NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

September 4, 2015

[redacted]
Arnot Odgen Medical Center
600 Roe Avenue
Elmira, New York 14905-1629

Re: Final Audit Report
Audit #: 14-6312
Provider ID #: [redacted]

Dear [redacted]:

The New York State Office of the Medicaid Inspector General (OMIG) has reviewed Report 2011-S-9 from the Office of the State Comptroller (OSC), which examined Medicaid payments made to Arnot Odgen Medical Center (the Provider) for physician administered J-Code drugs from April 1, 2011, through September 30, 2011 (the "Review period"). In accordance with Section 517.5 of Title 18 of the Official Compilation of Codes, Rules, and Regulations of the State of New York (NYCRR), this notice shall serve as our final audit report of the recently completed review of payments made to the Provider under the New York State Medicaid Program. Since you did not respond to our revised draft audit report dated June 9, 2015, the findings in the final audit report are identical to those in the revised draft audit report.

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 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 by the Departments of Health and Education (Titles 8, 10, and 18 of the NYCRR) and the Medicaid Management Information System (MMIS) Provider Manuals.

OSC is responsible for overseeing the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through audits performed pursuant to authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law. OSC audits identify opportunities for improving operations, strategies for reducing costs, and strengthening controls.

Ordered ambulatory policy requires Medicaid providers to bill physician administered J-Code drugs at actual acquisition cost (per invoice).

The purpose of this audit was to identify overpayments caused by overcharging the acquisition cost of physician administered J-Code drugs. The audit covers claims paid by Medicaid from April 1, 2011, through September 30, 2011.

OMIG has determined that the Provider's failure to comply with New York State Social Services Law and Titles 8, 10 and/or 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) resulted in a total overpayment of $3,392.02.

REGULATIONS OF GENERAL APPLICATION

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

The following audit findings reflect the results of our audit. This audit report incorporates consideration of any additional documentation and information presented in response to the revised draft audit report dated June 9, 2015.

Since you did not respond to the revised draft audit report, the findings remain the same.

Billed in Excess of Actual Acquisition Cost

Medicaid policy states, "Reimbursement for drugs furnished by practitioners/providers to their patients is based on the acquisition cost to the practitioner/provider of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the practitioner/provider will maintain auditable records of the actual itemized invoice cost of the drug, including the numbers of doses of the drug represented on the invoice.
New York State Medicaid does not intend to pay more than the acquisition cost of the drug dosage, as established by invoice, to the practitioner/provider. Regardless of whether an invoice must be submitted to Medicaid for payment, the practitioner/provider is expected to limit his or her Medicaid claim amount to the actual invoice cost of the drug dosage administered."
New York State Medicaid Program Ordered Ambulatory Procedure Codes, Version 2011-1

Medicaid policy states, "Fees in the Fee Schedule are the maximum reimbursable Medicaid fees and are available at http://www.emedny.org/ProviderManuals/OrderedAmbulatory/index.html".
New York State Medicaid Program Ordered Ambulatory Procedure Codes, Version 2011-1

In 3 claims, physician administered J-Code drugs were billed in excess of the actual acquisition cost (per invoice). This resulted in an overpayment of $3,392.02 (Exhibit 1).

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 total overpayment amount of $3,392.02, 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:

New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #14-6312
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

If you choose not to settle this audit through repayment of the total overpayment, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the total overpayment of $3,392.02. 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 .

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.

If you have any questions, or should you wish to make arrangements to settle this audit, please contact me at .

Thank you for the cooperation and courtesy extended to our staff during this audit.

Sincerely,

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

Enc.

CERTIFIED MAIL #
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

Arnot Odgen Medical Center
600 Roe Avenue
Elmira, New York 14905-1629

AMOUNT DUE: $3,392.02

PROVIDER ID #

AUDIT #14-6312

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:

New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File #14-6312
Albany, New York 12237-0048

Thank you for your cooperation.

Exhibit 1 Itemized Overpayments Arnot Odgen Medical Center MMIS# [redacted] OMIG audit# 14-6312

Procedure Code	Date of Service	Units	Original Amount Paid	Cardinal (340B) vial price QTR DOS	340B price per unit	Actual acquisition cost per invoice (340B) price	Current amount paid*	OMIG calculated overpayment (netted)
J9171	8/19/2011	149	$2,923.38	$990.42	6.190125	$922.33	$922.31	($0.02)
J9355	8/19/2011	44	$3,098.04	$1,631.51	37.079773	$1,631.51	$2,651.88	$1,020.37
J9355	6/17/2011	80	$5,324.80	$1,624.22	36.914091	$2,953.13	$5,324.80	$2,371.67
			$11,346.22			**$5,506.97**	**$8,898.99**	**$3,392.02**

* Current amount paid based on any voids/credits and/or rebills that may have occurred

Note to provider: The last claim was adjusted without the UD indicator in the procedure modifier code field. The UD code denotes 340B claim status.