NEW YORK STATE OF OPPORTUNITY. Department of Health

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April 29, 2024

Andrea Inman
Audit Director
Division of State Government Accountability
NYS Office of the State Comptroller
110 State Street, 11th Floor
Albany, New York 12236

Dear Andrea Inman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2022-S-16 entitled, "Medicaid Program: Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims."

Should you have questions, please feel free to contact Mischa Sogut, Assistant Commissioner for Governmental Affairs, at (518) 473-1124 or mischa.sogut@health.ny.gov.

Sincerely,

Johanne E. Morne

Johanne E. Morne, M.S.
Executive Deputy Commissioner

Enclosures

cc: Mischa Sogut
Melissa Fiore
DOH Audit

Department of Health Comments to Final Audit Report 2022-S-16 entitled, "Medicaid Program: Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims" by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Final Audit Report 2022-S-16 entitled, "Medicaid Program: Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims" by the Office of the State Comptroller (OSC). Included in the Department's response are the Office of the Medicaid Inspector General's (OMIG) replies to applicable recommendations. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations.

Recommendation #1:

Develop and provide Medicaid guidance to hospitals to assist them in determining when services should be billed as an inpatient or outpatient claim.

Response #1:

The Department is publishing a Medicaid Update article that will provide guidance to hospitals to review before submitting a claim to Medicaid.

Recommendation #2:

Advise hospitals to develop controls to verify inpatient billing requirements are met prior to billing Medicaid (e.g., the existence of a valid admission order and room and board).

Response #2:

The Medicaid Update included in Response #1 will cite existing policy and regulations for what constitutes an inpatient admission.

Recommendation #3:

Review the improperly billed inpatient claims we sampled that have not yet been voided by hospitals and recover overpayments, as appropriate.

Response #3:

In collaboration with the Department, the Office of the Medicaid Inspector General (OMIG) has performed analysis on the identified claims, as well as the methodology OSC used to calculate the potentially inappropriate overpayments. OMIG has identified 43 claims which have been voided. Two additional claims have been identified in other OMIG projects related to OSC 2020-S-8. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #4:

Develop a risk-based approach to review the remaining 34,074 inpatient claims, totaling $356 million, identified in this audit to identify improper payments and make recoveries as appropriate.

Response #4:

OMIG staff performed analysis and disagrees with the 34,074 OSC-identified claims. OMIG removed claims already voided, recovered, or included in other OMIG projects for the previous OSC audit 2020-S-8. OMIG's analysis also removed the codes of the inpatient claims determined to be to be paid appropriately. The following claims and dollar amounts should be excluded from the OSC audit universe:

	Number of Claims	Dollar Amount
OSC Audit Universe	34,074	$356,388,181
OMIG Verified Voids and Recoveries	(1,099)	($10,748,912)
Identified in OMIG Projects for OSC Audit 2020-S-8	(62)	($761,471)
OMIG Analysis:		
Patient Code 7 (Left Against Medical Advice)	(6,222)	($57,292,104)
Patient Code 20 (Patient Expired)	(1,226)	($40,733,394)
Top 10 Inpatient DRG Codes:		
1. DRG Code 137 – Major Respiratory Infections & Inflammation	(419)	($5,972,926)
2. DRG Code 663 – Anemia & Blood Disorders	(466)	($4,054,701)
3. DRG Code 720 – Septicemia & Disseminated Infections	(261)	($3,395,078)
4. DRG Code 465 – Urinary Stones & Urinary Tract Obstruction	(351)	($2,447,533)
5. DRG Code 812 – Poisoning of Medicinal Agents	(322)	($2,405,144)
6. DRG Code 544 – D&C, Aspiration Curettage or Hysterectomy	(305)	($2,355,419)
7. DRG Code 347 – Back & Neck Disorders, Fractures, Injury	(189)	($1,596,406)
8. DRG Code 174 – Cardiovascular Procedures	(92)	($1,684,226)
9. DRG Code 816 – Toxic Effects of Non-Medicinal Substances	(190)	($1,593,359)
10. DRG Code 640 – Neonatal Birthweight >2,499-gram newborn	(369)	($1,585,036)
Remaining Critical Inpatient DRG Codes (104 unique DRGs)	(2,841)	($30,417,896)
Remaining claims	19,660	$189,344,576

There are 360 OMIG audit projects at various stages which contain claims identified by OMIG not as a result of the 2022-S-16 OSC audit. Additionally, OMIG identified 213 claims totaling

$2,207,671 from the 2022-S-16 OSC audit universe that were previously included in the 2020-S-8 OSC audit universe. OMIG is requesting an explanation on how OSC is counting these claims; as transfers (2020-S-8) or as inappropriate inpatient/outpatient claims (2022-S-16). For purposes of OMIG's audits, a Medicaid claim can only be recovered once for program integrity purposes.

