



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

May 22, 2008

Report Number A-02-04-01006

Richard F. Daines, M.D.
Commissioner
New York State Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Dr. Daines:

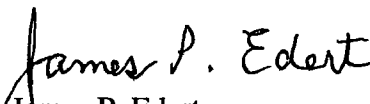
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Medicaid Services Provided on the Day of Admission to an Inpatient Hospital or During an Inpatient Hospital Stay in New York State." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please do not hesitate to call me or contact James C. Cox, Audit Manager, at (518) 437-9390, extension 222 or through e-mail at James.Cox@oig.hhs.gov. Please refer to report number A-02-04-01006 in all correspondence.

Sincerely,


James P. Edert
Regional Inspector General
for Audit services

Enclosure

Direct Reply to HHS Action Official:

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cc:

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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID SERVICES
PROVIDED ON THE DAY OF
ADMISSION TO AN INPATIENT
HOSPITAL OR DURING AN
INPATIENT STAY IN
NEW YORK STATE**



Daniel R. Levinson
Inspector General

May 2008
A-02-04-01006

Office of Inspector General

<http://oig.hhs.gov>

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

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. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan.

In New York State, the Department of Health operates the Medicaid program. Within the Department of Health, the Office of Medicaid Management administers the program. The Department of Health uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

Pursuant to the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) Title 10, Section 86-1.18 and the New York Medicaid State Plan (effective August 1, 1991), Medicaid claims for inpatient hospital care are paid at an all-inclusive rate. This rate includes the cost of services, including ancillary services, furnished to each beneficiary during a single hospital stay. Pursuant to NYCRR Title 10, Section 441.32, these ancillary services are defined as:

Diagnostic or therapeutic services performed by specific facility departments as distinguished from general or routine patient care such as room and board.
Ancillary services generally are those special services for which charges are customarily made in addition to routine charges and include such services as laboratory, radiology, surgical services, etc.

The State's MMIS Provider Manual also states that Medicaid reimbursement is limited to the hospital's inpatient rate if a beneficiary received services in a hospital's emergency room or outpatient clinic immediately preceding an admission to the same hospital on the same day. For the ancillary service to be considered part of the inpatient rate, the beneficiary had to be admitted with a related diagnosis to the hospital with the same Medicaid provider number as the service provider.

OBJECTIVE

Our objective was to determine whether New York State separately reimbursed Medicaid providers for ancillary services provided either during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital. Our audit included inpatient admissions during the period October 1, 2000, through September 30, 2002.

SUMMARY OF FINDINGS

Of the 196 ancillary services in our sample, New York separately reimbursed Medicaid providers for 138 ancillary services provided either during a beneficiary's inpatient hospital stay or on the

day of a beneficiary's admission to an inpatient hospital. Of these 138 services, 77 payments were recouped by the State through its postpayment review process. However, the remaining 61 payments were not recouped by the State. As a result, we estimated that \$293,256 (\$146,616 Federal share) was improperly paid by the State and not recouped.

This overpayment occurred because (1) MMIS prepayment edit routines did not identify separately billed ancillary services provided either during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital, and (2) the postpayment review process did not identify all separately billed ancillary services.

RECOMMENDATIONS

We recommend that the State:

1. refund \$146,616 to the Federal Government, and
2. improve its internal controls to preclude Medicaid payments for ancillary services provided during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital.

STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its February 5, 2008, comments on our draft report, the State indicated that it did not agree with our first recommendation. The State commented that the U.S. Department of Health and Human Services, Office of Inspector General (OIG) incorrectly classified all claims billed in addition to an inpatient claim as an ancillary service, including clinic and emergency room claims. The State also disputed the OIG findings because only 11 of the 61 questioned claims had an inpatient provider number which matched the Medicaid provider number of the provider performing the ancillary service. Therefore, the State concluded that the majority of claims in the OIG sample were appropriate. Regarding our second recommendation, the State generally agreed and indicated that it has developed two edits in its MMIS to edit across service type and report when ancillary services have already been paid for dates of service during the inpatient admission. This report would then be used to target inappropriately billed ancillary services. The State's comments are included in their entirety as Appendix C.

