



NEW YORK STATE
DEPARTMENT OF HEALTH
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF ROCHESTER GENERAL HOSPITAL
CLAIMS FOR OUTPATIENT CLINIC/EMERGENCY ROOM (ER) AND
ORDERED AMBULATORY SERVICES - OTHER THAN LABORATORY SERVICES
PAID FROM
APRIL 1, 2007 – NOVEMBER 30, 2008

FINAL AUDIT REPORT
AUDIT #13-1694

James C. Cox
Medicaid Inspector General

October 21, 2014



STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
259 Monroe Avenue, Suite 312
Rochester, NY 14607

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

October 21, 2014

[REDACTED]
Rochester General Hospital
1425 Portland Avenue
Rochester, NY 14621

Re: Final Audit Report
Audit #: 13-1694
Provider ID # [REDACTED]
FEIN: [REDACTED]
NPI #: [REDACTED]

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Rochester General Hospital" (Provider) paid claims for Outpatient Clinic/Emergency Room (ER) and Ordered Ambulatory – Other Than Laboratory services covering the period April 1, 2007, through November 30, 2008.

In the attached final audit report, the OMIG has detailed our scope, procedures, laws, regulations, rules and policies, sampling technique, findings, provider rights, and statistical analysis.

The OMIG has attached the sample detail for the paid claims determined to be in error. This final audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report dated August 28, 2014. The adjusted mean point estimate overpaid is \$43,033. The adjusted lower confidence limit of the amount overpaid is \$19,607. We are 95% certain that the actual amount of the overpayment is greater than the adjusted lower confidence limit. This audit may be settled through repayment of the adjusted lower confidence limit of \$19,607.

[REDACTED]
Page 2
October 21, 2014

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED] or through email at [REDACTED]. Please refer to report number 13-1694 in all correspondence.

Sincerely, [REDACTED]

[REDACTED]
Division of Medicaid Audit, Rochester Office
Office of the Medicaid Inspector General

[REDACTED]
Enclosure

CERTIFIED MAIL [REDACTED]
RETURN RECEIPT REQUESTED

Ver-1.0

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve 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.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to assess compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to assess the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

DIVISION OF MEDICAID INVESTIGATIONS

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and state governments jointly fund and administer the Medicaid program. In New York State, the Department of Health (DOH) administers the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

Hospital outpatient services are provided by hospitals licensed under Article 28 of the NYS Public Health Law and certified by the NYS Department of Health to provide preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished by or under the direction of a physician. The outpatient department must comply with all applicable provisions of State law. Hospital outpatient departments may provide those necessary medical, surgical, and rehabilitative services and items authorized by their operating certificates. In addition, hospitals may provide ambulatory services upon the order of a qualified physician, nurse practitioner, physician's assistant, dentist or podiatrist to diagnose or treat a patient or test a specimen taken from a patient. The specific standards and criteria for outpatient department services are principally found in various parts of 10 NYCRR Chapter V and 18 NYCRR Chapter II, as well as the separate MMIS provider manual for each type of service: Clinic and Ordered Ambulatory services.

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for Outpatient Clinic/ER and Ordered Ambulatory – Other Than Laboratory services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to Outpatient Clinic/ER and Ordered Ambulatory – Other Than Laboratory services, this audit covered services paid by Medicaid from April 1, 2007, through November 30, 2008. The outpatient clinic area includes emergency room, outpatient clinic and ambulatory surgery services. The ordered ambulatory-other than laboratory area includes radiology, cardiology, pulmonary, therapies and other services.

**ORDERED AMBULATORY – OTHER THAN LABORATORY
SUMMARY OF FINDINGS**

We inspected a random sample of 100 services with \$6,745.09 in Medicaid payments. Of the 100 services in our random sample, 18 services had at least one error and did not comply with state requirements. Of the 18 noncompliant services, some contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
No Written Order	9
Incorrect Ordering Provider on Claim	6
Ordered Ambulatory Service Billed for Article 28 Facility Patient	3
Missing Documentation of Service	2
Service Ordered from a PAC Visit	1

Based on the procedures performed, the OMIG has determined that the Provider was overpaid \$436.04 in sample overpayments for the Ordered Ambulatory – Other Than Laboratory area with an extrapolated adjusted point estimate of \$43,033. The adjusted lower confidence limit of the amount overpaid is \$19,607.

