NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

July 1, 2025

Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 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, 2024-F-26 entitled," Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims (Report 2022-S-16)."

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 Gentile
Brian Kiernan
Timothy Brown
James Dematteo
James Cataldo
Michael Atwood
Melissa Fiore
OHIP Audit
DOH Audit

Department of Health Comments on the Office of the State Comptroller's Follow-Up Audit Report 2024-F-26 entitled, Medicaid Program – Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims (Report 2022-S-16)

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2024-F-26 entitled, "Medicaid Program – Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims (Report 2022-S-16)." Included in the Department's response is 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.

General Comments:

OSC Use of A Judgmental Sample

OSC used a judgmental sample to select which payments they would review, which means the auditors selected the payments based on their professional judgement, opinion, and knowledge. As a result, the selected sample and any OSC findings or conclusions are not representative of the entire population.

State Comptroller's Comment 1 – DOH's comment that "any" OSC findings or conclusions are not representative of the entire population is not accurate. Additionally, the audit itself was a focus on high-risk claims (hospital stays of 24 hours or less) and, accordingly, so was the audit sample that identified overpayments. The audit appropriately recommended DOH develop a similar risk-based approach to review high-risk claims. Furthermore, we remind DOH that judgmental samples are routinely used and widely acceptable to reach audit conclusions. As mentioned in the audit report, the sample review was supplemented with reviews of policies and procedures, interviews with various DOH and hospital officials, assessments of internal controls, and data analysis to reach audit conclusions and make the recommendations.

Audit Recommendation Responses:

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.

Status – Partially Implemented

Agency Action – The initial audit found that a lack of DOH guidance to assist hospitals in determining when to bill services as inpatient or outpatient likely contributed to improper billings and Medicaid overpayments. At the time of our follow-up, DOH officials were in the process of drafting a Medicaid Update (DOH's official publication for Medicaid providers) with guidance to assist hospitals in determining whether to bill a service as inpatient or outpatient.

Response #1

The Department has included a Medicaid Update article in the January 2025 issue, titled "Inpatient Admission and Observation Policy for New York State Medicaid Providers" which addresses the OSC recommendation. The article can be found in Volume 41- Number 1: New York State Medicaid Update - January 2025 Volume 41 - Number 1.

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).

Status – Partially Implemented

Agency Action – Inpatient services are provided to people who have been admitted to a hospital and are receiving room and board. DOH officials stated all inpatient claims should contain room and board charges, and inpatient claims without them are likely due to billing errors. The initial audit found 3,983 inpatient claims, totaling $57.2 million, that did not contain room and board charges (highlighting a risk that the services might have been less expensive outpatient care). Other issues found within documentation obtained from hospitals during the initial audit demonstrated the need for DOH guidance on whether the presence of an admission order, the intent to admit, or the medical necessity of services warrant inpatient billing. At the time of our follow-up, DOH officials were in the process of drafting a Medicaid Update to advise hospitals to verify that inpatient billing requirements are met, including a review of medical record support, prior to billing Medicaid.

Response #2

The Medicaid Update referenced in response #1 provides guidance for proper utilization review to ensure claims meet the requirements for inpatient billing prior to submitting a claim to Medicaid. This includes evaluating whether the medical factors documented in the medical record support the appropriateness of the inpatient admission, the duration of the stay and professional services, including drugs and biologicals. Providers must also ensure their staff have a thorough understanding of billing requirements for inpatient admissions and observation status by providing ongoing staff education, routine internal audits, and regular evaluations of billing practices.

Recommendation #3

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

Status – Not Implemented

Agency Action – The initial audit determined 91 claims (of 190 sampled claims), totaling $1,577,821, were inappropriately billed as inpatient instead of outpatient. By the conclusion of the audit fieldwork, hospitals voided 41 claims, totaling $703,798, and the remaining 50 claims, totaling $874,023, still needed to be adjusted. OMIG investigates and recovers improper Medicaid payments on behalf of DOH. New York State statute allows OMIG to audit providers' claims and recover overpayments up to 6 years from the date services were furnished or billed,

whichever is later. We shared the details of our findings with OMIG at the conclusion of our initial audit. By the time of our follow-up, hospitals voided 13 claims (of the 50) totaling $164,696. However, OMIG officials acknowledged none of the recoveries were related to projects initiated, or claims reviewed, by OMIG in response to our initial audit. We note OMIG may have already lost the opportunity to recover over $50,000 of the payments due to look-back provisions. We encourage DOH and OMIG to take prompt action on the improper payments we identified to prevent further loss of recoveries.