Contrary to the State's comments, the inpatient provider number for 13 of the 61 questioned claims matched the Medicaid provider number of the provider performing the ancillary service. We questioned the remaining 48 claims because the ancillary service was provided during an inpatient stay. Pursuant to NYCRR Title 10, Section 86-1.18 and the New York Medicaid State Plan (effective August 1, 1991), Medicaid claims for inpatient hospital care are paid at an all-inclusive rate. This rate includes the cost of ancillary services furnished to a beneficiary during an inpatient hospital stay. As a result, we continue to believe that the 61 services identified by our review are unallowable because the costs of these services were included in the inpatient hospital reimbursement rate. Although the State indicated it has developed two edits to address our second recommendation, we did not test these edits as part of this audit.

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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. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan.

In New York State, the Department of Health operates the Medicaid program. Within the Department of Health, the Office of Medicaid Management administers the program. The Department of Health uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

Ancillary Medical Services

Pursuant to the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) Title 10, Section 86-1.18 and the New York Medicaid State Plan (effective August 1, 1991), Medicaid claims for inpatient hospital care are paid at an all-inclusive rate. This rate includes the cost of services, including ancillary services, furnished to each beneficiary during a single hospital stay. Pursuant to NYCRR Title 10, Section 441.32, ancillary services are defined as:

Diagnostic or therapeutic services performed by specific facility departments as distinguished from general or routine patient care such as room and board.

Ancillary services generally are those special services for which charges are customarily made in addition to routine charges and include such services as laboratory, radiology, surgical services, etc.

In addition, the State's MMIS Provider Manual states that Medicaid reimbursement is limited to the hospital's inpatient rate if a beneficiary receives services in a hospital's emergency room or outpatient clinic immediately preceding an admission to the same hospital on the same day. For the ancillary service to be considered part of the inpatient rate, the beneficiary had to be admitted with a related diagnosis to the hospital with the same Medicaid provider number as the service provider.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

Our objective was to determine whether New York State separately reimbursed Medicaid providers for ancillary services provided either during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital.

Scope

Our review covered inpatient hospital stays during the period October 1, 2000, through September 30, 2002. We did not review the overall internal control structure of the State or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective. We did not review the claims in our sample for compliance with other Medicaid requirements for reimbursement.

We performed fieldwork at the State Department of Health in Albany, New York; the State MMIS fiscal agent in Menands and Rensselaer, New York; and at seven hospitals throughout New York State.

Methodology

To accomplish our objective, we:

- reviewed applicable State laws, regulations, guidance, and the New York State plan;
- held discussions with State officials to identify State policies, procedures, and guidance for payment of ancillary services provided either during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital;
- held discussions with State officials to identify prepayment and postpayment controls;
- identified specific procedure codes for laboratory and referred ambulatory claims, and clinic rate codes that should have been included in the inpatient hospital payment;¹
- ran computer programming applications at the MMIS fiscal agent, which identified a sampling frame of 65,804 Medicaid inpatient hospital stays for which an ancillary service was provided to a beneficiary, either during an inpatient stay or on the day of admission to an inpatient hospital. Within these inpatient stays, we identified 91,659 ancillary services totaling \$7,884,002 (\$3,936,513 Federal share);
- selected a stratified random sample of 105 Medicaid inpatient hospital stays from the population of 65,804 hospital stays;
- reviewed medical records from hospital providers supporting the 105 sampled items to determine whether New York State improperly reimbursed Medicaid providers for ancillary services provided either during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital;
- determined whether overpayments identified in our review were recouped by the State through its postpayment review process;

¹The rate codes identified were 1602 (Clinic Follow-up Prenatal Care Visit), 1610 (All Inclusive), 2870 (Outpatient Department), 2879 (Emergency Room Visit), and 3102 (Hospital-Based Follow-up Prenatal Care Visit).

