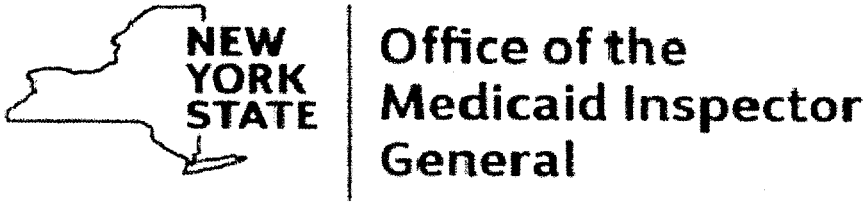

NEW YORK STATE
DEPARTMENT OF HEALTH
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF ST. JOSEPH'S HOSPITAL ELMIRA CLAIMS FOR OASAS INPATIENT CHEMICAL DEPENDENCE REHABILITATION SERVICES PAID FROM JANUARY 1, 2009 – DECEMBER 31, 2011

FINAL AUDIT REPORT
AUDIT #: 14-3929

Thomas R. Meyer
Acting Medicaid Inspector General

February 25, 2015

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

THOMAS R. MEYER
Acting Medicaid Inspector General

February 25, 2015

[redacted]
St. Joseph's Hospital Elmira
555 St. Joseph's Boulevard
Elmira, New York 14901

Re: Final Audit Report
Audit #: 14-3929
Provider ID #: [redacted]
FEIN: [redacted]
NPI #: [redacted]

Dear [redacted]:

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of St. Joseph's Hospital Elmira" (Provider) paid claims for Office of Alcohol and Substance Abuse Services (OASAS) inpatient chemical dependence rehabilitation services covering the period January 1, 2009, through December 31, 2011. Since you did not respond to our draft audit report dated January 20, 2015, the findings in the final audit report are identical to those in the draft audit report.

In the attached final audit report, the OMIG has detailed our scope, procedures, laws, regulations, rules and policies, sampling technique, findings, provider rights, and statistical analysis.

The OMIG has attached the sample detail for the paid claims determined to be in error. This audit may be settled through repayment of the sample overpayment of $1,776.23.

If the Provider has any questions or comments concerning this final audit report, please contact at or through email at . Please refer to report number 14-3929 in all correspondence.

Sincerely,

Division of Medicaid Audit, Rochester
Office of the Medicaid Inspector General

Cc:

Enclosure

CERTIFIED MAIL #
RETURN RECEIPT REQUESTED

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve 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.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to assess compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to assess the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

DIVISION OF MEDICAID INVESTIGATIONS

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and state governments jointly fund and administer the Medicaid program. In New York State, the Department of Health (DOH) administers the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

Chemical dependence inpatient rehabilitation services are provided in either hospital-based or free-standing settings. The purpose of chemical dependence inpatient rehabilitation programs for individuals with a diagnosis of chemical dependence is to provide medical evaluation, clinical care management, clinical services, and rehabilitation services. The specific standards and criteria for chemical dependence inpatient rehabilitation programs are outlined in Title 14 NYCRR Part 818 and Title 18 NYCRR Section 505.27. The MMIS Provider Manual for Clinics also provides program guidance for claiming Medicaid reimbursement for chemical dependence inpatient rehabilitation services.

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OASAS inpatient chemical dependence rehabilitation services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to OASAS inpatient chemical dependence rehabilitation services, this audit covered services paid by Medicaid from January 1, 2009, through December 31, 2011.

SUMMARY OF FINDINGS

We inspected a random sample of 100 cases with $782,614.95 in Medicaid payments. Of the 100 cases in our random sample, 5 services had at least one error and did not comply with state requirements. Of the 5 noncompliant services, none contained more than one deficiency. Specifics are as follows:

Error Description	Number of Errors
Missing Patient Signature on Treatment Plan	2
Improper Length of Stay Billing	2
Missing Discharge Plan	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid $1, 776.23 in sample overpayments.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including OASAS inpatient chemical dependence rehabilitation services claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

New York State's OASAS Inpatient Chemical Dependence Rehabilitation Program

Chemical dependence inpatient rehabilitation services are provided in either hospital-based or free-standing settings. The purpose of chemical dependence inpatient rehabilitation programs for individuals with a diagnosis of chemical dependence is to provide medical evaluation, clinical care management, clinical services, and rehabilitation services. The specific standards and criteria for chemical dependence inpatient rehabilitation programs are outlined in Title 14 NYCRR Part 818 and Title 18 NYCRR Section 505.27. The MMIS Provider Manual for Clinics also provides program guidance for claiming Medicaid reimbursement for chemical dependence inpatient rehabilitation services.

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for OASAS inpatient chemical dependence rehabilitation services complied with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

Scope

Our audit period covered payments to the Provider for OASAS inpatient chemical dependence rehabilitation services paid by Medicaid from January 1, 2009, through December 31, 2011. Our audit universe consisted of 554 claims totaling $3,672,748.20.

