State of New York
Office of the Medicaid Inspector General

Review of
Morris Heights Health Center
Fee-For-Service/Managed Care Crossover Payments

Final Audit Report
Audit #: 13-1706

James C. Cox
Medicaid Inspector General

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

October 17, 2013

[redacted]

Morris Heights Health Center
85 West Burnside Avenue
Bronx, NY 10453

Re: Final Audit Report
Audit #13-1706
Provider ID [redacted]

Dear [redacted]

Enclosed is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report entitled "Review of Morris Heights Health Center (Facility) Fee-For-Service/Managed Care Crossover Payments."

In accordance with Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York Section 517.6, the attached Final Audit Report represents the final determination on the issues found during OMIG's audit.

Since the Facility did not respond to OMIG's August 9, 2013 Revised Draft Audit Report, the overpayments identified in this Final Audit Report remain unchanged from those cited in the Revised Draft Audit Report. The total amount due is $98,072.40, inclusive of interest.

If you have any questions or comments concerning this report, please contact [redacted] or through email at [redacted] Please refer to audit number 13-1706 in all correspondence.

Sincerely,

[redacted]

Bureau of Managed Care Audit & Provider Review
Division of Medicaid Audit
Office of the Medicaid Inspector General

Attachments
Certified Mail Number [redacted]
Return Receipt Requested

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Mission

The mission of the Office of the Medicaid Inspector General is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care.

Vision

The Office of the Medicaid Inspector General's vision is to be the national leader in promoting and protecting the integrity of the Medicaid program.

Background, Objective, and Audit Scope

Background

The New York State Department of Health (DOH) is the state agency responsible for the administration of the Medicaid program. As part of its responsibility as an entity within DOH, the Office of the Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assessing 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 DOH (Titles 10, 14 and 18 of the New York Codes Rules and Regulations), DOH's Medicaid Provider Manuals and *Medicaid Update* publications.

DOH regulation found at Title 10 of the Official Compilation of the Codes, Rules, and Regulations of the State of New York (NYCRR) Section 86-4.9(b) states: "A threshold visit, including all part-time clinic visits, shall occur 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. Only one threshold visit per patient per day shall be allowable for reimbursement purposes..." The visit is all-inclusive as it includes all of the services medically necessary and rendered on that date.

Federal law 42 U.S.C. Section 1396a (bb)(5)(A) requires states to make supplemental payments to an Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) pursuant to a contract between the FQHC and a Managed Care Organization (MCO) for the amount, if any, that the FQHC's Prospective Payment System (PPS) rate exceeds the amount of payments provided under the managed care contract for the services rendered by the FQHC. FQHCs bill eMedNY directly for a supplemental payment when services are provided to contracted MCO enrollees that would otherwise qualify under Medicaid fee-for-service (FFS) rules for payment at the FQHC's PPS rate.

Objective

The objective of our audit was to assess Morris Heights Health Center's (Facility) adherence to applicable laws, regulations, rules and policies governing the New York State Medicaid program and to verify that:

- the Facility did not receive a supplemental payment (rate code 1609) and a FFS payment (rate code 1610) for individual recipients on the same date of service;
- claims for payment were submitted in accordance with DOH regulations and the appropriate provider manuals; and
- the Facility received the proper payment from the New York State Medicaid program.

Audit Scope

A review of instances where the Facility received both a Medicaid supplemental payment (rate code 1609), indicating payment for the threshold visit was paid by a MCO, as well as a FFS all inclusive payment (rate code 1610), for individual recipients on the same date of service for service dates included in the period beginning March 1, 2007 and ending August 31, 2008 was completed.

Laws, Regulations, Rules and Policies

The following are applicable Laws, Regulations, Rules, and Policies of the Medicaid program referenced when conducting this audit:

New York Public Health Law, New York Social Services Law, the regulations of the Department of Health (Titles 10 and 18 of the NYCRR), the regulations of the Office of Mental Health (Title 14 of the NYCRR) and the Department of Health's Medicaid Provider Manuals, and *Medicaid Update* publications.

Regulations state:

> (a) The unit of service used to establish rates of payment shall be the threshold visit, except for dialysis, abortion, sterilization services and free-standing ambulatory surgery, for which rates of payment shall be established for each procedure. For methadone maintenance treatment services, the rate of payment shall be established on a fixed weekly basis per recipient.
>
> (b) A threshold visit, including all part-time clinic visits, shall occur 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. Only one threshold visit per patient per day shall be allowable for reimbursement purposes, except for transfusion services to hemophiliacs, in which case each transfusion visit shall constitute an allowable threshold visit.
>
> *10 NYCRR § 86-4.9 (a) and (b)*

In addition to any specific detailed findings, rules and/or regulations which may be listed above, the following regulations pertain to all audits:

> Regulations state: "All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing . . .; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment . . .; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided. . . ." *18 NYCRR §540.7(a)*
>
> Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake." *18 NYCRR § 518.1(c)*
>
> Furthermore, according to regulations, all providers must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. In addition, the provider must keep, for a period of six years, all records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply. This information is subject to audit for a period of six years and must be furnished, upon request.
>
> *18 NYCRR § 517.3(b)*

