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

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

August 6, 2013

Arnot Ogden Medical Center
[redacted]
600 Roe Avenue
Elmira, NY 14905

FINAL AUDIT REPORT
Audit #2011Z56-119W
Provider [redacted]

Dear [redacted]:

The New York State Office of the Medicaid Inspector General (the "OMIG") completed an audit of Medicaid fee-for-service payments for ordered ambulatory services that were also included in the clinic's Ambulatory Patient Group (APG) payment. In accordance with Section 517.6 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.

Your response to the OMIG's October 16, 2012 Draft Audit Report agreed with the audit findings. As a result, the overpayments in the final report remain unchanged to those cited in the draft report. The total Medicaid overpayment is $2,649.27, inclusive of interest.

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:

New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
Albany, New York 12237

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General to have the overpayments applied against your future Medicaid payments. 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

Do not submit claim voids or adjustments in response to this Final 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] or by fax at [redacted].

Sincerely,

[redacted]

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

Arnot Ogden Medical Center
600 Roe Avenue
Elmira, NY 14905

AMOUNT DUE: $2,649.27

Provider [redacted]

AUDIT #2011Z56-119W

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:

[redacted]
Medicaid Financial Management
New York State Department of Health
GNARESP Corning Tower, Room 2739
File #2011Z56-119W
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

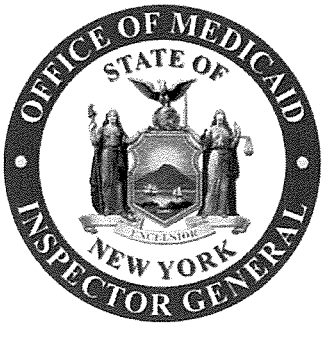
ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

FINAL REPORT

ARNOT OGDEN MEDICAL CENTER
600 ROE AVENUE
ELMIRA, NY 14905

AMBULATORY PATIENT GROUPS
#2011Z56-119W



ISSUED AUGUST 6, 2013

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 and Social Services, [Titles 10 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the eMedNY Provider Manuals.

Chapter 53 of the Laws of 2008 amended Article 2807 of the Public Health Law by adding a new Section (2-a). Public Health Law 2807 (2-a) required a new Medicaid payment methodology based on Ambulatory Patient Groups that would apply to most ambulatory care services provided by hospital outpatient departments, emergency departments and ambulatory surgery departments, and free-standing diagnostic and treatment centers and free-standing ambulatory surgery centers.

APG payment methodology is based on the Enhanced Ambulatory Patient Groups Classification System. APGs categorize the amount and type of resources used in various ambulatory visits. Patients within each APG have similar resource use and cost. APGs group together procedures and medical visits that share similar characteristics and resource utilization patterns for payment purposes. APGs are designed to predict the average pattern of resource use of a group of patients in a given APG. APG payment methodology pays differential amounts for ambulatory care services based on the resources required for each patient visit. APG payment methodology provides greater reimbursement for high intensity services and relatively less reimbursement for low intensity services.

APG methodology covers most medical outpatient services. It reimburses based on patients' conditions and severity, and packages the cost of certain ancillary lab and radiology services into the overall payment. It addresses the inadequacies of the previous system by paying varying amounts per visit, based on service intensity.

The purpose of this audit is to recoup fee-for-service payments for ordered ambulatory services that were also included in the clinic's APG payment. To accomplish this, all ordered ambulatory services paid fee-for-service, rendered and paid between January 1, 2010 and May 31, 2011 were reviewed.

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.

DETAILED FINDINGS

The exhibits are detailed in the following two categories:

1. **Routinely Packaged Ancillary Services are Included in the APG Payment and Should Not be Billed Fee-for-Service (Procedure Codes Subject to the Ancillary Billing Policy)**

   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 518.1(c)

   The eMedNY Provider Manual states: "The APG System uses three methods for grouping different services provided into a single payment unit: ancillary packaging, significant procedure consolidation or bundling; and multiple significant procedure and ancillary discounting.

   Ancillary Packaging: Ancillary packaging refers to the inclusion of certain ancillary services in the APG payment rate for a significant procedure or a medical visit. When ancillaries are packaged, the costs of the ancillaries are included in the payment amount for the significant procedure or medical visit. Under APGs, ancillary lab and radiology services that are inexpensive or frequently provided are generally packaged into the payment for the significant procedure or medical visit. Other ancillary services, particularly those that are expensive or infrequently ordered, such as MRIs are paid as separate ancillary APGs.

   Uniform packaging of ancillaries is used in the APG payment system. Ancillaries that are uniformly packaged include ancillaries that are performed for a wide range of different visits and which are relatively low cost in comparison with the average cost of the significant procedure and medical visit APGs. "

   Policy and Billing Guidance Ambulatory Patient Groups (APG)
   eMedNY Provider Manual, Chapter 2.4

   The eMedNY Provider Manual also states: "Under the new APG payment methodology, payment for laboratory and radiology services ordered by practitioners in hospital-based outpatient clinics is made to the clinic. When the hospital or D&TC patient receives the ancillary service from someone other than the clinic, the clinic is

responsible for paying the individual or entity providing the ancillary service, even in the absence of a contractual relationship between the two parties. The ancillary service provider may not bill Medicaid directly for lab or the technical component of radiology services related to an APG-reimbursed visit and therefore must bill the ordering clinic for the service provided to clinic patients.

