2014 ANNUAL REPORT

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GOVERNOR

DENNIS ROSEN
MEDICAID INSPECTOR GENERAL

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Message from the Inspector General

The Office of the Medicaid Inspector General (OMIG) is the national leader among Medicaid program integrity agencies. Results for 2014 reflect a continued focus in the area of managed care, where we completed 339 audits with over $38 million in identified overpayments. They also reflect cost avoidance that topped $1.79 billion.

OMIG strengthened our coordination with managed care special investigative units, social service districts, and law enforcement at every level. Through these efforts we investigated eligibility concerns at managed long term care plans including social adult day care services, certification issues with transportation providers, and drug diversion practices by medical practitioners. In our County Demonstration program, we identified $15 million in overpayments, more than twice the year before, while also doubling recoveries year-to-year.

We presented robust education programs as well as compliance efforts that led the nation. OMIG issued 25 compliance-related publications. We educated thousands of providers through webinars. As a result of OMIG's efforts, the number of providers certifying that they had an effective compliance program rose by more than one thousand to 18,529 - a new record. This was in addition to saving the Medicaid program more than $42 million by monitoring suspect providers' activities through corporate integrity agreements.

Program integrity efforts in past years were centered on a fee-for-service and rate-based payment infrastructure. With the transition to care management, OMIG continues to improve upon our processes and direct our resources to match this changing direction in the Medicaid program. OMIG used its knowledge of the Medicaid program to propose changes to the mainstream Medicaid model contract to strengthen program integrity. We will continue our focus on achieving dramatic improvements in Medicaid providers' compliance programs and aggressively fighting fraud, waste and abuse wherever it is found.

Sincerely,

DENNIS ROSEN
MEDICAID INSPECTOR GENERAL

OMIG is headquartered in Albany. Certain headquarter responsibilities, as well as field office functions, are based in New York City (NYC). Regional offices are located in White Plains, Hauppauge, Syracuse, Rochester, and Buffalo.

General Overview

History and Authority

On July 26, 2006, Chapter 442 of the Laws of 2006 was enacted, establishing OMIG as a formal state agency. The legislation amended the Executive, Public Health, Social Services, Insurance and Penal laws to create OMIG and institute the reforms needed to effectively fight fraud, waste, and abuse in the State's Medicaid program. The statutory changes separated the administrative and program integrity functions, while still preserving the single state agency structure required by federal law. Thus, although OMIG remains a part of the New York State Department of Health (DOH), it is required by statute to be an independent office. The Medicaid Inspector General reports directly to the Governor.

OMIG is charged with coordinating the work of fighting fraud, waste, and abuse in the Medicaid program. To fulfill its mission, OMIG performs its own reviews of the Medicaid program, while also working with other agencies which have either primary regulating authority or law enforcement powers. This means OMIG needs to understand Medicaid program regulations and guidance and use this knowledge to fight fraud and abuse, and to recommend improvements to the program.

Mission Statement

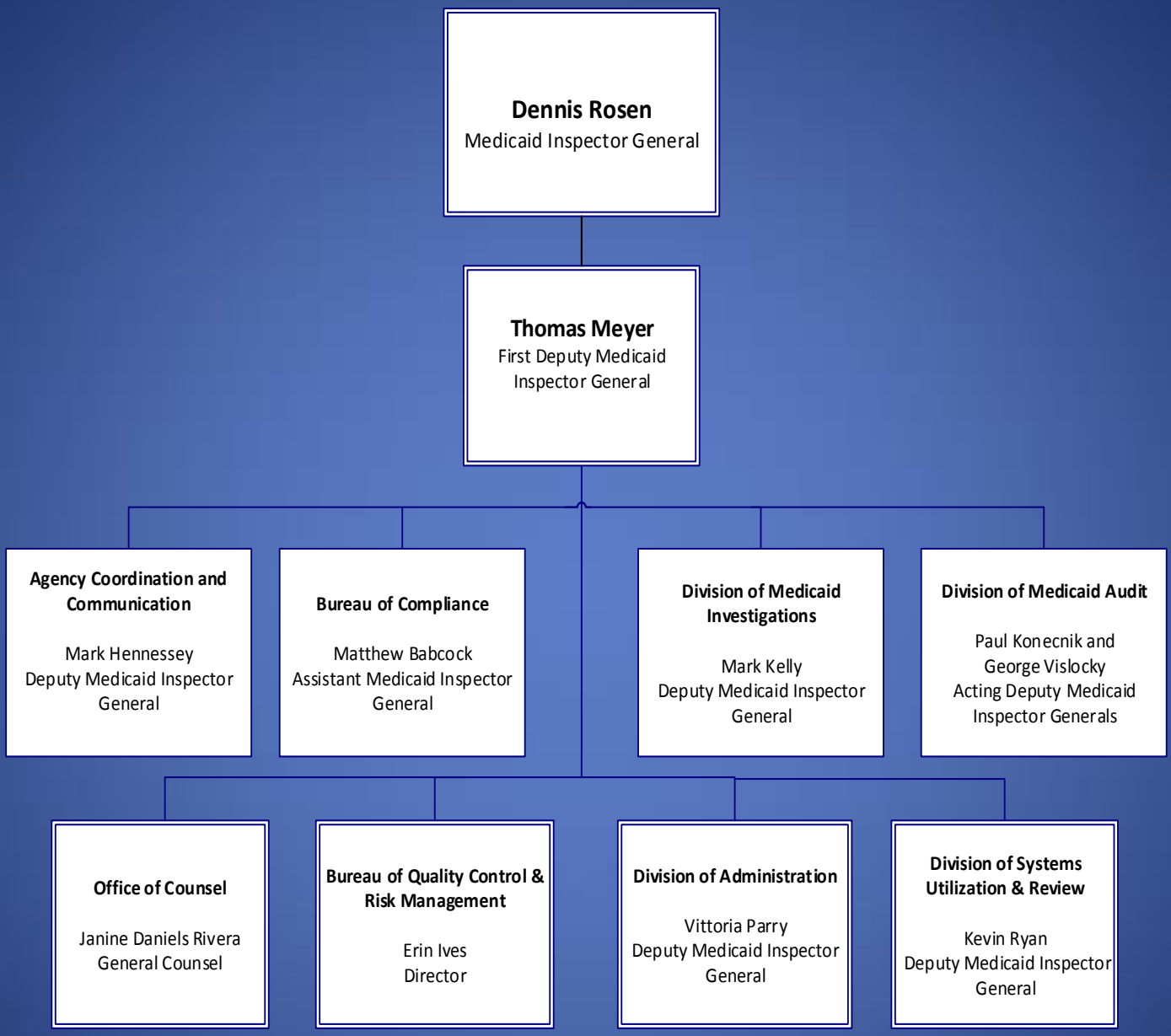
The mission of OMIG is to enhance the integrity of the New York State (NYS) Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds, while promoting high quality patient care.