State Comptroller's Comment – We agree it would not be appropriate to recover a claim payment more than once. However, a claim can be reviewed against multiple different criteria to confirm the appropriateness of payment. OSC audit 2020-S-8 identified a population of inpatient claims for Medicaid recipients who were reported as discharged from a hospital but then admitted to a different hospital within 24 hours of the discharge (which often meets the definition of a transfer). We found these claims are at a high risk of overpayment if the first hospital inappropriately reported an actual transfer as a discharge. As such, OMIG should review the appropriateness of the high-risk claims identified in both OSC audits by determining: (1) if the service provided was inpatient or outpatient and (2) if the recipient was discharged or transferred to another hospital.

The Public Health Emergency (PHE) was also in effect for half of the OSC audit review period. By removing the claims listed above in the chart, the remaining PHE overlap is 8,375 claims totaling $85.7 million dollars. While room and board are considered an integral component to inpatient care, the environment which health care facilities were operating in during the PHE must be taken into consideration. For any OSC findings after March 2020, OMIG will utilize guidance issued by Federal and State entities as to the appropriateness of the claims during the COVID-19 PHE.

Of the $356 million OSC audit universe, after excluding voids and OMIG recoveries (1,099 claims totaling $10,748,912), claims included in OMIG projects for OSC audit 2020-S-8 (62 claims totaling $761,471), Patient Codes 7 and 20 (7,448 claims totaling $98 million dollars), and Critical Inpatient DRG Codes (5,805 claims totaling $57.5 million dollars), the total remaining potentially recoverable amount is $189.3 million dollars. This dollar amount reflects the amount of the services performed but does not calculate actual recovery amount after any potential recalculation from inpatient claim status to outpatient claim status.

As stated in the Draft Audit Response, OMIG found that nearly 70% of the claims billed for five or fewer hours as inpatient that OSC identified as high-risk, were paid appropriately. OSC identified 3,489 claims for a total of $35.5 million and OMIG's analysis found that 2,222 claims totaling $24,530,778 should be considered appropriately billed as inpatient.

OMIG will perform further analysis and medical review to determine appropriateness of the remaining claims, as well as verify the methodology used to perform this audit. OMIG will continue to monitor the audit universe and make recoveries as necessary and appropriate. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

State Comptroller's Comment – OMIG used a flawed audit approach to conclude that various categories of claims in our audit were paid appropriately. OMIG's determination did not include a review of medical documentation, but rather was based on data analysis and a review of certain codes submitted on the claims. For example, OMIG determined over $57.2 million in claims were paid appropriately because the claims were billed with a Patient Status Code 7 (Left Against Medical Advice [AMA]). However, 13 inpatient claims we sampled during the audit that had a Patient Status Code 7 were found to be improperly billed, and hospitals agreed the services should have been billed as outpatient, not inpatient. For example, one patient record we reviewed documented that the patient refused inpatient admission and further monitoring in the hospital and left AMA from the Emergency Department within 15 minutes.

OMIG also used the same flawed approach to state that it found 70% of claims billed for 5 or fewer hours were billed appropriately. This statistic is in direct contrast to our audit findings and conclusions. Our review of a sample of claims included a medical records review and determined 70% of claims for patient stays of 5 hours or less were improper and should have been billed as outpatient, not inpatient (see p. 11). We encourage OMIG to reconsider its audit approach by considering the length of stay and including a medical records review to conclude on the appropriateness of inpatient billings.

Recommendation #5:

Develop an ongoing process to identify and review the appropriateness of high-risk short-stay inpatient claims, such as the ones identified in this audit.

Response #5:

The Department is exploring processes to identify and review inpatient hospital claims for stays of short duration.