There were minimal findings in the Outpatient Clinic Services area which did not meet the threshold to continue that part of the audit.

TABLE OF CONTENTS

	<u>PAGE</u>
INTRODUCTION.	1
Background	1
Medicaid Program	1
New York State’s Medicaid Program	1
New York State’s Outpatient Clinic/ER and Ordered Ambulatory – Other Than Laboratory Program	1
Purpose, Scope, and Methodology	1
Purpose	1
Scope	2
Methodology	2-3
LAWS, REGULATIONS, RULES AND POLICIES	4-5
AUDIT FINDINGS.	6
FINDINGS DETAIL.	7-9
PROVIDER RIGHTS.	10-11
REMITTANCE ADVICE	
ATTACHMENTS:	
A SAMPLE DESIGN	
B SAMPLE RESULTS AND ESTIMATES	
C DETAILED AUDIT FINDINGS – Ordered Ambulatory – Other Than Laboratory	
D BRIDGE SCHEDULE	

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including Outpatient Clinic/ER and Ordered Ambulatory – Other Than Laboratory services claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

New York State's Outpatient Clinic and Ordered Ambulatory – Other Than Laboratory Services Program

Hospital outpatient services are provided by hospitals licensed under Article 28 of the NYS Public Health Law and certified by the NYS Department of Health to provide preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished by or under the direction of a physician. The outpatient department must comply with all applicable provisions of State law. Hospital outpatient departments may provide those necessary medical, surgical, and rehabilitative services and items authorized by their operating certificates. In addition, hospitals may provide ambulatory services upon the order of a qualified physician, nurse practitioner, physician's assistant, dentist or podiatrist to diagnose or treat a patient or test a specimen taken from a patient. The specific standards and criteria for outpatient department services are principally found in various parts of 10 NYCRR Chapter V and 18 NYCRR Chapter II, as well as the separate MMIS provider manual for each type of service: Clinic and Ordered Ambulatory.

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for Outpatient Clinic/ER and Ordered Ambulatory – Other Than Laboratory services complied with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- the all inclusive rate was correctly billed;
- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations;
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals; and
- no duplicate payments were made.

Scope

Our audit period covered payments to the Provider for Outpatient Clinic/ER and Ordered Ambulatory – Other Than Laboratory services paid by Medicaid from April 1, 2007, through November 30, 2008. Universe and sample information is as follows:

<u>Category of Service</u>	<u>Sample</u>		<u>Universe</u>	
	<u>Services</u>	<u>Dollars Paid</u>	<u>Services</u>	<u>Dollars Paid</u>
Outpatient Clinic Services (0287)	100	\$ 13,038.82	90,743	\$12,540,072.23
Ordered Ambulatory-Other than Laboratory Services (0282)	<u>100</u>	<u>6,745.09</u>	<u>15,917</u>	<u>915,687.96</u>
Totals	<u>200</u>	<u>\$ 19,783.91</u>	<u>106,660</u>	<u>\$13,455,760.19</u>

During our audit, we did not review the overall internal control structure of the Provider. Rather, we limited our internal control review to the objective of our audit.

Methodology

To accomplish our objective, we:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with the Provider's management personnel to gain an understanding of the Outpatient Clinic/ER and Ordered Ambulatory – Other Than Laboratory services program;
- ran computer programming application of claims in our data warehouse that identified paid Outpatient Clinic/ER and Ordered Ambulatory – Other Than Laboratory services claims as indicated above;
- selected a random sample of services from the population of services as indicated above; and,
- estimated the overpayment paid in the population of 15,701 services. (Adjusted for MFCU audit overlap)

For each sample selection we inspected, as available, the following:

- Medicaid electronic claim information
- Patient record, including, but not limited to:
 - Clinic/ER record
 - Radiology, cardiology, therapy orders and results
 - Medicare EOB's
- Any additional documentation deemed by the Provider necessary to substantiate the Medicaid paid claim

