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

Division of State Government Accountability

Overpayments of Ambulatory Patient Group Claims

Medicaid Program
Department of Health

Report 2011-S-43 August 2013

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, 2012.

Background

The Ambulatory Patient Groups (APG) payment methodology covers most medical outpatient services. Claims are reimbursed based on a patient's condition and complexity of service. The APG system was adopted by the Department of Health (Department) in an effort to more accurately pay providers for services rendered. Prior to the APG implementation, outpatient services were paid under an all-inclusive reimbursement model. The patient's condition and complexity of service were not factored into the claim payment. Under the new APG system, the Department assigned providers new APG rate codes and deactivated the rate codes used under the previous payment methodology. The Department phased in APGs beginning with hospital outpatient departments and ambulatory surgery centers on December 1, 2008. APGs were then implemented in freestanding diagnostic and treatment centers and freestanding ambulatory surgery centers on September 1, 2009. The Department uses its automated eMedNY system to process Medicaid claims and make payments.

Key Findings

- Providers used five prohibited combinations of APG reimbursement codes on 6,615 claims which resulted in improper Medicaid payments totaling $1,204,186. These improper payments occurred because the Department did not properly design automated system edits to deny claims with the prohibited rate code combinations.
- For example, Medicaid paid a provider $149 for a clinic visit that was billed under one particular rate code. Later, the provider submitted a second claim for the same service to the same recipient on the same date using a different rate code, and Medicaid paid the provider $128 for this claim. Because the edit was not programmed to stop this particular rate code sequence, the applicable eMedNY edit did not prevent payment of the second claim.
- We also identified $933,399 of duplicate payments made to providers for the same services under both the old and the new (APG) payment methodologies. Furthermore, the Department must reprocess $4,286,603 of payments made under the pre-APG methodology.

Key Recommendations

- Review the 6,615 instances of improper payments (totaling $1,204,186) and make recoveries, as appropriate.
- Design and implement eMedNY system edits which prevent the improper payments we identified.
- Review the 8,819 duplicate payments (totaling $933,399) and make recoveries, as appropriate.

Other Related Audits/Reports of Interest

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

Department of Health: Medicaid Claims Processing Activity April 1, 2011 Through September 30, 2011 (2011-S-9)

State of New York
Office of the State Comptroller

Division of State Government Accountability

August 20, 2013

Nirav R. Shah, M.D., M.P.H.
Commissioner
Department of Health
Corning Office Building
Empire State Plaza
Albany, NY 12237

Dear Dr. Shah:

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 *Overpayments of Ambulatory Patient Group 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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This report is also available on our website at: www.osc.state.ny.us

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. The federal government funds about 49 percent of New York's Medicaid costs, the State funds about 34.5 percent, and the localities (the City of New York and counties) fund the remaining 16.5 percent. For the year ended March 31, 2012, New York's Medicaid program had more than 5.5 million enrollees and claims' costs totaled about $50 billion.

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, other edits verify the eligibility of the medical service, and other edits verify the appropriateness of the amount billed for the service. In addition, some edits compare the claim to other related claims to determine whether any of the claims duplicate one another.

In 2008, changes to the State's Public Health Law required a new Medicaid outpatient payment methodology (known as Ambulatory Patient Groups [or APG]) for clinic and ambulatory surgery services as well as hospital-based emergency room services. These include a range of services such as primary care (for example, immunizations) and ambulatory procedures (such as colonoscopies).

Prior to the implementation of APG's, Medicaid paid these claims based on an all-inclusive rate code method wherein providers were paid fixed dollar amounts, regardless of the severity of the illness, the complexity of the services, or the number of procedures performed. For example, Medicaid paid a provider the same amounts for clinic treatment for a common cold and clinic treatment for abdominal pain including laboratory work and other services. Under the APG payment methodology, payments are based on similarly grouped clinical characteristics, such as the diagnosis, the procedures performed, as well as the amount and type of resources used. As a result, medical services requiring a higher level of professional care are paid a higher amount than those requiring lower levels of care.