During our audit, we did not review the overall internal control structure of the Provider. Rather, we limited our internal control review to the objective of our audit.

Methodology

To accomplish our objective, we:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with the Provider's management personnel to gain an understanding of the OASAS inpatient chemical dependence rehabilitation services program;
- ran computer programming application of claims in our data warehouse that identified 554 paid OASAS inpatient chemical dependence rehabilitation services claims, totaling $3,672,748.20;
- selected a random sample of 100 cases from the population of 554 claims; and,
- calculated the overpayment paid in the population of 100 cases.

For each sample selection we inspected, as available, the following:

- Medicaid electronic claim information
- Patient record, including, but not limited to:
  - Comprehensive Evaluation and updates
  - Progress/Session notes
  - Discharge plans and summaries
- Any additional documentation deemed by the Provider necessary to substantiate the Medicaid paid claim

LAWS, REGULATIONS, RULES AND POLICIES

The following are applicable Laws, Regulations, Rules and Policies of the Medicaid program referenced when conducting this audit:

- Departments of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].

- Medicaid Management Information System and eMedNY Provider Manual.

- Specifically, Title 18 NYCRR Section 540.6, Title 14 NYCRR Section 818, Title 18 NYCRR Section 505.27 and the MMIS Provider Manual for Clinics

- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

  Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . 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 . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (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 Section 504.3*

  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 Section 517.3(b)

  Regulations require that bills for medical care, services and supplies contain patient name, case number and date of service; itemization of the volume and specific types of care, services and supplies provided; the unit price and total cost of the care, services and supplies provided; and a dated certification by the provider that the care, services and supplies itemized have been in fact furnished; that the amounts listed are in fact due and owing; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may

be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided.

18 NYCRR Section 540.7(a)(1)-(3) and (8)

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 Section 518.1(c)*

Regulations state: "Vendor payments for medical care and other items of medical assistance shall not be made unless such care or other items of assistance have been furnished on the basis of the appropriate authorization prescribed by the rules of the board and regulations of the department."

18 NYCRR Section 540.1

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 Section 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 Section 518.3(b)*

Regulations state: "Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record." *18 NYCRR Section 518.3(b)*

AUDIT FINDINGS

This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated January 20, 2015. Since you did not respond to the Draft Audit Report, the findings remain the same.

AUDIT FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2009, through December 31, 2011, identified 3 claims with at least one error, for a total sample overpayment of $1,776.23 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated January 20, 2015. No adjustments were made to the findings.

1. Missing Patient Signature on Treatment Plan

Regulations state, "The treatment plan shall be developed in collaboration with the patient as evidenced by the patient's signature thereon; ...."

14 NYCRR Section 818.4(i)(1)

In 2 instances pertaining to 1 patient, the treatment plan lacked the required patient signature. This finding applies to Sample 23.

2. Improper Length of Stay Billing

Regulations state, "In computing patient days, the day of admission shall be counted, but not the day of discharge." *14 NYCRR Section 841.10(a)(2)*

In 2 instances pertaining to 1 patient, the number of patient days billed to Medicaid exceeded the number of days the patient received billable treatment services. This finding applies to Sample 74.

3. Missing Discharge Plan

Regulations state, "A discharge plan shall be developed in collaboration with the patient and any significant other(s) the patient chooses to involve."

14 NYCRR Section 818.4(p)

In 1 instance, a discharge plan was not completed. This finding applies to Sample 36.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the sample overpayment of $1,776.23, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make 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 and be sent with the attached Remittance Advice to:

[redacted]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #14-3929
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 the 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 #: [redacted]
Fax#: [redacted]

If you choose not to settle this audit through repayment of the sample overpayment, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the sample overpayment of $1,776.23. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

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

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

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing you have the right to:

a) be represented by an attorney or other representative, or to represent yourself;
b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE
St. Joseph's Hospital Elmira
555 St. Joseph's Boulevard
Elmira, New York 14901

PROVIDER ID # [redacted]
and [redacted]

AUDIT # 14-3929

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

AMOUNT DUE: $1,776.23

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 # 14-3929
Albany, New York 12237

Thank you for your cooperation.

Attachment A

SAMPLE DESIGN

Our sample design used for Audit #14-3929 was as follows:

- Universe - Medicaid claims for OASAS inpatient chemical dependence rehabilitation services paid during the period January 1, 2009, through December 31, 2011.

- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for OASAS inpatient chemical dependence rehabilitation services paid during the period January 1, 2009, through December 31, 2011

- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2009, through December 31, 2011.

- Sample Design – Simple sampling was used for sample selection.

- Sample Size – The sample size is 100 cases.

Attachment B

SAMPLE RESULTS AND ESTIMATES

Universe Size	468
Sample Size	100
Sample Value	$ 782,614.95
Sample Overpayments	$ 1,776.23
Net Financial Error Rate	.23%