Department of Health

Medicaid Program: Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims

Report 2022-S-16 | August 2023

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine whether Medicaid made improper payments to hospitals for outpatient services that were erroneously billed as inpatient claims. The audit covered the period from January 2018 through March 2022.

About the Program

The State's Medicaid program is administered by the Department of Health (Department). The Medicaid program reimburses hospitals for inpatient and outpatient services. A recipient's status in a hospital – inpatient versus outpatient – affects Medicaid's reimbursement for services provided.

Inpatient care generally requires recipients to stay overnight in the hospital and be monitored by the health care team at the hospital throughout treatment and recovery. Generally, outpatient services are medical procedures that can be performed in the same day.

Medicaid uses the All Patient Refined Diagnosis Related Groups (DRG) methodology to reimburse hospitals for inpatient medical care. The DRG methodology classifies recipients according to their diagnosis and severity of illness, which provides the basis for calculating the reimbursement. Outpatient services are typically reimbursed using rate codes, and each service provided could trigger a separate payment. Outpatient services are generally less expensive than inpatient treatments because they are less involved and do not require a patient's continued presence in a facility.

Key Findings

We found that a lack of Department guidance to assist hospitals in determining when to bill services as inpatient or outpatient likely contributed to improper billings and Medicaid overpayments. The audit identified 34,264 fee-for-service inpatient claims, totaling $360.6 million, where hospitals reported Medicaid recipients were discharged within 24 hours of admission. There is a high risk that a portion of these claims were improper if the services provided should have been billed as outpatient. We selected a judgmental sample of 190 claims, totaling $4,261,428, from six hospitals and reviewed the associated recipient's medical records. For these 190 claims, 91 claims (48%), totaling $1,577,821, were billed improperly.

Key Recommendations

- Develop and provide Medicaid guidance to hospitals to assist them in determining when services should be billed as an inpatient or outpatient claim.
- Review the improperly billed inpatient claims we sampled that have not yet been voided by hospitals and recover overpayments, as appropriate. Develop a risk-based approach to review the remaining 34,074 inpatient claims, totaling $356 million, to identify improper payments and make recoveries, as appropriate.
- Develop an ongoing process to identify and review the appropriateness of high-risk short-stay inpatient claims such as those identified in this audit.

Office of the New York State Comptroller
Division of State Government Accountability

August 30, 2023

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. McDonald:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
Department	Department of Health	*Auditee*
CMS	Centers for Medicare & Medicaid Services	*Federal Agency*
DRG	All Patient Refined Diagnosis Related Groups	*Key Term*
ED	Emergency department	*Key Term*
eMedNY	Department's Medicaid claims processing and payment system	*System*
FFS	Fee-for-service	*Key Term*
IPRO	Island Peer Review Organization	*Contractor*
MDW	Medicaid Data Warehouse	*System*
NYCRR	New York Codes, Rules and Regulations	*Regulation*
OMIG	Office of the Medicaid Inspector General	*Agency*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Medicaid program is administered by the State's Department of Health (Department). For the State fiscal year ended March 31, 2022, New York's Medicaid program had approximately 7.8 million recipients and Medicaid claim costs totaled about $74.6 billion. The federal government funded about 57.1% of New York's Medicaid claim costs, and the State and localities (the City of New York and counties) funded the remaining 42.9%.

The Department's eMedNY system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. When eMedNY processes claims, the claims are subject to various automated controls (edits), which determine whether the claims are eligible for reimbursement and if the amounts claimed for reimbursement are appropriate.

The Medicaid program reimburses hospitals for both inpatient and outpatient services. Inpatient services are provided to an individual who has been admitted to a hospital on the recommendation of a physician or licensed practitioner and is receiving room, board, and professional services in the hospital. Inpatient care generally requires recipients to stay overnight in the hospital and be monitored by the hospital health care team throughout treatment and recovery. Outpatient care is defined as hospital care that a patient receives without being admitted to a hospital or for a stay in an emergency or observation room, even if the patient spends the night receiving medical care. Generally, outpatient services are medical procedures that can be performed in the same day.

A recipient's status in a hospital – inpatient versus outpatient – affects Medicaid's reimbursement for services provided. Medicaid uses the All Patient Refined Diagnosis Related Groups (DRG) methodology to reimburse hospitals for inpatient medical care. The DRG methodology classifies recipients according to their diagnosis and severity of illness, which provides the basis for calculating the reimbursement. Outpatient services are typically reimbursed using rate codes, and primarily depend on the resources and days needed to treat the patient. For outpatient claims, each service provided could trigger a separate payment; however, outpatient services are generally less expensive than inpatient treatments because they are less involved and do not require a patient's continued presence in a facility.

According to New York Codes, Rules and Regulations (NYCRR) Title 10, Section 441.177, inpatient admissions are defined as "The formal acceptance by a health facility of a patient who is to be provided with room, board, and continuous nursing service in an area of the health facility where patients generally stay at least overnight." NYCRR Title 10, Section 405.10 sets the criteria for what information should be contained in the medical record, such as the admitting diagnosis and discharge summary.

The Centers for Medicare & Medicaid Services (CMS) uses a “Two-Midnight” rule to differentiate between billing for Medicare Part A (inpatient) and Part B (outpatient) claims. According to the Two-Midnight rule, a hospital inpatient admission should generally be considered reasonable and necessary if the physician (or other qualified practitioner) orders an inpatient admission based on the expectation that the patient will require at least two midnights of medically necessary hospital care. According to CMS guidance, there may be rare and unusual cases where the physician does not expect a stay lasting two or more midnights but nonetheless believes inpatient admission is appropriate and documents the circumstance. Such instances must be clearly documented, and the initial expectation of a hospital stay spanning two or more midnights must be reasonable for this circumstance to be considered an acceptable inpatient admission payable under Part A.

According to CMS policies, an inpatient admission order is required to be present in the patient’s medical record. While CMS does not require specific language to be used on the inpatient admission order, it strongly recommends that the ordering practitioner use language that clearly expresses intent to admit the patient that will be commonly understood by any individual who could potentially review documentation of the inpatient stay. Under this policy, CMS treats orders that specify a typically outpatient or other limited service (e.g., admit “to ER,” “to Observation,” “to Recovery,” “to Outpatient Surgery,” “to Day Surgery,” or “to Short-Stay Surgery”) as defining a non-inpatient service, and such orders will not be treated as meeting the inpatient admission requirements.

Audit Findings and Recommendations

We found that a lack of Department guidance to assist hospitals in determining when to bill services as inpatient or outpatient likely contributed to improper billings and Medicaid overpayments. For the period from January 1, 2018 through March 31, 2022, the audit identified 34,264 fee-for-service (FFS) inpatient claims, totaling $360.6 million, where hospitals reported Medicaid recipients were discharged within 24 hours of admission. There is a high risk that a portion of these claims were improper if the services provided should have been billed as outpatient. We selected a judgmental sample of 190 claims, totaling $4,261,428, from six hospitals and found 91 claims (48%), totaling $1,577,821, were billed improperly. The Department should review these 91 claims and recover overpayments as appropriate, as well as develop a process to review high-risk claims from the remaining 34,074 inpatient claims (totaling $356 million) to determine if they should have been billed as outpatient services.

Outpatient Claims Misclassified as Inpatient Claims

For the period January 2018 through March 2022, we identified 34,264 DRG inpatient FFS claims totaling $360.6 million where hospitals reported Medicaid recipients were discharged within 24 hours of admission. According to CMS, it is rare and unusual where a physician believes an inpatient admission is appropriate when they do not expect a stay to last two or more midnights. Therefore, we determined there is a high risk that a portion of the 34,264 inpatient claims were overpaid if the services provided should have been billed as outpatient claims.

Review of Medical Documentation for Sampled Claims

We selected a judgmental sample of 190 claims from six of the 10 hospitals with the largest number of inpatient claims where recipients were admitted and discharged from hospitals within 24 hours. We reviewed recipient medical records and determined 90 claims were improperly billed as inpatient instead of outpatient services. We also found that one additional claim was overpaid because the hospital incorrectly billed the claim as if the recipient was discharged home instead of correctly indicating the recipient was transferred to another hospital (which would have reduced the payment). The following table summarizes our sample review.

