DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUL - 2 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Medicaid Claims Made by Freestanding Residential Treatment Facilities in New York State (A-02-06-01021)

Attached is an advance copy of our final report on Medicaid claims for rehabilitative services provided in freestanding residential treatment facilities in New York State. We will issue this report to the New York State Department of Health (DOH) within 5 business days.

New York State submitted State plan amendment 91-18 to the Centers for Medicare & Medicaid Services (CMS) in March 1991 to cover reimbursement for rehabilitative services provided in freestanding alcoholism residential treatment facilities. CMS's approval letter stated that any residential facility with 17 or more beds that primarily provides medical substance abuse treatment services would be considered an Institution for Mental Diseases (IMD) and that the State may not bill the Federal Medicaid program for services furnished to beneficiaries under the age of 65 who resided in these facilities. Pursuant to section 1905(a) of the Social Security Act, Federal Medicaid funding does not cover any services to residents under the age of 65 who are in an IMD except, at the State's option, inpatient psychiatric services to individuals under the age of 21 and in some cases under the age of 22.

Our objective was to determine whether DOH properly claimed Federal Medicaid reimbursement for services provided by 11 freestanding alcohol and substance abuse residential treatment facilities that meet the Medicaid definition of an IMD.

DOH improperly claimed $21,531,996 in Federal Medicaid reimbursement for services provided to beneficiaries residing in 11 freestanding alcohol and substance abuse residential treatment facilities that were IMDs. All 30 of the sampled claims were for beneficiaries from the ages of 22 through 64.

This overpayment occurred because: (1) DOH improperly designated claims with detoxification rate code 4220, submitted by nine IMDs, as eligible for Federal Medicaid reimbursement; (2) one provider (NRI Group LLC) improperly billed Medicaid for inpatient rehabilitation

services using an outpatient category-of-service code; and (3) DOH continued to improperly claim Federal Medicaid reimbursement for services furnished by one provider (Can Am Youth Services) after the provider had increased its number of beds from 15 to 30, bringing it within the Medicaid definition of an IMD.

In its comments on our draft report, DOH officials said that the State refunded $14,949,737 to the Federal Government in the CMS-64 report for the July to September 2006 quarter. We obtained documentation that verified this amount was refunded.

We recommend that DOH:

- refund the balance of the $21,531,996 overpayment, or $6,582,259, to the Federal Government;

- ensure that the control established in its Medicaid Management Information System (MMIS) to designate all claims with detoxification service rate code 4220 as federally nonparticipating is properly working;

- designate NRI Group LLC claims for inpatient rehabilitation services as federally nonparticipating in its MMIS for beneficiaries under 65 years of age;

- designate Can Am Youth Services claims as federally nonparticipating in its MMIS for beneficiaries under 65 years of age; and

- determine the amount of improper Federal Medicaid reimbursement claimed subsequent to our audit period and return these overpayments to the Federal Government.

In its comments on our draft report, DOH generally agreed with our first recommendation by indicating that it has already refunded $14,949,737 to the Federal Government and will refund the balance it determines to be outstanding. DOH fully concurred with our remaining recommendations.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through e-mail at James.Edert@oig.hhs.gov. Please refer to report number A-02-06-01021.

Attachment

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

JUL - 8 2008

Report Number: A-02-06-01021

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 Claims Made by Freestanding Residential Treatment Facilities 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG 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). Accordingly, the final report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact John Berbach, Audit Manager, at (518) 437-9390, extension 228, or through e-mail at John.Berbach@oig.hhs.gov. Please refer to report number A-02-06-01021 in all correspondence

Sincerely,

James P. Edert

James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID CLAIMS MADE BY FREESTANDING RESIDENTIAL TREATMENT FACILITIES IN NEW YORK STATE

Daniel R. Levinson
Inspector General

July 2008
A-02-06-01021

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

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 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 Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

New York State submitted State plan amendment (SPA) 91-18 to CMS in March 1991 to cover reimbursement for rehabilitative services provided in freestanding alcoholism residential treatment facilities. In a December 19, 1994, letter to the State, CMS approved SPA 91-18 with an effective date of January 1, 1991. The letter stated that the approval was granted for payment for rehabilitative services (but not room and board) furnished in alcoholism residential treatment facilities that are not Institutions for Mental Diseases (IMD).

