

COMPTROLLER'S INTERNAL CONTROL AND
ACCOUNTABILITY DIRECTIVES

Directive 20 - PROCEDURES REQUIRED FOR VOLUNTARY HOSPITALS
TO SUBSTANTIATE MEDICAID CLAIMS FOR
INPATIENT SERVICES

1.0 Introduction

This directive sets forth uniform procedures to be followed by Voluntary Hospitals submitting medicaid claims for reimbursement for services provided to New York City medicaid eligible individuals. Adherence to these procedures will (a) result in substantially reduced audit disallowances, (b) improve hospital internal control procedures and (c) enable the Comptroller's Office to expedite the audit process.

Recent audits of Voluntary Hospital medicaid claims have resulted in disallowances in excess of \$6 million. More than 85% of these disallowances involve the following:

- o Failure to exhaust all third-party resources and/or unreported third-party payments
- o Improper infant care rate charges
- o Missing patient account records
- o Incorrectly reported length of patient stay

2.0 Organization

This directive is organized into two major categories as follows:

- o Discussion of the major areas of audit disallowance (3.0)
- o Required procedures to be adopted by the hospital (4.0)

3.0 Discussion of the Major Areas of Audit Disallowance

3.1 Failure to Exhaust All Third-Party Resources and/or Unreported Third-Party Payments

The medicaid program is designed to provide payment for medical care and services only after all other resources have been exhausted; medicaid is the payor of last resort. If a recipient has third-party insurance coverage, the hospital must bill for those benefits prior to billing medicaid. Examples of third-party resources are medicare Part A and/or Part B, workers compensation, veterans benefits, Blue Cross/Blue Shield, union coverage, individual and/or family commercial health insurance carried by present or absent parent or guardian.

Our current audits indicate that some hospitals have been seriously deficient in complying with medicaid regulations. Procedures to insure proper identification of available third-party resources either do not exist or are not followed. In addition, hospitals often do not follow up to obtain reimbursements from identified available resources. In other instances, hospitals sought and obtained reimbursement from third-parties after having been paid in full by the medicaid program. Some hospitals accumulated these duplicate reimbursements and retained them for extended periods of time before making refunds to the City. In other instances, third-party reimbursements were identified only after our auditors arrived at the hospital to conduct audits. Duplicate payments appear to have become a source of interest-free loans; the City reserves the right to charge interest in the future if hospitals fail to make prompt restitution to the City for third-party reimbursement.

3.2 Improper Infant Care Rate Charges

Medicaid rates for inpatient care are set by New York State. The rate set by the State for a full-term, healthy newborn infant

is one-third of the rate for an adult; the rate for an infant in jeopardy or prematurely born is the same as for an adult. The State does not recognize a "Boarder Baby" category and has not set a rate for an infant thus classified.

On August 9, 1966 the New York City Comptroller's Office issued a memorandum, establishing a New York City rate for Boarder Babies. The Boarder Baby rate was lower than the newborn rate, but it granted relief to the hospitals providing such care. The Boarder Baby rate established was in accordance with Budget Modification MA 9149 signed by the Deputy Mayor on August 3, 1966. The same memorandum states that:

"Feeding Problems" and similar minor disturbances are not to be used as medicaid diagnoses to justify requests for full adult per diem rate.

"Premature infants weighing less than four and one-half pounds (2,000 grams) was recognized as being in jeopardy under our audit guidelines".

Our audits have found that many hospitals improperly submitted claims that represented newborns as needing special care and thus claimed full rate reimbursement. The medical charts, however, indicated that many of these "special treatment cases," particularly prematures had reached a normal healthy state and no longer required more than routine care.

3.3. Missing Patient Account Records

At many hospitals we have had difficulty locating records to support medicaid claims. In the event that records are not located by hospital staff before the conclusion of our field work, the charges will be disallowed. Hospitals should insure that adequate records are maintained to support all billings.