LAWS, REGULATIONS, RULES AND POLICIES

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

- Departments of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, Title 18 NYCRR Sections 540.6, 504.3, 540.7, 517.3 and 518.1; and Title 10 NYCRR Sections 405.10 and 441.339.
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."
18 NYCRR Section 504.3

Regulations state: "Fee-for-service providers.(1) All providers ... must prepare and maintain contemporaneous records demonstrating their right to receive payment . . . All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor ... must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department ... for audit and review."
18 NYCRR Section 517.3(b)

Regulations require that bills for medical care, services and supplies contain patient name, case number and date of service; itemization of the volume and specific types of care, services and supplies provided; the unit price and total cost of the care, services and supplies provided; and a dated certification by the provider that the care, services and supplies itemized have been in fact furnished; that the amounts listed are in fact 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 Section 540.7(a)(1)-(3) and (8)

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 Section 518.1(c)

Regulations state: "Vendor payments for medical care and other items of medical assistance shall not be made unless such care or other items of assistance have been furnished on the basis of the appropriate authorization prescribed by the rules of the board and regulations of the department."

18 NYCRR Section 540.1

Regulations state: "The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim."

18 NYCRR Section 518.3(a)

Regulations state: "The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished...."

18 NYCRR Section 518.3(b)

Regulations state: "Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record."

18 NYCRR Section 518.3(b)

AUDIT FINDINGS

This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated August 28, 2014. The attached Bridge Schedule (Attachment D) indicates any changes to the findings as a result of your response.

ORDERED AMBULATORY - OTHER THAN LABORATORY FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from April 1, 2007, through November 30, 2008, identified 18 claims with at least one error, for a total sample overpayment of \$436.04 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated August 28, 2014. Appropriate adjustments were made to the findings.

1. No Written Order

Medicaid policy states: "Ordered ambulatory services must be ordered in writing by the recipient's attending physician, nurse practitioner, physician's assistant, dentist or podiatrist who is providing direct patient care services."

*MMIS Provider Manual for Hospital Based Ordered Ambulatory
Version July 2002, Section 2.2F*

Regulations require that all practitioners' diagnostic and therapeutic orders be documented in the patient's medical record.

10 NYCRR Section 405.10(b)(2)(vi)

In 9 instances pertaining to 9 patients, there was no written order for the service billed. This finding applies to Sample #'s 110, 111, 114, 129, 136, 146, 180, 195 and 197.

2. Incorrect Ordering Provider on Claim

Regulations state: "By enrolling the provider agrees . . . that the information provided in relation to any claim for payment shall be true, accurate and complete; and to comply with the rules, regulations and official directives of the department."

18 NYCRR Section 504.3(h)(i)

Regulations further 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 Section 518.1(c)

Medicaid policy states: "Ordered ambulatory services must be ordered in writing by the recipient's attending physician, nurse practitioner, physician's assistant, dentist or podiatrist who is providing direct patient care services."

*MMIS Provider Manual for Hospital Based Ordered Ambulatory, Version July 2002
Section 2.2 F*

In 6 instances, pertaining to 6 patients, the ordering provider was not accurately identified. The ordering provider's name on the claim did not match the name of the

provider who signed the order for service. This finding applies to Sample #'s 120, 125, 160, 161, 191 and 192.

3. Ordered Ambulatory Service Billed for Article 28 Facility Patient

Regulations state: "The physical appearance of an outpatient at a hospital complex is recognized as contributing one visit regardless of the number of diagnostic and/or therapeutic services the patient receives or the number of sections (clinics), operating rooms, laboratories and treatment areas in which he/she receives them. The classification of the visit (i.e., emergency, clinic, etc.) will be determined by the first location where service is rendered."

10 NYCRR Section 441.339

Regulations further state that payments to hospitals are based on ". . . all-inclusive prospective rates for inpatient services, emergency services, clinic services and such other services for which a separate rate is deemed appropriate by the commissioner."

10 NYCRR Section 86-1.18(a)

Medicaid policy states that at the time ordered ambulatory services are prescribed, the recipient may not be under the primary care/responsibility of the Article 28 facility where the service is to be performed; and/or the ordering practitioner may not be an employee of the Article 28 facility where the service is to be performed.