Pursuant to section 1905(i) of the Act, an IMD is defined as a hospital, a nursing facility, or an other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. The SPA approval letter specified that any facility with 17 or more beds that primarily provides medical substance abuse treatment services would be considered an IMD. Pursuant to section 1905(a) of the Act, Federal Medicaid funding is not available for any services to residents under the age of 65 who are in an IMD except, at the State's option, inpatient psychiatric services to individuals under the age of 21 and in some cases under the age of 22. For Federal reimbursement to be available for inpatient psychiatric services to individuals under the age of 21/22, an IMD must have a provider agreement with the Medicaid program and meet the accreditation and other requirements at 42 CFR § 441.151.

In New York State, the Department of Health (DOH) is responsible for operating the Medicaid program. DOH uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims. DOH assigns various codes (for example, rate and category-of-service codes) to providers for them to claim Medicaid reimbursement via the MMIS.

OBJECTIVE

Our objective was to determine whether DOH properly claimed Federal Medicaid reimbursement for services provided by 11 freestanding alcohol and substance abuse residential treatment facilities that meet the Medicaid definition of an IMD. Our audit period covered April 1, 2001, through March 31, 2006.

SUMMARY OF FINDING

DOH improperly claimed $21,531,996 in Federal Medicaid reimbursement for services provided to beneficiaries residing in 11 freestanding alcohol and substance abuse residential treatment facilities that were IMDs. All 30 of the sampled claims were for beneficiaries from the ages of 22 through 64.

This overpayment occurred because: (1) DOH improperly designated claims with detoxification rate code 4220, submitted by nine IMDs, as eligible for Federal Medicaid reimbursement; (2) one provider (NRI Group LLC) improperly billed Medicaid for inpatient rehabilitation services using an outpatient category-of-service code; and (3) DOH continued to improperly claim Federal Medicaid reimbursement for services furnished by one provider (Can Am Youth Services) after the provider had increased its number of beds from 15 to 30, bringing it within the Medicaid definition of an IMD.

In a June 27, 2006, letter to the Office of Inspector General, a DOH official said that the ". . . facilities in question are classified as Institutions for Mental Diseases (IMDs) and cannot receive federal participation on their Medicaid services." (Emphasis in the original.) In subsequent e-mail messages, officials indicated that DOH credited $14,949,737 to the Federal Government but did not provide documentation to support that a credit was made or how the amount was determined. DOH did not respond to our three e-mail requests seeking documentation to support the credit. Thus, we were unable to verify that an appropriate credit took place. DOH officials also said that the MMIS was modified to ensure that no detoxification service claims using detoxification rate code 4220 are submitted for Federal Medicaid reimbursement. DOH provided documents indicating that this MMIS control was instituted on February 1, 2007. We did not test the output of this control as part of this audit.

RECOMMENDATIONS

We recommend that DOH:

- refund the balance of the $21,531,996 overpayment, or $6,582,259, to the Federal Government;

- ensure that the control established in its MMIS to designate all claims with detoxification service rate code 4220 as federally nonparticipating is properly working;

- designate NRI Group LLC claims for inpatient rehabilitation services as federally nonparticipating in its MMIS for beneficiaries under 65 years of age;

- designate Can Am Youth Services claims as federally nonparticipating in its MMIS for beneficiaries under 65 years of age; and

- determine the amount of improper Federal Medicaid reimbursement claimed subsequent to our audit period and return these overpayments to the Federal Government.

DEPARTMENT OF HEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its May 2, 2008, comments on our draft report, DOH generally agreed with our first recommendation. DOH indicated that it has already refunded $14,949,737 to the Federal Government in the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (CMS-64) report for the July through September 2006 quarter and will refund the balance it determines to be outstanding. We obtained documentation verifying that DOH refunded $14,949,737 to the Federal Government. DOH fully concurred with our remaining recommendations. DOH's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the 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 Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

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 Medicaid Management administers the Medicaid program. The Office of Alcoholism and Substance Abuse Services (OASAS) is a separate State agency with oversight responsibilities of inpatient and outpatient alcoholism and substance abuse providers. DOH requires an inpatient alcoholism and substance abuse provider to be certified by OASAS and in possession of an OASAS operating certificate before the provider applies for enrollment in the Medicaid program. DOH uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims. The Federal Government's share of costs is known as the Federal medical assistance percentage (FMAP). During our audit period (April 1, 2001, through March 31, 2006), the FMAP in New York was 50 or 52.95 percent.[1]

