



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

January 17, 2013

[REDACTED]
Rochester General Hospital
1425 Portland Avenue 1st Floor
Rochester, New York 14621-2001

RE: Rochester General Hospital
Provider ID [REDACTED]
Audit #2012Z17-010G

Dear Administrator:

The New York State Office of Medicaid Inspector General (OMIG) has completed a review of the submission we received from you on behalf of Rochester General Hospital dated January 8, 2013. This submission concerned inappropriately paid claims totaling \$93,428.91.

OMIG staff reviewed the claims submitted as part of your correspondence, compared it with payments made, and agrees with your determination that the overpayment amount is \$93,428.91.

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. One of the following repayment options **must be selected within 20 days** from the date of this letter:

OPTION #1: Make full payment within 20 days of the date on this letter. A check should be made payable to New York State Department of Health, have the audit/project number listed on it, and be sent with the enclosed remittance advice to:

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

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 percent of your Medicaid billings to secure payment and liquidate the overpayment amount.

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
[REDACTED]

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

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.

The OMIG would like to thank you for coming forward with this submission. Please be aware that this submission relates solely to the claims disclosed, and is not meant to be construed or interpreted to preclude any other audits or reviews by OMIG, either for a different time period and the same basis, for any other basis than that which was the subject of the submission, or

for any other time period to the extent authorized by law. In addition, this submission is not meant to be applicable to or binding on any other state, federal or other law enforcement agency authorized to take administrative, civil or criminal action, nor is it meant to preclude an audit, review or investigation by such agency for the same time period and a different basis, or for a different time period and the same basis to the extent authorized by law.

Questions may be directed to [REDACTED]

Sincerely,

[REDACTED]
Bureau of Business Intelligence
Office of the Medicaid Inspector General

Enclosure
Certified Mail # [REDACTED]



**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

PROVIDER NAME AND ADDRESS:

Rochester General Hospital
1425 Portland Avenue 1st Floor
Rochester, New York 14621-2001

PROVIDER ID [REDACTED]

AUDIT/PROJECT # 2012Z17-010G

AMOUNT DUE \$93,428.91

PROVIDER
TYPE

<input type="checkbox"/>	Fee For Service
<input type="checkbox"/>	Rate - LTC
<input type="checkbox"/>	Rate - NH
<input type="checkbox"/>	Managed Care
<input checked="" type="checkbox"/>	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/project number on your check.
4. Mail check to:

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

5. If the Provider ID number shown above is incorrect, please enter the correct number in the space provided:

[REDACTED]

Correct Provider ID Number

Additional comments or instructions:
