NEW YORK STATE | Office of the Medicaid Inspector General

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

FQHC Fee-For-Service/ Managed Care Crossover

Final Audit Report
Audit #: 17-7219

The Floating Hospital

Provider ID #: 00245038

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

June 3, 2021

[redacted]
The Floating Hospital
25-15 Queens Plaza North
Long Island City, New York 11101

Re: Final Audit Report
Audit #:17-7219
Provider ID #: 00245038

Dear [redacted]

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for The Floating Hospital (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, this Final Audit Report represents the final determination on the issues found during OMIG's audit.

After reviewing the Provider's written responses to OMIG's November 13, 2017 Draft Audit Report, OMIG has reduced the overpayments identified in the Draft Audit Report to $65,845.49 in this Final Audit Report. Based on this determination, the total amount due is $70,818.11, inclusive of interest. A detailed explanation can be found in the Audit Findings section of this report.

If you have any questions or comments concerning this report, please contact [redacted] at [redacted] or through email at [redacted]. Please refer to audit number 17-7219 in all correspondence.

[redacted]
Division of Medicaid Audit
Office of the Medicaid Inspector General

Attachments
Certified Mail Number: 7019-1120-0001-4888-2282
Return Receipt Requested

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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 Department of Mental Hygiene (Title 14 of the New York Codes Rules and Regulations), DOH's Medicaid Provider Manuals and *Medicaid Update* publications.

DOH regulation found at Title 10 of the Official Compilation of the Codes, Rules, and Regulations of the State of New York (NYCRR) Section 86-4.9(b) states: "A threshold visit, including all part-time clinic visits, shall occur each time a patient crosses the threshold of a facility to receive medical care without regard to the number of services provided during that visit. Only one threshold visit per patient per day shall be allowable for reimbursement purposes..." The visit is all-inclusive as it includes all of the services medically necessary and rendered on that date.

Federal law 42 U.S.C. Section 1396a (bb)(5)(A) requires states to make supplemental payments to an FQHC or Rural Health Center (RHC) pursuant to a contract between the Federally Qualified Health Center (FQHC) and a Managed Care Plan (Plan) for the amount, if any, that the FQHC's Prospective Payment System (PPS) rate exceeds the amount of payments provided under the managed care contract for the services rendered by the FQHC. FQHC's bill eMedNY directly for a supplemental payment when services are provided to contracted MCO enrollees that would otherwise qualify under Medicaid fee-for-service (FFS) rules for payment at the FQHC's PPS rate.

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 verify that:

- the Provider did not receive a Medicaid supplemental payment and a FFS all-inclusive payment for individual recipients on the same date of service;
- claims for payment were submitted in accordance with DOH regulations and the appropriate provider manuals; and
- claims for payment were submitted in accordance with applicable rules and requirements.

Audit Scope

OMIG identified instances where the Provider received both a Medicaid supplemental payment (indicating payment for the threshold visit was paid by a Plan) and a FFS all-inclusive payment for the same individual recipient on the same date of service. The audit period is for dates of service beginning January 1, 2014 and ending December 31, 2016.

Laws, Regulations, Rules and Policies

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

New York Public Health Law, New York Social Services Law, the regulations of the Department of Health (Titles 10 and 18 of the NYCRR), the regulations of the Office of Mental Health (Title 14 of the NYCRR) and the Department of Health's Medicaid Provider Manuals, and *Medicaid Update* publications.

Regulations state:

> (a) The unit of service used to establish rates of payment shall be the threshold visit, except for dialysis, abortion, sterilization services and free-standing ambulatory surgery, for which rates of payment shall be established for each procedure. For methadone maintenance treatment services, the rate of payment shall be established on a fixed weekly basis per recipient.
>
> (b) A threshold visit, including all part-time clinic visits, shall occur each time a patient crosses the threshold of a facility to receive medical care without regard to the number of services provided during that visit. Only one threshold visit per patient per day shall be allowable for reimbursement purposes, except for transfusion services to hemophiliacs, in which case each transfusion visit shall constitute an allowable threshold visit.
>
> 10 NYCRR § 86-4.9 (a) and (b)

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

> Regulations state: "All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are 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 §540.7(a)

> 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)

> Furthermore, according to regulations, all providers must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. In addition, the provider must keep, for a period of six years, all records necessary to disclose the nature and extent of services furnished and the medical necessity

therefore, including any prescription or fiscal order for the service or supply. This information is subject to audit for a period of six years and must be furnished, upon request.