Response #3

OMIG has identified recoveries and provider-initiated voids totaling $211,485. Two additional claims have been identified in other OMIG projects related to OSC 2020-S-8. 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. 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.

Status – Partially Implemented

Agency Action – The initial audit identified 34,074 inpatient claims (in addition to the 190 sampled claims), totaling $356 million, where hospitals reported Medicaid recipients were discharged within 24 hours of admission—indicating a high risk the services were actually outpatient. Based on the 190 claims we sampled, the audit concluded DOH and OMIG should develop a risk-based approach, with consideration of short lengths of stay, to review the 34,074 claims. For example, we determined 70% of the inpatient claims in our sample that contained hospital stays of 5 hours or less should have been billed as outpatient claims. In response to the audit, OMIG reviewed the claims but presented a flawed methodology that failed to account for the length of stay or a review of medical records and erroneously concluded that many of the claims were billed appropriately. At the time of our follow-up, 3,454 claims, totaling over $31 million, were voided by hospitals or had been recovered. However, OMIG officials acknowledged none of the recoveries were related to projects initiated, or claims reviewed, by OMIG in response to our initial audit. Also, DOH contracts with the Island Peer Review Organization (IPRO) to perform inpatient diagnostic and admission reviews (including reviews of claims with a length of stay less than 8 hours) and OMIG officials provided results of IPRO reviews that included claims in the initial audit. However, none of the IPRO-reviewed claims were for inpatient stays of less than 8 hours. We encourage OMIG officials to reconsider their audit approach by incorporating the recipient's length of stay and a review of medical records, and to re-review the high-risk claims we identified and make recoveries. We note that OMIG may have already lost the opportunity to review over $51 million of the payments due to look-back provisions.

Response #4

OMIG has identified recoveries and provider-initiated voids totaling more than $33 million

dollars. OMIG staff performed analysis and disagree with the universe of 34,074 OSC-identified claims. OMIG removed claims already voided, recovered, or included in other OMIG projects identified in the previous OSC audit 2020-S-8. OMIG's analysis also removed inpatient claims considered to be of low risk. The following are the results of our independent analysis, these claims and related 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	(3,455)	($33,268,012)
No Longer Recoverable Due to 6-year Lookback	(4,504)	($41,887,653)
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	12,880	$124,937,823

OMIG has already initiated 360 audit projects in this area, which are at various stages of the review process and contain claims identified exclusively identified by OMIG oversight. 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 notes that OSC would seem to recover for these claims twice; as transfers (2020-S-8) or as inappropriate inpatient/outpatient claims (2022-S-16). A Medicaid claim can only be recovered once for program integrity purposes.

State Comptroller's Comment 2 – 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). That audit found those claims are at a high risk of overpayment if the first hospital inappropriately reported an actual transfer as a discharge. Therefore, 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 was also in effect for half of the OSC audit review period. After removing the claims listed above in the chart, the remaining Public Health Emergency overlap is 8,375 claims for a total of $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 Public Health Emergency 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 Public Health Emergency.

Of the $356 million OSC audit universe, after excluding voids and OMIG recoveries (3,455 claims totaling $33,268,012), 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), Critical Inpatient Diagnosis-Related Group Codes (5,805 claims totaling $57.5 million dollars), claims no longer recoverable due to 6-year lookback (4,504 claims totaling $41,887,653), the total remaining potentially recoverable amount is $124.9 million dollars. This dollar amount reflects the amount of the services performed but does not reflect the actual recovery amount after any potential recharacterization from inpatient claim status to outpatient claim status.

State Comptroller's Comment 3 – OMIG used a flawed 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 our audit that had a Patient Status Code 7 were found to be improperly billed, and the 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 continues to perform 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.

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.

Status – Not Implemented

Agency Action – The initial audit found 52 of 74 claims (70%) we sampled on behalf of recipients who stayed in the hospital for 5 hours or less (i.e., high-risk short-stays) were improperly billed as inpatient instead of outpatient. As such, we concluded DOH needed an ongoing process to review these high-risk claims for appropriateness. DOH and OMIG have not taken any action to address this recommendation. We analyzed claims for inpatient stays of 5 hours or less billed since our initial audit and identified 1,962 inpatient claims, totaling $22.1 million through July 2024. According to information provided by OMIG officials, IPRO reviews include a focus on 1-day stay claims and claims with a length of stay less than 8 hours. However, as stated in the Agency Action section of Recommendation 4, IPRO claims provided by OMIG did not include any inpatient stays of less than 8 hours. We encourage DOH to develop a process to identify and review the appropriateness of high-risk short-stay inpatient claims.

Response #5

OMIG continues to perform further analysis and medical review to determine appropriateness of the claims identified in this audit, 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.

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