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 26, 2010

St Elizabeth Medical Center
[redacted]
Business Office
2209 Genesee Street
Utica, NY 13501

FINAL AUDIT REPORT
Audit #2008Z56-106R
Provider [redacted]

Dear [redacted]

The New York State Office of the Medicaid Inspector General (the "OMIG") completed an audit of Medicaid claims that identified hospital based ancillary services that were billed in addition to an all-inclusive hospital based general clinic visit. In accordance with Section 517.5 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18 NYCRR), this report represents the final determination on issues found during the OMIG's review.

After reviewing your response to the OMIG's December 21, 2009 Draft Audit Report, the OMIG reduced the Draft Audit Report overpayments of $169,745.91 to $85,808.40 in the Final Report. A detailed explanation of the revision is included in the Final Report.

Based on this determination, restitution of the overpayments as defined in 18 NYCRR 518.1 is required in the amount of $85,808.40.

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 report. The check should be made payable to the New York State Department of Health and be sent with the enclosed Remittance Advice form, signed and dated, to:

[redacted]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 1237
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 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. 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:

Collections Management Group
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
[redacted]

Do not submit claim voids or adjustments in response to this Final Audit Report.

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 secure payment and liquidate the overpayment amount, 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.

You have 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 you wish 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

If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply along with your hearing request a signed authorization permitting that person to represent you. At the hearing, you may call witnesses and present documentary evidence on your behalf.

Questions concerning this audit may be directed to [redacted] at [redacted]

Sincerely,

[redacted]

Bureau of Business Intelligence
Office of the Medicaid Inspector General

Enclosure

CERTIFIED MAIL #[redacted]
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

St Elizabeth Medical Center
2209 Genesee Street
Utica, NY 13501

Provider [redacted]

AUDIT #2008Z56-106R

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

AMOUNT DUE: $85,808.40

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]
Medicaid Financial Management
New York State Department of Health
GNARESP Corning Tower, Room 1237
File #2008Z56-106R
Albany, New York 12237

5. If the provider number shown above is incorrect, please enter the correct number below.

CORRECT PROVIDER NUMBER

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

DAVID A. PATERSON
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

FINAL REPORT

ST ELIZABETH MEDICAL CENTER
2209 GENESEE STREET
UTICA, NY 13501

GENERAL CLINIC CROSSOVER TO CLINIC/ER
#2008Z56-106R

ISSUED AUGUST 26, 2010

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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 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 in NY Public Health Law, NY Social Services Law, regulations of the Departments of Health, [Titles 10 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

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. 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.

The threshold clinic visit is all-inclusive, i.e., it includes all of the services medically necessary and rendered on that date. 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. Ancillary services that are scheduled with affiliated ancillary providers 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.

The purpose of the review is to ensure that services appropriately included in the clinic rate were not billed separately and no duplicate payments were made. To accomplish this all ancillary services provided to hospital based clinic patients with payment dates from January 1, 2003 through December 31, 2006 were reviewed.

DETAILED FINDINGS

The detailed findings of our audit are as follows:

1. **Laboratory Services Billed Fee for Service that are Included in the All-Inclusive Clinic Rate**

   Regulations state: "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)

   Regulations state that by enrolling in the program, a provider agrees to comply with the rules, regulations, and official directives of the department.

   18 NYCRR 504.3(i)

Regulation 18 NYCRR 518.(c) defines "overpayment" as "any amount not authorized to be paid under the medical assistance program, whether paid as a result of ...improper claiming, unacceptable practices, fraud, abuse or mistake" and provides for the recovery by OMIG of these overpayments.

18 NYCRR 518.(c)

Regulations state: "The physical appearance of an outpatient at a hospital complex is recognized as contributing one visit regardless of the number of diagnostic and/or therapeutic services the patient receives or the number of sections (clinics), operating rooms, laboratories and treatment areas in which he/she receives them. The classification of the visit (i.e., emergency, clinic, etc.) will be determined by the first location where service is rendered."

10 NYCRR 441.339

Regulations further state that payments to hospitals are based on " . . . all-inclusive prospective rates for inpatient services, emergency services, clinic services and such other services for which a separate rate is deemed appropriate by the commissioner."

10 NYCRR 86-1.18(a)

The MMIS Manual states, "At the time ordered ambulatory services are prescribed . . . the recipient may not be under the primary care/responsibility of the Article 28 facility where the service is to be performed; and/or the ordering practitioner may not be an employee of the Article 28 facility where the service is to be performed."

MMIS Provider Manual for Clinic, 2.2.1H

Exhibit I is a list of laboratory services that are included in the general clinic rate structure and should not be billed fee for service. The clinic provider is responsible for reimbursing the laboratory service provider for these procedures. Our review found overpayments totaling $12,679.25 for these procedures.

2. **Ordered Ambulatory Service Billed Fee for Service that are Included in the All-Inclusive Clinic Rate**

Regulations state: "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)

Regulations state that by enrolling in the program, a provider agrees to comply with the rules, regulations, and official directives of the department.