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 approach required providers to use new (APG) rate codes when submitting Medicaid claims. To help transition to the APG methodology, the Department allowed certain providers to continue use of pre-APG rate codes through June 2011. In addition, since July 2010, providers were given the opportunity to adjust previously paid claims (under the former methodology) and resubmit them using APG rate codes. In July 2011, the Department began to deactivate reimbursement rates from the old payment methodology. At that time, the Department planned to reprocess the claims that providers had not previously adjusted.

Audit Findings and Recommendations

Medicaid overpaid providers $2,137,585 for improper APG claims. The overpayments included $1,204,186 for claims that eMedNY processed incorrectly because providers used certain improper combinations of APG rate codes. The remaining $933,399 in overpayments occurred because Medicaid made duplicate payments for the same services. Furthermore, we identified other claim payments totaling $4,286,603 that were processed using the pre-APG methodology. These claims are at risk of duplicate payment and the Department should reprocess them under the APG methodology.

Improper APG Rate Code Combinations

To prevent improper Medicaid payments, the Department prohibits providers from billing certain combinations of APG rate codes for the same date of service, for the same recipient. Nevertheless, providers applied five prohibited combinations of rate codes to 6,615 claims that resulted in overpayments totaling $1,204,186.

For four of the prohibited rate code combinations, the Department did not properly design eMedNY edits to deny improper claim payments. As a result, Medicaid overpaid 5,524 (of the 6,615) claims by $892,777. For example, Medicaid paid a provider $149 for a clinic visit that was billed under one particular rate code. A week later, the provider submitted a second claim for the same service to the same recipient on the same date using a different rate code, and Medicaid paid the provider $128 for this claim. Because of the order in which the provider billed these two claims, and the related rate codes, the applicable eMedNY edit did not prevent payment of the second claim. We determined that the edit in question denied a claim only when providers billed the rate codes in a certain sequence. Thus, the edit did not prevent improper payments when the rate codes were billed in the opposite sequence.

Medicaid overpaid the other 1,091 claims totaling $311,409 because eMedNY had no edit to address the remaining combination of prohibited rate codes. According to Department policy, providers should bill all services provided on a date of service on one claim using one rate code instead of billing multiple separate claims using multiple rate codes. However, we found providers billed services on two separate claims using two separate rate codes, which resulted in overpayments.

For example, a hospital provided emergency room care (including radiological and laboratory services) to a recipient. Provision of these services culminated with a procedure at the hospital's ambulatory surgery unit. The hospital submitted a claim for the emergency room treatment, and Medicaid paid the hospital $458. The hospital also submitted a second claim, with the same service date and a different rate code, for the recipient's ambulatory surgery. Medicaid paid $869 for the second claim. However, if a patient goes to an emergency room and is then sent to an ambulatory surgery unit, the hospital should bill all services on one claim only under the ambulatory surgery rate code. Therefore, Medicaid should not have paid the provider $458 for the emergency room rate code claim. Had the provider properly billed all the services on one

claim under the ambulatory surgery rate code, the provider would have been paid $1,128, not $1,327 ($458 + $869).

We informed the Department of the flaws in the eMedNY edits, and officials agreed the edits did not work as intended. At the time we concluded our fieldwork, the Department implemented projects to correct the edits.

Recommendations

1. Review the 6,615 instances of improper payments (totaling $1,204,186) and make recoveries, as appropriate.

2. Design and implement eMedNY system edits which prevent the improper payments we identified.

Duplicate Payments From Related Pre-APG and APG Claims

Medicaid overpaid 124 providers $933,399 for 8,819 duplicate claims. In these cases, Medicaid paid the providers under the pre-APG methodology and again under the APG methodology for the same services. The Department's phase-in of the APG methodology included the deactivation of the pre-APG rate codes. However, the Department did not deactivate many pre-APG codes in a timely manner. As a result, Medicaid made 8,819 duplicate payments totaling $933,399 for claims submitted under both the pre-APG and APG methodologies. These claim payments were for the same services provided to the same recipient by the same provider on the same date of service. For example, Medicaid paid a provider $214 for services provided on August 3, 2011 based on a claim using a pre-APG rate. Later, Medicaid paid the same provider $180 for an APG claim for the same service. Because the APG payment ($180) was correct, the Department should recover the original payment ($214) that was based on the pre-APG rate.

