NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

February 20, 2024

Andrea Inman, Audit Director
Office of the State Comptroller
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 Follow-Up Audit Report, 2023-F-26 entitled, "Improper Managed Care Payments for Misclassified Patient Discharges" (Report 2021-S-8).

Thank you for the opportunity to comment.

Sincerely,

Johanne E Morne

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

Enclosure

cc: Frank Walsh
Amir Bassiri
Jacqueline McGovern
Amber Rohan
Brian Kiernan
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James Dematteo
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Department of Health Comments to Follow-Up Audit Report 2023-F-26 entitled, "Improper Managed Care Payments for Misclassified Patient Discharges" (Report 2021-S-8) by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Follow-Up Audit Report 2023-F-26 entitled, "Improper Managed Care Payments for Misclassified Patient Discharges" by the Office of the State Comptroller (OSC).

Recommendation #1:

Review the $323,531 in overpayments associated with the 47 inpatient claims improperly coded as discharges and recover as appropriate.

Status – Not Implemented

Agency Action – The six hospitals we sampled in our initial audit agreed that 47 inpatient claims in our review were overpaid $323,531 because they were incorrectly coded as discharges. Subsequent to the audit, hospitals voided six of the claims, totaling $8,984 in overpayments. The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. We shared details of our findings with OMIG at the conclusion of our initial audit. Despite the providers agreeing the claims were inappropriately coded, OMIG has not yet started to review the remaining 41 claims, totaling $314,547 in overpayments, that had not yet been voided by the hospitals. OMIG stated that it is currently reviewing fee-for-service (FFS) payments related to a similar issue identified in another Office of the New York State Comptroller (OSC) audit, *Improper Medicaid Payments for Misclassified Patient Discharges* (Report 2020-S-8). According to OMIG officials, they are adjusting their methodology based on their FFS review before starting a review of the encounter claims referenced in this recommendation.

Response #1:

OMIG has verified provider-initiated voids of more than $59,000. OMIG performed audits in this program area for FFS claims previously identified by OSC. OMIG determined that a majority of the claims identified by OSC as possible transfers were in fact discharges, and thus were paid appropriately. OMIG requested the medical records supporting all the claims submitted by the providers audited, regardless of whether the claim was submitted as a first or second visit. The medical records were reviewed to determine whether the hospital discharged a patient or transferred them on the initial visit, and found a majority of the claims were appropriate discharges. OMIG explained to the OSC auditors that findings could not be determined without a review of the medical records to verify medical necessity, and the OSC auditors agreed that this was reasonable. OMIG is currently in the process of developing a methodology to address the OSC-identified issue of discharges and transfer, which will continue to require a medical review of the inpatient files of the discharging and admitting facilities.

State Comptroller's Comment – We are pleased OMIG's subsequent review found provider-initiated voids of more than $59,000, and that OMIG is also developing a methodology to address the OSC-identified issue of inpatient transfers improperly coded as discharge claims. However, OMIG's response about the claim and medical record review it performed pertains to a different OSC audit, not the 47 inpatient claims identified in this audit recommendation whereby the six hospitals already agreed they were overpaid $323,531.

Recommendation #2:

Review the remaining 2,642 high-risk claims totaling $29.8 million and recover overpayments as appropriate. Ensure prompt attention is given to those providers that received the highest amounts of payments and claims when the second admission was on the same day.

Status – Not Implemented

Agency Action – According to OMIG officials, a review of the FFS payments identified in OSC audit *Improper Medicaid Payments for Misclassified Patient Discharges* (Report 2020-S-8) is ongoing, and OMIG will be adjusting its methodology before starting a review of the encounter claims referenced in this recommendation. We note that providers have voided 103 of the claims, totaling $1,434,589, since our initial audit, and for another 81 claims, the related claim for the hospital the patient appeared to have been transferred to has been voided. However, OMIG may have already lost the opportunity to recover overpayments related to claims totaling $6.4 million due to federal look-back provisions. We encourage OMIG to expedite its review of the remaining claims (including the 81 claims for the origin hospital where a subsequent hospital's claim was voided) and recover overpayments as appropriate.

Response #2:

OMIG has verified provider-initiated voids of more than $3 million. OMIG performed audits in this program area for FFS claims previously identified by OSC. OMIG determined that a majority of the claims identified by OSC as possible transfers were in fact discharges, and thus were paid appropriately. OMIG requested the medical records supporting all the claims submitted by the providers audited, regardless of whether the claim was submitted as a first or second visit. The medical records were reviewed to determine whether the hospital discharged a patient or transferred them on the initial visit, and found a majority of the claims were appropriate discharges. OMIG explained to the OSC auditors that findings could not be determined without a review of the medical records to verify medical necessity, and the OSC auditors agreed that this was reasonable. OMIG is currently in the process of developing a methodology to address the OSC-identified issue of discharges and transfer, which will continue to require a medical review of the inpatient files of the discharging and admitting facilities.

State Comptroller's Comment – We are pleased OMIG's subsequent review found provider-initiated voids of more than $3 million – further validating our audit findings. However, the claim and medical review OMIG stated it performed pertains to a different OSC audit. We encourage OMIG to review every aspect of our claim selection methodology provided during the audit (2021-S-8) that this follow-up review pertains to as it develops a method to address the OSC-identified issue of inpatient transfers improperly coded as discharge claims.

Recommendation #3:

Review the 13 inpatient claims totaling $101,447 where outpatient services were provided. Recover any overpayments as well as the remaining $55,234 in GME payments associated with the outpatient claims.

