NEW YORK STATE | Office of the Medicaid Inspector General

DENNIS ROSEN
Medicaid Inspector General

Audit of Claims for Inappropriate Payments for Procedure Code Modifiers Paid from January 1, 2014 to December 31, 2018

Final Audit Report

Audit #: 2019Z70-056B

Coney Island Medical Practice Plan

Provider ID #: 03265092

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

January 10, 2020

Coney Island Medical Practice Plan
45 Research Way Suite 206
East Setauket, New York 11733-6401

Final Audit Report
Audit #: 2019Z70-056B
Provider ID #: 03265092

Dear Provider:

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Coney Island Medical Practice Plan (Provider).

In accordance with Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York Section 517.6, the attached Final Audit Report represents the final determination on the issues found during OMIG's audit.

The Provider did not respond to OMIG's November 19, 2019 Draft Audit Report. As a result, the overpayments identified in this Final Audit Report remain unchanged from those cited in the Draft Audit Report. The total amount due is $2,686.84, inclusive of interest.

To obtain the password for the enclosed disc, please email [redacted] If you have any questions or comments concerning this report, please contact [redacted] or through email at [redacted] Please refer to audit number 2019Z70-056B in all correspondence.

Sincerely,

[redacted]
System Match and Recovery
Division of Systems Utilization and Review
Office of the Medicaid Inspector General

Enclosure
Certified Mail #: 7018 1830 0000 1336 9154
Return Receipt Requested

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B – Improper Payment for Evaluation and Management (E/M) Services Billed During the Post-Operative Period of a Surgical Procedure for Dates of Service Paid from January 1, 2014 to December 31, 2018

Background, Objective, and Audit Scope

Background

The New York State Department of Health (DOH) is the single state agency responsible for the administration of the Medicaid program. As part of its responsibility as an independent entity within DOH, the Office of the Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment, and supplies. These audits and reviews are directed at assessing provider compliance with applicable laws, regulations, rules, and policies of the Medicaid program as set forth in New York Public Health Law, New York Social Services Law, the regulations of DOH (Titles 10 and 18 of the New York Codes Rules and Regulations), the regulations of the Office of Mental Hygiene (Title 14 of the New York Codes Rules and Regulations), DOH's Medicaid Provider Manuals and *Medicaid Update* publications.

OMIG performed an audit of Medicaid fee-for-service claims for Evaluation and Management (E/M) Services with missing or inappropriate Procedure Code Modifier either on the same day as or during the post-operative period of a surgical procedure.

To accomplish this review, claims for E/M Services with payment dates from January 1, 2014 to December 31, 2018 were reviewed.

Objective

The objective of this audit was to assess the Provider's adherence to applicable laws, regulations, rules, and policies governing the New York State Medicaid program and to:

- recover improper payments for E/M Services billed on the same day as a surgical procedure;
- recover improper payments for E/M Services billed during the post-operative period of a surgical procedure.

Audit Scope

An audit of inappropriate payments related to Procedure Code Modifiers of claims paid for payment dates included in the period beginning January 1, 2014 ending December 31, 2018 was completed.

Please note that due to the implementation of the National Provider Identifier (NPI) on September 1, 2008, there may be multiple Provider Identification Numbers associated with the Primary Provider Identification Number. The NPI is linked to the Primary Provider Identification Number. The Primary Provider Identification Number is used for correspondence and recoupment.

Audit Findings

OMIG issued a Draft Audit Report to the Provider on November 19, 2019 that identified $2,686.84 in Medicaid overpayments. The Provider did not respond to the Draft Audit Report. As a result, the overpayments identified in this Final Audit Report remain unchanged from those cited in the Draft Audit Report.

OMIG identified the following findings. All or a combination of the following two findings are included in this Final Audit Report.

1. **Improper Payment for Evaluation and Management (E/M) Services Billed on the Same Day as a Surgical Procedure.**

Surgical procedure codes billed to Medicaid may include a post-operative period in which evaluation and management (E/M) services directly related to the surgery may not be billed separately by the same entity. If the entity provides E/M services to the recipient for a service unrelated to the surgery, the claim must be submitted with Procedure Code Modifier '25'. If the E/M visit resulted in the decision to perform surgery, the claim must be submitted with Procedure Code Modifier '57'. The Medicaid payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services normally performed by the provider. Without the addition of Procedure Code Modifier 25 or 57, the E/M claim does not indicate the patient's condition required a significant, separately-identifiable service, above and beyond the usual care, the E/M service was unrelated to the original procedure, or a visit that resulted in the initial decision to perform surgery.

A review of claims for certain E/M services with payment dates from January 1, 2014 through December 31, 2018, showed that in numerous instances, Medicaid was inappropriately billed an E/M service without an appropriate Procedure Code Modifier.

> Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health.... (h) that the information provided in relation to any claim for payment shall be true, accurate, and complete; and (i) to comply with the rules, regulations and official directives of the department."
>
> *18 NYCRR 504.3*

> Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of ... improper claiming, unacceptable practices, fraud, abuse or mistake."
>
> *18 NYCRR 518.1(c)*

"Effective October 1, 2010, the Centers for Medicare & Medicaid Services (CMS) incorporated NCCI methodologies into the state Medicaid programs pursuant to the requirements of Section 6507, Mandatory State Use of Nation Correct Coding Initiative (NCCI), of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Recovery Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act, which amended section 1903 (r) of the Social Security Act. CMS has adopted the contents of the National Correct Coding Initiative Policy Manual for Medicare Services with minor modifications for state Medicaid programs."

National Correct Coding Initiative Policy Manual for Medicaid Services,
Introduction, Revised January 1, 2013, Pages 3-4
Introduction, Revised January 1, 2014, Pages 3-4
Introduction, Revised January 1, 2015, Pages 3-4
Introduction, Revised January 1, 2016, Pages 3-4
Introduction, Revised January 1, 2017, Pages 3-4

"Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: . . . global surgery modifiers: 24, 25, 57, 58, 78, 79 . . ."

National Correct Coding Initiative Policy Manual for Medicaid Services,
Chapter I, Revised January 1, 2013, Page I-20
Chapter I, Revised January 1, 2014, Pages I-19-20
Chapter I, Revised January 1, 2015, Page I-20
Chapter I, Revised January 1, 2016, Page I-21
Chapter I, Revised January 1, 2017, Page I-21

"a) **Modifier 25**: The *CPT Manual* defines modifier 25 as a "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service". Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s)."

National Correct Coding Initiative Policy Manual for Medicaid Services
Chapter I, Revised January 1, 2013, Pages I-21 to I-22

"a) **Modifier 25**: The *CPT Manual* defines modifier 25 as a "significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service". Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s)."

National Correct Coding Initiative Policy Manual for Medicaid Services
Chapter I, Revised January 1, 2014, Page I-21
Chapter I, Revised January 1, 2015, Pages I-21 to I-22
Chapter I, Revised January 1, 2016, Page I-22
Chapter I, Revised January 1, 2017, Page I-22

"If an E&M service is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other E&M preoperative services on the same date of service as a major surgical procedure are included in the global surgical package for the procedure and are not separately reportable."

National Correct Coding Initiative Policy Manual for Medicaid Services
Chapter I, Revised January 1, 2013, Pages I-18 to I-19
Chapter I, Revised January 1, 2014, Page I-18
Chapter I, Revised January 1, 2015, Page I-18
Chapter I, Revised January 1, 2016, Pages I-18 to I-19
Chapter I, Revised January 1, 2017, Page I-19

As a result of this finding, OMIG has determined that **$520.36** (Attachment A) was inappropriately billed to Medicaid, resulting in Medicaid overpayments.

2. **Improper Payment for Evaluation and Management (E/M) Services Billed During the Post-Operative Period of a Surgical Procedure.**

Surgical procedure codes billed to Medicaid may include a post-operative period in which evaluation and management (E/M) services directly related to the surgery may not be billed separately by the same entity. If the entity provides E/M services to the recipient for a service unrelated to the surgery, the claim must be submitted with one of the following Procedure Code Modifiers: '24', '79'. The Medicaid payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services normally performed by the provider. Without the addition of Procedure Code Modifier 24 or 79, the E/M claim does not indicate the patient's condition required a significant, separately-identifiable service, above and beyond the usual care, or the E/M service was unrelated to the original procedure.

A review of claims for certain E/M services with payment dates from January 1, 2014 through December 31, 2018, showed that in numerous instances, Medicaid was inappropriately billed an E/M service without an appropriate Procedure Code Modifier.

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health.... (h) that the information provided in relation to any claim for payment shall be true, accurate, and complete; and (i) to comply with the rules, regulations and official directives of the department."

18 NYCRR 504.3

Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of ... improper claiming, unacceptable practices, fraud, abuse or mistake."

18 NYCRR 518.1(c)

"Effective October 1, 2010, the Centers for Medicare & Medicaid Services (CMS) incorporated NCCI methodologies into the state Medicaid programs pursuant to the requirements of Section 6507, Mandatory State Use of Nation Correct Coding Initiative (NCCI), of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Recovery Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act, which amended section 1903 (r) of the Social Security Act. CMS has adopted the contents of the National Correct Coding Initiative Policy Manual for Medicare Services with minor modifications for state Medicaid programs."

National Correct Coding Initiative Policy Manual for Medicaid Services,
Introduction, Revised January 1, 2013, Pages 3-4
Introduction, Revised January 1, 2014, Pages 3-4
Introduction, Revised January 1, 2015, Pages 3-4
Introduction, Revised January 1, 2016, Pages 3-4
Introduction, Revised January 1, 2017, Pages 3-4

"Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: . . . global surgery modifiers: 24, 25, 57, 58, 78, 79 . . ."