Medicaid Management Information System ("MMIS") Provider Manual for Clinics states:

> Basis of Payment
>
> 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. New York State Department of Health (DOH) regulation at 10 NYCRR 86-4.9 states:
>
> > "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."
>
> Only one threshold visit per patient per day is allowed for reimbursement purposes, except for transfusion services to hemophiliacs, in which case each transfusion visit constitutes an allowable threshold visit. The visit is all-inclusive as it includes all of the services medically necessary and rendered on that date.
>
> > This policy does not apply to those services for which rates of payment have been established for each procedure, such as dialysis and freestanding ambulatory surgery.
>
> 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.
>
> > For example, the completion of clinical laboratory test, blood draws or X-rays that are scheduled 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.
>
> It is inappropriate for a clinic to call a client back for a service in order to generate an additional clinic visit for a service that should have been provided at the time of the first visit (and included in that payment).
>
> > For example, if a patient needs both physical and occupational therapy on the same day, a clinic cannot provide one session on the first day and call the patient back for a second visit on a subsequent day to generate another clinic bill.
>
> MMIS Policy Guidelines for Clinics, Version 2007-2 (eff. June 1, 2007), p. 3
> Version 2007-1 (eff. May 1, 2007), p. 3

Audit Findings

OMIG issued a Revised Draft Audit Report to the Facility on August 9, 2013 which identified that the Facility had inappropriately billed $81,261.03 to Medicaid in 1,108 cases where the Facility received both a 1609 supplemental payment and a 1610 all inclusive FFS payment for individual recipients on the same date of service. These 1,108 cases had dates of service from March 1, 2007 through August 31, 2008. Of these 1,108 cases, 15 of them were for covered services provided to Medicaid managed care recipients, resulting in inappropriate 1610 FFS payments totaling $3,088.92. The audit also found that 1,093 cases were for services provided that were not part of the MCO's scope of benefits, resulting in inappropriate 1609 Medicaid supplemental payments totaling $78,172.11. As a result, the requirements for 10 NYCRR Sections 86-4.9 (a) and (b) and MMIS Policy Guidelines for Clinics were violated.

The OMIG did not receive a response to our Revised Draft Audit Report. As a result, the overpayments identified (Attachment I) in this Final Audit Report remain unchanged from those cited in the Revised Draft Audit Report.

In accordance with 18 NYCRR Section 518.4, interest may be collected on any overpayments identified in this audit and will accrue at the current rate from the date of the overpayment. Interest was calculated on the overpayments identified in this Final Audit Report from the date of each overpayment through the date of the Draft Audit Report, February 28, 2013 using the Federal Reserve Prime Rate. For the overpayments identified in this audit, OMIG has determined that accrued interest of $16,811.37 (Attachment I) is now owed.

Based on this determination, the total amount due to DOH, as defined in 18 NYCRR Section 518.1 is $98,072.40 (Attachment I), inclusive of interest.

Repayment Options

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 Audit Report. The check should be made payable to the **New York State Department of Health** with this **audit number** included and be sent with the attached remittance advice to:

New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
Albany, New York 12237-0016

Option #2: Enter into a repayment agreement with OMIG to have the overpayments applied against your future Medicaid payments. 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 Federal Reserve Prime Rate plus two percent. If the process of establishing the repayment agreement exceeds 20 days from the date of the Final Audit Report, OMIG will impose a 15 percent withhold after 20 days until the agreement is established. OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, OMIG must receive the information within 30 days of the request or a 50 percent withhold will be imposed. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. OMIG will notify you no later than five 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:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

If within 20 days you fail to make full payment or contact OMIG to make repayment arrangements, OMIG will establish a withhold equal to 50 percent of your Medicaid billings to secure payment and liquidate the overpayment amount, interest and/or penalty, not barring any other remedy allowed by law. OMIG will provide notice to you no later than five 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.

Hearing Rights

The Facility 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 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 Facility wishes to request a hearing, the request must be submitted in writing within sixty (60) days of the date of this notice to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Questions regarding the request for a hearing should be directed to Office of Counsel, at [redacted]

At the hearing you have the right to:

a) Be represented by an attorney or other representative, or to represent yourself;
b) Present witnesses and written and/or oral evidence to explain why the action taken is wrong;
c) Cross examine witnesses of the DOH and/or OMIG; and
d) Have an interpreter if you do not speak English or are deaf.

If you have any questions regarding the above, please contact [redacted] or through email at [redacted]

State of New York
Office of the Medicaid Inspector General
Remittance Advice

Morris Heights Health Center
85 West Burnside Avenue
Bronx, NY 10453

Provider ID [redacted]

Audit #13-1706

Audit Type
- ☐ **Managed Care**
- ☒ **Fee-for-Service**
- ☐ **Rate**

Amount Due: $98,072.40

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 the check to:

[redacted]
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File #13-1706
Albany, New York 12237-0016