18 NYCRR § 517.3(b)

Medicaid Management Information System ("MMIS") Provider Manual for Clinics states:

Basis of Payment

For Medicaid patients, the basis of payment for most clinic services provided in hospital outpatient departments and diagnostic and treatment centers under Article 28 of the Public Health Law is the threshold visit. New York State Department of Health (DOH) regulation at 10 NYCRR 86-4.9 states:

> "A threshold visit occurs each time a patient crosses the threshold of a facility to receive medical care without regard to the number of services provided during that visit."

Only one threshold visit per patient per day is allowed for reimbursement purposes, except for transfusion services to hemophiliacs, in which case each transfusion visit constitutes an allowable threshold visit. The visit is all-inclusive as it includes all of the services medically necessary and rendered on that date.

> This policy does not apply to those services for which rates of payment have been established for each procedure, such as dialysis and freestanding ambulatory surgery.

When a Medicaid patient receives treatment(s) during a threshold clinic visit that cannot be completed due to administrative or scheduling problems, the Article 28 facility may not bill additional clinic visits for the completion of the service.

> For example, the completion of clinical laboratory test, blood draws or X-rays that are scheduled subsequent to the initial clinic visit do not qualify for reimbursement unless the patient is also seen for purposes of discussing the findings and for definitive treatment planning.

It is inappropriate for a clinic to call a client back for a service in order to generate an additional clinic visit for a service that should have been provided at the time of the first visit (and included in that payment).

> For example, if a patient needs both physical and occupational therapy on the same day, a clinic cannot provide one session on the first day and call the patient back for a second visit on a subsequent day to generate another clinic bill.

MMIS Policy Guidelines for Clinics, Version 2007-2 (eff. June 1, 2007), p. 3
Version 2007-1 (eff. May 1, 2007), p. 3

Audit Findings

OMIG issued a Draft Audit Report to the Provider on November 13, 2017 which identified that the Provider had inappropriately billed $67,260.13 to Medicaid in 389 cases where the Provider received both a Medicaid supplemental payment and a FFS all-inclusive payment for individual recipients on the same date of service, with dates of service between January 1, 2014 and December 31, 2016.

The Provider's written responses (Attachment A) to the Draft Audit Report disputed four of the inappropriate FFS all-inclusive payments identified due to the United States District Court's ruling that DOH must reimburse FQHCs at full FQHC Medicaid PPS rates when there is improper non-payment by MCOs. Subsequent to reviewing the Provider's response to the Draft Audit Report, OMIG determined an additional 19 inappropriate FFS-all-inclusive payments were identified in the Draft Audit Report that were related to the United States District Court's ruling. As a result of the United States District Court ruling, OMIG determined that the Medicaid supplemental payment was inappropriately billed in each of the 23 cases instead of the FFS all-inclusive payment originally cited in the Draft Audit Report. The Provider's written responses also disputed 17 of the payment amounts identified in the Draft Audit Report. After verifying each of the 17 payment amounts, the overpayments identified in this Final Audit Report remain unchanged from those cited in the Draft Audit Report. As a result of the United States District Court's ruling, in this Final Audit Report, OMIG reduced the overpayment amount identified in the Draft Audit Report by $1,414.64, from $67,260.13 to $65,845.49.

Overall, the audit found that the Provider inappropriately billed $65,845.49 to Medicaid in 389 cases where the Provider received both a Medicaid supplemental payment and a FFS all-inclusive payment for individual recipients on the same date of service. Of these 389 cases, 23 of them were for improper non-payment by MCOs, resulting in inappropriate Medicaid supplemental payments totaling $3,759.61. Six cases were for covered services provided to Medicaid managed care recipients, resulting in inappropriate FFS all-inclusive payments totaling $1,347.06. 358 cases were for services provided that were not part of the Plan's scope of benefits, resulting in inappropriate Medicaid supplemental payments totaling $60,399.92. The remaining two cases were for Medicaid FFS recipients, resulting in inappropriate Medicaid supplemental payments totaling $338.90. As a result, the requirements for 10 NYCRR Sections 86-4.9 (a) and (b) and MMIS Policy Guidelines for Clinics were violated.

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 $4,972.62 (Attachment B) is now owed.

Based on this determination, the total amount due to DOH, as defined in 18 NYCRR Section 518.1 is $70,818.11 (Attachment B), inclusive of interest.

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 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

[redacted]

[redacted]

New York State
Office of the Medicaid Inspector General
Division of Medicaid Audit
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.

NEW YORK STATE | Office of the Medicaid Inspector General

REMITTANCE ADVICE

The Floating Hospital
25-15 Queens Plaza North
Long Island City, New York 11101

Provider ID #: 00245038

Audit #: 17-7219

Amount Due: $70,818.11

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:

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]
Email: [redacted]

If you elect to pay electronically through OMIG's Online Payment Portal, please visit [redacted] or contact OMIG's Bureau of Collections Management by telephone or email, at the above number or address.