- estimated the dollar impact of the improper Federal funding claimed by the State.

Appendix A contains details on our sample design and methodology, and Appendix B contains our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Of the 196 ancillary services in our sample, New York separately reimbursed Medicaid providers for 138 ancillary services provided either during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital. Of these 138 services, 77 payments were recouped by the State through its postpayment review process. However, the remaining 61 payments were not recouped by the State. As a result, we estimated that \$293,256 (\$146,616 Federal share) was improperly paid and not recouped during our audit period.

This overpayment occurred because the (1) the MMIS prepayment edit routines did not identify separately billed ancillary services provided either during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital, and (2) the postpayment review process was not totally effective in identifying separately billed ancillary services.

IMPROPER ANCILLARY SERVICES PAYMENTS

Pursuant to NYCRR Title 10, Section 86-1.18 and the New York Medicaid State Plan (effective August 1, 1991), Medicaid claims for inpatient hospital care are paid at an all-inclusive rate. This rate includes the cost of services, including ancillary services, furnished to each beneficiary during a single hospital stay. The State's MMIS Provider Manual also states that Medicaid reimbursement is limited to the hospital's inpatient rate if a beneficiary receives services in a hospital's emergency room or outpatient clinic immediately preceding an admission to the same hospital on the same day. For these ancillary services to be considered part of the inpatient rate, the beneficiary had to be admitted, with a related diagnosis, to the hospital with the same Medicaid provider number as the service provider.²

Contrary to Medicaid requirements, in 138 of the 196 sampled ancillary services, medical records showed that the service was separately reimbursed even though it was provided either during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital. The ancillary service was rendered by a provider with the same Medicaid provider number as the inpatient hospital for 89 of 138 services.

Of these 138 services, 77 payments were recouped by the State through its postpayment review process. However, the remaining 61 payments were not recouped by the State. As a result, we

²Payments were also not in error if they went toward the Medicare inpatient deductible.

estimated that \$293,256 (\$146,616 Federal share) was improperly paid and not recouped by the State for ancillary services provided during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital.

INTERNAL CONTROLS WERE NOT ADEQUATE

The State did not have a prepayment edit to detect separately billed ancillary services. Rather it relied upon a postpayment review process. Of the 138 services we identified as overpayments, 77 payments were recouped by the State through its postpayment review process. However, the postpayment process was not adequate, since the remaining 61 overpayments were not identified and recouped by the State.

Specifically, the postpayment routines did not:

- identify ancillary services provided to a beneficiary while the beneficiary was an inpatient of a different Diagnosis Related Group-exempt hospital;
- include the date of admission when matching laboratory and referred ambulatory services to inpatient hospital claims;
- include the date of discharge when matching clinic, laboratory, and referred ambulatory services to inpatient hospital claims;
- identify correctly the first and last day of a month as dates of admission and discharge, respectively, if the inpatient hospital claim covered multiple months; and
- identify ancillary services billed subsequent to the computer programming match performed by the State.

RECOMMENDATIONS

We recommend that the State:

1. refund \$146,616 to the Federal Government, and
2. improve its internal controls to preclude Medicaid payments for ancillary services provided during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital.

STATE COMMENTS

In its February 5, 2008, comments on our draft report, the State indicated that it did not agree with our first recommendation. The State commented that the U.S. Department of Health and Human Services, Office of Inspector General (OIG) incorrectly classified all claims billed in addition to an inpatient claim as an ancillary service, including clinic and emergency room claims. The State also disputed the OIG findings because only 11 of the 61 questioned claims

had an inpatient provider number which matched the Medicaid provider number of the provider performing the ancillary service. Therefore, the State concluded that the majority of claims in the OIG sample were appropriate.

