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

REVIEW OF PRESBYTERIAN HOSPITAL CITY OF NEW YORK CLAIMS FOR NEWBORN BIRTH SERVICES PAID FROM JANUARY 1 2005 – DECEMBER 31, 2007

FINAL AUDIT REPORT

James G. Sheehan
Medicaid Inspector General

August 18, 2010

STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, New York 12204

DAVID A. PATERSON
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

August 18, 2010

[redacted]
Presbyterian Hospital City of New York
525 East 68th Street
Box 150, Patient Accounts
New York, NY 10016

Re: Final Audit Report
Audit #09-1172

Dear [redacted]

Enclosed is the Office of the Medicaid Inspector General ("OMIG") final audit report entitled "Review of Presbyterian Hospital City of New York" (the "Facility") paid claims for newborn birth services covering the period January 1, 2005 through December 31, 2007.

In the attached final report, the OMIG has detailed our objectives and scope, laws, regulations, rules and policies, findings, and provider rights.

After reviewing the Facility's written responses to the OMIG's February 5, 2009 draft report, the OMIG has reduced the draft report disallowances of $1,297,733 to $644,204 in the final report, inclusive of interest. A detailed explanation of the revision is included in the final report.

In addition to recovering the overpayments set forth in this final audit report, the OMIG reserves the right to take additional actions, including the imposition of sanctions pursuant to 18 NYCRR 515.6, if such action is warranted. If the OMIG determines to take such action, the OMIG will notify the Facility in a separate notice.

If the Facility has any questions or comments concerning this report, please contact [redacted] at [redacted] or through email at [redacted] Please refer to audit number 09-1172 in all correspondence.

Sincerely,

[redacted]

Bureau of Managed Care Audit & Provider Review
Office of the Medicaid Inspector General

CERTIFIED MAIL #[redacted]
RETURN RECEIPT REQUESTED

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.state.ny.us

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 ensure 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 ensure 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.

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ATTACHMENTS:

I – Provider Response to Draft Report

II – OMIG Analysis of Contested Claims

III - Disallowed Medicaid Payments

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 newborn birth 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 directed at ensuring provider compliance 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.

OBJECTIVE AND SCOPE

Objective

The objective of our audit was to ensure Presbyterian Hospital City of New York ("the Facility") compliance with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- the Facility sought reimbursement from liable third parties;
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

Scope

A review of the Medicaid payments made to the Facility related to newborn birth services from January 1, 2005 through December 31, 2007 was completed. The audit identified instances where both, the Facility received a fee for service Medicaid payment while the newborn was enrolled in Managed Care and the Managed Care Organization ("MCO") received a supplemental newborn capitation payment; indicating the hospital was either eligible for or did receive a payment from the MCO related to the newborn's birth.

LAWS, REGULATIONS, RULES AND POLICIES

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

- Department 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 ("MMIS") and eMedNY Provider Manual.

- Specifically, 18 NYCRR §540.6 and §515.2

- 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: "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 Section 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 Section 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 Section 517.3(b)

DETAILED FINDINGS

A draft report identifying inappropriate payments of $1,145,543, plus interest of $152,190, was issued to the Facility on February 5, 2009 for services rendered to newborns during a period which the newborns were enrolled in a Managed Care Plan (MCO). The Facility's written responses (Attachment I) to the draft report stated that the Facility received MCO payment denials for four beneficiaries [redacted] and therefore the Facility is entitled to retain the fee for service payment. After verifying that the Facility did receive payment denials for the four beneficiaries the OMIG has removed these services/claims from the final report (Attachment II). The Facility also stated in their response that five recipients [redacted] were retroactively disenrolled from Managed Care and as a result the Facility was entitled to bill these beneficiaries fee for service. After verifying that each beneficiary was in fact retroactively disenrolled from Managed Care the OMIG has removed these five services/claims from the final report. The Facility agreed with the remainder of the draft report findings.

As a result of these adjustments the overpayments in the final report are reduced by $360,042; from $1,145,543 to $785,500 (Attachment II).

After applying retroactive rate adjustments subsequent to the issuance of the draft report, the findings increased from $785,500 to $806,100 in the final report on those services billed to Medicaid that were rendered to newborns during a period the newborn was enrolled in Managed Care and should have been billed to their Managed Care Plan (Attachment III); a violation of §515.2 and §540.6 requirements.

The OMIG agrees with the Facility's draft report response that the Facility is entitled to GME payments related to 122 of the 123 disallowed services/claims identified within the final report. The Facility is not entitled to a GME for the services/claim for beneficiary [redacted] as it is a long stay day outlier. The Facility should go through the normal Medicaid reimbursement process to obtain the GME payment related to the services/claim that the Facility adjusted/voided subsequent to the issuance of the draft report (Attachment III - Type 4). For the remaining services/claims the OMIG has determined that the Facility is entitled to GME payments of $223,433 (Attachment III - Type 2). As a result, the total overpayment in the final report has been adjusted to reflect this GME entitlement, and the amount owed is reduced by $223,433; from $806,100 to $582,668 (Attachment III).

In accordance with 18 NYCRR §518.4, interest may be collected and will accrue at the current rate from the date of the overpayment. For the net overpayments identified in this audit, the OMIG has determined that accrued interest of $61,537 is owed (Attachment III). Interest was calculated using the Federal Reserve Prime rate, with the begin date of interest being the date of overpayment and the end date of interest being the date of the OMIG's Draft Report; January 5, 2009.

Based on this determination, the total amount of overpayment, as defined in 18 NYCRR §518.1 is $644,204 inclusive of interest (Attachment III). Subsequent to the issuance of the draft report, the Facility fully adjusted/voided 49 claims within the audit, totaling $387,874. As a result, repayment of $256,330 is now due the New York State Department of Health.

PROVIDER RIGHTS

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

OPTION #1: Make 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 attached Remittance Advice to:

New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 1237
Albany, New York 12237-0048

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 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 report, the OMIG will impose a 15% withhold after 20 days until the agreement is established.

Furthermore, the OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. 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. The OMIG will notify you no later than 5 days after initiating such action. If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

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

If within 20 days, you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to recover payment, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.

The Facility 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 Facility wishes 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

Questions regarding the request for a hearing should be directed to [redacted] 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

Presbyterian Hospital City of New York
525 East 68th Street
Box 150, Patient Accounts
New York, New York 10016

PROVIDER ID #[redacted]

AUDIT #09-1172

AUDIT TYPE	**[ ] PROVIDER** **[ ] RATE** **[ ] PART B** **[X] OTHER: Newborn FFS/MC Crossover**

AMOUNT DUE: $256,330

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 1237
File #09-1172
Albany, New York 12237-0048

Thank you for your cooperation.