Annual Reporting

As required by NYS Public Health Law §35(1), OMIG must annually submit a report that summarizes the activities of the agency for the prior calendar year. This Annual Report includes information about the audits, investigations, and administrative actions, initiated and completed by OMIG, as well as other operational statistics that exemplify OMIG's program integrity efforts.

Amounts reported within this document represent the value of issued final audit reports, self-disclosures, administrative actions and cost savings activities. OMIG recovers overpayments when it has been determined that a provider has submitted or caused to be submitted claims for medical care, services, or supplies for which payment should not have been made. OMIG recovers these amounts by receipt of cash, provider withholds, and/or voided claims. The recovery amounts may be associated with overpayments identified in earlier reporting periods. Identified overpayment and recovery amounts reflect total dollars due to the Medicaid program, as well as adjustments related to hearing decisions, stipulations and settlements.

OMIG Organizational Chart



2014 Program Integrity Activities

OMIG conducts and oversees program integrity activities that prevent, detect and investigate Medicaid fraud, waste and abuse, and coordinates such activities with other NYS agencies such as DOH, the Office for People with Developmental Disabilities (OPWDD), Office of Alcoholism and Substance Abuse Services (OASAS), Office of Temporary Disability Assistance, Office of Children and Family Services, the Justice Center for the Protection of People with Special Needs, the Education Department (NYSED), the fiscal agent employed to operate the Medicaid management information system, and local governments and entities.

OMIG receives and processes complaints of alleged fraud, waste, and abuse against the Medicaid program. These allegations are reviewed and investigated, and if it is suspected that fraud has occurred, or other illegal or inappropriate acts have been perpetrated within the Medicaid program, OMIG is required, in compliance with applicable regulations and laws, to refer cases to the NYS Attorney General's Medicaid Fraud Control Unit (MFCU).

Managed Care

In NYS, several different types of managed care plans participate in Medicaid managed care, including health maintenance organizations, prepaid health service plans, managed long-term care (MLTC) plans, and Human Immunodeficiency Virus (HIV) special needs plans. OMIG's ongoing efforts include performance of various match-based targeted reviews and other audits identified through data mining and analysis. These audits lead to the recovery of inappropriate premium payments and implementation of corrective actions that address system and programmatic concerns. During 2014, these efforts resulted in 339 finalized audits with over $38 million in identified overpayments.

Model Contract

In 2014, OMIG worked with MFCU and DOH to amend the October 1, 2012 Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract to strengthen program integrity requirements under the contract. These amendments include enhanced Health Plan (the Plan) reporting requirements; enhanced investigation and referral requirements for fraud and abuse; new screening requirements for network providers; and requiring network providers to adopt and implement compliance programs. The contract is retroactively effective to March 1, 2014.

Below are some examples of program integrity additions to the managed care model contract:

- **Fraud and Abuse Reporting Requirement (Section 18.5(a)(vii))**
  Referral obligation changed from "confirmed case" of fraud or abuse to "reasonably suspected or confirmed case" of fraud or abuse. In addition, the Plans must now simultaneously refer cases of fraud to both DOH and OMIG. The Plan must also submit a monthly report to DOH and OMIG of all Participating Providers who have been terminated "for cause," or who the Plan did not renew its Participating Provider agreement with "for cause." "For cause" includes, but is not limited to, fraud and abuse; integrity; or quality.

- **Certification Regarding Individuals who have been Excluded, Debarred or Suspended by Federal or State Government (Section 18.9)**
  DOH updated this section to comply with federal regulatory changes made as a result of the Affordable Care Act (ACA). OMIG's exclusion list was added to those lists already required to be checked monthly by Federal regulations. Finally, OMIG and MFCU added a requirement that the Plans check the status of subcontractors, and that the Plans must now check Non-Participating Provider exclusion status no later than 30 days after payment of the first claim.

- **Mandatory Terminations (Section 21.5(b))**
  Consistent with the requirements of ACA, the Plan must, upon notification from DOH or OMIG, now terminate its Medicaid Participating Provider Agreements with any Participating Provider who has been terminated by the Medicare program, the Medicaid program of any other state, or the Children's Health Insurance Program (CHIP) of any other state.

- **Self-Disclosures (Section 21.5(c))**
  If the Plan makes payments to an excluded or terminated provider for dates of service after the provider's exclusion or termination effective date, the Plan must report and explain within 60 days of identifying the payment, when and how the payment was identified, and the date on which the Plan adjusted the encounter data to reflect the recovery.

- **Required Components (Section 22.5(a)(iv))**
  OMIG and MFCU added language which clarifies that Participating Providers, regardless of whether they are enrolled as a Medicaid provider, are subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH.

- **NYS DOH Standard Clauses for Managed Care Provider/Independent Practice Association Contracts (Revised May 1, 2015)**
  All Participating Providers entering into a Participating Provider Agreement with a Managed Care Organizations (MCO), who meet the requirement to adopt and implement a compliance program under the provisions of New York State Social Services Law §363-d and Title18 of the New York Codes, Rules, and Regulations (NYCRR) §521.3, must

submit a certification to DOH within 30 days of entering this agreement attesting that the Participating Provider has a compliance program meeting those requirements. The Participating Provider must recertify every December thereafter that the Provider has a compliance program meeting the above referenced requirements.

Managed Care Investigation Unit

A new Managed Care Unit was created in OMIG's Division of Medicaid Investigations (DMI) that focuses investigative resources exclusively in the area of managed care. The Unit is responsible for the coordination, triage and investigations of complaints received from MCO relating to provider fraud, and works collaboratively with MCO Special Investigation Units (SIUs) in the development of comprehensive investigative plans to combat fraud, waste, and abuse in the Medicaid program. This includes coordinating and disseminating pertinent investigative information relating to allegations of possible fraudulent, wasteful, and/or abusive provider activity, and identifying investigative subjects across the MCO provider universe. The Unit reviews the quarterly and annual reports submitted by the MCOs, and also the results of the functional assessments conducted by DOH of the MCOs.

In an effort to coordinate program integrity efforts with the SIUs, OMIG created a database consisting of contact information for SIU staff in all managed care plans, and made the list accessible to OMIG investigators. OMIG's work with the SIUs resulted in nine criminal referrals to MFCU in 2014. OMIG staff regularly attends the Health Care Task Force meetings where representatives from state and federal law enforcement, and managed care providers, meet to discuss cases of mutual interest. These meetings are held in Albany, Buffalo, Rochester and NYC. The Unit has confirmed plans to visit each SIU during 2015 to continue to promote these effective relationships.