18 NYCRR 504.3(i)

Regulation 18 NYCRR 518.(c) defines "overpayment" as "any amount not authorized to be paid under the medical assistance program, whether paid as a result of ...improper claiming, unacceptable practices, fraud, abuse or mistake" and provides for the recovery by OMIG of these overpayments.

18 NYCRR 518.(c)

Regulations also state: "The physical appearance of an outpatient at a hospital complex is recognized as contributing one visit regardless of the number of diagnostic and/or therapeutic services the patient receives or the number of sections (clinics), operating rooms, laboratories and treatment areas in which he/she receives them. The classification of the visit (i.e., emergency, clinic, etc.) will be determined by the first location where service is rendered."

10 NYCRR 441.339

Regulations further state that payments to hospitals are based on " . . . all-inclusive prospective rates for inpatient services, emergency services, clinic services and such other services for which a separate rate is deemed appropriate by the commissioner."

10 NYCRR 86-1.18(a)

The MMIS Manual states, "At the time ordered ambulatory services are prescribed . . . the recipient may not be under the primary care/responsibility of the Article 28 facility where the service is to be performed; and/or the ordering practitioner may not be an employee of the Article 28 facility where the service is to be performed."

MMIS Provider Manual for Clinic, 2.2.1H

Exhibit II is a list of ancillary services that are included in the general clinic rate structure and should not be billed fee for service. The clinic provider is responsible for reimbursing the ancillary service provider for these procedures. Our review found overpayments totaling $73,129.15 for these procedures.

DETERMINATION

Failure to comply with Title(s) 10, 14 and/or 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) and the MMIS Provider Manuals for Clinics, Laboratories and Hospital Based Ordered Ambulatory Services resulted in a total overpayment of $85,808.40.

Based on this determination, the total amount of overpayment, as defined in 18 NYCRR 518.1(c) is $85,808.40. Repayment of $85,808.40 is due the New York State Department of Health.

Auditor's Note

We have carefully considered the arguments in your response of February 3, 2010. After conferring with the New York State Department of Health Bureau of Primary and Acute Care Reimbursement concerning the St. Elizabeth Medical Center clinic rate and other DOH program experts, we have determined that your clinic rate does indeed contain ordered ambulatory services. The ordered ambulatory categories of service are for patients sent from providers in the community, not your own clinic patients. All the ordered ambulatory services that we are seeking to recover have either the attending physician at St. Elizabeth Medical Center clinic or St. Elizabeth's provider ID as the orderer of the test. We will remove the claims for the physicians who you detailed in your response that were not employed by St Elizabeth Medical Center or contracted as an attending at your clinic or emergency room. In each case, the physician is listed as both the attending physician of the clinic visit AND the referring physician of the ancillary test. This information is supplied by your hospital on the Medicaid claim to identify the provider delivering service in the clinic and the orderer of the ordered ambulatory test. However, we accept your assertion that these physicians were not attending providers at your clinic and will remove these claims from the total disallowance.

Recipients under the primary care/responsibility of the Article 28 facility may not have ancillary testing (lab and non lab) billed under COS 0281 and 0282. There is no time limit to this rule. We use 7 or 14 days for the purpose of a system match only. We could have used any number of days covered by the order for testing. The regulation applies to all testing ordered for clinic patients. Ancillary services ordered at the clinic visit, but delivered at a later time, may not be billed fee for service. The EMedNY Provider Manuals, Medicaid Updates, and regulations in both Title 10 and 18 all support the parameters of this audit. Medicaid providers have been informed of policy concerning the billing of ordered ambulatory services for clinic patients in directives over many years. This policy has been an audit finding in our OPD audits for more than two decades. It is the duty of the Medicaid provider to keep informed and comply with all the official directives of the New York State Department of Health. The Medicaid Updates and the EMedNY Provider Manuals are formal directives.

The Chemotherapy clinic rate code 3092 is a specialty clinic rate established by the NYS Department of Health, Bureau of Primary and Acute Care Reimbursement (DOH BPACR). This specialty clinic rate takes into account the specialized staff, and equipment required to serve those in need of cancer treatment. The cost of providing these services exceeds the cost of delivering more routine diagnostic or treatment services. Rate code 3092 allows the facility to bill separately for clinic administered drugs under their ordered ambulatory category of service (0163 or 0282). Facilities that do not have this rate code can **not** bill drugs separately in addition to the clinic visit.

St. Elizabeth Medical Center does not have a chemotherapy clinic rate established by DOH BPACR. They are therefore not entitled to bill chemotherapy. In the Medicaid Update of November 2005 Vol.20, No.12; the chemotherapy clinic rates were discussed.
"NOTE: if you **do not have rate code 3092**, the drugs are included in your clinic rate reimbursement and **may not be billed separately**. This regulation covers the entire review period of the audit