Further, we determined that Medicaid paid 56,241 other claims totaling $4,286,603 to 361 different providers under the pre-APG methodology that are also at risk of duplicate payment under the APG methodology. Certain providers were unable to accommodate the new claiming methodology in 2008 and 2009. Consequently, to give these providers more time to make their billing systems APG-compatible, the Department allowed them to continue to submit their claims under the pre-APG method. Although the Department planned to reprocess such claims subsequent to July 2011, it had not reprocessed them as of March 31, 2012. Moreover, until the Department reprocesses the 56,241 claims in question under the APG method, the potential for duplicate payments exists.

At the time we concluded our audit fieldwork, the Department had not established a deadline for the providers in question to comply fully with APG requirements. As a result of our audit, Department officials began to deactivate pre-APG rate codes for providers that were allowed additional time to use them.

Recommendations

3. Review the 8,819 duplicate payments (totaling $933,399) and make recoveries, as appropriate.

4. Complete the deactivation of pre-APG rate codes providers use to submit claims.

5. Using the APG methodology, promptly reprocess the 56,241 claims that were processed using pre-APG rate codes.

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, 2012.

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, using entity IDs to identify providers. A small group of providers may opt out of the APG methodology and continue to submit claims under the previous all-inclusive (pre-APG) payment methodology. We did not include those providers in this audit. 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 generally concurred with our recommendations and indicated that certain actions 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

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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 department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

July 17, 2013

Mr. Brian Mason, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, New York 12236-0001

Dear Mr. Mason:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2011-S-43 entitled, "Overpayments of Ambulatory Patient Group 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 2011-S-43 entitled,
Overpayments of Ambulatory Patient Group Claims

The following are the New York State Department of Health's (Department) comments in response to the Office of the State Comptroller's Draft Audit Report 2011-S-43 entitled, "Overpayments of Ambulatory Patient Group Claims."

Recommendation #1:

Review the 6,615 instances of improper payments (totaling $1,204,186) and make recoveries, as appropriate.

Response #1:

The Office of the Medicaid Inspector General (OMIG) will review these payments and initiate recoveries as appropriate.

Recommendation #2:

Design and implement eMedNY edits which prevent the improper payments we identified.

Response #2:

The Department's analysis revealed that several systems edits designed to prevent all the billing combinations cited were created and implemented. Beginning January 1, 2013 (after the audit period in question), a system edit was implemented to prevent 1401/1402 billing combinations for the same recipient, on the same date of service. In November 2011 a Medical-Cantra Edit Request Form was submitted to implement billing system edits (effective 12/1/2008) for all the other improper billing combinations cited in this Audit. However, based on the findings of this Draft Audit Report it appears that the combination edits that were intended to prevent the majority of the improper billing combinations cited in the Audit (beginning 12/1/2008) are not working properly. Accordingly, the Department is in the process of assessing ways to resolve these issues and correct the edits so they function properly to prevent the improper billing combinations identified in this Audit.

Recommendation #3:

Review the 8,819 duplicate payments (totaling $933,399) and make recoveries, as appropriate.

Recommendation #4:

Complete the deactivation of pre-APG rate codes providers use to submit claims.

Recommendation #5:

Using the APG methodology, promptly reprocess the 56,241 claims that were processed using pre-APG rate codes.

Response to recommendations #3, #4 and #5:

The Department will set to zero the pre-APG rate codes for providers where it has been determined they are still active. This will result in the following:

1. Duplicate payments will be removed from the system as the payment for the claims where the rates have been set to zero will be recouped.

2. Pre-APG rate codes will then be deactivated.

3. In order for claims to reprocess (where appropriate) using the APG rate codes, providers will need to amend their claim to the appropriate rate code. Due to the timeliness of the re-submission of these claims, the providers affected will need to contact the Department of Health for approval prior to the claim re-submission.