Managed Care Enrollment Monitoring

OMIG conducts audits of monthly capitation payments made to the MCOs to ensure the accuracy and appropriateness of these payments. There are instances where a monthly capitation payment is inappropriately made to an MCO due to enrollee eligibility errors or untimely file updates. These instances can include an enrollee's death, incarceration, or institutionalization; as well as situations where an enrollee is found to have been assigned more than one client identification number, is covered by commercial insurance, enrolled in a federal waiver program or has moved out of state. These retroactive disenrollment situations are identified by local departments of social services (LDSS), NYC Human Resources Administration (NYC HRA), New York State of Health (NYSoH), or through reports generated by OMIG. When a capitation payment has been inappropriately made due to eligibility errors or untimely eligibility file updates, LDSS and/or NYC HRA retroactively adjusts the enrollee eligibility file and instructs the MCO to void the premium payments received for any month where the MCO was not at risk to provide services.

In 2014 the responsibility to maintain and update the retroactive disenrollment database was transferred from DOH to OMIG. The transition was mutually agreed upon to streamline the notification process and replace DOH's paper based process. OMIG implemented an electronic process in an effort to enhance accuracy and efficiency, and to expedite the recovery of inappropriate premium payments made to MCOs. Plans are now notified of the disenrollment transaction electronically and have 30 business days to void the inappropriate capitation payments associated with that enrollee. OMIG continues to work with and provide guidance to the external agencies on this transition.

Managed Care Transition

Audit Issues

OMIG faces many challenges as Medicaid reimbursement continues to transition to a managed care capitation payment system. Program integrity efforts must continue to support and maintain dual audit processes for rate-based and fee-for-service (FFS) claims over the next several years, throughout the transition to managed care. The continued audit efforts associated with each of these areas are critical to ensure program integrity and a high standard of care.

This work is especially challenging, as OMIG continues to dedicate staff to providing program integrity assistance to other State and local agencies. OMIG has assisted DOH with Medicaid Redesign and Global Cap initiatives as well as providing audit resources in support of waiver program initiatives required by Centers for Medicare and Medicaid Services (CMS).

Technology and Encounter Data Issues

The challenges in transitioning to managed care are not limited to auditing. Staff is required to learn new data sets and changing data formats in order to utilize the information to identify audit areas and meet reporting requirements. Efforts are underway to improve reporting of encounter data. Improving the way encounter data submissions are reported will allow data systems to recognize and interpret claims submissions by MCOs.

Historically, data used to perform program integrity oversight of Medicaid was produced from the FFS billing process whereby providers submit claims directly to the State for payment. With the shift to a managed care model, collection of encounter data is separate from payment information, diminishing the collection of accurate, complete and timely encounter information about the services delivered to Medicaid enrollees and the providers paid for these services. To improve integrity of the data, the format and processing of Medicaid encounters will change with the implementation of a new payment database.

All the above challenges are part of the transition to managed care. The State continues to develop new processes and skills in order to provide effective program integrity oversight of managed care.

Audits

OMIG conducts audits of Medicaid services provided to eligible beneficiaries. The objectives of the audits are to assess the provider's compliance with applicable Federal and State laws, rules and policies governing the NYS Medicaid program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with DOH regulations and the appropriate provider manuals.

In 2014, OMIG finalized 182 FFS audits which resulted in audit findings of over $39 million. A significant audit finding that has been commonly identified by OMIG's FFS auditors is plan of care documentation that is missing, late or not properly authorized. These care plans may have different titles across all audit types, but nevertheless, form the basis for authorized Medicaid services. Errors of this nature resulted in identified overpayments and reinforced to the affected providers the importance of maintaining this documentation.

There are approximately 930 cost based Medicaid providers throughout NYS including Residential Health Care Facilities (RHCFs), Adult Day Health Care centers, Certified Home Health Agencies, and Long Term Home Health Care Programs. OMIG's rate audit efforts largely concentrated on the State's approximately 637 RHCFs which accounted for 13% of the New York State's total Medicaid expenditures in 2014. RHCFs submit annual cost reports to DOH's Bureau of Long Term Care Reimbursement (BLTCR). BLTCR uses this cost information as the basis to calculate individual daily rates for each provider. The rates are comprised of operating and capital components. OMIG examines the costs reported by the facility for accuracy and to verify that the cost should be included in the rate calculation. Examples of invalid expenses found during review are costs that are not related to patient care, undocumented expenses, and/or duplicated expenses. The reported base year costs are trended forward by an inflation factor and used by BLTCR to calculate the operating portion of the rate for subsequent years. The reported capital costs for RHCFs are used as a basis for the property component of the nursing facility's Medicaid rate. During 2014, 11 base year audits and 47 property audits were finalized with more than $23 million in identified overpayments.

Table 1.1

2014 Initiated Audits by Region

Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	18	2	13	0	33
Managed Care	146	52	42	0	240
Medicaid in Education	4	13	11	0	28
Provider	608	143	188	6	945
Rate	216	177	265	0	658
Self Disclosure	94	64	49	5	212
System Match Recovery	60	36	49	7	152
Total	1,146	487	617	18	2,268

Table 1.2					
2014 Finalized Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	45	2	10	0	57
Managed Care	190	81	68	0	339
Medicaid in Education	4	3	12	0	19
Provider	108	35	35	4	182
Rate	90	30	17	0	137
Self Disclosure	89	48	30	3	170
System Match Recovery	87	46	50	30	213
Total	613	245	222	37	1,117

Table 1.3					
2014 Overpayments Identified for Recovery by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	$14,416,916	$ (163,480)[1]	$ 970,813	$ 0	$ 15,224,249
Managed Care	29,358,486	6,376,085	3,142,697	0	38,877,268
Medicaid in Education	69,226	18,155	424,192	0	511,573
Provider	30,808,013	(125,637)[2]	6,950,001	2,249,287	39,881,664
Rate	10,387,885	3,389,644	4,191,154	0	17,968,683
Self Disclosure	8,802,456	2,260,100	819,870	3,001	11,885,428
System Match Recovery	1,529,698	288,546	211,456	104,532	2,134,232
Total	$95,372,680	$12,043,413	$16,710,183	$2,356,820	$126,483,096

Table 1.4					
2014 Overpayments Recovered by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	$ 3,016,720	$ (33,809)[3]	$ 131,161	$ 0	$ 3,114,072
Managed Care	28,548,590	6,347,559	2,688,476	114	37,584,740
Medicaid in Education	187,832	305,279	827,768	0	1,320,879
Provider	34,825,011	8,181,113	5,739,750	5,863	48,751,737
Rate	44,383,264	5,459,188	5,610,590	0	55,453,042
Self Disclosure	11,410,563	2,933,281	1,662,826	19,753	16,026,423
System Match Recovery	2,226,735	410,138	197,409	431,157	3,265,438
Total	$ 124,598,715	$23,602,749	$16,857,980	$456,887	$165,516,331

1. Audit overpayments identified for recovery were lowered due to stipulations issued in 2014 related to final audit reports issued in prior reporting periods.
2. Audit overpayments identified for recovery were lowered due to stipulations issued in 2014 related to final audit reports issued in prior reporting periods.
3. Audit overpayments recovered were lowered due to stipulations issued in 2014 related to final audit reports issued in prior reporting periods.

