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

REVIEW OF ROME MEMORIAL HOSPITAL CLAIMS FOR NEWBORN BIRTH SERVICES PAID FROM JANUARY 1 2005 – DECEMBER 31, 2007

FINAL AUDIT REPORT

James G. Sheehan
Medicaid Inspector General

September 3, 2010

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

DAVID A. PATERSON
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

September 3, 2010

[redacted]
Rome Memorial Hospital
1500 N James Street
Rome, NY 13440

Re: Final Audit Report
Audit #09-1236

Dear [redacted]

Enclosed is the Office of the Medicaid Inspector General ("OMIG") final audit report entitled "Review of Rome Memorial Hospital" (the "Facility") paid claims for newborn birth services covering the period January 1, 2005 through December 31, 2007. 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.

After reviewing the Facility's written response to the OMIG's February 5, 2009 draft report, the OMIG has reduced the draft report disallowances of $3,143.43 to $0 in the final report. A detailed explanation of the revision is included in the final report.

If the Facility has any questions or comments concerning this report, please contact [redacted] at [redacted] or through email at [redacted] Please refer to audit number 09-1236 in all correspondence.

Sincerely,

[redacted]

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

CERTIFIED MAIL #[redacted]
RETURN RECEIPT REQUESTED

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.state.ny.us

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 ensure 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 ensure 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.

TABLE OF CONTENTS

	PAGE
INTRODUCTION.	
Background	
Medicaid Program	1
New York State's Medicaid Program	1
Objective and Scope	
Objective	2
Scope	2
LAWS, REGULATIONS, RULES AND POLICIES.	2-3
DETAILED FINDINGS.	4
ATTACHMENTS:	
I – Provider Response to Draft Report	
II – OMIG Analysis of Contested Claims	

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 newborn birth 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 directed at ensuring provider compliance 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.

OBJECTIVE AND SCOPE

Objective

The objective of our audit was to ensure Rome Memorial Hospital ("the Facility") compliance with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- the Facility sought reimbursement from liable third parties;
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

Scope

A review of the Medicaid payments made to the Facility related to newborn birth services from January 1, 2005 through December 31, 2007 was completed. The audit identified instances where both, the Facility received a fee for service Medicaid payment while the newborn was enrolled in Managed Care and the Managed Care Organization ("MCO") received a supplemental newborn capitation payment; indicating the hospital was either eligible for or did receive a payment from the MCO related to the newborn's birth.

LAWS, REGULATIONS, RULES AND POLICIES

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

- Department 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 ("MMIS") and eMedNY Provider Manual.

- Specifically, 18 NYCRR §540.6 and §515.2

- 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: "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 Section 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 Section 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 Section 517.3(b)

DETAILED FINDINGS

A draft report that identified an inappropriate payment of $2,722.47 plus interest of $420.96 was issued to the Facility on February 5, 2009 for services rendered to a newborn during a period which the newborn was enrolled in a Managed Care Plan. The Facility's written response (Attachment I) to the draft report stated that the Facility received a MCO payment denial for the beneficiary identified in the draft report (recipient ID [redacted]. After verifying that the Facility received a payment denial for this beneficiary, that the MCO did not receive a monthly capitated payment, and the MCO voided the supplemental newborn capitation payment subsequent to the issuance of our draft report, the OMIG is closing the above referenced audit with no findings. No further action is required by the Facility in relation to this audit.