Summary of Sample Results

Hospital Name	Number of Sampled Claims	Sampled Payment Amount	Number of Misclassified Claims	Misclassified Payment Amount
Albany Medical Center	31	$690,161	18	$273,467
Kings County Hospital Center	35	789,193	15*	303,975
Montefiore Medical Center	32	1,117,447	11	332,618
Nassau University Medical Center	31	671,094	15	257,526
Queens Hospital	31	565,996	17	258,939
Staten Island University Hospital	30	427,537	15	151,296
Totals	**190**	**$4,261,428**	**91**	**$1,577,821**

*One claim was misclassified as an inpatient discharge instead of an inpatient transfer and resulted in an overpayment of $22,855.

The hospitals agreed with our conclusion that 83 claims, totaling $1,444,604, were improperly billed, including the one claim that was misclassified as a discharge instead of a transfer. Hospital officials agreed that ambulatory surgery, observation services, and emergency department (ED) visits – which are all considered outpatient services – were incorrectly billed as inpatient claims. To illustrate, for one sampled claim, a recipient was scheduled for surgery in a hospital, but the surgery was canceled due to the unavailability of blood work. The recipient stayed in the hospital for 1 hour, and the hospital billed Medicaid for inpatient services, resulting in a payment of $11,073. Upon our inquiry, the hospital agreed the services provided should have been billed as outpatient. In another example, a recipient received an ambulatory surgery service in the hospital and was discharged from the Ambulatory Surgery Unit within 3 hours of admission. The hospital billed this service as an inpatient claim, and Medicaid paid $14,798 for this service. Hospital officials agreed the claim should have been billed as outpatient and, to avoid similar mistakes in the future, hospital officials stated that they will revisit their admission process and related payor requirements/expectations.

For eight inpatient claims, totaling $133,217, the hospitals did not agree with our conclusion that they were improperly billed. For each of the eight claims, medical records showed the recipients were either treated and discharged in the ED (five claims) or Ambulatory Surgery Unit (three claims). For example, one hospital billed three inpatient claims for unscheduled and emergency ambulatory surgeries. According to hospital officials, the inpatient billings were justified because these recipients needed some preoperative tests and post-surgical services. However, we determined these recipients were discharged from the Ambulatory Surgery Unit, and therefore, the services should have been billed as outpatient/observation services. In another example, medical records indicated that the recipient was in observation status in and discharged from the ED within 5 hours. Hospital officials stated that inpatient services were necessary at the time of admission to the ED.

We provided Department officials with the medical records for seven of the eight claims, and asked them to review the records to determine if the services should have been billed as outpatient. However, the Department review focused on the medical necessity of services, and officials did not provide criteria to be used to

determine if the services were correctly billed as inpatient. It is important to note that our audit conclusion did not question the medical necessity of services; rather, we based our findings on the appropriateness of the claim billing. As a result, we included the eight claims in our audit findings for the Department to review and determine the appropriateness of the billings as inpatient services.

Hospital Response to Sampled Claims

Of the 190 sampled claims, we determined 90 claims were improperly billed as inpatient instead of outpatient services, and found one claim was incorrectly billed as a transfer instead of a discharge. Hospitals voided 41 claims, as discussed next.

We do not have the coding information needed to be able to calculate the amount Medicaid would have paid for the claims in our sample had they been correctly billed as outpatient services. However, at the conclusion of our audit fieldwork, the hospitals had voided three of the claims, totaling $44,925, and rebilled them as outpatient services, resulting in payment of $8,006 – a Medicaid savings of $36,919. Hospitals had also voided another 31 claims, totaling $561,349, but had not yet received payment for the outpatient services.

Another eight claims in our sample, totaling $106,691, that we determined should have been billed as outpatient services were on behalf of recipients with an incarceration status on the claim service date. Medicaid coverage for incarcerated individuals is limited to inpatient hospitalization stays off the grounds of the correctional facility. Outpatient services, such as an ED visit and observation, that do not result in an inpatient stay are not covered by Medicaid for incarcerated individuals as these services are provided by the correctional facility. The eMedNY claims processing system has a claim edit in place that will deny outpatient claims for inmates. All eight claims should have been billed as outpatient services to the county where the individuals resided immediately prior to incarceration. Hospital officials voided seven of these claims upon our notification, resulting in Medicaid savings of $97,524. The remaining claim ($9,167) had not yet been voided at the conclusion of our audit fieldwork.