Data Mining and Technological Support

OMIG has dedicated staff that use technology and business automation to achieve agency goals. This staff provides a range of services and functions that drive agency initiatives through the optimal use of data. The data warehouse and many associated applications are used for various analytical tasks that assist in management decisions and auditors performing provider reviews. This group also focuses on maintaining Medicaid program integrity through the use of point-of-service controls, pre-payment edits, developing and monitoring changes to the Medicaid systems and identifying overpayments through system matching.

Protocols

Audit protocols are developed for each FFS category of service or program audited by OMIG. These protocols assist the provider community in developing programs to evaluate its compliance with Medicaid requirements. Audit protocols are intended solely as guidance in this effort. In 2014, six protocols were newly added or modified, bringing the total to 24 audit protocols posted to the OMIG website. OMIG protocols are available at: http://omig.ny.gov/audit/audit-protocols.

Presentations

Throughout the year OMIG staff participated in outreach and educational presentations to various provider associations. The OMIG Work Plan, the audit process, OPWDD audits, assisted living programs, personal care audit protocols, and what home care providers can expect pertaining to managed care audits were some of the topics of discussed with these associations. These groups included:

- The New York Health Information Association,
- The Alliance of Traumatic Brain Injury & Nursing Home Transition and Diversion Waiver Providers,
- The NYS Health Facilities Association,
- The NYS Association of Health Care Providers,
- Financial Managers' Association,
- NYSARC, Inc. and Cerebral Palsy Association of NYS, Interagency Counsel of Developmental Disabilities Agencies, Inc., and
- The Central NY Quality Assurance Coalition.

Lean Process

In conjunction with guidance received from the Spending and Government Efficiency (SAGE) Commission's NYS Lean Office, OMIG has implemented a number of Lean Process initiatives. These refinements are expected to result in a more effective and efficient FFS audit process. By focusing on quality at the source, a level of review and approval has been eliminated at two

stages of the audit report preparation process. Steps have also been taken to enhance an electronic work paper application in order to better suit auditor needs. Specifically, modifications have been made to the Provider Audit Disallowance System enabling the generation of financial impact reports that will be utilized in FFS audit reports. These system enhancements will save time and expedite the supervisory and managerial review and approval process of audit reports. Additionally, providing remote internet access to auditors should expedite field work time and reduce travel time and expenses.

DMI's Enrollment and Reinstatement Unit, has applied the Lean principles in the review of the pre-enrollment inspection process, and anticipates through standardizing work and eliminating unnecessary review steps, it will reduce its enrollment on-site inspections cycle time from 65 days to 45 days, a 30% improvement.

OMIG's Office of Counsel (OC) has reduced the average processing time to complete an administrative hearing from 400 days to 256 days by streamlining the method of requesting audit files, scheduling hearings and offering training to its staff. These changes have improved OC's processes, thereby decreasing costs, improving provider compliance, and assisting OMIG in its mission to safeguard Medicaid dollars.

Positive Reports

In the process of an audit there are times when OMIG finds that, for the audit period and objective reviewed, the provider has generally adhered to applicable Medicaid billing rules and regulations. In these instances OMIG will issue an audit summation letter advising the provider that pursuant to 18 NYCRR §517.3(h) the audit was concluded and no further action is required on their part. These reports are also listed on the OMIG website as "Positive Reports."

Table 1.5

Audit Department	Audit Summations
Fee-for-Service Audit	679
Rate Audit	148
Medicaid in Education	14
County Demonstration Program	12
Total	853

Investigations

OMIG actively investigates allegations of fraud, waste and abuse, within the Medicaid program. OMIG also conducts investigations of enrolled and non-enrolled providers, entities, and recipients. Allegations are analyzed utilizing a variety of methods, including but not limited to data mining, undercover operations, analyses of returned Explanation of Medicaid Benefits (EOMB), and interviews of complainants and subjects. Investigations can lead to administrative actions and sanctions, where appropriate.

Table 2.1

Summary of Investigations by Source of Allegation and Region*

	Downstate		Upstate		Out of State		Totals	
Initial Source	Opened	Completed	Opened	Completed	Opened	Completed	Opened	Completed
Anonymous	358	292	215	216	0	0	573	508
Fiscal Agent Fraud Unit	7	2	1	1	0	0	8	3
District Attorney	41	1	1	0	0	0	42	1
Enrolled Recipient	137	149	33	45	6	6	176	200
Federal Agencies	38	42	4	20	1	1	43	63
General Public (Non-enrolled)	188	171	120	149	5	2	313	322
Law Enforcement	0	11	0	6	0	0	0	17
Local District Social Services	15	21	121	121	8	7	144	149
Managed Care Plans	104	77	56	40	6	6	166	123
Non-Enrolled Provider	7	8	0	0	0	0	7	8
Non-Enrolled Recipient	0	2	0	0	0	0	0	2
Provider	62	81	65	71	3	1	130	153
Qui Tam	0	5	0	1	0	6	0	12
State Agencies (including OMIG)	1,190	1,077	284	257	79	29	1,553	1,363
Total	2,147	1,939	900	927	108	58	3,155	2,924

Special Narcotics Prosecutor

In 2014, an anesthesiologist, who gained notoriety for prescribing pain pills to a man who murdered four people during a pharmacy robbery in Long Island, was convicted on 198 of 211 charges, including manslaughter and reckless endangerment. Between January 2009 and November 2011, the doctor had been seeing as many as 100 patients a day on weekends in his Flushing clinic. He charged patients for prescriptions which he ordered in toxic levels and combinations. OMIG investigated this provider collectively with the Office of the Special Narcotics Prosecutor for the City of New York, along with other federal, state and city law enforcement agencies including DOH's Bureau of Narcotic Enforcement, the New York City Police Department, New York/New Jersey High Intensity Drug Trafficking Areas, and the New York Drug Enforcement Task Force. Additionally, assistance was provided by the United States Department of Health and Human Services Office of Inspector General (HHS OIG), the Office of National Drug Control Policy, and the Internal Revenue Service (IRS). OMIG investigators and nurse consultants

* Investigations completed may represent cases opened in prior periods.

assisted these various law enforcement agencies. In December 2014, the doctor was sentenced to a minimum of 10 2/3 years and a maximum of 20 years in prison, followed by a term of post release supervision.

Drug Enforcement Administration and the Internal Revenue Service

After OMIG investigators identified unusual prescribing patterns by a Long Island doctor, 63 Medicaid recipients were targeted for investigation based on their receipt of high dosages of narcotics. In the process of interviewing the doctor to determine if the prescriptions were forgeries, OMIG investigators found that he was printing and signing prescriptions without examining patients. The investigators met with the United States (U.S.) Drug Enforcement Administration and the IRS, who were also conducting an investigation on the physician. The collaborative efforts led to the arrest of the physician who pled guilty on May 6, 2014 to 19 counts of the illegal distribution of the highly addictive painkiller oxycodone.

United States Department of Justice Medicare Fraud Strike Force

In 2014, OMIG's investigators were presented with awards by the Assistant U.S. Attorneys for their outstanding assistance in every facet of a U.S. Department of Justice Medicare Fraud Strike Force investigation and subsequent trial of two podiatrists. The two podiatrists, both licensed to practice podiatric medicine in NYS, were found guilty of committing health care fraud and were sentenced to incarceration, restitution to Medicare and Medicaid, and a forfeiture of their financial assets. The case was concluded with both individuals being excluded from the NYS Medicaid program based on these convictions.

Program Integrity Referrals to MFCU and Outside Agencies

OMIG is required by NYS law to refer suspected fraud and criminality to MFCU. OMIG also refers its findings to the agencies responsible for oversight of professional licensure, specifically, NYSED's Office of Professional Discipline (OPD) and DOH's Office of Professional Medical Conduct (OPMC). OPD and OPMC may take administrative action on individuals who hold professional licenses.

Table 2.2
Referrals to MFCU

Provider Type	2014
Capitation Provider	5
Clinical Social Worker	2
Dental Groups	1
Dentist	4
Home Health Agency	7
Hospital	2
Laboratory	1
Long Term Care Facility	1
Medical Appliance Dealer	3
Multi-Type	1
Multi-Type Group	2
Nurse	16
No Provider Type	2
Non Enrolled Provider	105
Pharmacy	89
Physician	25
Physicians Group	3
Therapist	1
Transportation	15
Total	**285**

Table 2.3
Referrals to Outside Agencies

Agency	2014
Health and Human Services (HHS-OIG)	2
Law Enforcement Agency	114
Local District Attorney	41
Local District Social Services	197
Managed Care Organizations	1
NYC HRA Bureau of Client Fraud Investigations	550
Office of Professional Discipline	37
Office of Professional Medical Conduct	22
Office of Welfare Inspector General	9
Other DOH Unit (not OMIG)	9
Other Federal Agency	6
Other State Agency	53
Total	**1,041**

Transfer of Recipient Eligibility Functions

With the advent of NYSoH, the responsibility to determine recipient eligibility for most Medicaid categories of service was transferred to the State from the LDSS and NYC HRA. NYSoH began processing and approving Medicaid applications on January 1, 2014. This centralization resulted in the reassignment of many of the LDSS Medicaid staff who were responsible for processing and investigating eligibility at the local level.

Prior to this centralization, OMIG would refer eligibility related cases to the LDSS for investigation and redetermination of eligibility, if appropriate. Fraud referrals previously made by OMIG to the LDSS are now being investigated by OMIG. Additionally, all complaints regarding recipient eligibility received through the LDSS fraud hotlines are being referred to OMIG when the Medicaid case is opened by NYSoH. OMIG is currently working with DOH and the Welfare Inspector General to develop a process to investigate these new recipient eligibility fraud allegations and cases.

Compliance Initiatives

NYS Social Services Law §363-d and 18 NYCRR Part 521 outline the specific criteria for determining which providers are required to adopt and implement a compliance program. For these providers, an effective compliance program is required in order to be eligible to receive Medicaid payments or submit claims for Medicaid services.

Certification and Review

Each December, on OMIG's website, Medicaid providers subject to the mandatory compliance program obligation are required to complete and submit an annual certification that their compliance programs meet statutory and regulatory requirements. In 2014, the total number of providers meeting the annual certification obligation increased to more than 18,500, up from over 17,000 in 2013. If a provider is required to have a compliance program, then the certification must be completed at the time of initial enrollment; and, upon an existing Medicaid provider's revalidation of enrollment in the Medicaid program, proof of their certification must be provided to NYS.

The Bureau of Compliance (BOC) is authorized to conduct reviews of those providers falling within these statutory and regulatory requirements. When BOC conducts reviews of providers' mandatory compliance programs all reasonable steps are taken to work with providers to assist them in meeting these compliance obligations. BOC reserves the right to conduct unannounced follow-up reviews to confirm the provider has corrected any previously identified insufficiencies.

Corporate Integrity Agreements

OMIG imposes Corporate Integrity Agreements (CIA) on certain providers that OMIG determines have committed unacceptable practices, but whose removal from the Medicaid program would negatively impact access to necessary services. The CIA allows for strict oversight of a provider. Providers under a CIA are subjected to monitoring that includes, but is not limited to, annual claims reviews, cost reporting reviews, and compliance program reviews. Monitoring Medicaid providers' performance under the terms of CIAs resulted in more than $42 million in cost savings to the Medicaid program in 2014. CIAs are imposed for a five year term. In December 2014 three CIAs ended due to the expiration of the agreements.

Management of CIAs by OMIG requires coordination and collaboration with other OMIG divisions and with other state and federal agencies. During 2014, OMIG collaborated with DOH, OPWDD, MFCU, and HHS OIG. The collaboration involved matters related to changes being made to providers' reimbursement rates, issues associated with the CIA provider's performance in meeting Medicaid program requirements, unacceptable practices for Medicaid providers being considered for a CIA, and other enforcement matters.

Education and Outreach

OMIG also provides education and outreach to providers and other federal and State entities on compliance topics. During 2014, OMIG issued 25 compliance related publications which included provider type

specific compliance guidance, summaries of compliance program review results, updating the Compliance Library portion of OMIG's website, and revising the mandatory compliance program certification forms available on OMIG's website. Ten compliance presentations were held including webinars, a live Twitter session during May's Compliance Week, and presentations to provider groups and associations. BOC responded to 447 telephone calls, as well as 221 emails, regarding questions on a variety of compliance topics.

In an effort to assist the state of Arkansas's Office of the Medicaid Inspector General, OMIG provided background and information, at their request, on the mandatory compliance program regulations at 18 NYCRR Part 521. Arkansas' mandatory compliance program statute mirrors the New York law, but Arkansas had not developed regulations to complement its law. Arkansas sought information on lessons learned by New York in its oversight of providers' obligations under Part 521. Arkansas indicated it would use Part 521 as it developed its mandatory compliance program regulations.

Collaborative Activities

2014 Operational Survey

OMIG collaborated with DOH's Office of Health Insurance Programs (OHIP) to conduct a review of MCOs using an Operational Survey and on-site reviews. The Operational Surveys asked specific questions of 19 mainstream Medicaid MCOs related to operational procedures and business practices. OMIG provided OHIP with trained investigative staff who conducted interviews and reviewed the MCO SIUs to ensure they are adequately performing their investigative functions.