*MMIS Provider Manual for Clinic, Version April 2004, Section 2.2.1H
NYS Medicaid Program Policy Guidelines Manual for Article 28 Certified Clinics
Version 2007-2, Section II*

In 3 instances pertaining to 3 patients, ordered ambulatory services were incorrectly billed for patients who were under the care of the facility. This finding applies to Sample #'s 120, 129 and 167.

4. Missing Documentation of Service

Regulations require that the Medicaid provider agrees, "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years . . . all records necessary to disclose the nature and extent of services furnished. . . ."

18 NYCRR Section 504.3(a)

Regulations also require that bills for medical care, services and supplies contain a certification that such records as are necessary to disclose fully the services provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years. These records must be furnished to the Department upon request.

18 NYCRR Section 540.7(a)(8) and Section 517.3

In 2 instances pertaining to 2 patients, the services were not documented. This finding applies to Sample #'s 114 and 199.

5. Service Ordered from a PAC Visit

Regulations state that payments to hospitals are based on “. . . all-inclusive prospective rates for inpatient services, emergency services, clinic services and such other services for which a separate rate is deemed appropriate by the commissioner.”

10 NYCRR Section 86-1.18

Regulations also state that the all-inclusive rates for PACs provide full reimbursement for all components of the visit including all ancillary services ordered.

10 NYCRR Section 86-4.37(d)

Special instructions for Preferred Primary Care Providers (PPCP) specify that the basic rates of payment for services provided by the PPCP provide full reimbursement for all ancillary services, including laboratory tests and diagnostic technologies, regardless of when the services are rendered.

*DOH Dear Administrator Letter DAL: Issued January 22, 1993
Supplemental Instructions for Preferred Primary Care Providers*

In 1 instance, an ancillary service ordered from a PAC visit was incorrectly billed to Medicaid. This finding applies to Sample # 185.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the adjusted lower confidence limit amount of \$19,607, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make 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 and be sent with the attached Remittance Advice to:


New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #13-1694
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 15% withhold after 20 days until the agreement is established.

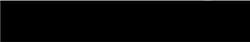
Furthermore, the OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. OMIG acceptance of the repayment agreement 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:

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 the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to recover payment and liquidate the adjusted lower confidence limit 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.

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the adjusted point estimate of \$43,033. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report 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 

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

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; and
- c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

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

NAME AND ADDRESS OF AUDITEE

**ROCHESTER GENERAL HOSPITAL
1425 PORTLAND AVENUE
ROCHESTER, NEW YORK 14621**

PROVIDER ID [REDACTED]

AUDIT #13-1694

AMOUNT DUE: \$19,607

AUDIT	<input checked="" type="checkbox"/>	PROVIDER
	<input type="checkbox"/>	RATE
TYPE	<input type="checkbox"/>	PART B
	<input 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 Number on your check.
4. Mail check to:

[REDACTED]
**New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #13-1694
Albany, New York 12237**

Thank you for your cooperation.

SAMPLE DESIGN

The sample design used for Audit #13-1694 was as follows:

- Universe - Medicaid claims for Outpatient Clinic/ER and Ordered Ambulatory – Other than Laboratory services paid during the period April 1, 2007, through November 30, 2008.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for Outpatient Clinic/ER and Ordered Ambulatory – Other than Laboratory services paid during the period April 1, 2007, through November 30, 2008.
- Sample Unit - The sample unit is a Medicaid claim paid during the period April 1, 2007, through November 30, 2008.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – There are 2 samples totaling 200 services (100 Outpatient Clinic/ER services and 100 Ordered Ambulatory – Other than Laboratory services).

SAMPLE RESULTS AND ESTIMATES

	Ordered Ambulatory Other-Than Laboratory Services (0282)
<u>Audit Statistics</u>	
Universe Size (Adjusted for MFCU audit overlap)	15,701
Sample Size	100
Sample Value	\$ 6,745.09
Sample Overpayments	\$ 436.04
Net Financial Error Rate	6.5%
Confidence Level	90%
<u>Extrapolation of Sample Findings</u>	
Sample Overpayments	\$ 436.04
Less Overpayments Not Extrapolated*	<u>(163)</u>
Sample Overpayments for Extrapolation Purposes	\$ 273.04
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	\$ 2.7304
Universe Size	15,701
Point Estimate of Total Dollars	\$ 42,870
Add Overpayments Not Extrapolated*	<u>\$ 163</u>
Adjusted Point Estimate of Total Dollars	<u>\$ 43,033</u>
Lower Confidence Limit	\$ 19,444
Add Overpayments Not Extrapolated*	<u>\$ 163</u>
Adjusted Lower Confidence Limit	<u>\$ 19,607</u>