The Department should work with hospitals to correct the remaining improper claims we identified and recover the overpayments.

Inadequate Inpatient Billing Guidance

The Department has not provided adequate Medicaid guidance to hospitals to assist in determining when to bill services as inpatient or outpatient – such as consideration of the duration of a stay or situations when a recipient's hospital stay included a valid admission order but the recipient left prior to actually being admitted to an inpatient setting (for instance, if the patient left against medical advice or was officially discharged or transferred to another hospital from an outpatient setting). The lack of guidance likely contributed to improper billings and Medicaid overpayments. As noted previously, CMS established the Two-Midnight rule to help hospitals assess inpatient and outpatient services for Medicare billings; however, this is not in New

York State Medicaid guidance. CMS regulations also require a valid admission order for a Medicare inpatient stay. Although we did not find the same requirement in our review of Medicaid regulations, Department officials stated that inpatient claims should generally contain an admission order.

The following two examples from our audit sample demonstrate the inconsistency in billings for hospital care. In the first example, the patient went to the hospital with shortness of breath and was admitted to telemetry for observation. Telemetry is a device that continuously monitors patient conditions and automatically transmits vital information to a central monitor; it helps medical staff identify potential problems. The medical records indicated the patient was treated in the ED and then discharged after 5 hours of admission. Hospital officials stated the inpatient admission was medically necessary for this patient because physicians could not foresee the rapid improvement of the patient's condition. Therefore, they concluded the inpatient billing was correct. In the second example, the patient went to the hospital after a seizure and hitting their head due to a fall. The patient was also admitted to telemetry for monitoring. The medical records indicated the patient was treated in the ED and discharged after 2 hours of admission. In this case, the hospital agreed that inpatient billing was incorrect. These two cases demonstrate the need for Department guidance on whether the presence of an admission order, the intent to admit, or the medical necessity of services warrant inpatient billing.

NYCRR Title 10, Section 441.177 states that, for an inpatient admission, a patient should be provided with room, board, and continuous nursing service in an area of the health facility where patients generally stay at least overnight. The eMedNY claims processing system captures room and board charges under certain revenue codes for inpatient claims. We found inconsistencies in hospitals' coding of room and board. We reviewed the 34,264 FFS inpatient claims in our high-risk population and found 3,983 claims ($57.2 million) did not contain room and board charges. In response, Department officials explained that inpatient claims billed without room and board charges are likely billing errors and all inpatient claims should contain the charges. Our audit sampling confirmed that hospitals incorrectly report room and board charges. For example, 81 of the 90 improperly billed inpatient claims from our sample were coded with room and board when they were actually outpatient services. Although room and board charges are not used for determining the payment amount for a DRG inpatient claim, advising hospitals to ensure the correct coding for room and board could help both the hospitals and the Department in differentiating between inpatient and outpatient services.

We believe the Department should have clear guidance on how hospitals determine if services meet inpatient billing requirements – especially for short-stay hospital care where, per CMS, it is rare to be admitted as an inpatient.

Short-Stay Inpatient Claim Reviews

The Department contracts with Island Peer Review Organization (IPRO) to perform claim reviews based on random sampling to validate the necessity for inpatient

services. The methodology for sampling claims to be reviewed by IPRO is negotiated in advance by the Department and IPRO. However, Department officials confirmed the review does not specifically target short-stay inpatient claims for review. The Office of the Medicaid Inspector General (OMIG) also performs post-payment claim reviews of inpatient services; however, its review does not include the specific area related to our audit objective.

The Department has not issued guidance pertaining to minimum duration of a hospital stay that would trigger assessment of whether the hospital care provided was actually outpatient services and not inpatient services. Our audit found that claims with a shorter duration of stay (such as 5 or less hours) are at higher risk of being billed incorrectly. Of the 190 sampled inpatient claims where hospitals reported Medicaid recipients were discharged within 24 hours of admission, and of which we determined 90 claims were outpatient services, we found:

- 52 of 74 claims (70%) were on behalf of recipients who stayed in the hospital for 5 or less hours.
- 26 of 59 claims (44%) were on behalf of recipients who stayed in the hospital for between 6 and 15 hours.
- 12 of 57 claims (21%) were on behalf of recipients who stayed in the hospital for between 16 and 24 hours.

