NEW YORK STATE | Office of the Medicaid Inspector General

ERIN E. IVES
Acting Medicaid Inspector General

Audit of Claims for Clinic/Emergency Room/Ancillary Services Billed During an Inpatient Hospital Stay Paid from March 1, 2014 to December 31, 2018

Final Audit Report
Audit #: 2019Z01-108V

Gilbert Lederman, MD PC

Provider ID #: 01686319

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

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Acting Medicaid Inspector General

July 29, 2020

Gilbert Lederman, MD PC
1384 Broadway
New York, New York 10018-6108

Final Audit Report
Audit #: 2019Z01-108V
Provider ID #: 01686319

Dear Provider:

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Gilbert Lederman, MD PC (Provider).

In accordance with Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York Section 517.6, the attached Final Audit Report represents the final determination on the issues found during OMIG's audit.

The Provider's March 25, 2020 response to OMIG's February 20, 2020 Draft Audit Report stated that the Provider is in agreement with the Draft Audit Report findings. As a result, the overpayments identified in this Final Audit Report remain unchanged from those cited in the Draft Audit Report. The total amount due is $1,724.66, including interest to date.

OMIG has attached the exhibit(s) of paid claims identified as overpayments. Please email [redacted] if you have any questions or comments concerning this report. Please refer to audit number 2019Z01-108V in all correspondence.

Sincerely,

[redacted]

System Match and Recovery
Division of Systems Utilization and Review
Office of the Medicaid Inspector General

Attachment

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Background, Objective, and Audit Scope

Background

The New York State Department of Health (DOH) is the single state agency responsible for the administration of the Medicaid program. As part of its responsibility as an independent entity within DOH, the Office of the Medicaid Inspector General (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 in New York Public Health Law, New York Social Services Law, the regulations of DOH (Titles 10 and 18 of the New York Codes Rules and Regulations), the regulations of the Office of Mental Hygiene (Title 14 of the New York Codes Rules and Regulations), DOH's Medicaid Provider Manuals and *Medicaid Update* publications.

The OMIG performed an audit of Medicaid fee-for-service claims for certain services billed separately while a Medicaid recipient was an inpatient at a hospital. To accomplish this, Medicaid inpatient and clinic/emergency room/ancillary claims billed with payment dates from March 1, 2014 to December 31, 2018 were reviewed.

During a Medicaid recipient's hospital stay, the inpatient Diagnosis Related Group (DRG)-based rate is a generally all-inclusive rate, and there should be no emergency room or clinic billings for an inpatient for service dates beginning on the date of admission. In addition, when Medicaid claims are paid separately for laboratory and/or other ordered ambulatory services for an inpatient, the same service is reimbursed twice: first when it is paid within the inpatient rate, and again when it is paid on the provider's separate claim. Dates of discharge were excluded from OMIG's review.

Objective

The objective of this audit was to assess the Provider's adherence to applicable laws, regulations, rules, and policies governing the New York State Medicaid program and to identify:

- claims for either clinic or emergency room services provided during an inpatient hospital stay; and
- claims for laboratory and/or other ordered ambulatory services provided during an inpatient hospital stay.

Audit Scope

An audit of of Medicaid claims for clinic/emergency room/ancillary services billed during an inpatient hospital stay paid from period beginning March 1, 2014 and ending December 31, 2018 was completed.

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.

Audit Findings

OMIG issued a Draft Audit Report to the Provider on February 20, 2020 that identified $1,724.66 in Medicaid overpayments. The Provider's March 25, 2020 response to the Draft Audit Report stated that the Provider is in agreement with the Draft Audit Report findings. As a result, the overpayments identified in this Final Audit Report remain unchanged from those cited in the Draft Audit Report.

One or more of the following audit criteria resulted in an audit finding and overpayment determination, as outlined below and in the enclosed exhibits.

1. **Clinic and/or Emergency Room Services Billed Fee-for-Service that are Included in the Inpatient Rate.**

   By enrolling the provider agrees … to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program 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 and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health.

   18 NYCRR 504.3(a)

   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)

   By enrolling, the provider agrees… to comply with the rules, regulations and official directives of the department.

   18 NYCRR 504.3(i)

   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)

   When an enrollee is admitted as an inpatient from either the hospital emergency room or hospital outpatient clinic, a separate claim for the emergency room or outpatient clinic visit **cannot** be billed to Medicaid. Under State Health Department regulations, the Department establishes all-inclusive hospital inpatient rates that generally cover the costs of all medical services provided to Medicaid enrollees during the hospital stay. No other payment should be made for services provided to these enrollees while they are hospitalized.

   DOH Medicaid Update March 2007 Vol. 22, No. 3

Medicaid utilizes a Diagnosis Related Group (DRG) payment methodology for services provided on an inpatient basis (rendered to a patient between the date of admission and date of discharge). The DRG facility payment is all inclusive and includes all services provided the patient during the inpatient stay.