3.4 Incorrectly Reported Length of Patient Stay

Recent reports contain disallowances as a result of hospitals reporting incorrect patient lengths of stay. One recent audit cited a case where a Voluntary Hospital continued to submit medicaid claims for 111 continuous days after the patient died. Other

hospitals submitted billings prior to the date of actual admission. Finally, some claims included charges for both the date of admission and the date of discharge. Current City policy is to allow claims for the date of admission but not for the date of discharge.

Claims for improper lengths of stay submitted by a hospital appear to be the result of sloppy internal procedures. Hospitals should review their procedures to insure correct billings for length of stay.

4.0 Required Procedures to be Adopted by Hospitals Providing Services to Eligible New York City Individuals

4.1 Third-Party Resources and Reimbursements

Providers of medicaid services must maintain appropriate financial records supporting their determination of available resources, collection efforts, receipt of funds, and application of monies received. Such records must be readily accessible for audit purposes.

- o No claims are to be submitted for payment under the medicaid program before exhausting all available third party sources.

- o Monies received from third parties for services that have been paid for by the medicaid program must be promptly refunded through the use of adjustment Form W-633D. "Promptly is defined as no later than the third business day succeeding the date of receipt of funds from a third-party source.

4.2 Infant Care Rate Charges

- o Claims should be submitted in accordance with the following guidelines:

- 1) Any premature or other jeopardized infant regardless of weight or gestation, admitted to a premature center or intensive care unit should be regarded as eligible for the full rate of reimbursement, i.e., the adult rate.

2) Any premature or other jeopardized infant in a nursery other than a premature center or intensive care unit i.e., regular, observation, isolation nursery, requiring specialized care should be regarded as eligible for the full rate of reimbursement.

3) Specialized care means additional nursing and medical surveillance since these infants may require some or all of the following: Feeding by gavage, parenteral feeding (intravenous) or transfusion), oxygen administration, placement in incubator and pre or post-operative care.

4) The weight of an infant should not be the sole factor in determining the reimbursement; a baby weighing over 4 1/2 lbs. who is in good condition may not necessarily require intensive or specialized care and can be cared for in a full term nursery.

5) Medical records and nurses notes must clearly describe any medical condition that qualifies the infant as being in jeopardy.

6) Entries in medical charts describing an infant as "is doing well" and/or "receiving routine care" may not be claimed at the full rate even while in a premature center or intensive care unit.

7) Claims involving healthy or well babies who remain in the hospital after their mothers' discharge because they are awaiting foster care placement should be billed at the rate prescribed for "Boarder Babies" indicated in the Terms and Conditions Governing Payments to Voluntary Institutions for the appropriate fiscal year.

8) All other newborn infants should be billed at the prevailing new born rate during the infants hospital stay.

4.3 Missing Patient Account Records

Hospitals must safeguard patient account and medical records pending audit. Failure to provide such records for audit purposes will result in a disallowance of the hospital claim.

4.4 Incorrectly Reported Length of Patient Stay

Providers of inpatient hospital services must adopt strict internal control procedures so that billings will not be submitted

for discharged or other terminated patients, or for days of care other than those actually rendered.

4.5 Required New Certification

To emphasize the matters raised in sub-paragraph 4.1 and 4.4 above, the following signed certification should be attached to the hospital copy of all future claims. (The underscored portion of the following represents the additional language.)

"I certify that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing and that, except as noted, no part thereof has been paid; that the same also contains an accurate list of all sums of money received by said institution from any sources, credit for which should be given to the City on said statement; that payment of fees and rates made in accordance with established schedules is accepted as payment in full for the care, services and supplies provided; that there has been compliance with title VI of the Federal Civil Rights Act of 1964 in furnishing care, services and supplies without discrimination on the basis of race, color or national origin; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State medicaid program will be kept, and information will be furnished regarding any payment claimed therefore as the local social services agency or the State Department of Social Services may request; and that the vendor understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he may be prosecuted under applicable Federal and State laws for any false claims, statements, or documents or concealment of a material fact. Services for in-patient hospital care have been certified by a physician as medically justified and such certifications are on file in the hospital's medical records.

- o Each and all of the persons herein named were actually and physically within said institution or under its control during the whole of the period charged."