Health Fraud Prevention Partnership - Data Analysis and Review Committee

The Health Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership between the Federal government, State Medicaid programs, law enforcement, private health insurance plans and associations, and healthcare anti-fraud associations. The HFPP aims to foster a proactive approach to detect and prevent healthcare fraud through data and information sharing.

The organization decides collectively on specific studies which could benefit all involved. Data is then collected by the participating entities and analyzed as a whole. The idea is that more knowledge can be gained by combining disparate sets of data.

OMIG participates in the Data Analysis Review Committee (DARC) technical subgroup. This group meets monthly for the purpose of data sharing and analytics.

As studies are created and data requested, OMIG staff query the Data Warehouse and provide HFPP with the requested data. When data has been analyzed and returned to the group, OMIG reviews and investigates any providers of interest.

Medicaid Integrity Contract Audits

As part of a federally required Medicaid program integrity project, OMIG continues to collaborate with Island Peer Review Organization (IPRO) auditors who are contracted by CMS to conduct audits of paid Medicaid claims from various Medicaid providers. OMIG works with IPRO to identify and target specific audit areas and providers as part of the Medicaid Integrity Contract (MIC) audits. These MIC audits are conducted in addition to OMIG's current audit activities; and, in 2014, 5 audits were finalized, with over $3 million in identified overpayments.

Electronic Health Records Incentive Payment Program

Through the Medicaid Electronic Health Record (EHR) Incentive Payment program, hospitals and eligible providers in NYS who adopt, implement, or upgrade certified EHR technology, and subsequently become meaningful users of the EHR technology, can qualify for financial incentives. The NY Medicaid EHR Incentive Program operates under program integrity guidelines developed by OMIG, DOH and CMS, in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009.

Ongoing collaboration between DOH and OMIG is necessary in order to adhere to the terms of the HITECH Act, which requires New York to conduct adequate oversight of the Medicaid EHR Incentive Program in order to ensure that Recovery Act funds are expended wisely, and to take appropriate actions to combat fraud, waste, or abuse.

DOH administers the program and performs a pre-payment validation. This process is designed to ensure that the provider completed the application correctly and accurately and, to the greatest extent possible, to address any problems prior to the issuance of the incentive payment.

OMIG provides oversight and conducts post-payment audits to ensure that the eligibility requirements of the NYS Medicaid EHR Incentive Program were met according to applicable federal and state guidelines. In 2014, OMIG initiated 749 audits, and issued 34 final audit reports with approximately $402,000 in identified overpayments. Additionally, OMIG determined that 624 providers were in compliance with EHR standards.

In an effort to provide outreach and education, both OMIG and DOH established outreach teams to collaborate and offer educational resources to the stakeholder community. These resources include, but are not limited to, an EHR Incentive Program website (https://www.emedny.org/meipass/), webinars, in-person presentations, and development of frequently asked questions.

ADMINISTRATIVE ACTIONS

Sanctions – Exclusions

Sanctions that can be imposed on a provider by OMIG include censure, exclusion, and conditional or limited participation in the Medicaid program (18 NYCRR §515). In 2014, OMIG conducted investigations and imposed exclusions based upon:

- investigations that identified unacceptable practices as defined by 18 NYCRR §515.2 and/or determined that the provider represented an imminent danger to the public health or welfare;
- NYSED actions, such as license surrender, suspension and revocation, for Medicaid and non-Medicaid providers;
- actions taken by DOH's OPMC involving professional misconduct and physician discipline actions, including suspensions, revocations, surrenders, and consent agreements;
- felony indictments and convictions of crime relating to the furnishing or billing for medical care, services, or supplies;
- federal HHS OIG exclusion actions; and/or,
- ownership information and affiliations of excluded providers.

OMIG issued 822 exclusions in 2014. The NYS Medicaid Exclusion List contains 5,458 Medicaid and non-Medicaid provider exclusions. This list is updated daily (except holidays and weekends) and is available to the public on OMIG's website, www.omig.ny.gov.

Under 18 NYCRR §515.7, OMIG may sanction any person or entity that has been charged with a felony, or convicted of a crime, related to the billing or furnishing of medical care, services or supplies. Of the 822 exclusions issued in 2014, OMIG issued 277 Notices of Immediate Agency Action to exclude individuals and entities from the Medicaid program based on MFCU prosecutorial activity. Four additional individuals and entities were censured based on MFCU actions.

Table 2.4

Sanctions By Type

Administrative Actions	Number of Actions Total
Censures	57
Affiliations – 18 NYCRR 504.1(d)(1)	67
Unacceptable Practice – 18 NYCRR 515.2	5
Indictments – 18 NYCRR 515.7(b)	167
Convictions – 18 NYCRR 515.7(c)	230
Imminent Danger – 18 NYCRR 515.7(d)	16
Professional Misconduct – 18 NYCRR 515.7(e)	59
Mandatory Exclusion – 18 NYCRR 515.8	278
Grand Total	879

Affordable Care Act

In March of 2010, ACA was enacted into federal law. ACA includes numerous provisions designed to increase Medicaid program integrity. For OMIG, this entails recommending termination or denying enrollment of providers that are barred by other state and federal entities from participating in government funded health care programs. ACA also requires states to suspend provider's Medicaid payments when it is determined that a credible allegation of fraud exists.

Under Section 6501, States must terminate the participation of any individual or entity if such individual or entity is terminated under Medicare or any Medicaid State plan. OMIG utilizes CMS's web based portal known as the TIBCO MFT Server by searching for any current NYS providers that have been terminated "for cause" by another state or Medicare. OMIG downloads these lists every other month, and reviews documentation that is provided through the portal to confirm that the action taken was indeed "for cause" which, in accordance with ACA, may include but is not limited to, fraud, integrity or quality. After OMIG confirms the action was indeed "for cause", OMIG then refers this information along with the list of providers terminated from Medicare to DOH for termination of their NYS Medicaid contracts. In 2014, five active NYS Medicaid providers were identified on the portal as terminated "for cause". OMIG referred these providers to DOH for termination.

Additionally, OMIG regularly sends information regarding actions taken by OMIG or DOH pertaining to NYS providers who have been excluded or terminated "for cause" to CMS for upload to the TIBCO MFT Server

In 2014, 98 providers were uploaded to this portal.

OMIG and OHIP worked together in 2014 to address the ACA requirements regarding provider revalidation, and devise an implementation plan. OMIG agreed to assist OHIP in effectuating the ACA requirement that all providers enrolled prior to April 1, 2011, must be revalidated by March 31, 2016.

