



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

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

January 16, 2013

[REDACTED]
NY Hospital
525 E 68th St, Box 150
New York, New York 10065-4870

Re: Final Audit Report
Audit #: 12-5103
NPI #: [REDACTED]
Provider ID #: [REDACTED]

Dear [REDACTED]:

The New York State Office of the Medicaid Inspector General (OMIG) has completed its review of improper Medicaid payments of misclassified patient discharge(s) made to NY Hospital. The claims reviewed were referred to OMIG by the Office of the State Comptroller (OSC) and were identified in an OSC review (Report 2009-S-26; Improper Medicaid payments For Misclassified Patient Discharges). In accordance with Sections 517.6 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York, this report represents the final determination on issues found during the review.

BACKGROUND, PURPOSE AND SCOPE

The New York State Department of Health ("Department") is responsible for the administration of the Medicaid program. As an independent office within the Department, the OMIG conducts audits and reviews of providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at preserving the integrity of the Medicaid program and ensuring 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 the Department of Health (Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York) and the Department's Medicaid Provider Manuals and Medicaid Update publications.

OSC referred for OMIG review and recovery high risk claim payments to hospitals and subsequently identified claims that were incorrectly coded as a "discharge" (instead of a "transfer") and resulted in Medicaid overpayments. In addition, OSC identified other claims for which there was a high risk of significant overpayments because the claims were improperly coded as discharges when they should have been coded as transfers.

The Medicaid program uses a case-based reimbursement methodology known as diagnosis related groups (DRGs) to pay most hospitals for inpatient services. Payments under the DRG system are based on factors such as a patient's medical diagnosis, sex, age, birth weight, length of time in the hospital, procedures performed, and whether the patient was discharged or transferred. Consequently, when a hospital bills Medicaid for services, it must indicate whether the patient was a "transfer" or a "discharge." This is important because a discharge DRG payment typically exceeds a transfer DRG payment for essentially the same services, and the differences in payment amounts are often material. A discharge payment generally pays more than a transfer payment under the presumption that a full range of medical services was provided to a patient, and therefore, the patient was well enough to go home. In contrast, in the case of a transfer, the patient required additional medical services provided by another institution.

OMIG's scope consists of the claims that were identified as overpayments in OSC's Audit of Improper Medicaid payments for Misclassified Patient Discharges (Report 2009-S-26).

LAWS, REGULATIONS, RULES AND POLICIES

The following citations provide authority for the OMIG's review of records:

1. SOCIAL SECURITY ACT SECTION 1902(a)

"A State plan for medical assistance must...(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees... (B) to furnish the State agency...with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency...may from time to time request."

2. 18 NYCRR

Regulation § 504.3 states: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program... and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health;" and "(g) to permit audits, by the persons and agencies denominated in subdivision (a) of this section, of all books and records or, in the discretion of the auditing agency, a sample thereof, relating to services furnished and payments received under the medical assistance program, including patient histories, case files and patient-specific data."

Pursuant to § 517.1 – 517.17, the OMIG may conduct fiscal audits and reviews of a provider's claims, books, records, reports, or other available documentation.

3. PUBLIC HEALTH LAW SECTION 32(9)

The OMIG shall have the power to require and compel the production of such books, papers, records and documents as may be deemed to be relevant or material to an investigation, examination or review.

Title 10 NYCRR 86-1.50(i) and (j) are guidelines for properly reporting diagnosis related group (DRG) transfers. As part of our review we will determine if you properly followed the guidelines of these regulations. Providers were reminded and apprised of the guidelines in the January 2005 Medicaid Update.

The DOH and Medicaid providers are covered entities pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191). Federal regulations, at 45 CFR 164.506 (c)(4)(ii), provide that a covered entity may disclose protected health information to another covered entity where the disclosure is for the purpose of detecting health care fraud or abuse and compliance.

DETAILED FINDINGS

The review has found instances where you received Medicaid overpayments of \$15,013.77 (Attachment 1). Since no documentation was submitted in response to our August 22, 2012 draft report, the claims identified as paid in error in the final report remain unchanged to those cited in the draft report. Based on this determination, and after consideration of all rate adjustments as of the date of this final report, the total amount of overpayment as defined in 18 NYCRR §518.1 is \$15,013.77. Total claims voided and adjusted as of the date of this report total \$15,013.77; resulting in \$0 remaining due the New York State Department of Health. No further action is required.

PROVIDER 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 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 Provider 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

If a hearing is held, the Provider may have a person represent the Provider 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 the Provider's hearing request a signed authorization permitting that person to represent the Provider the hearing, the Provider may call witnesses and present documentary evidence on the Provider's behalf.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid program, take action where appropriate, and recover any associated overpayments. If you have any questions regarding the above, please contact [REDACTED] at [REDACTED] or by email at [REDACTED]. Thank you for your cooperation.

Sincerely,

[REDACTED]

Audit Manager
Division of Medicaid Audit
Office of the Medicaid Inspector General

Attachment 1 – Adjusted Medicaid Payments for Misclassified Patient Discharges

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED