How High-Cost Specialists are Exploiting NY's IDR Process

The IDR process was originally designed for commercial insurance, where fee schedules mirror market rates. Medicaid's inclusion has provided an opportunity for high-cost specialists to game the system and generate excessive reimbursement rates from what is intended to be a low-cost, taxpayer-funded program. In some instances, these providers are utilizing separate tax identification numbers (TINs) so that they appear to be out-of-network when treating Medicaid patients and utilizing the IDR process. Rather than negotiating manageable, in-network rates, these providers are exploiting the system, reducing access for members, and taking away resources that should be directed to primary care providers, FQHCs and safety net providers.

Medicaid IDR examples:

- Anesthesia Provider #1 is an in-network provider but has a separate entity (Anesthesia Provider #2) that they bill as an out-of-network entity, so they appear in-network but bill as out-of-network. Both provider entities operate from the same address and use the same billing company. When in-network hospitals and surgery centers arrange anesthesia services through the in-network anesthesia provider, the Medicaid fee schedule payment is $130 but the claims are intentionally submitted under the second entity, disguising in-network services as out-of-network. The second entity then rejects the out-of-network payment and submits the claims into New York's IDR process. It falsely attests the claims qualify as "surprise bills," to extract far higher payments. In one instance, the IDR award reimbursement was $15,030, an 11,561% increase over the Medicaid rate.

- An outofnetwork anesthesia group administered a nerve block to a Medicaid member at a participating provider's office. While the Medicaid fee schedule allows $120.00 for 90 units, the group billed $13,200.00. After review, the independent reviewer determined that the anesthesia group's requested amount was the more reasonable charge.

- A downstate neurosurgery group that was outofnetwork performed a laminectomy on a Medicaid member who was admitted through the ED at an innetwork hospital, where the group was serving as the oncall neurosurgery provider. Although the Medicaid fee schedule allows $709.47 for these procedures, the group billed nearly $46,100. After review, the independent reviewer determined that the neurosurgery group's requested amount was the more reasonable charge.

- A downstate neurosurgery group that was out-of-network performed spinal fusion surgery on an individual at an in-network hospital. The Medicaid fee schedule set a rate of $1,757, while the group charged nearly $81,000, with the independent reviewer determining that the neurosurgery group's requested amount to be more reasonable.

- An individual needed emergency back surgery at a downstate hospital, which was performed by an out-of-network surgeon. While the Medicaid fee schedule reimbursed for the surgery at nearly $3,000, the provider disputed the amount, submitting a bill in excess of $566,000 – almost 200 times the Medicaid rate. The independent reviewer determined the surgeon should have been reimbursed over $514,000, which became the ultimate cost to the taxpayers.

- A patient was admitted to a downstate hospital and required spinal surgery due to nerve compression that was causing muscle weakness. An out-of-network orthopedic surgeon performed the procedure, charging over $563,000, well above the Medicaid fee schedule of roughly $1,300. The independent reviewer rendered a decision that the provider was owed over $507,000.

- An out-of-network provider assisted with a spinal fusion procedure and then disputed payment through the IDR. Total charges according to the Medicaid fee schedule were $264.07. After disputing, the total amount paid to this provider post-IDR was $43,750.88.

- An out-of-network provider disputed reimbursement for claims submitted for a spinal surgery procedure. The total charges according to the Medicaid fee schedule were $1,289.26. Total payment made to this provider after disputing through IDR was $177,575.81.

- An outofnetwork plastic surgeon was called into the operating room by a participating surgeon to perform a Muscle Myo/Fasciocutaneous Flap – Trunk procedure. This surgery involves moving muscle and the skin above it from one part of the torso to another area that requires reconstruction or coverage. Although the Medicaid fee schedule allows $956.43 for this service, the surgeon billed $80,000. After review, the independent reviewer determined that the surgeon's requested amount represented the more reasonable charge.

<u>Commercial no surprises act billing examples:</u>

- A Manhattan gastroenterology that is an in-network provider that owns a separate Midtown endoscopy surgery center. The facility, anesthesiologists and other services are out-of-network (OON). The gastroenterologist schedules the member for a colonoscopy or other procedure to take place at the OON endoscopy surgery. The in-network provider performs the procedure, but the anesthesia is provided by a OON provider, and the tissue samples are sent to an OON pathologist. The health plan is billed for the in-network services, but because the facility, anesthesiologists, and pathology services are out-of-network, the provider submits those services through the IDR process to generate significantly higher reimbursement rates by exploiting NY's Surprise Billing law.

- A provider was inexplicably awarded $315,848 for a scheduled surgery that had been approved by the plan, with an out-of-network payment of $7,239. Despite the surgery being pre-authorized, the provider billed it as an emergency service and submitted the claim for IDR. The arbiter sided with the provider, requiring $308,575 in additional payment without providing an explanation for the decision.

- An out-of-network plastic surgeon that billed $67,500 for the closure of a surgical wound compared to the health plan's in-network reimbursement rate of $2,146. After submitting the claim to IDR, the surgeon received $19,493 – more than 1,000% above what Medicare typically pays for this procedure.

- An out-of-network provider billed $59,750 for remote neuromonitoring of a patient, which is $57,077 more than the plan's in-network reimbursement of $2,673. Through IDR, they received $45,372.