Table 2.5
Referrals of Credible Allegation of Fraud to MFCU

Provider Type	2014
Capitation Provider	3
Clinical Social Worker	2
Dental Groups	1
Dentist	4
Home Health Agency	5
Hospital	1
Long Term Care Facility	1
Medical Appliance Dealer	2
Multi-Type	1
Multi-Type Group	2
Nurse	15
Non Enrolled Provider	1
Pharmacy	76
Physician	23
Physicians Group	3
Therapist	1
Transportation	14
Total	155

Third Party Liability and Cost Savings

Third Party Liability

Medicaid is the payer of last resort; however, providers often do not bill the responsible third-party insurer before billing Medicaid. A significant amount of the State's Medicaid recoveries are the result of OMIG's efforts to obtain payments from private insurers responsible for services inappropriately reimbursed by Medicaid funds. Other insurance coverage, including Medicare and/or commercial insurance, should be identified during the enrollee's intake process.

Third Party Insurance Identification for New York State of Health Enrollees

NYSoH, New York State's official health plan Marketplace enrolled 525,283 people in Medicaid through its first enrollment period in 2014. A new third party insurance identification process, which was previously conducted at the LDSS, had to be established for Medicaid recipients enrolled through the Marketplace. OMIG collaborated with NYSoH, DOH Third Party Liability Unit and the state's fiscal agent over several months to develop this process and include these Medicaid enrollees within OMIG's third party liability identification and recovery processes. Due to the work conducted by these parties in the months prior to implementation, the third party identification and recovery processes were uninterrupted when NYSoH opened. OMIG also collaborated with DOH Third Party on a managed care disenrollment project specifically for Medicaid recipients enrolled though NYSoH.

Backlog of Home Health Cases at the Office of Medicare Hearings and Appeal

The purpose of the Home Health Care Medicare Maximization Project is to determine the Medicare share of the cost of home health services for dual-eligible beneficiaries whose claims were originally submitted to and paid by NYS Medicaid. OMIG and its contractor, the University of Massachusetts Medical School, participated in a CMS pilot program titled "Demonstration of Home Health Agencies Settlement for Dual Eligibles" (Demonstration Program) to review these dual-eligible beneficiary claims. The Demonstration Program utilized a sampling methodology in which 200 cases per federal fiscal year were selected from a universe of home health claims. Results from adjudication of the sampled claims were used to calculate the Medicare share of payments for the universe.

In 2013, despite the efficacy of the Demonstration Program, CMS did not approve continuation of this project for review periods of 2011 and later. Therefore, NYS has had to return to the traditional case-by-case process of adjudicating thousands of appeals per year. Unfortunately, the volume of appeals associated with the traditional process is more burdensome for all involved parties.

In addition, delays exist at all four Medicare administrative levels of appeal. The most notable backlog exists at the third level of appeal, the Office of Medicare Hearing and

Appeals (OMHA). Even with these significant delays, neither OMHA nor CMS have offered a feasible alternative administrative remedy to state Medicaid agencies. On numerous occasions, NYS has advocated for resumption of the Demonstration Program or a similar method to adjudicate claims more expeditiously through the use of sampling and arbitration. OMIG continues to closely monitor the status of appeals and will continue to request a more effective process for resolving them.

In 2014, utilizing the case-by-case review process, OMIG recovered over $2.6 million as part of this project, as opposed to $502 million in 2013. The recoveries in 2013 were higher than in previous years as a result of a large multi-year settlement with the federal government related to this project. However, even without the settlement, this year's recoveries reflect a significant decrease from the average annual recoveries of more than $99 million in prior years when the sampling methodology was used. This decrease in recoveries is a direct result of CMS's discontinuation of the Demonstration Project and backlog of appeals.

Medicaid Recovery Audit Contractor

Pursuant to ACA, Medicaid agencies are required to contract with a Recovery Audit Contractor (RAC) to identify and recover Medicaid overpayments. The Medicaid RAC Program is modeled after CMS's Medicare RAC Program, but provides significant discretion for states to tailor activities to meet their unique Medicaid program requirements.

As the NYS designated RAC, HMS performs data mining algorithms on the Medicaid database to identify potential areas of recovery. HMS then develops an Improper Payment Scenario Development Request (IPSDR) for each initiative. This document includes the overpayment scenario methodology used to identify the finding, and and any pertinent State and federal regulations. The IPSDR is approved by OMIG staff prior to implementation.

Overpayments associated with these projects can be tracked and reported through the PORTal that was developed by HMS. This process allows for validation of the overpayment at the time of data mining and notifies providers of such via mail and electronically via the PORTal. This process places more emphasis on provider compliance and program oversight as each overpayment is reviewed at the claim level.

During 2014, HMS identified and recovered approximately $19.2 million in inappropriate Medicaid expenditures. Some of the RAC projects undertaken by HMS were reviews of hospital based credit balances, long-term care bed holds, net available monthly income (NAMI), vaccines for children reviews, Medicare Part B coinsurance, and the recovery of managed care and FFS overlap.

Table 3.1

2014 Third Party Liability and RAC Recoveries

Activity Area	Amount
Third Party Liability	$ 108,834,734
Casualty & Estate	74,868,461
Recovery Audit Contractor	19,292,871
Home Health Care Demonstration Project	2,617,417
Self-Disclosed TP Health Insurance	605,866
Total	$ 206,219,349

Cost Savings

Cost savings activities prevent inappropriate, duplicate, or erroneous Medicaid payments from being made. OMIG's cost savings are calculated as estimates based on historical and current Medicaid claims data. Cost savings amounts are not cash recoveries. Cost savings initiatives are proactive actions to save taxpayer dollars and help OMIG to protect the integrity of the Medicaid program. Each OMIG action or initiative has its own methodology for calculating program costs that are avoided. For example, OMIG utilizes program edits in the Medicaid billing system that deny provider claims, thereby preventing improper Medicaid payments from being made; those denied claims represent cost savings. In another example, when OMIG has an intervention with a provider, the agency will compare billing patterns prior to the intervention with those after to determine the cost savings attributable to the agency's actions.

OMIG puts great effort into developing, reviewing and approving its cost savings methodologies including utilizing internal workgroups consisting of cross functional teams. Teams will review all cost savings initiatives on an ongoing basis to identify and assess fluctuations in the savings amounts reported. Fluctuations can occur naturally over time for any of OMIG's actions or initiatives, and the workgroup ensures that methodologies are being reviewed on a timely basis.

Throughout 2014, OMIG estimates it saved NYS taxpayers more than $1.7 billion as a result of these proactive efforts. Some examples of these activities are outlined below.

Payment/Claims System Edits - Improvements to edits on the Medicaid payment/claims system resulted in savings of approximately $67.6 million. Claims that were denied by the edit improvements recommended by OMIG and not resubmitted to Medicaid within the 90 day resubmission allowance period generated these savings.