* The actual dollar disallowance for the following finding was subtracted from the total sample overpayment and added to the Point Estimate and Lower Confidence Limit:

- **Finding #2 – Incorrect Ordering Provider on Claim**

The dollar disallowance associated with this finding was not used in the extrapolation. However, this does not apply if an extrapolated finding was also identified for a sampled claim.

OFFICE OF THE MEDICAID INSPECTOR GENERAL
ROCHESTER GENERAL HOSPITAL
REVIEW OF HOSPITAL OUTPATIENT DEPARTMENT SERVICES
PROJECT NUMBER: 13-1694
REVIEW PERIOD: 4/1/2007 - 11/30/2008

Sample Number	Date of Service	Procedure Code		Amount		Over Payment		DETAILED AUDIT FINDINGS					
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. No Written Order	2. Incorrect Ordering Provider on Claim	3. Ordered Ambulatory Service Billed for Article 28 Facility Patient	4. Missing Documentation of Service	5. Service Ordered from a PAC Visit	
101	06/12/08	97530	97530	\$ 2.35	\$ 2.35	\$ -	\$ -						
102	12/28/05	90781	90781	10.00	\$ 10.00	-	-						
103	10/23/07	78464	78464	93.68	\$ 93.68	-	-						
104	07/24/07	97530	97530	2.35	\$ 2.35	-	-						
105	01/05/06	97530	97530	3.65	\$ 3.65	-	-						
106	10/09/08	97530	97530	2.35	\$ 2.35	-	-						
107	10/24/06	90471	90471	3.92	\$ 3.92	-	-						
108	02/29/08	77413	77413	22.33	\$ 22.33	-	-						
109	05/27/08	74000	74000	6.00	\$ 6.00	-	-						
110	10/11/06	76805	-	32.00	\$ -	32.00	-	X					
111	11/30/06	94720	-	21.57	\$ -	21.57	-	X					
112	01/14/08	77417	77417	5.94	\$ 5.94	-	-						
113	11/08/07	J2469	J2469	334.80	\$ 334.80	-	-						
114	05/22/08	76512	-	35.35	\$ -	35.35	-	X			X		
115	04/14/08	77413	77413	31.28	\$ 31.28	-	-						
116	02/18/08	J1100	J1100	0.18	\$ 0.18	-	-						
117	09/22/06	76830	76830	36.00	\$ 36.00	-	-						
118	11/27/07	J0882	J0882	135.60	\$ 135.60	-	-						
119	10/25/07	94060	94060	21.54	\$ 21.54	-	-						
120	10/09/07	76830	-	35.00	\$ -	35.00	-		X	X			
121	02/25/08	77417	77417	51.84	\$ 51.84	-	-						
122	05/25/05	J9181	J9181	46.16	\$ 46.16	-	-						
123	08/22/07	97530	97530	2.35	\$ 2.35	-	-						
124	09/25/08	97530	97530	2.35	\$ 2.35	-	-						
125	06/20/07	94720	-	30.00	\$ -	-	30.00		X				

OFFICE OF THE MEDICAID INSPECTOR GENERAL
ROCHESTER GENERAL HOSPITAL
REVIEW OF HOSPITAL OUTPATIENT DEPARTMENT SERVICES
PROJECT NUMBER: 13-1694
REVIEW PERIOD: 4/1/2007 - 11/30/2008

