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

December 4, 2014

[redacted]
Glen Cove Hospital
972 Brush Hollow Road
Westbury, New York 11590

FINAL AUDIT REPORT
Audit #2014Z01-099E
Provider [redacted]

Dear [redacted]:

The New York State Office of the Medicaid Inspector General (the "OMIG") completed an audit of Medicaid clinic and emergency room claims for Medicaid recipients who were inpatients at the hospital affiliated with the outpatient providers. In addition, an audit of Medicaid ancillary services claims for Medicaid recipients who were an inpatient in a hospital on the date of service was also performed.

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 September 9, 2014 Draft Audit Report agreed with the audit findings. Subsequently, OMIG adjustments resulted in the Draft Audit Report overpayments being reduced from $6,060.43 to $5,002.79 in the Final Report. The total Medicaid overpayment is $5,002.79, inclusive of interest.

Based on this determination, restitution of the overpayments as defined in 18 NYCRR 518.1 is required in the amount of $5,002.79, 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. 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%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until an agreement is established. 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. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

Bureau of Collections Management
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.

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].

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

Glen Cove Hospital
972 Brush Hollow Road
Westbury, NY 11590

AMOUNT DUE: $ 5,002.79

Provider [redacted]

AUDIT #2014Z01-099E

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]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #2014Z01-099E
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

GLEN COVE HOSPITAL
972 BRUSH HOLLOW ROAD
WESTBURY, NEW YORK 11590

INPATIENT/CLINIC/ER/ANCILLARY CROSSOVER
#2014Z01-099E

ISSUED DECEMBER 4, 2014

BACKGROUND, PURPOSE AND SCOPE

The New York State Department of Health (DOH) is responsible for the administration of the Medicaid program. As an independent office within DOH, the OMIG conducts audits and reviews of providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assuring 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 Department of Health, (Titles 10 and 18 of the NYCRR), Medicaid Provider Manuals, and *Medicaid Update* publications.

Under Section 86-1.18 of Title 10 of the New York Codes, Rules and Regulations, the Department of Health establishes all-inclusive hospital inpatient rates that cover the costs of almost all services provided to Medicaid recipients who are hospitalized. Additionally, the EMedNY Provider Manual for Clinics specifically prohibits separate emergency room and clinic billing during a recipient's inpatient hospital stay.

During a Medicaid recipient's hospital stay, the inpatient DRG based rate is a generally all-inclusive rate and there should be no emergency room or clinic billings by the hospital for that patient. In addition, no clinic or emergency room visit is to be billed if the patient is subsequently admitted that same day to the hospital.

The purpose of this audit is to identify Medicaid provider claims for either clinic or emergency room services, billed during a Medicaid patient's inpatient stay, excluding date of discharge. To accomplish this, claims submitted for clinic and/or emergency room services with payment dates from July 1, 2011 through June 30, 2013 were reviewed. Claims on the last day of an inpatient hospital stay were excluded from the audit.

In addition, this audit identified potential Medicaid overpayments made to you for laboratory and/or other ordered ambulatory services provided to Medicaid patients, who on the same date as these services, received inpatient services at a hospital. When Medicaid pays for such outpatient service for a hospitalized recipient, it is paying twice for the same service: first when it pays the inpatient rate and again when it pays the outpatient provider's separate claim. Inpatient hospital rates include all the costs incurred for the care of inpatients. To accomplish this, laboratory and/or ordered ambulatory service claims with payment dates from January 1, 2010 through June 30, 2013 were reviewed. Certain dates of hospital admission were excluded from this report. All dates of discharge were excluded from this report.

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 three categories. All or a combination of the following three exhibits are included in this Final Audit Report.

1. Clinic and Emergency Room Outpatient Visits Billed On the Same Day as a Hospital Inpatient Stay

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

18 NYCRR §504.3(i)

Regulation 18 NYCRR 518.1(c) defines "overpayment" as "any amount not authorized to be paid under the medical assistance program, whether paid as the 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 for Inpatient states: "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."

EMedNY Provider Manual for Inpatient Policy Guidelines
Version 2007-1 (effective 25 May 2007), p.18 of 26;
Version 2011-1 (effective 05 Dec 2011), p. 20 of 30;
Version 2012-1 (effective 21 Nov 2012), p. 19 of 27.

The EMedNY Provider Manual for Clinic states: "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 (effective 01 June 2007) p. 4 of 42.

Exhibit 1 is a list of all claims that contain clinic and emergency room services billed to Medicaid during a Medicaid patient's inpatient hospital stay. These services must be billed to the original admitting hospital. Submitting these claims to Medicaid resulted in an overpayment of $2,325.20.

2. Laboratory Services Billed Fee for Service that are Included in the Inpatient 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: "By enrolling, the provider agrees... to comply with the rules, regulations and official directives of the department."

18 NYCRR 504.3(i)

Regulation 18 NYCRR 518.1(c) defines "overpayment" as "any amount not authorized to be paid under the medical assistance program, whether paid as the 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)

Regulations state: "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)

The EMedNY Provider Manual for Laboratory states: "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 2005-1 (effective 01 Jan 2005), p.13 of 24;
Version 2011-1 (effective 06 Sept 2011), p.15 of 27.

The EMedNY Provider Manual for Inpatient states: "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 2007-1 (effective 25 May 2007), p.15 of 26;
Version 2011-1 (effective 05 Dec 2011), p. 17 of 30;
Version 2012-1 (effective 21 Nov 2012), p. 16 of 27.

"The EMedNY Provider Manual for Inpatient states: 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 2007-1 (effective 25 May 2007), p.9 of 26;
Version 2011-1 (effective 05 Dec 2011), p. 11 of 30;
Version 2012-1 (effective 21 Nov 2012), p. 10 of 27.

Exhibit 2 is a list of all claims that contain laboratory services billed to Medicaid during a Medicaid patient's inpatient hospital stay. These services must be billed to the original admitting hospital. Submitting these claims to Medicaid resulted in an overpayment of $293.96.

3. **Ordered Ambulatory Services (Other Than Labs) Billed Fee for Service that are Included in the Inpatient 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: "By enrolling, the provider agrees… to comply with the rules, regulations and official directives of the department."

18 NYCRR 504.3(i)

Regulation 18 NYCRR 518.1(c) defines "overpayment" as "any amount not authorized to be paid under the medical assistance program, whether paid as the 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 DOH Medicaid Update states: "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

The EMedNY Provider Manual for Inpatient states: "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 2007-1 (effective 25 May 2007), p.15 of 26;
Version 2011-1 (effective 05 Dec 2011), p. 18 of 30;
Version 2012-1 (effective 21 Nov 2012), p.16 of 27.

Exhibit 3 is a list of all claims that contain ordered ambulatory services (other than labs) billed to Medicaid during a Medicaid patient's inpatient hospital stay. These services must be billed to the original admitting hospital. Submitting these claims to Medicaid resulted in an overpayment of $2,127.34.

DETERMINATION

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 $256.29.

Based on this determination, the total amount of overpayment, as defined in 18 NYCRR 518.1(c) is $5,002.79, inclusive of interest.

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