NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

April 1, 2016

[redacted]
Mercy Hospital of Buffalo
144 Genesee Street Floor 3
Buffalo, New York 14203-1560

FINAL AUDIT REPORT
Audit #2015Z76-032A
Provider # [redacted]

Dear [redacted]:

The New York State Office of the Medicaid Inspector General (OMIG) completed an audit of Medicaid fee-for-service payments for services that were billed using inappropriate APG Rate Combinations.

In accordance with Section 517.6 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18 NYCRR), this report represents the final determination on issues found during the OMIG's review.

Your response to the OMIG's December 21, 2015 Draft Audit Report agreed with the audit findings. As a result, the overpayments in the Final Report remain unchanged to those cited in the Draft Report. The total Medicaid overpayment is $8,397.49, inclusive of interest.

Based on this determination, restitution of the overpayments as defined in 18 NYCRR 518.1 is required in the amount of $8,397.49, inclusive of interest.

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described as follows:

OPTION #1: Make a full payment by check or money order within 20 days of the date of the final report. The check should be made payable to the New York State Department of Health and be sent with the enclosed Remittance Advice form, signed and dated, to:

New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
Albany, New York 12237

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. 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%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until an agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

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

Do not submit claim voids or adjustments in response to this Final Report.

You have 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 you wish to request a hearing, the request must be submitted in writing to:

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

If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply along with your hearing request a signed authorization permitting that person to represent you. At the hearing, you may call witnesses and present documentary evidence on your behalf.

Questions concerning this audit may be directed to [redacted] at [redacted]

Sincerely,

[redacted]
System Match and Recovery
Office of the Medicaid Inspector General

Enclosure
CERTIFIED MAIL # [redacted]
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

Mercy Hospital of Buffalo
144 Genesee Street Floor 3
Buffalo, New York 14203-1560

AMOUNT DUE: $ 8,397.49

Provider # [redacted]

AUDIT #2015Z76-032A

AUDIT TYPE	
	[X] PROVIDER
	[ ] RATE
	[ ] PART B
	[ ] OTHER:

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 check to:

[redacted]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #2015Z76-032A
Albany, New York 12237

5. If the provider number shown above is incorrect, please enter the correct number below.

CORRECT PROVIDER NUMBER

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

ANDREW M. CUOMO
GOVERNOR

DENNIS ROSEN
MEDICAID INSPECTOR GENERAL

FINAL REPORT

MERCY HOSPITAL OF BUFFALO
144 GENESEE STREET FLOOR 3
BUFFALO, NEW YORK 14203-1560

INAPPROPRIATE APG RATE COMBINATIONS
#2015Z76-032A

ISSUED APRIL 1, 2016

BACKGROUND, PURPOSE AND SCOPE

The New York State Department of Health (DOH) is responsible for the administration of the Medicaid Program. As part of this responsibility, the OMIG conducts audits and reviews of providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth in NY Public Health Law, NY Social Services Law, regulations of the Departments of Health and Social Services, [Titles 10 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the eMedNY Provider Manuals.

Chapter 53 of the Laws of 2008 amended Article 2807 of the Public Health Law by adding a new Section (2-a). Public Health Law 2807 (2-a) required a new Medicaid payment methodology based on Ambulatory Patient Groups (APGs) that would apply to most ambulatory care services provided by hospital outpatient departments, emergency departments and ambulatory surgery departments, and free-standing diagnostic and treatment centers and free-standing ambulatory surgery centers.

APG payment methodology is based on the Enhanced Ambulatory Patient Groups Classification System. APGs categorize the amount and type of resources used in various ambulatory visits. Patients within each APG have similar resource use and cost. APGs group together procedures and medical visits that share similar characteristics and resource utilization patterns for payment purposes. APGs are designed to predict the average pattern of resource use of a group of patients in a given APG. APG payment methodology pays differential amounts for ambulatory care services based on the resources required for each patient visit. APG payment methodology provides greater reimbursement for high intensity services and relatively less reimbursement for low intensity services.

The new APG payment methodology became effective on December 1, 2008 for hospital outpatient departments and ambulatory surgery centers, on January 1, 2009 for hospital emergency departments, and on September 1, 2009 for diagnostic and treatment centers and freestanding ambulatory surgery centers.

APG methodology covers most medical outpatient services. It reimburses based on patients' conditions and severity, and packages the cost of certain ancillary lab and radiology services into the overall payment. It addresses the inadequacies of the previous system by paying varying amounts per visit, based on service intensity.

APG payment methodology uses visit and episode rates. When using visit rate codes to claim for a visit, all associated ancillary or radiology services must be reported on the same claim as the medical visit or significant procedure that generated the ancillary service. When using episode rate codes, for purposes of APG reimbursement, an "episode of care" consists of a medical visit and/or significant procedure that occurred on a single date of service and all of the associated ancillary laboratory or radiology services that occurred on or after the date of the medical visit or significant procedure. Combined use of visit and episode rate codes is not allowed.