Sample Number	Date of Service	Procedure Code		Amount		Over Payment		DETAILED AUDIT FINDINGS					
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. No Written Order	2. Incorrect Ordering Provider on Claim	3. Ordered Ambulatory Service Billed for Article 28 Facility Patient	4. Missing Documentation of Service	5. Service Ordered from a PAC Visit	
126	01/09/07	77413	77413	\$ 24.93	\$ 24.93	\$ -	\$ -						
127	07/08/05	93017	93017	32.76	\$ 32.76	-	-						
128	05/01/08	73562	73562	13.40	\$ 13.40	-	-						
129	10/22/07	76827	-	14.00	\$ -	14.00	-	X		X			
130	03/19/07	97110	97110	20.34	\$ 20.34	-	-						
131	12/03/07	97530	97530	4.70	\$ 4.70	-	-						
132	05/25/07	77413	77413	39.15	\$ 39.15	-	-						
133	08/02/06	71010	71010	6.00	\$ 6.00	-	-						
134	07/01/05	78465	78465	161.27	\$ 161.27	-	-						
135	09/05/07	93005	93005	7.50	\$ 7.50	-	-						
136	03/04/08	97530	-	2.35	\$ -	2.35	-	X					
137	08/04/08	97530	97530	2.35	\$ 2.35	-	-						
138	07/21/08	71010	71010	6.00	\$ 6.00	-	-						
139	03/16/07	J0886	J0886	39.15	\$ 39.15	-	-						
140	05/02/07	77413	77413	37.22	\$ 37.22	-	-						
141	07/23/07	77413	77413	24.93	\$ 24.93	-	-						
142	06/18/07	97110	97110	20.34	\$ 20.34	-	-						
143	01/05/07	72100	72100	7.25	\$ 7.25	-	-						
144	11/27/07	93798	93798	13.11	\$ 13.11	-	-						
145	06/01/07	97110	97110	40.68	\$ 40.68	-	-						
146	02/26/08	97110	-	10.32	\$ -	10.32	-	X					
147	05/28/07	J0886	J0886	70.47	\$ 70.47	-	-						
148	02/13/06	36430	36430	40.57	\$ 40.57	-	-						
149	09/30/05	97530	97530	15.81	\$ 15.81	-	-						
150	02/06/08	97530	97530	4.70	\$ 4.70	-	-						

OFFICE OF THE MEDICAID INSPECTOR GENERAL
ROCHESTER GENERAL HOSPITAL
REVIEW OF HOSPITAL OUTPATIENT DEPARTMENT SERVICES
PROJECT NUMBER: 13-1694
REVIEW PERIOD: 4/1/2007 - 11/30/2008

Sample Number	Date of Service	Procedure Code		Amount		Over Payment		DETAILED AUDIT FINDINGS					
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. No Written Order	2. Incorrect Ordering Provider on Claim	3. Ordered Ambulatory Service Billed for Article 28 Facility Patient	4. Missing Documentation of Service	5. Service Ordered from a PAC Visit	
151	06/11/07	86580	86580	\$ 2.12	\$ 2.12	\$ -	\$ -						
152	04/15/08	J9185	J9185	368.01	\$ 368.01	-	-						
153	04/25/07	77417	77417	7.18	\$ 7.18	-	-						
154	01/11/06	J1745	J1745	452.65	\$ 452.65	-	-						
155	05/14/08	G0283	G0283	3.72	\$ 3.72	-	-						
156	05/14/07	97530	97530	2.35	\$ 2.35	-	-						
157	08/15/08	J2469	J2469	169.90	\$ 169.90	-	-						
158	03/21/07	97530	97530	2.35	\$ 2.35	-	-						
159	10/24/08	90767	90767	5.00	\$ 5.00	-	-						
160	07/10/07	71270	-	90.84	\$ -	-	90.84		X				
161	11/06/07	97110	-	5.08	\$ -	-	5.08		X				
162	12/05/07	97110	97110	10.17	\$ 10.17	-	-						
163	07/14/08	94060	94060	21.29	\$ 21.29	-	-						
164	03/22/07	97110	97110	10.17	\$ 10.17	-	-						
165	03/27/07	77413	77413	37.22	\$ 37.22	-	-						
166	04/16/07	J0886	J0886	31.32	\$ 31.32	-	-						
167	07/12/07	76805	-	32.00	\$ -	32.00	-			X			
168	08/09/07	97530	97530	11.20	\$ 11.20	-	-						
169	06/10/08	97530	97530	2.35	\$ 2.35	-	-						
170	03/16/07	J1745	J1745	2,485.20	\$ 2,485.20	-	-						
171	05/24/07	90761	90761	10.00	\$ 10.00	-	-						
172	11/20/07	J0886	J0886	39.15	\$ 39.15	-	-						
173	10/24/06	93307	93307	71.62	\$ 71.62	-	-						
174	01/08/08	J9360	J9360	4.80	\$ 4.80	-	-						
175	04/07/08	77413	77413	37.22	\$ 37.22	-	-						

