the Department's policies. During the audit, we shared our methodology and provided data and findings to Department and Office of the Medicaid Inspector General officials for their review.

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 that 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 to certain boards, commissions, and public authorities, some of whom have minority voting rights. 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 the report. In their response, Department officials concurred with the audit recommendations and indicated that certain actions have been and will be taken to address them.

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

Andrea Inman, Audit Director
Christopher Morris, Audit Manager
Daniel Towle, Audit Supervisor
Emily Proulx, Examiner-in-Charge
Lisa Rooney, Senior Examiner
Kevin Fung, Senior Editor

Division of State Government Accountability

Andrew A. SanFilippo, Executive Deputy Comptroller
518-474-4593, asanfilippo@osc.ny.gov

Tina Kim, Deputy Comptroller
518-473-3596, tkim@osc.ny.gov

Ken Shulman, Assistant Comptroller
518-473-0334, kshulman@osc.ny.gov

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

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

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

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

April 2, 2018

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2016-S-63 entitled, "Inappropriate Payments Related to Procedure Modifiers."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
Jason A. Helgerson
Dennis Rosen
Erin Ives
Brian Kiernan
Timothy Brown
Elizabeth Misa
Geza Hrazdina
Jeffrey Hammond
Jill Montag
James Dematteo
James Cataldo
Diane Christensen
Lori Conway
OHIP Audit SM

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

Department of Health
Comments on the
Office of the State Comptroller's 2016-S-63
Draft Audit Report entitled, Inappropriate Payments Related to Procedure Modifiers

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2016-S-63 entitled, "Inappropriate Payments Related to Procedure Modifiers."

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 1,276,304 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,609 in 2016, consistent with levels from a decade ago.

Recommendation #1

Review the $2.6 million in inappropriate payments made to providers for E/M services and recover overpayments, as appropriate.

Response #1

OMIG reviewed the identified payments, and will determine an appropriate course of action.

Recommendation #2

Formally advise providers that received inappropriate payments to report accurate claim information when billing Medicaid for E/M services during global surgery periods to ensure claims are paid appropriately.

Response #2

In the preliminary, the Department stated it would publish a Medicaid Update to remind providers of "global days" and/or "follow-up days" billing requirements and the need to accurately report the appropriate modifiers when billing for Evaluation and Management services and surgical procedures that are provided as separate and distinct services. This update was published in the January 2018 Medicaid Update as follows:

"This is a reminder to providers of fee-for-service (FFS) Medicaid payment rules for global surgery periods, also known as follow-up days or post-operative periods. New York State Medicaid follows Medicare rules on billing and payment during global surgery periods. Medicare's March 2015 guidance on global surgery periods is available on the Centers for

Medicare and Medicaid Services website here: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166

Global surgery includes all necessary services normally furnished by a surgeon before, during, and after a procedure. New York State Medicaid payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services normally performed by the practitioner. Global surgery days, or follow-up days, are identified on each practitioner's fee schedule. For procedures with 10- and 90-day follow-up periods, all routine services related to the surgery are included in payment for the procedure. There may be instances when evaluation and management services, unrelated to the original procedure, may occur during the post-operative period. ***In these instances, providers may select the appropriate modifier to include on the claim; however, this should not be routine practice.***

Minor procedures and endoscopies may not have a follow-up period (indicated by a "0" in the follow-up days column on the practitioner fee schedule). When the evaluation and management service that leads to the decision to provide the minor procedure occurs on the same day as the procedure, providers should bill Medicaid only for the procedure. There may be instances when the patient's condition requires a significant, separately identifiable evaluation and management service, above and beyond the usual care. ***In these instances, providers may select the appropriate modifier to include on the claim; however, this should not be routine practice****.*

For questions related to Medicaid FFS policy, please contact the Office of Health Insurance Programs, Division of Operations and Systems at (518) 474–8161. Billing questions for individuals enrolled in Medicaid managed care plans should be directed to the individual enrollee's Medicaid managed care plan."