Pre-payment Review - A provider can be placed on pre-payment review (PPR) if it is demonstrated that the provider may have suspected unacceptable or inappropriate billing practices. PPR affords OMIG the opportunity to review provider submitted Medicaid claims before they are paid. Claims transactions are manually reviewed prior to any payment being made; and, as part of this review, staff will contact providers and request information necessary to support the submitted claims. Based on the review of the provider's documentation, claims will be paid or denied. As a result of these in-depth PPRs, providers can be referred for further investigation and/or administrative action. Those claims that are denied result in cost savings to the Medicaid program. For example:

> **Transportation PPR** - The PPR Unit in OMIG reviewed 65 transportation providers in 2014. The majority of the reviews involved invalid or suspended vehicle plate numbers, inactive or suspended 19-A drivers or inadequate documentation to support the claim. Five referrals were made to DMI for further action. The total cost savings realized in

2014 from these transportation reviews was more than $8 million.

OMIG can also recognize cost savings by measuring "sentinel" effect on the providers Medicaid billings. The sentinel effect is achieved by measuring the change in a provider's Medicaid billing practice by determining their average Medicaid billings before placing the provider on PPR, and comparing it to their Medicaid billing after PPR has been completed.

Private Duty Nursing PPR - The Medical Review Team routinely performs queries on the Medicaid Data Warehouse of independently enrolled private duty nurses (PDN) and nurse registries. Results of this activity indicate that many providers, especially those who care for multiple recipients, are billing for more than 16 hours a day. In addition, the billing patterns of some providers were highly suspect. For example, OMIG found providers who billed for 16 hours a day, 7 days a week, and 365 days a year.

In a case referred to DMI, a PDN worked for two recipients. The documentation review indicated that on numerous occasions the PDN's shifts would overlap. On several occasions documentation indicated the PDN's shift was completed at 10:30 p.m., yet on the same date, the other recipient's documentation indicated the PDN started at 10:00 p.m. The progress notes also indicated the PDN worked between 23 and 30 consecutive hours.

As a result of these reviews, OMIG found a number of PDNs appeared to "drop out" of the program, either in response to the PPR, or when requested to provide required documentation. Cost savings for the PDN review project were over $7 million in 2014.

Third Party Liability Pre-payment Insurance Verification – The NYS third-party liability vendor, HMS, obtains rosters of insured individuals from many insurance carriers across the country. HMS matches this identified coverage against Medicaid beneficiaries enrolled in NYS in an effort to identify those beneficiaries that have additional insurance coverage. Once identified, this information is added to eMedNY so that medical services are first billed to the other insurance, leaving Medicaid as the payer of last resort. This activity resulted in cost savings of over $1.4 billion in 2014.

Enrollment Screening Activities

Another way OMIG saved taxpayer dollars was to prevent potentially problematic providers from enrolling in the NYS Medicaid program. The tools and methods used in reviewing these cases included pre-enrollment on-site inspections, undercover operations, federal and State database checks, and coordination between OMIG and OHIP policy staff. ACA requires states to conduct pre-enrollment reviews of physical therapy providers, portable X-ray, and durable medical equipment suppliers. In addition to these required categories, OMIG also conducted pre-enrollment reviews of pharmacies, physicians, nurses, laboratories and transportation

companies in order to prevent potentially fraudulent, abusive or fiscally irresponsible providers from being enrolled in the Medicaid program. OMIG denied 154 applications for provider enrollment and/or reinstatement, resulting in estimated cost savings of over $16.3 million in 2014.

Pharmacy Denial - A pre-enrollment on-site inspection conducted by OMIG found that the pharmacy was not sanitary. The pharmacy had dirty and water-stained ceiling tiles, and a bucket full of dirty water was on the floor in the dispensing area to catch water dripping from the tiles. One of the pharmacy walls was bare and covered with plastic sheeting as if it needed to be repaired; however, there was no sign of any current renovation being done. Water from the sink in the dispensing area came out rust-colored and drained into a hole in the floor. Pharmacy equipment was found in the sink next to dirty dishes. OMIG denied this application.

Dental Group Denial - During an on-site visit conducted by OMIG, investigators found that an unlicensed employee was performing the duties of a dental hygienist. The employee was sterilizing instruments, taking X-rays, and cleaning teeth without a license. In addition, investigators found that a dentist working for the group is currently excluded from the Medicaid program. These circumstances caused OMIG to deny this application.

Physical Therapist Denial - OMIG conducted two on-site inspections of this provider as part of the enrollment process. The first on-site visit was attempted by OMIG, and no one was at the listed service location. A second on-site visit found that the provider's service address was located in the basement of his house. There were no exterior or interior signs showing that services were provided at the location and there was no business office on premises. The only equipment in the basement was a dirty treadmill, a stationary bicycle that had not been used for some time that was covered with miscellaneous items, one balance ball and small weight. There were very few patient records, and the provider did not accept any third party insurers. Based on the information found by the investigators, it was apparent that the therapist did not have a viable established business prior to enrollment and the application was denied.

Table 3.2	
2014 Cost Savings Activities	
Activity Area	**Amount**
Clinic License Verification	$ 8,166,855
Corporate Integrity Agreement Sentinel Effect	42,364,369
Dental Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	375,991
Duplicate Claim included in Inpatient Coverage – Edit 760	1,138,745
Enrollment and Reinstatement Denials	16,304,197
Exclusions/Terminations – Internal	11,258,572
Exclusions/Terminations – External	9,879,872
Managed Care Locator Code	30,374,352
Medical Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	224,532
Medicaid Claim Denials (Providers Removed from Active PPR <= 12 Months) – Edit 1141	235,368
Medicaid Claim Denials (Providers Removed from Active PPR 13-24 Months) – Edit 1141	226,148
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	64,276,044
Ordering Provider Excluded Prior to Order Date – Edit 939	2,694,719
Ordering/Referring Provider Number Missing – Edit 903	2,699,587
Order/Servicing/Referring Provider Number Verification – Edit 1236/1238	3,701,529
Pharmacies License Verification	5,222,298
Pre-Payment Insurance Verification Commercial	908,690,952
Pre-Payment Insurance Verification Medicare	510,666,478
Pre-Payment Review Sentinel Effect – Edit 1141	17,999,578
Prescription Serial Number Missing, Lost, Stolen, Altered	40,359,570
Provider ID/Service ID are the same – Edit 1357	575,904
Recipient Restriction	114,313,322
Service Date prior to Birth Date – Edit 102	776,508
Transportations Claims-Modifier Invalid for Submitted Procedure Code – Edit 927	2,136,473
Transportation Claims-Procedure Code Modifier Missing – Edit 1344	54,116
Transportation Service Performed During Inpatient Stay – Edit 02062	32,409
Total	**$ 1,794,748,488**

CONCLUSION

OMIG appreciates the opportunity to share the results of its Medicaid program integrity activities for 2014. Across all sectors of the Medicaid program, OMIG's provider education and outreach programs coupled with its comprehensive investigative efforts and success in identifying and recovering inappropriate Medicaid payments play a vital role in preventing and detecting Medicaid fraud and abuse while promoting the delivery of high-quality care to millions of New Yorkers. OMIG's commitment to preventing, detecting and rooting out fraud and abuse in the Medicaid program is unwavering.

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