National Correct Coding Initiative Policy Manual for Medicaid Services,
Chapter I, Revised January 1, 2013, Page I-20
Chapter I, Revised January 1, 2014, Pages I-19 to I-20
Chapter I, Revised January 1, 2015, Page I-20
Chapter I, Revised January 1, 2016, Page I-21
Chapter I, Revised January 1, 2017, Page I-21

"For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("unrelated Evaluation and Management Service by the same Physician or Other Qualified Health Care Professional During a Postoperative Period")."

National Correct Coding Initiative Policy Manual for Medicaid Services
Chapter I, Revised January 1, 2013, Page I-19
Chapter I, Revised January 1, 2014, Page I-18
Chapter I, Revised January 1, 2015, Page I-19
Chapter I, Revised January 1, 2016, Pages I-19 to I-20
Chapter I, Revised January 1, 2017, Pages I-19 to I-20

"-79 Unrelated Procedure or Service by the Same Practitioner During the Postoperative Period: The practitioner may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier -79 to the related procedure."

New York State Medicaid Program, Physician – Procedure Codes, Section 1 – General Information
Version 2008-1 (effective May 15, 2008), Page 7
Version 2015-1 (effective October 15, 2015), Page 7
Version 2017, Page 7

As a result of this finding, OMIG has determined that **$1,771.73** (Attachment B) was inappropriately billed to Medicaid, resulting in Medicaid overpayments.

In accordance with 18 NYCRR Section 518.4, interest may be collected on any overpayments identified in this audit and will accrue at the current rate from the date of the overpayment. Interest on the overpayments identified in this Final Audit Report was calculated from the date of each overpayment through the date of the Draft Audit Report, using the Federal Reserve Prime Rate. For the overpayments identified in this audit, OMIG has determined that accrued interest of **$394.75** (Attachments A & B) is now owed.

Based on this determination, the total amount due to DOH, as defined in 18 NYCRR Section 518.1, is **$2,686.84** (Attachments A & B), inclusive of interest.

Do not submit claim voids or adjustments in response to this Final Audit Report. Repayment instructions are outlined on the next page.

Repayment Options

In accordance with 18 NYCRR Part 518, which regulates the collection of overpayments, your repayment options are described below.

Option #1: Make a full payment by check or money order within 20 days of the date of the Final Audit Report. The check should be made payable to the **New York State Department of Health** with the audit number included and be sent with the attached remittance advice to:

[redacted]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
Audit #: 2019Z70-056B
Albany, New York 12237

Option #2: Enter into a repayment agreement with OMIG. If your repayment terms exceed 90 days from the date of the Final Audit Report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

New York State
Office of the Medicaid Inspector General
Bureau of Collections Management
800 North Pearl Street
Albany, New York 12204
Phone #: [redacted]
Fax #: [redacted]

Should you fail to select a payment option above, OMIG, in its discretion, may use any remedy allowed by law to collect the amount due. Pursuant to the State Finance Law Section 18(5), a collection fee equal to twenty two percent (22%) of the amount due, including interest, may be added to the amount owed. OMIG's remedies may include, without limitation, filing this Final Audit Report as the final administrative determination for purposes of obtaining a judgment lien pursuant to Section 145-a of the New York State Social Services Law; withholding Medicaid payments otherwise payable to the provider or its affiliates pursuant to 18 NYCRR Section 518.6; and imposing a sanction, pursuant to 18 NYCRR Section 515.2, against a provider who fails to reimburse the department for overpayments discovered by this audit.

Hearing Rights

The Provider has the right to challenge this action and determination by requesting an administrative hearing within sixty (60) days of the date of this notice. In accordance with 18 NYCRR Section 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If the Provider wishes to request a hearing, the request must be submitted in writing within sixty (60) days of the date of this notice to:

General Counsel
New York State
Office of the Medicaid Inspector General
Office of Counsel
800 North Pearl Street
Albany, New York 12204

Questions regarding the request for a hearing should be directed to Office of Counsel, at [redacted]

If a hearing is held, the Provider may have a person represent it or the Provider may represent itself. If the Provider chooses to be represented by someone other than an attorney, the Provider must supply along with its hearing request a signed authorization permitting that person to represent the Provider at the hearing; the Provider may call witnesses and present documentary evidence on its behalf.

For a full listing of hearing rights please see 18 NYCRR Part 519.

Contact Information

[redacted]

Office Address:

New York State
Office of the Medicaid Inspector General
Division of Systems Utilization and Review
800 North Pearl Street
Albany, New York 12204

Mission

The mission of the Office of the Medicaid Inspector General is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care.

Vision

To be the national leader in promoting and protecting the integrity of the Medicaid program.

NEW YORK STATE | Office of the Medicaid Inspector General

REMITTANCE ADVICE

Coney Island Medical Practice Plan
45 Research Way Suite 206
East Setauket, New York 11733-6401

Provider ID #: 03265092

Audit #: 2019Z70-056B

Amount Due: $ 2,686.84

Audit Type
- ☐ Managed Care
- ☒ Fee-for-Service
- ☐ Rate

Checklist

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: New York State Department of Health.
3. Record the audit number on your check.
4. Mail the check to:

[redacted]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
Audit #: 2019Z70-056B
Albany, New York 12237