Hospitals are... responsible for advising outside lab and radiology service providers on the order for the service when the payment for the ancillary service is subject to APG reimbursement and the APG ancillary billing policy. They must also advise radiology service providers if they want the provider to "read" the radiology results and bill Medicaid directly for these professional services. Alternatively, if the hospital provider plans to bill for "reading" the radiology result, the hospital should advise the radiology vendor not to bill for the professional component of the radiology service. Only one professional component per radiology procedure per recipient may be billed to Medicaid."

Policy and Billing Guidance Ambulatory Patient Groups (APG)
eMedNY Provider Manual, Chapter 4.4

The eMedNY Provider Manual states: "All laboratory and the technical component of radiology services, both those that are provided by the hospital facility as well as those that are referred to an outside laboratory or radiology provider, are the fiscal responsibility of the hospital outpatient clinic and should be included on an APG Medicaid claim. The hospital clinic must reimburse the laboratory or radiology provider directly. The laboratory/radiology provider may not bill Medicaid for these services, except for the professional component of the radiology service."

Policy and Billing Guidance Ambulatory Patient Groups (APG)
eMedNY Provider Manual, Chapter 4.4

Exhibit 1 is a list of ordered ambulatory services that were packaged in the clinic's APG payment and should not have been billed fee for service. When the ordered ambulatory provider was paid an amount exceeding the professional component fee and no additional professional claim was billed, the amount disallowed reflects the difference between the amount paid and the professional component fee; when there was an additional professional claim billed, the amount disallowed reflects the amount paid. For services that do not have a technical/professional component, the amount disallowed reflects the amount paid. Our review found overpayments totaling $ 1,899.71 for these procedures.

2. **Non-Packaged Ancillary Services Should Not be Billed Fee-for-Service when the Ancillary Service was Included in the APG Payment (Procedure Codes Subject to the Ancillary Billing Policy)**

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 518.1(c)

The eMedNY Provider Manual states: "Under the new APG payment methodology, payment for laboratory and radiology services ordered by practitioners in hospital-based outpatient clinics is made to the clinic. When the hospital or D&TC patient receives the ancillary service from someone other than the clinic, the clinic is responsible for paying the individual or entity providing the ancillary service, even in the absence of a contractual relationship between the two parties. The ancillary service provider may not bill Medicaid directly for lab or the technical component of radiology services related to an APG-reimbursed visit and therefore must bill the ordering clinic for the service provided to clinic patients.

Hospitals are... responsible for advising outside lab and radiology service providers on the order for the service when the payment for the ancillary service is subject to APG reimbursement and the APG ancillary billing policy. They must also advise radiology service providers if they want the provider to "read" the radiology results and bill Medicaid directly for these professional services. Alternatively, if the hospital provider plans to bill for "reading" the radiology result, the hospital should advise the radiology vendor not to bill for the professional component of the radiology service. Only one professional component per radiology procedure per recipient may be billed to Medicaid."

Policy and Billing Guidance Ambulatory Patient Groups (APG)
eMedNY Provider Manual, Chapter 4.4

The eMedNY Provider Manual states: "All laboratory and the technical component of radiology services, both those that are provided by the hospital facility as well as those that are referred to an outside laboratory or radiology provider, are the fiscal responsibility of the hospital outpatient clinic and should be included on an APG Medicaid claim. The hospital clinic must reimburse the laboratory or radiology provider directly. The laboratory/radiology provider may not bill Medicaid for these services, except for the professional component of the radiology service."

Policy and Billing Guidance Ambulatory Patient Groups (APG)
eMedNY Provider Manual, Chapter 4.4

Exhibit 2 is a list of ordered ambulatory services that were included in the clinic's APG payment and should not have been billed fee for service. When the ordered ambulatory provider was paid an amount exceeding the professional component fee and no additional professional claim was billed, the amount disallowed reflects the difference between the amount paid and the professional component fee; when there was an additional professional claim billed, the amount disallowed reflects the amount paid. For services that do not have a technical/professional component, the amount disallowed reflects the amount paid. Our review found overpayments totaling $662.88 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 eMedNY Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual resulted in a total overpayment of $2,562.59.

In accordance with 18 NYCRR 518.4, interest may be collected on any overpayments identified in this audit and will accrue at the current rate from the preliminary determination of the overpayment. For the overpayments identified in this audit, the OMIG has determined that accrued interest totals $86.68.

Based on this determination, the total amount of overpayment, as defined in 18 NYCRR 518.1(c) is $2,649.27, inclusive of interest.

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