DOH Medicaid Update October 2015 Vol. 31, No. 11
Policy and Billing Guidance

If a patient is seen in the hospital's emergency room or outpatient clinic and is subsequently admitted to the hospital on the same day, Medicaid reimbursement will be limited to the hospital's inpatient rate. The hospital may not bill for the emergency room or clinic services provided on the day of admission. For reimbursement purposes, the date of admission, but not the date of discharge, may be counted as a day of care. In no instance will the date of discharge be reimbursable.

eMedNY Provider Manual for Inpatient Policy Guidelines
Version 2012-1, p.19

When a Medicaid-eligible patient is admitted as an inpatient on the same day as a clinic or emergency room visit, payment can be claimed only for the inpatient cost per discharge. Payment to the hospital under diagnosis related groups (DRGs) or per diems is payment in full. No emergency room or clinic services may be billed to Medicaid during the Medicaid eligible patient's inpatient stay, i.e., billing additionally for an MRI while a patient is hospitalized.

eMedNY Provider Manual for Clinic
Version 2007-2, p.4

Exhibit A* is a list of claims that contain clinic and emergency room services billed to Medicaid during an inpatient hospital stay. These services must be billed to the original admitting hospital. As a result, OMIG has determined that **$0.00** was inappropriately billed to Medicaid, resulting in Medicaid overpayments.

2. <u>Laboratory Services Billed Fee-for-Service that are Included in the Inpatient Rate</u>

By enrolling the provider agrees… to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program 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 and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health.

18 NYCRR 504.3(a)

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)

By enrolling, the provider agrees… to comply with the rules, regulations and official directives of the department.

18 NYCRR 504.3(i)

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)

No payment will be made on a fee-for-service basis for laboratory services ordered for an MA recipient on either an in-patient or out-patient basis when the cost of providing laboratory services has been included in the MA rate of payment for the provider of such in-patient or out-patient care.

18 NYCRR 505.7(g)(7)

Ancillary services that are already included in a facility's all inclusive DRG payment, such as laboratory tests, should not be billed on a fee-for-service basis. Services rendered to hospital inpatients should not be billed on an ordered ambulatory basis. This situation is considered to be a duplicate payment and therefore subject to recoupment.

DOH Medicaid Update July 2008 Vol. 24, No. 8
Hospital, Laboratory, & Ambulatory Care Providers

Medicaid utilizes a Diagnosis Related Group (DRG) payment methodology for services provided on an inpatient basis (rendered to a patient between the date of admission and date of discharge). The DRG facility payment is all inclusive and includes all services provided the patient during the inpatient stay.

DOH Medicaid Update October 2015 Vol. 31, No. 11
Policy and Billing Guidance

Medicaid payment rates for hospital inpatient stays include all laboratory tests provided to hospital inpatients. Accordingly, no laboratory procedures rendered to hospital inpatients are authorized to be billed separately to Medicaid on a fee-for-service basis.

eMedNY Provider Manual for Laboratory Policy Guidelines
Version 2011-1, p.15
Version 2015-2, p.15

For reimbursement purposes, the date of admission, but not the date of discharge, may be counted as a day of care. In no instance will the date of discharge be reimbursable.

eMedNY Provider Manual for Inpatient Policy Guidelines
Version 2012-1, p.19

Billing on a fee-for-service basis for tests already included in a facilities rate structure is considered to be a duplicate payment and, as such, will be recouped by Medicaid.

eMedNY Provider Manual for Inpatient Policy Guidelines
Version 2012-1, p.16

Medicaid patients are provided a full range of necessary diagnostic, palliative, and therapeutic inpatient hospital care, including but not limited to surgical, medical, nursing, radiological, laboratory, and rehabilitative services.

eMedNY Provider Manual for Inpatient Policy Guidelines
Version 2012-1, p.10

Exhibit B* is a list of claims that contain laboratory services billed to Medicaid during an inpatient hospital stay. These services must be billed to the original admitting hospital. As a result, OMIG has determined that **$0.00** was inappropriately billed to Medicaid, resulting in Medicaid overpayments.

3. **Ordered Ambulatory Services (Other Than Labs) Billed Fee-for-Service that are Included in the Inpatient Rate**

By enrolling the provider agrees … to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program 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 and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health.

18 NYCRR 504.3(a)

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)

By enrolling, the provider agrees … to comply with the rules, regulations and official directives of the department.

18 NYCRR 504.3(i)

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)

Ancillary services that are already included in a facility's all inclusive DRG payment… should not be billed on a fee-for-service basis. Services rendered to hospital inpatients should not be billed on an ordered ambulatory basis. This situation is considered to be a duplicate payment and therefore subject to recoupment.