Regarding our second recommendation, the State generally agreed and indicated that it has developed two edits in its MMIS to edit across service type and report when ancillary services have already been paid for dates of service during the inpatient admission. This report would then be used to target inappropriately billed ancillary services.

The State's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

Contrary to the State's comments, the inpatient provider number for 13 of the 61 questioned claims matched the Medicaid provider number of the provider performing the ancillary service. We questioned the remaining 48 claims because the ancillary service was provided during an inpatient stay. Pursuant to NYCRR Title 10, Section 86-1.18 and the New York Medicaid State Plan (effective August 1, 1991), Medicaid claims for inpatient hospital care are paid at an all-inclusive rate. This rate includes the cost of ancillary services furnished to a beneficiary during an inpatient hospital stay. As a result, we continue to believe that the 61 services identified by our review are unallowable because the costs of these services were included in the inpatient hospital reimbursement rate.

Although the State indicated it has developed two edits to address our second recommendation, we did not test these edits as part of this audit.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine whether New York State separately reimbursed Medicaid providers for ancillary services provided either during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital.

POPULATION

The population consisted of inpatient hospital stays for Medicaid-eligible beneficiaries who received laboratory, clinic or referred ambulatory services, either during an inpatient stay or on the day of admission to an inpatient hospital. The clinic services reviewed were limited to the following five rate codes:

- 1602 – Clinic Follow-up Prenatal Care Visit,
- 1610 – All Inclusive,
- 2870 – Outpatient Department,
- 2879 – Emergency Room Visit, and
- 3102 – Hospital-Based Follow-up Prenatal Care Visit.

These ancillary services were provided in connection with inpatient hospital claims with a beginning service date of October 1, 2000, through September 30, 2002.

SAMPLING FRAME

The sampling frame consisted of a database containing 65,804 Medicaid inpatient stays with ancillary services furnished to a beneficiary, either during an inpatient stay or on the day of admission to an inpatient hospital. These ancillary services were provided in connection with inpatient hospital claims with a beginning service date of October 1, 2000, through September 30, 2002. There were 91,659 ancillary services totaling \$7,884,002 (\$3,936,513 Federal share) corresponding to the 65,804 inpatient stays.

SAMPLE UNIT

The sample unit was a Medicaid inpatient stay where an ancillary service was provided, either during an inpatient stay or on the day of admission to an inpatient hospital.

SAMPLE DESIGN

We used a stratified random sample to evaluate the population of Medicaid ancillary services provided during the inpatient hospital stay.

The claims were separated into three strata as follows:

- Stratum 1: ancillary service less than \$100.00, corresponding to 25,207 inpatient stays;
- Stratum 2: ancillary service between \$100.00 to \$299.99, corresponding to 37,837 inpatient stays; and
- Stratum 3: ancillary service equal to or greater than \$300.00, corresponding to 2,760 inpatient stays.

SAMPLE SIZE

We selected 35 inpatient hospital stays from each of the 3 strata, for a sample size of 105 inpatient stays.

SOURCE OF RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services statistical sampling software, RAT-STATS, dated September 2003. We used the random number generator for our stratified sample.

METHOD OF SELECTING SAMPLE ITEMS

We sequentially numbered the claims in each stratum of the sampling frame and selected 3 sets of 35 random numbers for the 3 strata. We selected the corresponding frame items and the appropriate matching ancillary services from the database of ancillary services. We then created a list of sample items.

CHARACTERISTICS TO BE MEASURED

We classified ancillary services as overpayments if:

- the service was provided during the inpatient hospital stay, or
- the service was provided by the same provider and resulted in the patient being admitted to the hospital on the same day.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate the total amount of Medicaid reimbursement for related ancillary services provided either during the inpatient stay or on the day of admission to an inpatient hospital.