Status – Not Implemented

Agency Action – Our initial audit found hospitals incorrectly billed 13 inpatient claims, totaling $101,447, because the hospitals actually provided outpatient services rather than inpatient

services. The audit also identified $55,234 in improper GME payments related to the 13 claims. Since Medicaid does not make GME payments for outpatient services, the GME payments should not have been made. At the time of our follow-up, OMIG had not yet reviewed any of the 13 claims or related GME payments, stating that it is still reviewing the FFS payments identified in OSC audit *Improper Medicaid Payments for Misclassified Patient Discharges* (Report 2020-S-8).

Response #3:

OMIG has verified provider-initiated voids of more than $3,000. OMIG performed audits in this program area for FFS claims previously identified by OSC. OMIG determined that a majority of the claims identified by OSC as possible transfers were in fact discharges, and thus were paid appropriately. OMIG requested the medical records supporting all the claims submitted by the providers audited, regardless of whether the claim was submitted as a first or second visit. The medical records were reviewed to determine whether the hospital discharged a patient or transferred them on the initial visit, and found a majority of the claims were appropriate discharges. OMIG explained to the OSC auditors that findings could not be determined without a review of the medical records to verify medical necessity, and the OSC auditors agreed that this was reasonable. OMIG is currently in the process of developing a methodology to address the OSC-identified issue of discharges and transfer, which will continue to require a medical review of the inpatient files of the discharging and admitting facilities.

State Comptroller's Comment – OMIG's comments pertain to a different OSC audit and are not relevant to the issue discussed in this recommendation, which was hospitals improperly billing higher-cost inpatient services instead of outpatient services. We encourage OMIG to review these claims and recover overpayments timely.

Recommendation #4:

Ensure MCOs develop processes to identify and recover Medicaid managed care overpayments for inpatient claims that have a high risk of miscoded patient status codes like those identified by this audit.

Status – Not Implemented

Agency Action – Department officials stated the Department does not prescribe a specific method by which MCOs should identify and recover overpayments for inpatient claims or any other claims. However, we note the New York State Medicaid Plan states that the Department is responsible for administering or supervising the administration of the Medicaid program under the Social Security Act, which requires post-payment claims review to ensure the proper and efficient payment of claims. While the Department does not need to "prescribe a specific method," it should ensure MCOs develop processes to identify and recover Medicaid managed care overpayments for inpatient claims that have a high risk of miscoded patient status codes.

Response #4:

Part 98-1.21 of Title 10 NYCRR (Fraud and Abuse Prevention Plans and Special Investigation Units), and more specifically Section 98-1.21 (b)(5) requires MCOs to develop procedures for detecting and preventing possible fraud and abuse, as well as procedures for case investigations and detection of patterns of repetitive fraud and abuse involving one or more MCOs, including (vi), the submission of claims for services not provided. Additionally, Section 98-1.21 (b)(14) requires the development of a fraud and abuse detection procedures manual for use by officers, directors, managers, and claims, underwriting, member services, utilization

management, complaint, and investigative personnel. These requirements ensure that MCOs develop the necessary policies and procedures required to conduct post-payment claims reviews. Specifically, during a full operational survey, MCO policies and procedures are reviewed by Department surveyors to evaluate compliance with Sections 98-1.21(b)(5) and 98-1.21(b)(14). Furthermore, it should also be noted that the OMIG performs post-payment claim reviews on behalf of the Department that are consistent with SSA requirements.

State Comptroller's Comment – We encourage the Department to use its full operational surveys to ensure MCOs have processes for identifying and recovering overpayments on inpatient claims that have miscoded patient status codes.

Recommendation #5:

Enhance the MDW's ability to obtain more complete data for encounter inpatient claims, including admission hour and discharge hour, to allow for a more thorough review of the claims submitted by the MCOs and correct the derived LOS [length of stay] field.

Status – Not Implemented

Agency Action – Our initial audit found the Department's encounter data on the MDW was either missing certain data fields or contained incomplete fields that would otherwise be useful, including admission hour, discharge hour, and LOS. According to Department officials, even though such information is deemed critical to the intended analytics anticipated to be part of quality measures by the Department, it is not required information to be reported by MCOs. As a result, we found there continues to be empty admission hour and discharge hour fields in the MDW. In addition, our initial audit found that the LOS field in the MDW, which is derived by the Department, included an extra day (except where a patient's admission date and discharge date were the same). Although Department officials stated the derived LOS field had been fixed, they were unable to provide support for the fix, and we identified incorrect LOS fields on encounters in the MDW with service dates after the date officials stated the fix had been made.

Response #5:

The Original Submitter Data Source (OSDS) does not require the reporting of admission and discharge hours. In the NYS Companion Guide it states the following: "*2300 DTP Discharge Hour* NYSDOH strongly encourages the collection and submission of this data. It is critical to the intended analytics anticipated to be part of the quality measures." Encounter edits are reviewed by the OSDS team. This recommendation will be brought to their attention. It will be their decision to make admission and discharge hour on encounters a mandatory field. OSC found an issue with the LOS in the Encounter Intake System. A ticket has been opened with the OSDS team to determine if the same issue exists in OSDS. Please note: LOS is only used for Transfer pricing. The LOS field had more bearing in the All Patient Discharge Related Group (AP-DRG) methodology which was replaced by the All Patient Refined Discharge Related Group (APR-DRG) method in 2009.