Based on OSC Audit 2011-S-43, "Overpayments of Ambulatory Patient Group Claims", the purpose of this audit is to recoup inappropriate APG rate code combinations. To accomplish this, all services paid between September 1, 2010 and December 31, 2012, were reviewed.

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.

DETAILED FINDINGS

The exhibits are detailed in two categories. One or both of the exhibits are included in this Draft Audit Report.

1. Combined Use of Hospital Ambulatory Surgery APG and Hospital Emergency Room APG Not Allowed

Regulations state: "Duties of the provider. By enrolling the provider agrees: ...that the information provided in relation to any claim for payment shall be true, accurate, and complete."

18 NYCRR 504.3(h)

Regulations state: "Duties of the provider. By enrolling the provider agrees: ...to comply with the rules, regulations, and official directives of the department.

18 NYCRR 504.3(i)

Regulations state: "Fee-for-service providers. (1) All providers ... must prepare and maintain contemporaneous records demonstrating their right to receive payment. . . All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor ... must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished upon request, to the department ... for audit and review."

18 NYCRR 517.3(b)

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

18 NYCRR 518.1(c)

Regulations state: "The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim."

18 NYCRR 518.3(a)

Regulations state: "The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished."

18 NYCRR 518.3(b)

Regulations state: "Persons furnishing, or supervising the furnishing of, medical care, services or supplies are jointly and severally liable for any overpayments resulting from the furnishing of the care, services or supplies."

18 NYCRR 518.3(c)

Medicaid Policy states: "If a patient is initially seen in the hospital emergency room and the visit ultimately results in the provision of a same-day ambulatory surgery service outside of the

emergency room, the hospital should bill the visit only under the ambulatory surgery rate code."

Ambulatory Patient Groups (APG) Provider Manual, Revision 1, July 2009, pg. 17
Ambulatory Patient Groups (APG) Provider Manual, Revision 2, June 2010, pg. 33
Ambulatory Patient Groups (APG) Provider Manual, Revision 2.1, August 2012, pg. 33

As a result of this finding, OMIG has determined that $5,824.40 (Attachment 1) was inappropriately billed to Medicaid, resulting in Medicaid overpayments.

2. Combined Use of Visit and Episode Rate Codes Not Allowed

Regulations state: "Duties of the provider. By enrolling the provider agrees: ...that the information provided in relation to any claim for payment shall be true, accurate, and complete."

18 NYCRR 504.3(h)

Regulations state: "Duties of the provider. By enrolling the provider agrees: ...to comply with the rules, regulations, and official directives of the department.

18 NYCRR 504.3(i)

Regulations state: "Fee-for-service providers. (1) All providers ... must prepare and maintain contemporaneous records demonstrating their right to receive payment. . . All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor ... must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished upon request, to the department ... for audit and review."

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18 NYCRR 518.3(b)

Regulations state: "Persons furnishing, or supervising the furnishing of, medical care, services or supplies are jointly and severally liable for any overpayments resulting from the furnishing of the care, services or supplies."

18 NYCRR 518.3(c)

Medicaid Policy states: "Hospital OPDs and D&TCs clinic will be required to use episode of care rate codes effective January 1, 2010. In the interim, APG billers may use **either** the appropriate visit based rate codes (1400, 1407, 1435) or the appropriate new episode of care rate codes (1432, 1422,1525) , **but not both**."

Ambulatory Patient Groups (APG) Provider Manual- Revision 1, July 2009 pg.9

Medicaid Policy states: "APG billers assigned episode rate codes (hospital OPDs, D&TCs, and SBHCs) are expected to use episode rate codes for all claims effective January 1, 2011, except when billing for Medicaid/Medicaid dual eligible or for services routinely billed on a monthly basis. In the interim, APG billers may use either the appropriate visit based rate codes (1400, 1407,1435) or the appropriate new episode of care rate codes (1432, 1422, 1425). After January 1, 2011, visit based rate codes may only be used for claims for Medicare/Medicaid dually eligible patients or for services that are billed for a patient on a monthly basis.

The SDOH strongly encourages providers to use episode rate codes as episode rate codes enable more accurate reporting with respect to the date of ancillary lab and radiology services and, when used properly, episode rate codes will always result in as much or more payment than use of a visit rate code for the same bundle of services."

Ambulatory Patient Groups (APG) Provider Manual- Revision 2, June 2010 pg.19

Medicaid Policy states: *"Combined Use of Visit and Episode Rate Codes Not Allowed*: Episode and visit rate codes should not be billed on the same date of service for the same recipient by the same provider under the same certification. "

Ambulatory Patient Groups (APG) Provider Manual- Rev. 2.1, August 2012 pg.22

As a result of this finding, OMIG has determined that $1,342.12 (Attachment 2) was inappropriately billed to Medicaid, resulting in Medicaid overpayments.

DETERMINATION

In accordance with 18 NYCRR §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. The OMIG has determined that accrued interest for the overpayments identified in this audit total $1,230.97.

Based on this determination, the total amount of overpayment, as defined in 18 NYCRR Section 518.1(c), is $8,397.49, inclusive of interest.

Do not submit claim voids or adjustments in response to this Final Audit Report.