DOH Medicaid Update July 2008 Vol. 24, No.8
Hospital, Laboratory, & Ambulatory Care Providers

When hospital emergency department, ambulatory surgery, or hospital Article 28 outpatient rate codes for APGs or inpatient rate codes for APR-DRGs are billed, the physician may also submit a separate claim to Medicaid for their professional services. This includes physicians who are on staff and salaried by the hospital… Physicians should bill Medicaid using the fee schedule published in the physician provider manual. Physicians should bill the global fee or the professional fee using the -26 modifier, when appropriate (e.g. radiology).

DOH Medicaid Update March 2010 Vol. 26, No. 4
Policy and Billing Guidance

Medicaid utilizes a Diagnosis Related Group (DRG) payment methodology for services provided on an inpatient basis (rendered to a patient between the date of admission and date of discharge). The DRG facility payment is all inclusive and includes all services provided the patient during the inpatient stay.

DOH Medicaid Update October 2015 Vol. 31, No. 11
Policy and Billing Guidance

> For reimbursement purposes, the date of admission, but not the date of discharge, may be counted as a day of care. In no instance will the date of discharge be reimbursable.
>
> *eMedNY Provider Manual for Inpatient Policy Guidelines*
> *Version 2012-1, p.19*

> The Medicaid payment for inpatient care is considered to include all procedures and services regardless of where they were performed. The original hospital is responsible for reimbursing all other hospitals, clinics or ambulatory surgery centers which provide the services not available at the admitting hospital.
>
> *eMedNY Provider Manual for Inpatient Policy Guidelines*
> *Version 2012-1, p.16*

Exhibit C* is a list of claims that contain ordered ambulatory services (other than labs) billed to Medicaid during an inpatient hospital stay. These services must be billed to the original admitting hospital. As a result, OMIG has determined that **$1,470.19** was inappropriately billed to Medicaid, resulting in Medicaid overpayments.

In accordance with 18 NYCRR Section 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. Interest on the overpayments identified in this Final Audit Report was calculated from the date of each overpayment through the date of the Draft Audit Report, using the Federal Reserve Prime Rate. For the overpayments identified in this audit, OMIG has determined that accrued interest of **$254.47** (Exhibits A through C) is now owed.

Based on this determination, the total amount due to DOH, as defined in 18 NYCRR Section 518.1, is **$1,724.66** (Exhibits A through C), including interest to date.

Where there is no overpayment (reflected herein as $0.00) associated with a disallowance category, no Exhibit will be included.

Do not submit claim voids or adjustments in response to this Final Audit Report. Repayment instructions are outlined on the next page.

Repayment Options

In accordance with 18 NYCRR Part 518, which regulates the collection of overpayments, your repayment options are described below.

Option #1: Make a 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** with the audit number included and be sent with the attached remittance advice to:

[redacted]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
Audit #: 2019Z01-108V
Albany, New York 12237

Option #2: Enter into a repayment agreement with OMIG. 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%. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

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

Should you fail to select a payment option above, OMIG, in its discretion, may use any remedy allowed by law to collect the amount due. Pursuant to the State Finance Law Section 18(5), a collection fee equal to twenty two percent (22%) of the amount due, including interest, may be added to the amount owed. OMIG's remedies may include, without limitation, filing this Final Audit Report as the final administrative determination for purposes of obtaining a judgment lien pursuant to Section 145-a of the New York State Social Services Law; withholding Medicaid payments otherwise payable to the provider or its affiliates pursuant to 18 NYCRR Section 518.6; and imposing a sanction, pursuant to 18 NYCRR Section 515.2, against a provider who fails to reimburse the department for overpayments discovered by this audit.

Hearing Rights

The Provider has 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 the Provider wishes to request a hearing, the request must be submitted in writing within sixty (60) days of the date of this notice to:

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

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

If a hearing is held, the Provider may have a person represent it or the Provider may represent itself. If the Provider chooses to be represented by someone other than an attorney, the Provider must supply along with its hearing request a signed authorization permitting that person to represent the Provider at the hearing; the Provider may call witnesses and present documentary evidence on its behalf.

For a full listing of hearing rights please see 18 NYCRR Part 519.

Contact Information

Office Address:

New York State
Office of the Medicaid Inspector General
Division of Systems Utilization and Review
800 North Pearl Street
Albany, New York 12204

Mission

The mission of the Office of the Medicaid Inspector General is to enhance 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 while promoting high quality patient care.

Vision

To be the national leader in promoting and protecting the integrity of the Medicaid program.

Office of the Medicaid Inspector General

REMITTANCE ADVICE

Gilbert Lederman, MD PC
1384 Broadway
New York, New York 10018-6108

Provider ID #: 01686319

Audit #: 2019Z01-108V

Amount Due: $1,724.66

Audit Type

- ☐ **Managed Care**
- ☒ **Fee-for-Service**
- ☐ **Rate**

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 the check to:

[redacted]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
Audit #: 2019Z01-108V
Albany, New York 12237