

STOP IDR ABUSE

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

The IDR process was originally designed for commercial insurance to protect consumers against balance billing – an issue that does not even arise in Medicaid. Fee schedules for Medicaid are lower than for commercial insurance, reflecting that it is a taxpayer-funded program intended to help vulnerable populations. Medicaid's inclusion in the IDR process has provided an opportunity for high-cost specialists to game the system and generate excessive reimbursement rates. These providers are often utilizing abusive practices to maximize their income, including separate tax identification numbers (TINs) so that they appear to be out-of-network when treating Medicaid patients. 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.

Approximately 75% of the IDR cases arise from a small group of physicians based on Long Island, and approximately 20% come from New York City.

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 reimbursement to the provider was \$15,030, an 11,561% increase over the Medicaid rate, which was accepted by the independent reviewer.
- 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, which was accepted by the independent reviewer.
- 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 neurosurgery group's requested amount was accepted by the independent reviewer.
- 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, which was accepted by the independent reviewer.
- 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 final amount reimbursed was over \$514,000, which was accepted by the independent reviewer.
- 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 final amount reimbursed was over \$507,000 which was accepted by the independent reviewer.

- 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 was \$43,750.88, which was accepted by the independent reviewer.
- 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, which was accepted by the independent reviewer.
- 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. Although the Medicaid fee schedule allows \$956.43 for this service, the surgeon billed \$80,000, which was accepted by the independent reviewer.

Commercial no surprises act billing examples:

- 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 an 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 provider received \$308,575 in additional payment, which was accepted by the independent reviewer.
- 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, which was accepted by the independent reviewer.
- 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, the provider received \$45,372, which was accepted by the independent reviewer.