Federal Requirements

Pursuant to section 1905(i) of the Act, an Institution for Mental Diseases (IMD) is defined as a hospital, a nursing facility, or an other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. Pursuant to section 1905(a) of the Act, Federal Medicaid funding does not cover any services to residents under the

[1]The FMAP was 50 percent from April 1, 2001, through March 31, 2003; 52.95 percent from April 1, 2003, through June 30, 2004; and 50 percent from July 1, 2004, through March 31, 2006.

age of 65 who are in an IMD except, at the State's option, inpatient psychiatric services to individuals under the age of 21 and in some cases under the age of 22.[2]

State Plan Amendment 91-18

In March 1991, the New York State Department of Social Services[3] submitted to CMS State plan amendment (SPA) 91-18, entitled "Rehabilitative Services Provided in Freestanding Alcoholism Residential Treatment Facilities." In a December 19, 1994, letter to the State, CMS approved SPA 91-18 with an effective date of January 1, 1991. The CMS approval letter stated that rehabilitative services were federally reimbursable through a "carve out" of charges for rehabilitative services from room and board fees.[4] The letter further stated that any residential facility with 17 or more beds that primarily provides medical substance abuse treatment services would be considered an IMD and that the State may not bill the Federal Medicaid program for services furnished to beneficiaries under the age of 65 who resided in these facilities. Finally, the letter refers the State to Section 4390 of the "State Medicaid Manual" for additional information on IMDs.

Prior Office of Inspector General Audit Reports

The Office of Inspector General (OIG) has issued four prior audit reports related to inpatient alcoholism residential treatment facilities in New York State.[5] All four reports identified improper Federal Medicaid reimbursement received by the State and recommended financial adjustments.

[2]Medicaid regulations at 42 CFR part 441, subpart D, specify the applicable requirements if a State opts to provide inpatient psychiatric services to individuals under age 21. Pursuant to 42 CFR § 441.151 (a)(2), inpatient psychiatric services for recipients under age 21 must be provided by a psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by a psychiatric facility that is not a hospital and is accredited by JCAHO, the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children (CASFC), or any other accrediting organization with comparable standards that is recognized by the State. Pursuant to 42 CFR § 441.151 (a)(3), inpatient psychiatric services for beneficiaries under age 21 must be provided before the individual reaches age 21 or, if the individual was receiving the services immediately before he or she reached age 21, before the earlier of the following: the date the individual no longer requires the services or the date the individual reaches age 22.

[3]In 1997, the Department of Social Services was dissolved, and its functions were distributed within DOH.

[4]At the time CMS approved SPA 91-18, CMS's approval letter noted that there were only six freestanding alcoholism residential treatment facilities that were not IMDs and whose rehabilitative services could be included in claims for Federal financial participation under the SPA. We determined and State officials from DOH and OASAS confirmed that there were only three freestanding residential treatment facilities with 16 or fewer beds in operation for all or a portion of our April 1, 2001, through March 31, 2006, audit period for which SPA 91-18 applied.

[5]Report Numbers A-02-91-01030 (December 1991), A-02-91-01033 (April 1992), A-02-91-01048 (July 1992), and A-02-94-01026 (September 1995).

Medicaid Claims for Freestanding Alcohol and Substance Abuse Residential Treatment Facilities

DOH primarily assigned two rate codes (4213 and 4220) and one category-of-service code (0285) to freestanding alcohol and substance abuse residential treatment facilities for claiming Medicaid reimbursement via the MMIS.[6] For these facilities with 17 beds or more, claims for services were to be designated by DOH as federally nonparticipating.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether DOH properly claimed Federal Medicaid reimbursement for services provided by 11 freestanding alcohol and substance abuse residential treatment facilities that meet the Medicaid definition of an IMD.

Scope

Our audit period covered April 1, 2001, through March 31, 2006. We did not review the overall internal control structure of DOH or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We conducted fieldwork at DOH and OASAS in Albany, New York; the State MMIS fiscal agent in Rensselaer, New York; and freestanding alcohol and substance abuse residential treatment facilities throughout the State.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance, as well as the New York Medicaid State plan;

- held discussions with DOH and OASAS officials to identify State policies, procedures, and guidance;

- reviewed controls in the State's MMIS related to Federal Medicaid funding for claims submitted by freestanding alcohol and substance abuse residential treatment facilities;

[6]DOH assigns rate and category-of-service codes to all providers who enroll in the State's Medicaid program. When billing for Medicaid services, the providers must use these codes. During our entire audit period, the rehabilitative services rate code 4213 was in effect. The detoxification services rate code 4220 was assigned and began to be used by providers in 2004 and 2005. The category-of-service code 0285 (defined as inpatient hospital) was in effect during our entire audit period.

- conducted survey work at four freestanding alcohol and substance abuse residential treatment facilities to understand their Medicaid billing procedures;

- used computer applications to identify 72,707 Medicaid claims made by 15 freestanding alcohol and substance abuse residential treatment facilities totaling $54,038,268 ($22,802,470 Federal share);

- conducted site visits at 13 of the 15 providers[7] to determine if they were IMDs and whether they were accredited by JCAHO, CARF, CASFC, or any other accrediting organization and to review their Medicaid claiming procedures;

- eliminated from the 72,707 Medicaid claims:

    - claims from two providers that were covered by SPA 91-18 for our entire audit period;

    - one provider's claims from April 1, 2001, through December 13, 2001, that were covered by SPA 91-18 (after December 13, 2001, the provider was an IMD because it increased its beds from 15 to 30 and, therefore, SPA 91-18 did not apply);

    - claims from one provider that appeared to be for retroactive rate adjustments;

    - claims from one provider that had 16 beds and was therefore not within the Medicaid definition of an IMD;

    - claims for beneficiaries aged 65 and older at 11 providers that were IMDs;

    - claims for beneficiaries under the age of 22 at 8 providers that were accredited by JCAHO or CARF; and

    - nine claims with the inpatient alcoholism treatment rate code (4212) billed by one provider, as they were immaterial to the scope of our audit;

- determined that our population contained 64,959 claims submitted by 11 freestanding alcohol and substance abuse residential treatment facilities that were IMDs totaling $43,338,573 in Medicaid reimbursement ($21,531,996 Federal share);

- selected a simple random sample of 30 claims from the population of 64,959 claims; and

[7]Two of these fifteen providers were eliminated from our audit. The first provider was both covered by SPA 91-18 and closed prior to our site visits. The second provider had claims that appeared to be retroactive rate adjustments.

- determined through site visits to providers that the 30 sample claims were for beneficiaries who resided in an IMD who were under the age of 65 or, if the provider was accredited by JCAHO or CARF, were from the ages of 22 through 64.[8]

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 objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

DOH improperly claimed $21,531,996 in Federal Medicaid reimbursement for services provided to beneficiaries residing in 11 freestanding alcohol and substance abuse residential treatment facilities that were IMDs. All 30 of the sampled claims were for beneficiaries from the ages of 22 through 64.

IMPROPER INSTITUTION FOR MENTAL DISEASES CLAIMS

Pursuant to section 1905(a) of the Act, Federal Medicaid funding does not cover any services to residents under the age of 65 who are in an IMD except, at the State's option, inpatient psychiatric services to individuals under the age of 21 and in some cases under the age of 22.

In a June 27, 2006, letter to OIG, a DOH official said that the ". . . facilities in question are classified as Institutions for Mental Diseases (IMDs) and cannot receive federal participation on their Medicaid services." (Emphasis in the original.) In subsequent e-mail messages, officials indicated that DOH credited $14,949,737 to the Federal Government but did not provide documentation to support that a credit was made or how the amount was determined. DOH did not respond to our three e-mail requests seeking documentation to support the credit.[9] Thus, we were unable to verify that an appropriate credit took place. DOH officials also said that the MMIS was modified to ensure that no service claims using detoxification rate code 4220 are submitted for Federal Medicaid reimbursement. DOH provided documents indicating that this MMIS control was instituted on February 1, 2007. We did not test the output of this control as part of this audit.

In its May 2, 2008, comments to our draft report, DOH officials said that DOH refunded $14,949,737 to the Federal Government in the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (CMS-64) report for the July to September 2006 quarter. We obtained documentation that verified that this amount has been refunded.

[8]Based on this determination, we estimated that the entire population of Medicaid claims were improperly claimed for Federal Medicaid reimbursement.

[9]In an October 23, 2007, e-mail message, however, the DOH liaison to OIG stated that we should issue the draft audit report and that DOH would address the specifics of the credit in its comments to our draft report.

CAUSES OF UNALLOWABLE CLAIMS

We identified three main causes of the unallowable claims:

- Claims for IMD residents with detoxification rate code 4220 do not qualify for Federal financial participation. However, DOH failed to designate this code as federally nonparticipating in its MMIS when it assigned the code to nine IMDs included in our audit. As a result, DOH improperly claimed Federal Medicaid reimbursement for services claimed using this detoxification rate code.

- One provider (NRI Group LLC) improperly billed Medicaid for inpatient rehabilitation services using an outpatient category-of-service code (0287). DOH incorrectly assigned the provider two category-of-service codes for inpatient rehabilitation services: inpatient (0285—the correct code) and outpatient. The provider submitted claims using the outpatient service category for beneficiaries who were inpatients. These claims bypassed MMIS controls for detecting claims not eligible for Federal financial participation. As a result, DOH improperly claimed Federal Medicaid reimbursement.

- DOH continued to claim Federal Medicaid reimbursement for services furnished to individuals by one provider (Can Am Youth Services) after the provider increased its number of beds from 15 to 30, thus bringing it within the Medicaid definition of an IMD.

RECOMMENDATIONS

We recommend that DOH:

- refund the balance of the $21,531,996 overpayment, or $6,582,259, to the Federal Government;

- ensure that the control established in its MMIS to designate all claims with detoxification service rate code 4220 as federally nonparticipating is properly working;

- designate NRI Group LLC claims for inpatient rehabilitation services as federally nonparticipating in its MMIS for beneficiaries under 65 years of age;

- designate Can Am Youth Services claims as federally nonparticipating in its MMIS for beneficiaries under 65 years of age; and

- determine the amount of improper Federal Medicaid reimbursement claimed subsequent to our audit period and return these overpayments to the Federal Government.

DEPARTMENT OF HEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its May 2, 2008, comments on our draft report, DOH generally agreed with our first recommendation. DOH indicated that it has already refunded $14,949,737 to the Federal Government in the CMS-64 report for the July through September 2006 quarter and will refund the balance it determines to be outstanding in the CMS-64 report for January through March 2008. We obtained documentation verifying that DOH refunded $14,949,737 to the Federal Government in the CMS-64 report for July through September 2006. DOH fully concurred with our remaining recommendations. The DOH comments are included in their entirety as the Appendix.

APPENDIX

STATE OF NEW YORK
DEPARTMENT OF HEALTH
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

May 2, 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-02-06-01021

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-02-06-01021 on "Review of Medicaid Claims Made by Freestanding Residential Treatment Facilities in New York State."

Thank you for the opportunity to comment.

Sincerely,

Wendy E. Saunders
Chief of Staff

Enclosure

cc: Stephen Abbott
Deborah Bachrach
Randall Griffin
Gail Kerker
Nicholas Meister
Sandra Pettinato
Robert W. Reed
Douglas Rosenberry
Philip Seward
James Sheehan

New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-06-01021 on
"Review of Medicaid Claims Made By Freestanding Residential Treatment Facilities"

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General's draft audit report A-02-06-01021 on "Review of Medicaid Claims Made By Freestanding Residential Treatment Facilities."

Recommendation #1:

We recommend that DOH refund $21,531,996 to the Federal Government.

Response #1:

The Department has already refunded $14,949,737.49 in the CMS-64 report for July-September 2006, for claims with service dates through May 18, 2006. The Department is currently analyzing additional claim data and will refund the balance it determines remains outstanding in the CMS-64 report for January - March 2008.

Recommendation #2:

We recommend that DOH ensure that the control established in its MMIS to designate all claims with detoxification service rate code 4220 as federally nonparticipating is properly working.

Response #2:

The Department agrees and will ensure that the noted control is properly working.

Recommendation #3:

Designate NRI Group LLC claims for inpatient rehabilitation services as federally nonparticipating in its MMIS for beneficiaries under 65 years of age.

Response #3:

The Department agrees and will work with the Office of Alcoholism and Substance Abuse Services (OASAS) to implement any necessary system changes.

Recommendation #4:

Designate Can Am Youth Services claims as federally nonparticipating in its MMIS for beneficiaries under 65 years of age.

Response #4:

The Department agrees and will work with OASAS to implement any necessary system changes.

Recommendation #5:

Determine the amount of improper Federal Medicaid reimbursement claimed subsequent to our audit period and return these overpayments to the Federal Government.

Response #5:

The Department's analysis noted in Response #1 above includes claim data subsequent to the audit period, which will be included in the refund processed in the CMS-64 report for January - March 2008.