OFFICE OF THE MEDICAID INSPECTOR GENERAL
ROCHESTER GENERAL HOSPITAL
REVIEW OF HOSPITAL OUTPATIENT DEPARTMENT SERVICES
PROJECT NUMBER: 13-1694
REVIEW PERIOD: 4/1/2007 - 11/30/2008

Sample Number	Date of Service	Procedure Code		Amount		Over Payment		DETAILED AUDIT FINDINGS					
		Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. No Written Order	2. Incorrect Ordering Provider on Claim	3. Ordered Ambulatory Service Billed for Article 28 Facility Patient	4. Missing Documentation of Service	5. Service Ordered from a PAC Visit	
176	03/05/08	93971	93971	\$ 78.83	\$ 78.83	\$ -	\$ -						
177	10/30/06	76075	76075	12.77	\$ 12.77	-	-						
178	09/25/07	J9040	J9040	250.52	\$ 250.52	-	-						
179	04/02/08	77418	77418	64.02	\$ 64.02	-	-						
180	09/11/07	97530	-	2.35	\$ -	2.35	-	X					
181	11/14/07	97530	97530	4.70	\$ 4.70	-	-						
182	07/30/07	77290	77290	85.46	\$ 85.46	-	-						
183	05/31/07	97530	97530	4.70	\$ 4.70	-	-						
184	12/28/07	J2469	J2469	169.90	\$ 169.90	-	-						
185	04/25/08	72220	-	8.00	\$ -	8.00	-						X
186	11/06/07	J9360	J9360	36.00	\$ 36.00	-	-						
187	01/24/08	J0886	J0886	23.49	\$ 23.49	-	-						
188	02/19/07	J0886	J0886	15.66	\$ 15.66	-	-						
189	01/09/08	J0886	J0886	39.15	\$ 39.15	-	-						
190	12/13/06	97110	97110	10.78	\$ 10.78	-	-						
191	01/10/08	76856	-	32.00	\$ -	-	32.00		X				
192	02/14/07	97110	-	5.08	\$ -	-	5.08		X				
193	10/11/07	77334	77334	54.81	\$ 54.81	-	-						
194	02/08/08	77418	77418	62.81	\$ 62.81	-	-						
195	04/04/06	97110	-	16.17	\$ -	16.17	-	X					
196	09/29/05	77417	77417	5.47	\$ 5.47	-	-						
197	11/17/05	73610	-	55.67	\$ -	55.67	-	X					
198	12/16/05	71020	71020	8.00	\$ 8.00	-	-						
199	12/07/05	97530	-	8.26	\$ -	8.26	-				X		
200	05/23/07	90649	90649	149.69	\$ 149.69	-	-						
Totals				\$ 6,745.09	\$ 6,309.05	\$ 273.04	\$ 163.00	9	6	3	2	1	

ATTACHMENT D

FINAL DISPOSITION FOR SAMPLED SELECTIONS CHANGED FROM DRAFT TO FINAL AUDIT REPORT

ROCHESTER GENERAL HOSPITAL
HOSPITAL OUTPATIENT SERVICES AUDIT
AUDIT #13-1694
AUDIT PERIOD: 04/01/07 - 11/30/08

BRIDGE SCHEDULE

<u>SAMPLE #</u>	<u>FINDING</u>	<u>DRAFT REPORT AMOUNT DISALLOWED</u>	<u>FINAL REPORT AMOUNT DISALLOWED</u>	<u>CHANGE</u>
190	MISSING DOCUMENTATION OF SERVICE	\$10.78	\$0.00	(\$10.78)
	TOTALS	<u>\$10.78</u>	<u>\$0.00</u>	<u>(\$10.78)</u>

Note: The adjustments shown above only reflect those that were revised as a result of the provider's response. All other financial adjustments remain the same as shown in the Draft Audit Report.