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State Comptroller

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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

March 12, 2025

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

Re: Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims
Report 2024-F-26

Dear Dr. McDonald,

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 have followed up on the actions taken by officials of the Department of Health (DOH) to implement the recommendations contained in our audit report, *Medicaid Program – Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims* (Report 2022-S-16).

Background, Scope, and Objective

DOH administers New York's Medicaid program. 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, and are less expensive than inpatient treatments because they are less involved and do not require a patient's continued presence in a facility.

The objective of our initial audit, issued August 30, 2023, was 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. The 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. The audit identified a high-risk population of 34,264 fee-for-service inpatient claims, totaling $360.6 million, where hospitals reported Medicaid recipients were discharged within 24 hours of admission. We selected a judgmental sample of 190 of the claims, totaling $4,261,428, and determined 91 claims (48%), totaling $1,577,821, were billed improperly.

The objective of our follow-up was to assess the extent of implementation, as of December 5, 2024, of the five recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

DOH and Office of the Medicaid Inspector General (OMIG) officials made little progress in addressing the problems we identified in the initial audit report, and additional actions are needed. In particular, officials did not develop a process to identify and review the appropriateness of high-risk short-stay inpatient claims and OMIG was unable to demonstrate that any recoveries were initiated in response to our initial audit. Of the initial report's five audit recommendations, three were partially implemented and two were not implemented.

Follow-Up Observations

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.

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.

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.

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.

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.

Major contributors to this report were Thomas Sunkel, Edward Reynoso, Benjamin Babendreier, and David Metacarpa.

DOH officials are requested, but not required, to provide information about any actions planned to address the unresolved issues discussed in this follow-up within 30 days of the report's issuance. We thank the management and staff of DOH for the courtesies and cooperation extended to our auditors during this follow-up.

Sincerely,

Christopher Morris
Audit Manager

cc: Melissa Fiore, Department of Health
Frank T. Walsh, Jr., Office of the Medicaid Inspector General