We further note that, of the 34,074 high-risk inpatient claims not included in our sample, there were 3,489 claims, totaling $35.5 million, on behalf of recipients who stayed in the hospital for 5 or less hours. We believe these claims could be at particularly high risk of being inappropriately billed. The Department should develop a risk-based approach with consideration of the short length of hospital stay to review the remaining claims in our high-risk population and make recoveries where appropriate.

Recommendations

1. Develop and provide Medicaid guidance to hospitals to assist them in determining when services should be billed as an inpatient or outpatient claim.
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).
3. Review the improperly billed inpatient claims we sampled that have not yet been voided by hospitals and recover overpayments, as appropriate.
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.
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.

Audit Scope, Objective, and Methodology

The objective of the audit was to determine whether Medicaid made improper payments to hospitals for outpatient services that were billed as inpatient claims. This audit examined inpatient FFS claims from January 2018 through March 2022 for recipients who were admitted to a hospital and discharged within 24 hours. We excluded Medicare crossover claims and claims with other third-party insurance payments.

To accomplish our audit objective and assess related internal controls, we used the Medicaid Data Warehouse (MDW) to identify DRG inpatient claims. We interviewed officials from the Department and examined the Department's relevant Medicaid policies and procedures as well as applicable rules and regulations. We contacted six hospitals with a high number of claims in our audit population and requested medical records to assess the appropriateness of the inpatient billing for a judgmental sample of 190 claims. The claims were selected based on payment amount and number of hours between the admission and discharge time. We shared our findings with the hospitals and considered their feedback in finalizing the review of claims. The results of our sample cannot be projected to the population as a whole. We compared MDW claims data – such as admission date and time, discharge date and time, recipient demographics – with medical records that we obtained from the hospitals and concluded that the data we used for purposes of this audit was reliable.

During the audit, we shared our methodology and our findings, including claims detail, with officials from the Department and OMIG for their review.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our 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.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these functions do not affect our ability to conduct this independent performance audit of the Department's oversight of Medicaid payments for outpatient services.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials agreed with the audit recommendations and indicated that certain actions have been and will be taken to address them.

Within 180 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Agency Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

July 25, 2023

Andrea Inman, Audit Director
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Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2022-S-16 entitled, "Medicaid Program: Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims."

Thank you for the opportunity to comment.

Sincerely,

Megan Baldwin

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

cc: Melissa Fiore
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Department of Health Comments to Draft 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 Draft 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).

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 provides guidance to hospitals on how to bill for the services provided through the Inpatient Manual. The Inpatient Manual is posted on the eMedNY website. A review of the Inpatient Manual contents will be done to determine if the existing information clearly explains the criteria to submit an inpatient claim. Updates will be made where appropriate.

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 Department will issue guidance to hospitals in a Medicaid Update publication reminding hospitals to submit the appropriate claim to Medicaid based on setting. Services provided in the Outpatient Department, Clinic or Emergency Department should be billed with the corresponding Ambulatory Patient Group claim. An inpatient claim should only be submitted when there is an admission order signed by a physician. A link to New York Codes, Rules and Regulations (NYCRR) Title 10, Section 441.77 will be embedded in the article explaining the information that needs to be retained as supporting documentation for the inpatient claim.

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) is performing analysis on the identified claims, as well as the methodology OSC used to calculate the potentially inappropriate overpayments. OMIG is requesting the data for the 190 OSC reviewed claims to include the patient code field.

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:

In collaboration with the Department, OMIG is currently performing analysis on the remaining inpatient claims focusing on claims which were identified by OSC as having a higher risk, the five hour or less claims as well as the two hour or less claims. OMIG has identified principal diagnosis codes within the OSC-identified claims that would indicate inpatient status. Additionally, OMIG staff is reviewing the patient status codes to determine which claims are most likely to be inappropriate, and which claims should be excluded from the sample such as patient code 7 (patient left against medical advice) and patient code 20 (discontinue care and patient expired). Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process. For clarification, the $356 million identified is to be reviewed, and is not the amount to be recovered.

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 will explore processes to identify and review inpatient hospital claims for stays of short duration.

Contributors to Report

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