SAMPLE RESULTS AND ESTIMATES

The results of our review of the 105 sampled hospital stays were as follows:

Sample Details and Results

| Population | | | | | Sample | | | Sample Errors | | |
|----------------|-------------------|------------|--------------------|------------------------------------|------------|--------------------|------------------------------------|---------------|--------------------|------------------------------------|
| Stratum Number | Stratum Range | Admissions | Ancillary Services | Ancillary Services (Federal share) | Admissions | Ancillary Services | Ancillary Services (Federal share) | Admissions | Ancillary Services | Ancillary Services (Federal share) |
| 1 | \$.01 to \$99.99 | 25,207 | 37,995 | \$645,214 | 35 | 42 | \$927 | 10 | 15 | \$116 |
| 2 | \$100 to \$299.99 | 37,837 | 46,006 | \$2,449,351 | 35 | 38 | \$2,274 | 2 | 3 | \$145 |
| 3 | \$300 and greater | 2,760 | 7,658 | \$841,948 | 35 | 116 | \$10,194 | 9 | 43 | \$2,744 |
| Total | | 65,804 | 91,659 | \$3,936,513 | 105 | 196 | \$13,395 | 21 | 61 | \$3,005 |

Estimates

(Limits Calculated for a 90-Percent Confidence Interval)

| | |
|----------------|-----------|
| Upper Limit | \$454,201 |
| Point Estimate | \$300,409 |
| Lower Limit | \$146,616 |



Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

February 5, 2008

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No. A-02-04-01006

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the Department of Health and Human Services, Office of Inspector General's draft audit report A-02-04-01006 on "Review of Medicaid Services Provided on the Day of Admission to an Inpatient Hospital or During an Inpatient Stay."

Thank you for the opportunity to comment.

Sincerely,

Wendy E. Saunders
Chief of Staff

Enclosure

cc: Stephen Abbott
Deborah Bachrach
Homer Charbonneau
Ronald Farrell
Gail Kerker
Sandra Pettinato
Robert W. Reed
Philip Seward

**New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-04-01006 on
“Review of Medicaid Services Provided
on the Day of Admission
to an Inpatient Hospital or During an Inpatient Stay”**

The following are the New York State Department of Health's comments in response to the Department of Health and Human Services, Office of Inspector General's (OIG) draft audit report A-02-04-01006 on "Review of Medicaid Services Provided on the Day of Admission to an Inpatient Hospital or During an Inpatient Stay."

Recommendation #1:

We recommend that the State refund \$146,616 to the Federal Government.

Response #1:

Both the Department and the New York State Office of the Medicaid Inspector General (OMIG) disagree with the recommendation. Review of the draft audit report and the associated claims determined the OIG incorrectly classified all claims billed in addition to an inpatient claim as an ancillary service, including clinic and emergency room claims. According to the draft audit report, "For the ancillary service to be considered part of the inpatient rate, the beneficiary had to be admitted, with a related diagnosis, to the hospital with the **same** (emphasis added) Medicaid provider number as the service provider." The OIG sampled 196 claims and concluded that 138 were for services provided to Medicaid beneficiaries who were admitted with a related diagnosis to a hospital. They further concluded that 77 of the 138 were recouped by the state and 61 were outstanding. OMIG review of these claims disputes the OIG findings; only 11 of the 61 had an inpatient provider number which matched the Medicaid provider number of the provider performing the ancillary service. Therefore, the Department and OMIG conclude the majority of the claims are appropriate.

Recommendation #2:

We recommend that the State improve its internal controls to preclude Medicaid payments for ancillary services provided during a beneficiary's inpatient hospital stay or on the day of a beneficiary's admission to an inpatient hospital.

Response #2:

Inpatient hospital claims are often submitted after the claim for the ancillary service is processed, making it difficult to systemically preclude payment for the ancillary service because the hospital admission is not known to the system at the time the ancillary

service is paid. Two eMedNY edits (edits 759 and 760) have been developed to edit across service type and report when ancillary services have already been paid for dates of service during the inpatient admission. This report would then be used by the OMIG along with other audit tools to target inappropriately billed ancillary services.